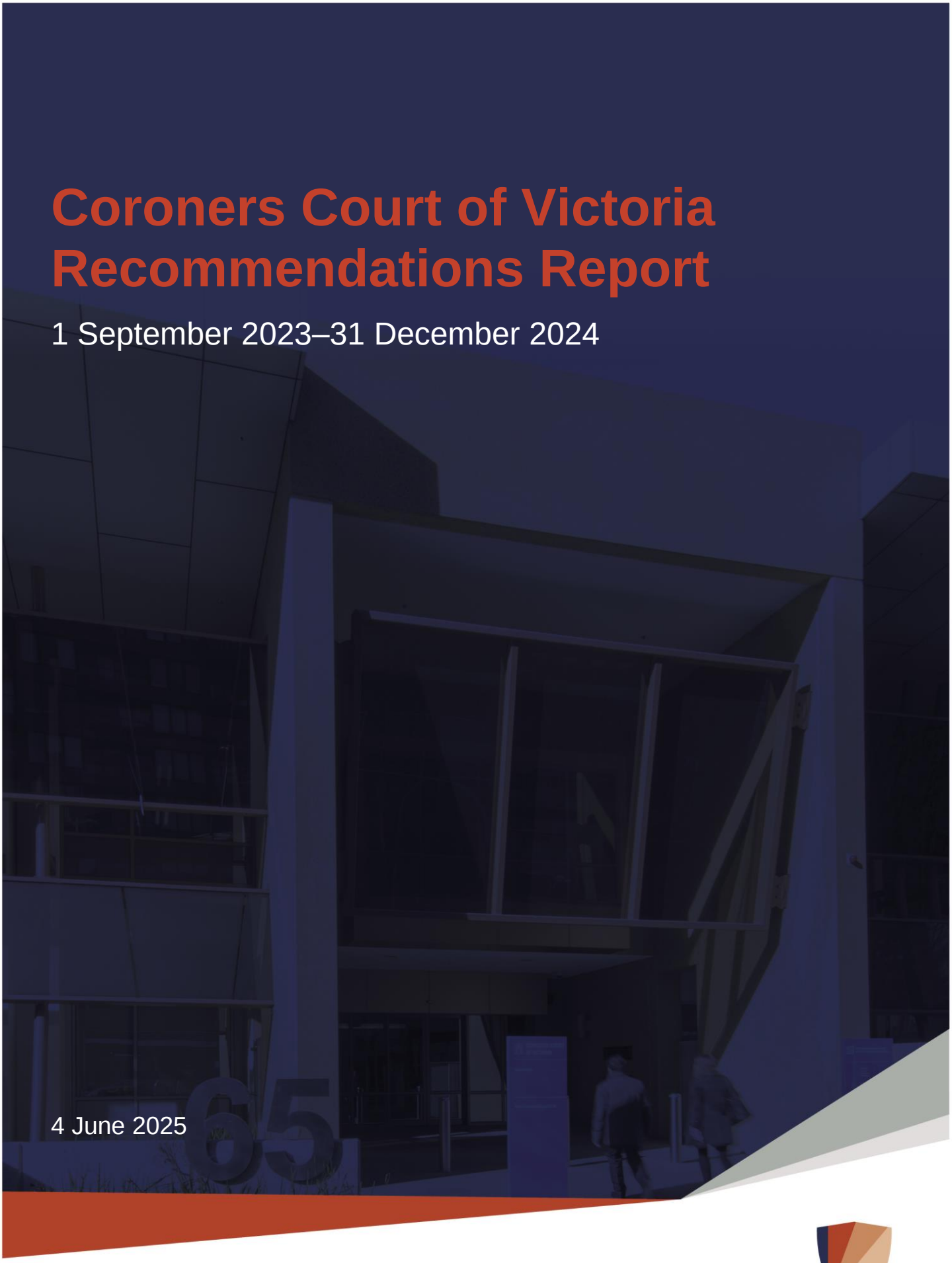
# Coroners Court of Victoria Recommendations Report

1 September 2023–31 December 2024



4 June 2025

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 on Aboriginal land in Victoria. Readers are warned that there are words and descriptions that may be culturally distressing.

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# 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 15 month period and the status of responses received.

This eighth edition covers the period from 1 September 2023 – 31 December 2024. During this period, coroners made 381 recommendations across 114 findings.

Following these recommendations, the Court received:

- 211 responses stating the recommendation was accepted in full.
- 56 responses stating the recommendation was accepted in part or an alternative was proposed.
- 81 responses stating the recommendation remains under consideration.
- 19 responses where the recommendation was not accepted.

In addition to these:

- 5 responses are still being prepared, have been granted an extension or were directed to entities that are not required to respond (awaiting response).
- 9 responses have not been received within the required time frame (overdue).

The report also contains a chapter on overdue responses reported since the first edition of this publication that remain outstanding. There is currently one response overdue across one finding in this category.

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

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

The status of responses received is accurate at 3 June 2025.

# Contents

# Suicide

## 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:<br><br>a. a detailed and current medication list including details of commencement date and dates of dose changes;<br><br>b. suggested frequency of monitoring the patient's mental state; and<br><br>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 Mr A

**Keywords:** Family Violence, Suicide, release from prison, mental health, substance use, criminal offending, posttraumatic stress disorder, child protection services, FVIO, risk assessment, risk management

| Recommendation | Response | Response outcome |
|---|---|---|
| With the aim of improvements to the administration of justice and preventing like deaths, I recommend that the Department of Justice and Community Safety and the Department of Families, Fairness and Housing review and update existing protocols between Justice Services and Child Protection to ensure that MARAM aligned information sharing, risk assessment and risk management activities take place prior to the release of offenders who are imprisoned for family violence related offenses and who pose a risk to children who have preexisting engagement with Child Protection. The departments should consider the circumstances of Mr A's death, including the lack of family violence risk assessment and management surrounding his release to an address across the road from Ms B, when updating these protocols. | Response from Department of Justice and Community Safety (DJCS)<br><br>Response from Department of Families, Fairness and Housing (DFFH) | Alternative adopted<br><br>Alternative adopted |
| With the aim of improvements to the administration of justice and preventing like deaths, I recommend that the Department of Justice and Community Safety also review the above existing protocols with the Department of Families, Fairness and Housing to ensure that other relevant frontline services including Victoria Police and the Orange Door are notified to proactively share risk information and provide additional supports to affected family members. | Response from Department of Justice and Community Safety (DJCS)<br><br>Response from Department of Families, Fairness and Housing (DFFH) | Alternative adopted<br><br>Alternative adopted |

## 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 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 |

## Finding into passing of Jason

**Keywords:** Family violence, suicide, mental health, FVIO

| Recommendation | Response | Response outcome |
|---|---|---|
| With the aim of promoting public health and safety and preventing similar deaths, I recommend that Family Safety Victoria:<br><br>(a) in consultation with the sector, develop a standardised safety plan template that must be completed with the victim-survivor and provided to security providers responsible for monitoring personal safety devices funded by the Personal Safety Initiative (PSI). This template must, at a minimum:<br><br>i. provide instruction on how the security provider should respond to the activation of a personal safety alarm when the victim-survivor and/or their contacts are unable to be reached; and<br><br>ii. a copy of the safety plan should also be provided to the victim-survivor and reviewed at regular intervals | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |
| (b) make changes to the Minimum requirements for auditing, installation and monitoring services to ensure that all security providers that are contracted to deliver monitoring services under the Personal Safety Initiative are required to have a copy of a victim survivor's completed safety plan template on file, as outlined in Recommendation 1(a) and that this must be followed by the security provider when a personal safety alarm is activated | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |
| (c) coordinate with the Australian Security Industry Association Limited (ASIAL) to develop an update to the National Police Alarm | Response from Department of Families, Fairness | Under consideration |

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|---|---|---|
| Response Guideline to provide clear instructions on when security providers are required to contact police following the activation of a Monitored Personal Safety Alarm by a user who has an alarm for family violence related reasons. Amendments to this document should include:<br><br>i. clear guidance on when activation of a Monitored Personal Safety Alarm should be considered 'validated', including in circumstances where the user cannot be contacted;<br><br>ii. the limitations of reviewing audio captured by a Monitored Personal Safety Alarm to determine risk to the users who are victim-survivors of family violence;<br><br>iii. explicit instructions that silent or non-violent audio captured by an activated Monitored Personal Safety Alarm is not an indication that the activation was invalid, and that further investigation is required to determine whether police should be contacted; and iv. requirements for security providers to check if a safety plan exists when a personal safety device is activated and to comply with the requirements of the safety plan, including contacting police even if there is no 'validated' response from the user | and Housing (DFFH) | |
| (d) review and update the policies Personal Safety Initiative – Minimum Technology Standards and Personal Safety Initiative – Minimum requirements for auditing, installation and monitoring services in accordance with the suggested amendments outlined above; and | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |
| (e) work with Statewide Personal Safety Initiative Coordinators to ensure that PSI coordinators are provided with guidance on the above amendments. The Statewide | Response from Department of Families, Fairness | Under consideration |

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|---|---|---|
| Personal Safety Initiative Coordinator should also collaborate with the PSI coordinators to ensure that case managers supporting victim-survivors to access personal safety alarms are aware of the limitations of the device and the limited circumstances in which security providers can call police upon activation of the alarm. | and Housing (DFFH) | |

## Finding into passing of Nathan Ruan Roy Greenwood

**Keywords:** Sodium nitrite, sodium nitrite toxicity, Amazon Australia, Sanctioned Suicides forum, mental health concerns, mental health care

| Recommendation | Response | Response outcome |
|---|---|---|
| That the Assistant Minister for Mental Health and Suicide Prevention; The Hon Emma McBride investigate in conjunction with other appropriate Ministers, Departments and Agencies of the Commonwealth ways to further restrict the online sale and distribution of Sodium Nitrite in Australia. | Response from the office of the Assistant Minister for Mental Health and Suicide Prevention | Accepted in full |

## Finding into death of Rohan Patrick Cosgriff

**Keywords:** Suicide, young person, sextortion, sexual extortion, image-based abuse, eSafety Commissioner, SnapChat

| Recommendation | Response | Response outcome |
|---|---|---|
| With the aim of preventing like deaths and promoting public health and safety, I recommend that Delia Rickard PSM consider the circumstances in which Rohan Cosgriff suicided and how these circumstances might inform the Statutory Review of the Online Safety Act 2021 (Cth), particularly with respect to combatting sextortion led by transnational crime syndicates. | Response from Department of Infrastructure, Transport, Regional Development, Communications and the Arts | Under consideration |

## Finding into death of HMI

**Keywords:** Suicide, depression, mental health, cannabis use, paranoia, medical treatment

| Recommendation | Response | Response outcome |
|---|---|---|
| I recommend the Royal Australian College of General Practitioners (RACGP) and the General Practice Mental Health Standards Collaboration (GPMHSC) consider incorporating into their educational material a focus on obtaining collateral information, where legally and ethically feasible, as a key step in facilitating comprehensive mental health assessment and treatment planning. | Response from General Practice Mental Health Standards Collaboration (GPMHSC)<br><br>Response from Royal Australian College of General Practitioners (RACG) | Accepted in full<br><br>Accepted in full |

## Finding into death of Bridget Flack; Finding into the death of Natalie Wilson; Finding into the death of Matt Byrne; Finding into the death of Heather Pierard; Finding into the death of AS

**Keywords:** Suicide, transgender, gender diverse, LGBTIQA+, access to mental health services, access to gender-affirming care, cultural safety and wellbeing, postvention supports, missing persons, Victoria Police.

| Recommendation | Response | Response outcome |
|---|---|---|
| That Victoria Police implement, as a matter of priority, all five recommendations contained in the Victoria Police Operational Safety Committee Incident review (OSCIR) relating to Bridget Flack's missing person investigation, dated 1 December 2021, including through amendments to the Law Enforcement Assistance Program (LEAP) or as otherwise deemed appropriate. These recommendations require that Victoria Police:<br><br>i. Develop a prompt sheet to guide members through the compilation of a missing person's report, including when to seek expert advice when the missing person is vulnerable or a member of a priority community;<br><br>ii. Review the missing person risk assessment to help identify risks specific to priority communities and vulnerable people, and to consider including 'LGBTIQA+' and/or specifically 'TGD' status as discrete factors to take into account in assessing risk;<br><br>iii. Review the electronic and hard copy missing person risk assessment forms, to achieve consistency between the two; and<br><br>iv. Review the 'Crime Investigative Guidelines – Missing Persons' and 'Missing Persons Squad - Initial Action Guide' to provide for specific procedures applicable to missing persons investigations occurring in | Response from Victoria Police | Accepted in part |

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| urban areas, including through reference to the application of the 'Victoria Police Practice Guide on Spontaneous Volunteers'; and<br><br>v. Develop a risk assessment matrix in line with risk status/factors, to provide greater clarity in determining what may constitute a 'serious threat to the life or health of a person', to assist informing the mobile phone triangulation decision making process in missing persons investigations. | | |
| That Victoria Police, under the guidance of experts from TGD community, make LGBTIQA+ awareness training mandatory for all police members and staff. Such training should include a TGD-specific component, addressing factors that can contribute to the risk of suicide in LGBTIQA+ and TGD communities, and the ways in which police members can appropriately assess and respond to such risks. | Response from Victoria Police | Accepted in full |
| That Victoria Police, in accordance with Priority Area 3 of 'Pride in our future: Victoria's LGBTIQA+ strategy 2022-32' progress, as a matter of priority, steps to improve data collection in relation to TGD people to capture all gender identities, by amending the Law Enforcement Assistance Program (LEAP) or as otherwise deemed appropriate. This should include amending the Form 83 'Police Report of Death for the Coroner' to include fields to capture all gender identities, to assist in improving the accuracy of data on deaths in the TGD communities, and specify a timeframe for this to be carried out | Response from Victoria Police | Under consideration |
| That the Attorney-General of Victoria, the Honourable Jacyln Symes, consider (or refer for the consideration of the Victorian Law Reform Commission) whether the | Response from the Office of the Attorney General | Under consideration |

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| current definition of 'senior next of kin' in section 3 of the Coroners Act 2008 can be reformulated to reduce the hurdles and distress it can create for the loved ones of LGBTIQA+ Victorians who die in reportable circumstances, including where they may be estranged from family members, while still allowing for the 'senior next of kin' to be 'identified quickly and with certainty'. | | |
| That the Victorian Department of Health, as lead, in conjunction with the Department of Families, Fairness and Housing and any other relevant Victorian Government departments, consider urgently increasing resourcing to meet the growing demand for publicly funded health services delivering gender-affirming care to TGD patients, in order to reduce the current waitlists and to support and expand the existing health workforce delivering such care. The Department may consider whether this should involve revision of the existing framework for delivery of gender-affirming healthcare and supports to TGD Victorians. | Response from Department of Health<br><br>Response from Department of Families, Fairness and Housing (DFFH) | Accepted in full<br><br>Accepted in full |
| That the Victorian Department of Health, under the guidance of experts from TGD communities, consider devising and implementing a statewide framework for the provision of culturally-appropriate care to TGD people in public hospitals and health services, including in rural and regional Victoria, with additional training to support staff in delivering culturally-appropriate care to TGD patients. | Response from Department of Health | Accepted in full |
| That the Victorian Department of Health, as lead, in conjunction with the Department of Families, Fairness and Housing and any other relevant Victorian Government departments, consider ongoing funding options available to ensure that TGD people and their families have appropriate | Response from Department of Health<br><br>Response from Department of Families, | Accepted in full<br><br>Accepted in full |

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| access to culturally appropriate: (i) social and emotional wellbeing supports; and (ii) suicide prevention, postvention and bereavement supports, as a means by which to address the high levels of suicidality, social exclusion and mental ill health in the TGD community. | Fairness and Housing (DFFH) | |
| That the Royal Australian College of General Practitioners (RACGP) and Royal Australian and New Zealand College of Psychiatrists (RANZCP), under the guidance of experts from TGD communities, develop and offer training and support to all healthcare professionals under their remits, including those who provide or want to provide care to TGD people, with the aim of ensuring cultural safety for TGD people accessing health services across these settings and which includes training on the factors that can contribute to the risk of suicide these communities. | Response from RACGP<br><br>Response from RANZCP | Alternative adopted<br><br>Alternative adopted |
| That the State Coroner of the Coroners Court of Victoria, Judge John Cain, under the guidance of experts from TGD communities, consider introduction of a LGBTIQA+ awareness training module, with a TGD-specific component, into the induction training for all staff and Coroners, specifically addressing the factors that can contribute to the risk of suicide in these communities. | Response from Coroners Court of Victoria | Accepted in full |
| That the Assistant Minister for Mental Health and Suicide Prevention, The Honourable Emma McBride, investigate in conjunction with other appropriate Ministers, Departments and Agencies of the Commonwealth, ways to further restrict the online sale and distribution of sodium nitrite in Australia, noting that three of the five deaths in the TGD suicide cluster were attributable to sodium nitrite toxicity. | Response from The Hon. Emma McBride | Accepted in full |

## Finding into deaths of Laurence John Cox & Ryley Ann Cox

**Keywords:** sodium nitrite toxicity, familial relationship, substance use, complex medical history

| Recommendation | Response | Response outcome |
|---|---|---|
| That the Assistant Minister for Mental Health and Suicide Prevention, The Hon Emma McBride MP, give consideration to the Findings into the deaths Without Inquest of Laurence Cox and Ryley Cox as part of any investigation regarding ways to further restrict the online sale and distribution of Sodium Nitrite in Australia. | Response from Assistant Minister for Mental Health and Suicide Prevention | Accepted in full |

## Finding into death of TK

**Keywords:** Mixed drug toxicity, overdose, young person, suicide, chronic suicidality, housing, Royal Commission into Victoria's Mental Health System, LGBTIQA+ supports, youth residential/recovery services, supported housing.

| Recommendation | Response | Response outcome |
|---|---|---|
| Noting that mental health and wellbeing services need to minimise the risk of harm to patients being discharged to sexually unsafe environments, I recommend the Office of the Chief Psychiatrist consider extending the 'Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units guideline' (2012) to incorporate managing situations whereby vulnerable patients may be discharged into environments whereby their sexual safety may be at risk. | Response from Chief Psychiatrist of Victoria | Accepted in full |

## Finding into death of Danielle Julie Kaye Thomson

**Keywords:** Chronic pain, mental health, substance use, suicide, complex medical history, withdrawal management, discharge planning

| Recommendation | Response | Response outcome |
|---|---|---|
| That the Suicide Prevention and Response Office of the Department of Health examine the relationship between chronic pain, mental illness, substance abuse and suicide to seek to identify strategies that may be available to address the clinical dilemma facing clinicians that people who experience chronic pain along with mental illness (and substance abuse) often do not respond effectively to treatment of their chronic pain. | Response from Department of Health | Accepted in full |
| The Suicide Prevention and Response Office liaise with the Commonwealth Department of Health and Aged Care regarding the National Strategic Action Plan for Pain Management to identify areas of mutual interest concerning the relationship between chronic pain, mental illness, substance abuse and suicide | Response from Department of Health | Accepted in full |

## Finding into death of DM

**Keywords:** Combined drug toxicity, complex medical history, mental health, prescription medication, chronic pain, medication overdose

| Recommendation | Response | Response outcome |
|---|---|---|
| That Western Health review its practices to ensure that discharge summaries for patients who have received treatment for self-harm are promptly prepared and forwarded to their General Practitioners as soon as possible. | Response from Western Health | Accepted in full |

## Finding into death of CL

**Keywords:** In-patient admission, risk assessment, discharge planning, mental health

| Recommendation | Response | Response outcome |
|---|---|---|
| That Northern Health review its accommodation support services provided to eligible patients after discharge from hospital, to ensure that they are available to be allocated towards accommodation that may be required subsequent to an intervening "step down" admission to the Prevention and Recovery Centre (PARC). | Response from Northern Health | Accepted in full |
| Northern Health review their discharge process for mental health in-patients, and associated policies and procedures, to ensure that they are consistent with the Chief Psychiatrist's guideline: Transfer of care and shared care and the Department of Health's guideline: Transfer of care from acute inpatient services. | Response from Northern Health | Accepted in full |
| Safer Care Victoria review Category 11 (Subcategory 4) of the Victoria sentinel event guide (Version 2) to consider explicit inclusion of suicide deaths that occur within 24 hours of discharge from an inpatient facility | Response from Safer Care Victoria | Accepted in full |
| Northern Health review their policies and procedures in relation to the reporting of Sentinel Events to ensure they are consistent with Safer Care Victoria's Victoria sentinel event guide (Version 2). | Response from Northern Health | Accepted in full |
| Northern Health review their policies and procedures in relation to their reporting obligations in response to patients who have died by suicide within 24 hours of discharge to ensure they are consistent with Safer Care Victoria's Adverse Patient Safety Event Policy. | Response from Northern Health | Accepted in full |

## Finding into death of EK

**Keywords:** Suicide, police contact death, suspect welfare considerations, health-led response, alleged sexual offences, SOCIT, train incident, multiple injuries

| Recommendation | Response | Response outcome |
|---|---|---|
| That the Secretary of the Department of Justice and Community Safety, in tandem with the Secretary of the Department of Health, explore the development of a program in contact with relevant health experts, to support mental health and coping mechanisms with the view to reduce suicidality among Victorian persons who are under investigation for alleged sexual offences. | Response from Department of Justice and Community Safety (DJCS)<br><br>Response from Department of Health | Under consideration<br><br>Under consideration |

## Finding into death of Zoran Alic

**Keywords:** In custody, Marngoneet Correctional Centre, suicide risk rating, psychiatric review, waitlist, prison mental health care

| Recommendation | Response | Response outcome |
|---|---|---|
| (a) That Justice Health collaborates with Forensicare to ensure that the timeframe measuring how long a prisoner has been waiting for a non-urgent psychiatric appointment, is: (i) measured in respect of every referral; and (ii) routinely available to the Regional Clinical Coordinator role that triages and schedules all referrals from primary mental health service providers; and<br><br>(b) That Justice Health collaborates with Forensicare and provides the appropriate training, knowledge transfer and support in respect of the functionality within JCare software that generates timeframe data between referral and psychiatric consultation for individual prisoners. | Response from Department of Justice and Community Safety (DJCS)<br><br>Response from Forensicare | Accepted in full<br><br>Accepted in full |
| (a) That Justice Health reviews resourcing of forensic mental health services at regional prisons to enable Forensicare to achieve compliance with a prescribed timeframe within which non-urgent referrals for psychiatric consultations are to occur (whether that be according to the current KRA 4.4 or any newly negotiated performance target); and<br><br>(b) That Justice Health, in consultation with primary health service providers and Forensicare, develops a clear process to ensure that:<br><br>a. A prisoner waiting for a non-urgent psychiatric consultation with the forensic mental health service, continues to be monitored and reviewed by the primary mental | Response from Department of Justice and Community Safety (DJCS)<br><br>Response from Forensicare | Accepted in full<br><br>Accepted in full |

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| health service provider, to ensure care is escalated to the forensic mental health service when clinically indicated; and<br><br>b. The above process should include that where a non-urgent referral for a psychiatric consultation does not occur within a prescribed timeframe or within a timely manner, the prisoner be re-reviewed by the primary health service provider. | | |

# Overdose and poisoning

## Finding into death of Mr SL

**Keywords:** Nitazenes, mixed drug toxicity, benzimidazole, opioids, new psychoactive substances, novel psychoactive substances, NPS, drug testing, drug checking, pill testing

| Recommendation | Response | Response outcome |
|---|---|---|
| As the appropriate arm of the Victorian Government, I recommend the Department of Health trial a drug checking service in the State of Victoria to gather evidence, experience and insights into how drug checking might reduce risks (including preventable deaths) associated with the use of drugs obtained from unregulated drug markets. " | Response from Department of Health | Accepted in full |

## Finding into death of KM

**Keywords:** Drug toxicity, unintentional overdose, high dose MDMA, music festival, drug checking, pill testing, drug testing

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

## Finding into death of LI

**Keywords:** SafeScript, real-time prescription monitoring, drug toxicity, opioid use disorder, factitious disorder, borderline personality disorder, young person, 'in care', 'prescription shopping', recommendation.

| Recommendation | Response | Response outcome |
|---|---|---|
| Following the expert evidence of Professor Ogden, I recommend that the Australian Commission on Safety and Quality in Health Care consider making compliance with real-time prescription monitoring a standard to be assessed under the National General Practice Accreditation Scheme. | Response from Australian Commission on Safety and Quality in Health Care | Accepted in full |
| I further recommend that the Victorian Department of Health develop, as a matter of priority, additional strategies to enhance its oversight and compliance role in relation to the checking of SafeScript, as well as to consider increasing the scope of application across the state, including by:<br><br>a) Working with the Royal Australian College of General Practitioners, Medical Board of Australia and the Pharmacy Board of Australia, along with medical indemnity insurers and any other identified stakeholders, to develop education and training tools for clinicians that focus on and promote the positive benefits of SafeScript, reinforce its role as a clinical tool for the clinician's own decision-making, and address the perception among some clinicians that SafeScript usurps their clinical judgment;<br><br>b) Continuing to consider the ways in which to surmount technological barriers to implementing SafeScript throughout hospitals in Victoria; and<br>c) Continuing to work with the Commonwealth Department of Health and Aged Care to implement | Response from Department of Health | Accepted in full |

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| cross-border data-sharing of real-time prescription monitoring | | |

## Finding into death of Loreta Maria Del Rossi

**Keywords:** Wild mushrooms, death cap mushrooms, foraging, amanita poisoning

| Recommendation | Response | Response outcome |
|---|---|---|
| That the Department of Health, in conjunction with the Victorian Poisons Information Centre, design and run an annual advertising campaign that can be released each autumn, to warn Victorians about the dangers of consuming wild mushrooms. | Response from Department of Health<br><br>Response from Victorian Poisons Information Centre (VPIC) | Accepted in full<br><br>Accepted in full |

# Medical

## Finding into passing of BCT

**Keywords:** 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:<br><br>a. Providing a clinical space with the relevant support staff for Interventional Radiology to review patients and gain informed consent before any procedures; and,<br><br>b. Providing Interventional Radiology a stand-alone bedcard with associated staff to facilitate all hours, in-house, and ward-based care.<br><br>c. Develop and implement a learning module on Cognitive Bias | Response from Monash Health | 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 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 |

## Finding into death of Alan Edward Stewart

**Keywords:** Colonoscopy, splenic injury, day procedure, patient discharge information, Nurse-on-Call, haemoperitoneum, ruptured spleen

| Recommendation | Response | Response outcome |
|---|---|---|
| That Melbourne Health review its written patient discharge information with the aim of:<br><br>(a) removing ambiguity concerning the appropriate emergency action to be taken in the event of serious symptoms such as breathing difficulties;<br><br>(b) including complete symptoms of significant internal haemorrhage among the group of serious symptoms requiring emergency action; and<br><br>(c) emphasising the significance of the post operative period when considering any symptoms. | Response from Melbourne Health | Under consideration |
| That Melbourne Health review its patient discharge procedures to ensure a record is kept of the discharge information provided to the patient. | Response from Melbourne Health | Accepted in full |

## Finding into death of Lilian Isabella Lister

**Keywords:** Ulcerated varicose vein, haemorrhage, venous insufficiency, peripheral arterial disease, venous bleeding

| Recommendation | Response | Response outcome |
|---|---|---|
| I recommend this simple first aid advice [*'You should lie down, raise your leg, and apply direct pressure to your wound. Seek immediate medical advice if this does not stop the bleeding.'*] should be broadly communicated to the general public via public health channels, including the Better Health website. | Response from Department of Health | Alternative adopted |

## Finding into death of Antonios Myrianthopoulos

**Keywords:** Pulmonary thromboembolism, deep vein thrombosis, complex medical history, therapeutic anticoagulation, VTE prophylaxis

| Recommendation | Response | Response outcome |
|---|---|---|
| i) I recommend that Western Health:<br><br>a. Develop an anticoagulant stewardship program. | Response from Western Health | Accepted in full |
| b. Complete their review of administration practices at the time of registration of patients by clerical staff to ensure that they comply with the relevant procedures and policies. | Response from Western Health | Accepted in full |
| c. Review their policies and practice around the provision of timely discharge summaries and advice to general practitioners to ensure that essential information regarding ongoing management requirements is communicated in a clinically appropriate timeframe. | Response from Western Health | Accepted in full |
| d. Take steps to ensure that written advice is provided to patients and their carers regarding important medication, care, and follow-up plans. | Response from Western Health | Accepted in full |
| e. Review their VTE prevention guidelines against the suggested state-wide guideline from Safer Care Victoria and the facts of this case. | Response from Western Health | Accepted in full |

## Finding into death of Adelaide Wilson

**Keywords:** Type-II Myocardial Infarction, iSTAT, Point-of Care-Testing, point-of-care testing, cardiogenic shock, coronary artery disease, hypertension, high cholesterol

| Recommendation | Response | Response outcome |
|---|---|---|
| I recommend that Abbott point of care diagnostics consider a software update for iSTAT-1 machines that includes reference ranges, interpretation of result and other cognitive aids. | Response from Abbott Point of Care Diagnostics | Accepted in full |
| I recommend that CAH and Australian Clinical Labs reconsider a point-of-care testing machine whose print-out/interface contains reference ranges and other cognitive aids | Response from Australian Clinical Labs<br><br>Response from Colac Area Health | Rejected in full<br><br>Under consideration |
| I recommend that Safer Care Victoria consider distributing the learnings of case to health services that utilize i-STAT-1 machines. | Response from Safer Care Victoria | Rejected in full |
| I recommend that the National Association of Testing Authorities and the National Pathology Accreditation Advisory Council consider whether current guidelines for point-of-care testing should be changed so that biological reference intervals or clinical decision values be included on point-of-care testing printouts as well as final reports | Response from National Association of Testing Authorities (NATA)<br><br>Response from National Pathology Accreditation Advisory Council (NPAAC) was expected by 15 July 2024. No response has been received to date. | Under consideration<br><br>Overdue |

## Finding into death of Trevor Lindsay Jones

**Keywords:** Ruptured abdominal aortic aneurysm, groin pain, back pain, nausea, hypertension, diabetes, Victorian Health Incident Management System, misdiagnosis, missed opportunity

| Recommendation | Response | Response outcome |
|---|---|---|
| I recommend that Mr Jones' case be used for educational purposes as a case study for Emergency Department staff. | Response from Bairnsdale Regional Health Service was expected by 30 August 2024. No response has been received to date. | Overdue |
| I recommend that Safer Care Victoria consider whether further guidance is required to clarify the types of events (such as misdiagnosis leading to patient harm) that should be reported as adverse patient safety events, and which should be registered with the Victorian Health Incident Management System and formally investigated. | Response from Safer Care Victoria | Accepted in full |

## Finding into death of Joshua Paul Coates

**Keywords:** Aortic dissection, warfarin care plan, clinical communication, mechanical aortic valve replacement, remote reconstruction of the ascending aorta, complex medical history

| Recommendation | Response | Response outcome |
|---|---|---|
| That Monash Health and Dorevitch Pathology consider reviewing the process within their respective clinical information systems, particularly for discharged patients and outpatients, such that:<br><br>a. it is user-friendly in a way that allows staff to accurately capture patients' information; and<br><br>b. it is consumer-friendly in a way that allows patients and/or carers to swiftly raise clinical concerns about ongoing care. | Response from Monash Health<br><br>Response from Dorevitch Pathology was expected by 17 September 2024. No response has been received to date. | Accepted in full<br><br>Overdue |

## Finding into death of Denise Lucina Roberts

**Keywords:** Missed appointment, patient follow-up, notification protocol, bronchopneumonia, emphysema, ischaemic heart disease

| Recommendation | Response | Response outcome |
|---|---|---|
| That North Richmond Community Health review its practice to ensure that arrangements made between clinicians and a patient's next of kin regarding notification in the event of a patient's non-attendance at appointments are recorded in the patient's records. | Response from North Richmond Community Health | Accepted in full |

## Finding into death of Victor Dale Fenech

**Keywords:** Metastatic colorectal carcinoma, complex medical history, ESTA, Ambulance Victoria, Computer Aided Dispatch System (CAD), Refcomm

| Recommendation | Response | Response outcome |
|---|---|---|
| That Triple Zero Victoria consider mechanisms to confirm the type of dwelling, or that additional address information is required, when verifying the address of an event to prompt direct questioning of this information. | Response from Triple Zero Victoria | Accepted in full |
| That Ambulance Victoria, in consultation Triple Zero Victoria, consider:<br><br>(a) providing information in closing scripts about when to call Triple Zero again in cases where callers are expecting a call back from another health professional, including what to do if the call back does not occur; and<br><br>(b) reinstating the inbound call warm transfer process as the primary means of facilitating secondary triage. | Response from Triple Zero Victoria<br><br>Response form Ambulance Victoria | Accepted in full<br><br>Accepted in full |

## Finding into death of Abraham Sleiman Transcendo

**Keywords:** Subarachnoid haemorrhage, ruptured aneurysm, 000, hospital transfer, MICA, time-critical neurological emergency

| Recommendation | Response | Response outcome |
|---|---|---|
| That Adult Retrieval Victoria implement policy and procedure which will achieve the following outcomes:<br><br>a) Early dispatch of paramedics for time-critical cases whilst sourcing and/or confirming the appropriate destination or hospital to expedite transfer.<br><br>b) Development of clear criteria for ARV coordinators to define time-critical neurosurgical emergencies to the closest centre without having to call for bed availability.<br><br>c) Development of processes which will ensure a referrer contacts ARV initially for time critical neurosurgical cases. | Response from Ambulance Victoria | (a) Under consideration<br><br>(b) Under consideration<br><br>(c) Alternative adopted |
| That Adult Retrieval Victoria consider the submission of a business case for more available ARV resources and a 24-hour ARV ambulance and crew. | Response from Ambulance Victoria | Alternative adopted |

# Transport and Road Safety

## 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)<br><br>Response from Department of Transport and Planning | Accepted in Full<br><br>Accepted in full |

## Finding into death of Martin Lui

**Keywords:** Electric scooter, head injury, e-scooter, collision, water drainage culvert, transporting PVC piping, head injury

| Recommendation | Response | Response outcome |
|---|---|---|
| That the Transport Accident Commission consult with the Department of Transport on how best to improve community education about the conditions and requirements for the safe riding of e-scooters. | Response from Transport Accident Commission (TAC) | Accepted in full |

## Finding into the deaths of Ian Perry, Dean Neal, Sashi Vasudeva, Paul Troja, Linda Woodford

**Keywords:** Helicopter incident, flight planning, instrument meteorological conditions, Mount Disappointment, clouds, reduced visibility, collision, flight rules, poor weather conditions, instrument flight training

| Recommendation | Response | Response outcome |
|---|---|---|
| CASA amend CASR (Part 133) to introduce a mandatory instrument flying component (including recovery from IIMC events) to the requirements for a commercial pilot licence for helicopters carrying passengers, together with a requirement for such training to be included in proficiency checks conducted by operators. | Response from Civil Aviation Safety Authority (CASA) | Alternative adopted |

## Finding into death of Pramod Acharya

**Keywords:** Motor vehicle collision, wildlife hazard, regional area, rural roads

| Recommendation | Response | Response outcome |
|---|---|---|
| That Regional Roads Victoria conduct a safety review of the Princes Highway in the Pomborneit area, with particular consideration to be given to the display of advisory wildlife warning signs. | Response from Regional Roads Victoria was expected by 14 November 2024. No response has been received to date. | Overdue |

## Finding into death of Angus Collins

**Keywords:** Cyclist, traffic signals, intersection design, truck collision, road works, construction, changed traffic conditions, reported safety concerns, restricted visibility

| Recommendation | Response | Response outcome |
|---|---|---|
| That the Department of Transport and Planning consult with relevant authorities to formulate and implement a public safety campaign to highlight the risks that exist at intersections between left turning vehicles and cyclists that are travelling straight ahead, and to clearly set out the law as to who has right of way. | Response from Department of Transport and Planning | Accepted in full |
| That the Department of Transport and Planning consider amending its contract arrangements for road works carried out pursuant to a Worksite Traffic Management Plan so that serious risks to the safety of road users (including cyclists) which are identified in a Road Safety Audit are required to be “closed” by an independent road safety auditor, not the contractor that has been retained to carry out the works. | Response from Department of Transport and Planning | Alternative adopted |

## Finding into death of Peigi Frances Hudson

**Keywords:** Motor vehicle collision, tree impact, roadside hazards, rural roads, falling tree

| Recommendation | Response | Response outcome |
|---|---|---|
| That Transport for Victoria and the Municipal Association of Victoria consider coordinating with rural Shire and City Councils, particularly those with a large tree stock near rural roads, to conduct regular public information campaigns to highlight the importance of reporting by members of the public of dangerous trees (and other roadside hazards), and the avenues available for such reporting. | Response from Department of Transport and Planning<br><br>Response from Municipal Association of Victoria | Accepted in full<br><br>Accepted in full |

## Finding into death of Noraishah Binti Ismail

**Keywords:** motor vehicle collision, GPS navigation, phone use, stop sign, intersection, driver distraction, speed limit

| Recommendation | Response | Response outcome |
|---|---|---|
| That MRCC reduce the speed limit at the intersection of Paschendale Avenue and Fifth Street, having regard to the concern raised by Victoria Police that the speed limit is inappropriate. | Response from Mildura Rural City Council | Alternative adopted |

## Finding into the deaths of Christiaan Gobel, Pasinee Meeseang, Ido Segev, Peter Phillips

**Keywords:** aircraft incident, aircraft crash, Mangalore, mid-air collision, air traffic control, short term conflict alert (STCA), instrument meteorological conditions, ADS-B technologies

| Recommendation | Response | Response outcome |
|---|---|---|
| I recommend that CASA develop and disseminate educational material for the aviation industry aimed at reinforcing the importance of accurate departure calls being made by pilots in command of aircraft. It is a matter for CASA to determine the process by which the educational material is disseminated to the aviation industry. | Response from Civil Aviation Safety Authority (CASA) | Accepted in full |
| Airservices, in anticipation of harmonisation of operating requirements for Brisbane ATSC and Melbourne ATSC, provide additional training to ATCs on managing and responding to STCAs within 5 nautical miles of aerodromes with similar aircraft movements to Mangalore. | Response from Airservices Australia | Accepted in full |
| Airservices should consider providing additional training to current and prospective Air Traffic Controllers on the use of velocity vectors in Class G airspace. It is a matter for Airservices to determine how this training is developed and facilitated. | Response from Airservices Australia | Accepted in full |
| I recommend that the ATSB, AMSA and CASA continue to work together to promote the voluntary uptake of ADS-B technology in Australian-registered aircraft. It is a matter for the ATSB, AMSA and CASA to determine how to best promote this initiative in the aviation industry. | Response from Australian Transport Safety Bureau (ATSB)<br><br>Response from Civil Aviation Safety Authority (CASA) | Accepted in full<br><br>Accepted in full |

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|---|---|---|
| I recommend that CASA conduct a cost-benefit study into the feasibility and potential benefits of requiring the installation of ADS-B IN devices in IFR-certified aircraft. | Response from Civil Aviation Safety Authority (CASA) | Under consideration |
| I recommend that the Minister for the Commonwealth Department of Infrastructure give consideration to expanding the ADS-B rebate program to extend to Australian registered IFR aircraft. | Response from Department of Infrastructure | Accepted in full |

## Finding into death of Laurence Maxwell Attwood

**Keywords:** Road safety, pedestrian safety, motor vehicle collision, Warrigal Road, head injury

| Recommendation | Response | Response outcome |
|---|---|---|
| With the aim of promoting public health and safety and preventing like deaths, I recommend that the VicRoads review the design of the relevant section of Warrigal Road, Hughesdale, in light of the circumstances of this collision and consider improving the existing infrastructure with a view to enhancing pedestrian safety and accessibility. | Response from Department of Transport and Planning | Accepted in full |
| With the aim of promoting public health and safety and preventing like deaths, I recommend that the City of Monash consider developing and implementing a local education campaign directed at pedestrians in their catchment areas. | Response from City of Monash | Accepted in full |

## Finding into death of KLH

**Keywords:** tram, pedestrian, collision, tram warning gong, safety zones, intersection

| Recommendation | Response | Response outcome |
|---|---|---|
| Yarra Trams carry out works to Stop 117 to ensure that it complies with the requirements under the definition of 'safety zone' pursuant to Regulation 162(2)(a) and (b) of the Road Safety Road Rules 2017 | Response from Yarra Trams | Alternative adopted |
| Yarra Trams' amend its safety management system, to require trams travelling through occupied pedestrian crossings adjacent to tram stops classified as 'safety zones' to restrict their speed to a maximum speed of 20 kilometres per hour. | Response from Yarra Trams | Alternative adopted |

## Finding into death of Leslie Taylor

**Keywords:** motor vehicle collision, head injury, pedestrian

| Recommendation | Response | Response outcome |
|---|---|---|
| That Brimbank City Council and Head, Transport for Victoria review the adequacy of the street lighting along the Ballarat Road Service Road in the vicinity of the site of the collision to ensure safe levels of illumination for pedestrians, motorists and other road users. | Response from Brimbank City Council<br><br>Response from Department of Transport and Planning (DTP) | Rejected in full<br><br>Under consideration |

## 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:<br><br>a. Repainting the traffic island;<br><br>b. Replacement of the cats eyes; and<br><br>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 Mr LM

**Keywords:** pedestrian crossing, mobility scooter, train crossing, collision, alcohol intoxication

| Recommendation | Response | Response outcome |
|---|---|---|
| That Metro Trains Melbourne review the condition of the Smeaton Avenue Pedestrian Crossing to determine whether it requires remedial works to ensure the safety of the public. | Response from Metro Trains Melbourne | Accepted in full |

## Finding into death of Gaurav Malhotra

**Keywords:** train overrun, pedestrian, intoxication

| Recommendation | Response | Response outcome |
|---|---|---|
| With the aim of preventing like deaths and promoting public health and safety, I recommend that the Department of Transport and Planning and Metro Trains Melbourne consider installing anti-trespasser fencing along the railway line at South Crescent in Northcote | Response from Metro Trains Melbourne<br><br>Response from Department of Transport and Planning | Rejected in full<br><br>Rejected in full |

## Finding into death of Zulfiqar Ali Hosseini

**Keywords:** pedestrian, motor vehicle collision, child

| Recommendation | Response | Response outcome |
|---|---|---|
| That the Victorian Government, in consultation with the Greater Dandenong Council, improve pedestrian access to and from Dandenong Stadium and consider installing traffic lights at the intersection of Stud Road, Dandenong North and the unnamed road leading to Dandenong Stadium. | Response from Department of Transport and Planning<br><br>Response from Greater Dandenong Council | Alternative adopted<br><br>Alternative adopted |

# 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 passing of Michael Suckling

**Keywords:** Death in custody, custodial healthcare system, obesity, cardiomegaly, natural causes, Ravenhall Correctional Centre, First Nations healthcare

| Recommendation | Response | Response outcome |
|---|---|---|
| 1. That the Department of Justice and Community Safety update the Justice Health Quality Framework 2023 to reflect that the principle of equivalency of care should be: a) Measured in terms of health outcomes in addition to accessibility and availability of health services; and b) For Aboriginal prisoners, measured against the types of services provided by Aboriginal Community Controlled Health Organisations (ACCHOs) rather than those of mainstream health providers. | Response from Department of Justice and Community Safety (DJCS) | Accepted in part |
| 2. That the Department of Justice and Community Safety update the Justice Health Quality Framework 2023 to reflect the recommendations of the Equally Well Consensus Statement. | Response from Department of Justice and Community Safety (DJCS) | Accepted in full |
| 3. That the Department of Justice and Community Safety ensure that the standard comprehensive medical and psychiatric reception assessment processes are structured to apply to all newly-received prisoners, regardless of entry points. Where a prisoner is received via a non-reception prison, Corrections Victoria will ensure that notice is provided to: (i) the contracted prison manager (if applicable); (ii) the primary health service provider; and (iii) Forensicare, that comprehensive medical and psychiatric assessments are required to be arranged within 24 hours for a particular prisoner. | Response from Department of Justice and Community Safety (DJCS) | Accepted in full |

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| 4. That Justice Health work with Forensicare, Correct Care Australasia (CCA), GEO and St Vincents Correctional Health Services (SVCHS) to ensure access to therapeutic counselling / psychologists is provided at all prisons in Victoria without being tethered to offender management programs. | Response from Department of Justice and Community Safety (DJCS) | Under consideration |
| 5. That Justice Health prepare and circulate a guideline or bulletin to all Health Service Providers for people in Victorian prisoners to remind prison-based clinicians that:<br><br>a) weight measurements should be confirmed via scales as far as reasonably practicable and witnessed by clinicians, unless reasons otherwise exist which should be documented.<br><br>b) records should clearly indicate whether a weight measurement has been recorded using standing scales, or has been self-reported. | Response from Department of Justice and Community Safety (DJCS) | Alternative adopted |
| 6. That Justice Health, in conjunction with all Health Service Providers, ensure there is a policy or operating instruction addressing multidisciplinary case management for prisoners with complex health issues, including:<br><br>a) clear referral criteria for identification of complex cases and inclusion in complex case management meetings;<br><br>b) that one of the criteria for multidisciplinary referral is obesity, where the prisoner has a BMI is above 35 (Class II obesity), or where girth measurement places a patient in a high risk category, and where the patient has at least one comorbidity, unless otherwise clinically indicated; | Response from Department of Justice and Community Safety (DJCS) | Accepted in full |

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| c) when the above criteria at (b) are met but the prisoner is not referred to multidisciplinary case management, the clinical rationale should be documented. | | |
| 7. That Justice Health mandates a requirement for primary health service providers in prisons that:<br><br>a) a prisoner who is prescribed psychotropic medication should be screened for cardiometabolic risks; and<br><br>b) where significant or rapid weight gain occurs which, in the opinion of the clinician, increases the individual prisoner's cardiometabolic risk profile this triggers reassessment. | Response from Department of Justice and Community Safety (DJCS) | Accepted in full |
| 8. That Justice Health makes modifications necessary in J-Care to allow for the following:<br><br>a) Inclusion of details in J-Care that indicate the full name, role, discipline and employer of clinicians;<br><br>b) Add in fields or drop-down options to accurately record reasons for non-attendance;<br><br>c) Development of fields to record height, weight, waist circumference and calculation of BMI; | Response from Department of Justice and Community Safety (DJCS) | Accepted in full |
| 9. That Justice Health explore the feasibility of developing the following:<br><br>a) a prompt for cardiometabolic monitoring in relation to patients on psychotropic and other weight-gaining medications; and<br><br>b) a system to ensure that Gateway and J-Care can interact to capture patient referrals and follow-up. | Response from Department of Justice and Community Safety (DJCS) | Under consideration |

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| 10. That Justice Health ensure all Aboriginal passings in custody give rise to a Root Cause Analysis coordinated by the primary health care provider in conjunction with any secondary or tertiary health services involved in the patient's care. | Response from Department of Justice and Community Safety (DJCS) | Accepted in full |
| 11. That Health Service Providers proactively consult with ACCHOs to explore further opportunities for ACCHOs to provide in-reach services for Aboriginal prisoners | Response from GEO Group<br><br>Response from St Vincent's Hospital Melbourne<br><br>Response from Forensicare<br><br>Correct Care Australasia was expected to respond by 13 March 2025. No response has been received to date. | Accepted in full<br><br>Accepted in full<br><br>Accepted in full<br><br>Overdue |
| 12. That Health Service Providers, in circumstances where an Aboriginal Health Worker position remains vacant for more than 3 months, ensure an ACCHO is contacted to determine if it is possible for the ACCHO to provide in-reach services until the vacancy is filled. | Response from GEO Group<br><br>Response from St Vincent's Hospital Melbourne<br><br>Response from Forensicare<br><br>Correct Care Australasia was expected to respond by 13 March 2025. No response has been received to date. | Accepted in full<br><br>Accepted in full<br><br>Accepted in full<br><br>Overdue |
| 13. That Justice Health, SCVHS, CCA and GEO work with the Yilam and the Aboriginal community to identify opportunities to increase the pool of potential Aboriginal Health Workers, with the view of having a | Response from Department of Justice and Community Safety (DJCS) | Accepted in full<br><br>Accepted in full |

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| minimum of one full-time equivalent AHW at every prison in Victoria. | Response from GEO Group<br><br>Response from St Vincent's Hospital Melbourne<br><br>Correct Care Australasia was expected to respond by 13 March 2025. No response has been received to date. | Accepted in full<br><br>Overdue |
| 14. That Health Service Providers, with support from DJCS as required, explore opportunities to provide the services of traditional healers for Aboriginal and Torres Strait Islander prisoners. | Response from GEO Group<br><br>Response from St Vincent's Hospital Melbourne<br><br>Response from Forensicare<br><br>Correct Care Australasia was expected to respond by 13 March 2025. No response has been received to date. | Accepted in full<br><br>Accepted in full<br><br>Accepted in full<br><br>Overdue |
| 15. That Health Service Providers ensure there is a policy or operating instruction addressing multidisciplinary case management for prisoners with complex health needs, including referral criteria. | Response from GEO Group<br><br>Response from St Vincent's Hospital Melbourne<br><br>Response from Forensicare<br><br>Correct Care Australasia was expected to respond by 13 March 2025. No response has been received to date. | Accepted in full<br><br>Accepted in part<br><br>Accepted in full<br><br>Overdue |
| 16. That Health Service Providers develop a policy or operating | Response from GEO Group | Accepted in full |

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| instruction that identifies that a Senior Clinician in the relevant prison health service is appointed responsible for organising a multidisciplinary meeting at regular intervals to ensure that complex cases are reviewed and discussed holistically, including specifically mental health and medication reviews, and a process for obtaining patient consent. | Response from St Vincent's Hospital Melbourne<br><br>Response from Forensicare<br><br>Correct Care Australasia was expected to respond by 13 March 2025. No response has been received to date. | Accepted in part<br><br>Accepted in full<br><br>Overdue |
| 17. That Health Service Providers consider developing additional KPI measurements that are outcome focussed rather than quantitative measurements. | Response from GEO Group<br><br>Response from St Vincent's Hospital Melbourne<br><br>Response from Forensicare<br><br>Correct Care Australasia was expected to respond by 13 March 2025. No response has been received to date. | Accepted in part<br><br>Accepted in part<br><br>Accepted in full<br><br>Overdue |
| 18. That Health Service Providers review current KPI measurements and assess them for unintended consequences that impact on quality of delivery as has previously been covered in recommendations in the CRACCS. | Response from GEO Group<br><br>Response from St Vincent's Hospital Melbourne<br><br>Response from Forensicare<br><br>Correct Care Australasia was expected to respond by 13 March 2025. No response has been received to date. | Accepted in part<br><br>Accepted in part<br><br>Accepted in full<br><br>Overdue |
| 19. That GEO educates its correctional staff about appropriate | Response from GEO Group | Accepted in full |

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| referral pathways for prisoners facing mental health or medical issues, including clarifying the role and function of the key clinician | | |
| 20. That GEO continue work on addressing the issue of weight gain amongst prisoners and ensure that an iteration of the Obesity Management Work Group becomes a permanent feature of the healthcare system at Ravenhall. | Response from GEO Group | Accepted in full |
| 21. That GEO undertakes a feasibility study in relation to obesity, comorbidities and complex case management interventions with a focus on determining the most appropriate level of obesity and the level and type of co morbidity for referral criteria. | Response from GEO Group | Under consideration |

## 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:<br><br>(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<br><br>(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 |

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

## Finding into death of Andrew David Berry

**Keywords:** Death in police custody, use of force, oleoresin capsicum foam, OC spray aftercare, transport of arrested person, drug intoxication (methylamphetamine), sympathomimetic syndrome, Victoria Police

| Recommendation | Response | Response outcome |
|---|---|---|
| That Victoria Police review all policies and manuals that relate to the aftercare of persons who have been subjected to OC foam to ensure clarity in all respects. Particularly, the relevant policies and manuals should:<br><br>(a) treat separately the concept of "aftercare" as active treatment of the effects of OC foam (for example, irrigation of the face and eyes), and the concept of "observation" of the subject person;<br><br>(b) provide greater clarity of the steps that may be taken when a subject refuses aftercare (or further aftercare) or no longer displays signs or symptoms of OC exposure;<br><br>(c) provide greater clarity regarding the permitted manner in which observation of the subject may be maintained, and for what period of time. | Response from Victoria Police | Alternative adopted |
| That Victoria Police review the equipment used for remote monitoring of persons in the custody pod of police vehicles to ensure that it provides an image of suitable size and quality to operate as the best possible aid to police members. | Response from Victoria Police | Accepted in full |

## Finding into passing of Stanley Gordon Turvey

**Keywords:** Police custody, Victoria Police, mental health, gunshot injury, drug use, firearm, lethal force

| Recommendation | Response | Response outcome |
|---|---|---|
| I recommend that the Chief Commissioner of Police continues to review the viability and feasibility of acquiring Body Worn Camera (or alternative technologies) facilitating the recording of the conduct of all Special Operations Group Operatives when deployed in an overt capacity; and | Response from Victoria Police | Accepted in full |
| Where an operationally viable technology is identified, I further recommend its implementation across the Special Operations Group including the review and amendment of Victoria Police policies and procedures as required. | Response from Victoria Police | Accepted in full |

## Finding into passing of Joshua Steven Kerr

**Keywords:** In custody, medical treatment, drug toxicity, observation, communication between correctional and medical staff, Code Black call, methylamphetamine, drug induced acute behavioural disturbance (ABD)

| Recommendation | Response | Response outcome |
|---|---|---|
| G4S and SVCHS staff receive training to assist them in recognising and managing drug affected prisoners, including those who may be experiencing ABD and drug toxicity, and its effect on their decision making capacity; | Response from St Vincent's Hospital Melbourne (SVHM)<br><br>Response from G4S Custodial Services Pty Ltd | Accepted in full<br><br>Accepted in full |
| SVCHS receive training about the practical application of the Acute Poisoning Management Guideline; | Response from St Vincent's Hospital Melbourne (SVHM) | Accepted in full |
| SVCHS staff receive training to reinforce their authority and responsibility to advocate for the treatment of prisoners in their care and to escalate where appropriate; | Response from St Vincent's Hospital Melbourne (SVHM) | Accepted in full |
| G4S TOG staff receive training about the importance of consulting with medical staff prior to cancellation of a medical escort; | Response from G4S Custodial Services Pty Ltd | Accepted in full |
| SVHM ED staff receive training about the limitations of providing medical treatment in prison; the benefit of communication of a prisoner's treatment plan with escorting correctional staff; and the importance of prompt preparation of a discharge summary including the treatment plan; | Response from St Vincent's Hospital Melbourne (SVHM) | Accepted in full |
| G4S staff receive training about the circumstances in which they can exercise individual discretion to allow medical staff to enter a cell to | Response from G4S Custodial Services Pty Ltd | Accepted in full |

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| provide a prisoner with medical treatment; and | | |
| Corrections Victoria develop and implement a training program, to be undertaken by correctional staff and medical staff together:<br><br>(a) to enhance their mutual understanding of each other's respective roles in Victoria's prison system; and<br><br>(b) to encourage a co-ordinated and cooperative relationship which recognises the respective roles and their corresponding authority in a way which reduces hierarchical barriers. | Response from Department of Justice and Community Safety (DJCS) | Accepted in full |

## Finding into death of Brian Richard Pope

**Keywords:** In custody, recent reception, disability, mental health, substance use, collateral information collection, clinical risk assessment

| Recommendation | Response | Response outcome |
|---|---|---|
| The DJCS Secretary, in conjunction with Justice Health, Corrections Victoria and any new Health Service Provider at the MRC:<br><br>i. Arrange for face-to-face reception assessments for quarantine patients; and<br><br>ii. Develop a policy and processes for the timely acquisition of collateral information to assist in the risk assessment and formulation of care plans for patients. | Response from Department of Justice and Community Safety (DJCS) | Accepted in part |
| That Justice Health oversee Health Service Providers in Victorian prisons developing a detailed procedure for the collection and storage of collateral information during reception health assessments. The procedure must:<br><br>i. set out staff roles and responsibilities;<br><br>ii. include a requirement to verify substance use (type and quantity) in a consistent manner (e.g., standard measure of alcohol units) with prisoners at the time of assessment;<br><br>iii. require staff to make appropriate efforts to collect information from family members to inform mental health assessments, recognising that this requires consent and acknowledging that this can be challenging where a family member is an alleged victim;<br><br>iv. set out an approach for gathering and using information about prisoners' offences and the impact on their relationships and future | Response from Department of Justice and Community Safety (DJCS) | Accepted in full |

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| planning to inform assessments and decisions made;<br><br>v. provide guidance on the actions that must be taken following the review of collateral information, including a review of the prisoner's risk rating and mental health care plan; and vi. ensure that any actions taken following a review of collateral information are recorded in JCare. | | |

## Finding into death of Jessica Anne Thomas

**Keywords:** In custody, suicide, mental health, gender diverse, gender identity, Dame Phyllis Frost Centre, complex medical history, mental health unit, asphyxia

| Recommendation | Response | Response outcome |
|---|---|---|
| That Corrections Victoria give consideration to developing a process that gives prisoners the option of allowing custodial staff to record a person's gender identity on the Prisoner Profile Screen within the Prisoner Information Management System. | Response from Department of Justice and Community Safety (DJCS) | Under consideration |

# 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 Berry Street Victoria (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)<br><br>Response from Department of Families, Fairness and Housing (DFFH) | Accepted in Full<br><br>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:<br><br>a. Workers are allocated dedicated, paid time to complete all required training modules;<br><br>b. Workers are assessed on their comprehension of training content; and | Response from Berry Street Victoria (BSV) | Under consideration |

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| 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 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:<br><br>a. Recognition and response to a deterioration in their state;<br><br>b. Management of an unconscious person;<br><br>c. When to commence CPR; and<br><br>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<br><br>Response from Department of Health | Rejected in Full<br><br>Rejected in Full |

## Finding into passing of Shane Anthony Pappas

**Keywords:** Sequential presentations to ED, mental health crisis, clinical management, Mental Health Act 2014, Inpatient Assessment Order, collapse in police presence, in care, complex medical history, police contact proximal to passing, suicide

| Recommendation | Response | Response outcome |
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| In the interests of preventing like deaths and promoting public health and safety in the mental health setting, I recommend that Grampians Health further update the MR980 Form (and, if necessary, make consequential amendment to the Clinical Practice Protocol – Intake Assessment – Mental Health dated 19/9/2022) to ensure that, in addition to prompting clinicians to consider the need to obtain collateral information (and providing a place to document it) under a heading 'Reported Mental Health Concerns of Consumer and/or Support Person(s),'<br><br>a. Efforts to obtain collateral information;<br><br>b. The success or otherwise of efforts to obtain collateral information;<br><br>c. The rationale for not attempting to obtain collateral information;<br><br>d. Collateral information relevant to the patient's psychiatric/medical/social history, current mental health symptoms, perceived risks, vulnerabilities and strengths (that is, information beyond "concerns") is sought and;<br><br>is documented. | Response from Grampians Health | Accepted in full |
| In the interests of preventing like deaths and promoting public health and safety, I recommend that Grampians Health conduct a review/audit (and, if necessary, periodic audit) of the following new practices and tools to ensure their | Response from Grampians Health | Accepted in full |

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| consistent use and identification of any barriers to their effective implementation: a. The creation by the CLT of a separate electronic mental health file for patients of the mental health service admitted to medical units to optimise continuity of care and “real time” access to records; and<br><br>b. The MR980 form (particularly as it – or any subsequent iteration – relates to obtaining collateral information from a patient’s family and/or carers and the documentation of efforts to obtain collateral information and that information). | | |
| In the interests of promoting public health and safety, I recommend that Grampians Health consider the need to adopt robust processes to ensure its staff are aware of new processes, guidelines or programs implemented following an In-depth Case Review or otherwise. | Response from Grampians Health | Accepted in full |

## Finding into death of Allison Leah Randall

**Keywords:** In Care, ensuite door design, prohibited items, inpatient, mental health, psychiatric care, CRAMM guidelines, observation conduct and frequency, delusional disorder, risk assessment

| Recommendation | Response | Response outcome |
|---|---|---|
| The Chief Psychiatrist consider the following with a view to promote consistency and sharing across Victorian mental health services,<br><br>The development of research ligature audit tools appropriate for Victorian public mental health services and identify or develop a standard ligature audit tool for consistent use across all Victorian public mental health services;" | Response from The Chief Psychiatrist | Accepted in full |
| Further, that state-wide implementation of such a tool should be accompanied by appropriate guidelines and training for staff in the effective use of the audit tool; | Response from The Chief Psychiatrist | Accepted in full |
| Assess whether the Chief Psychiatrist's guideline - Criteria for searches to maintain safety in an inpatient unit should be revised to include reference to a long-handled bag as an example of a dangerous item, or its implications should otherwise be the subject of a communication with the sector; and | Response from The Chief Psychiatrist | Accepted in full |
| The development of best practice information around what is considered appropriate ensuite door design in patient's rooms, noting in this case that a WorkSafe Improvement notice was issued, despite the facility's best endeavours to minimise a known risk. | Response from The Chief Psychiatrist | Accepted in full |

## Finding into passing of Jacob William Kennedy

**Keywords:** Involuntary inpatient, mental health, substance use, Inpatient Assessment Order, family consultation, cultural care, cultural safety, cultural awareness training, Aboriginal patient

| Recommendation | Response | Response outcome |
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| In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the MBA, as supported by the AHPRA, develop guidelines for treating clinicians working in inpatient psychiatric units to follow when prescribing or administering multiple medications to their patients which have a sedative effect. The guidelines should consider and admonish treating clinicians of the cumulative effect, if any, of multiple sedating medications. | Response from Australian Health Practitioner Regulation Agency (AHPRA) | Alternative adopted |
| In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the MBA, as supported by AHPRA, implement policy or protocol to admonish clinicians of the importance of adhering to health service provider guidelines aimed at ensuring that clinicians monitor sedated patients more closely and on a more frequent basis until they are ambulant. | Response from Australian Health Practitioner Regulation Agency (AHPRA) | Alternative adopted |
| In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the Nursing and Midwifery Board of Australia implement policy or protocol to admonish nursing staff of the importance of adhering to health service provider guidelines aimed at ensuring that nursing staff monitor sedated patients more closely and on a more frequent basis until they are ambulant. | Response from Australian Health Practitioner Regulation Agency (AHPRA) | Alternative adopted |
| In the interests of public health and safety and with the aim of | Response from Australian Health | Alternative adopted |

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| preventing like deaths, given the benefits of using an oximeter to monitor sedated patients in an inpatient psychiatric unit, as indicated by the evidence before me, I recommend that the MBA, as supported by AHPRA, consider implementing policy or protocol to advise clinicians to consider the benefits of using an oximeter to monitor heart rate and oxygen saturation levels of sedated patients. | Practitioner Regulation Agency (AHPRA) | |
| In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the MBA, as supported by AHPRA, develop guidelines to reflect the use of an oximeter as an achievable, practical and reasonable measure for clinicians to take in observing or monitoring sedated patients in inpatient psychiatric units. | Response from Australian Health Practitioner Regulation Agency (AHPRA) | Alternative adopted |
| In the interests of public health and safety and with the aim of preventing like deaths, I recommend that PH consider reviewing their policy or protocol to ensure compliance with the Monitoring Recommendations in their Guideline which mandate vital sign observations for sedated patients admitted to their inpatient psychiatric units. | Response from Peninsula Health | Accepted in full |
| AND FURTHER, in the interests of public health and safety and with the aim of preventing like deaths, I recommend that PH initiate and undertake regular staff training measures for its mental health care workers to ensure the enforcement of a uniform monitoring regime to observe the vital signs of sedated patients. | Response from Peninsula Health | Accepted in full |
| AND FURTHER, in the interests of public health and safety, I recommend that PH undertake an | Response from Peninsula Health | Under consideration |

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| external review of all policies and training that relate to culturally competent and safe care, to ensure that they are fit for purpose.<br><br>That review be led by an external, First Nations-identified individual or organisation.<br><br>PH implement the recommendations of that review.<br><br>PH introduce, and make publicly available on an annual basis, compliance monitoring for cultural competency and safety training, and statistics concerning complaints about the provision of such care | | |

## Finding into death of Russell Leslie James Hewat

**Keywords:** aspiration pneumonia, COVID-19, complex medical history, supported living, disabilities, NDIS

| Recommendation | Response | Response outcome |
|---|---|---|
| With the aim of promoting health and safety in the supported independent living disability sector where this vulnerable cohort are dependent on others for care, I recommend that Aruma Disability Services advance, without further delay, the implementation of a handover policy that is both rigorous and supports its workforce to effectively deliver handover between shifts by providing appropriate compensation to facilitate this handover crossover time. | Response from Aruma Disability Services | Accepted in part |
| With the aim of promoting health and safety in the supported independent living disability sector where this vulnerable cohort are dependent on Disability Support Workers who are not medically trained and hold only a basic First Aid Certificate, I recommend that Aruma Disability Services implement and mandate training on escalation - escalation on the type of situations and/or change in conditions that should be escalated by disability support workers. | Response from Aruma Disability Services | Accepted in full |

# Aged care

## Finding into death of Shirley Hill Jones

**Keywords:** Fracture, pressure injury, residential aged care, post discharge care, palliation, complex medical history, residential aged care, functional and cognitive decline, pain management

| Recommendation | Response | Response outcome |
|---|---|---|
| I recommend that Baptcare consider amending its Residential Aged Care 'Readmission from Hospital Checklist' to include a reference to confirming and documenting dates of planned follow-up care and future appointments. | Response from Baptcare | Accepted in full |

# Family Violence

## Finding into passing of BCJ

**Keywords:** Family violence, suicide, mental health, FVIO, risk assessment, Mental Health Act 2014, child protection services, intimate partner violence, suicidal ideation

| Recommendation | Response | Response outcome |
|---|---|---|
| With the aim of promoting public health and safety and preventing like deaths, I recommend that Family Safety Victoria review and update the guidelines for entities sharing information under the Family Violence Information Sharing Scheme to require that any risk information significantly altered within three days of being shared is proactively shared with the requesting entity. | Response from Department of Families, Fairness and Housing (DFFH) | Accepted in part |
| With the aim of promoting public health and safety and the administration of justice, I recommend that the Victorian Government ensure that all Specialist Family Violence Courts in Victoria have adequately-funded and resourced specialist legal and non-legal specialist family violence services on site to engage with both affected family members and respondents in an intervention order hearing to provide both legal and non-legal advice and support, including where Victoria Police is the applicant for an intervention order. | Response from Department of Premier and Cabinet | Under consideration |

## Finding into passing of RB

**Keywords:** Suicide, sexual assault, rape, mental health, posttraumatic stress disorder, impact of crime support, trauma informed approaches, Mental Health Act 2014, information sharing, suicidal ideation, FVIO, bail conditions

| Recommendation | Response | Response outcome |
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| That the Victoria Police FVCT update its operating procedures to include that, following the FVCT's initial approach to the victim survivor, police members are required to offer to make a referral to a trauma or specialist support service counsellor on behalf of the victim survivor. If the victim survivor agrees to a referral, the referral should be made as soon as practicable. This requirement should also apply in circumstances where investigators make a renewed approach to a victim survivor. | Response from Victoria Police | Accepted in full |
| With the aim of promoting public health and safety and the administration of justice, I recommend that the Victorian Government ensure that all Specialist Family Violence Courts in Victoria have adequately-funded and resourced specialist legal and non-legal specialist family violence services on site to engage with both affected family members and respondents in an intervention order hearing to provide both legal and non-legal advice and support, including where Victoria Police is the applicant for an intervention order. | Response from Department of Justice and Community Safety (DJCS) | Accepted in full |

## Finding into death of Caroline Anne Willis

**Keywords:** homicide, family violence, elder abuse, mental health, sharp force injuries, FVIO, knife, mental health, risk assessment, general practitioner, personal safety device

| Recommendation | Response | Response outcome |
|---|---|---|
| To improve processes related to public health and safety and the administration of justice, I recommend that Family Safety Victoria review processes for victim-survivors eligibility to access Safe at Home technology through the Personal Safety Initiative during high-risk periods immediately following family violence incidents and/or individual and police initiated FVIO applications. This includes consulting with Victoria Police Family Violence Command and the Magistrates Court of Victoria Family Violence Action Taskforce. | Response from Department of Families, Fairness and Housing (DFFH) | Accepted in full |

## Finding into death of TCW

**Keywords:** Adolescent family violence, family violence, homicide, manslaughter, sexual abuse, intellectual disability

| Recommendation | Response | Response outcome |
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| In line with the recommendations of the RCFV and ANROWS, I recommend that the Victorian Government develop additional crisis and longer-term supported accommodation options with attached therapeutic support for adolescents who use family violence in the home. The Victorian Government should also consider how this accommodation would be accessible to young people with a disability. | Response from Department of Families Fairness and Housing (DFFH) | Under consideration |
| That the Victorian Government review whether NDIS service providers in Victorian are equipped to work with young people who have a disability who also use AFV and provide resourcing and/or training to address any deficiencies. | Response from Department of Families Fairness and Housing (DFFH) | Alternative adopted |
| That the Victorian Government review the current Victorian AFV and AFVP service providers to determine whether they are equipped to work with young people who have a disability who also use AFV and provide resourcing and/or training to address any deficiencies. | Response from Department of Families Fairness and Housing (DFFH) | Under consideration |
| That the Victorian Government support ANROWS' calls for further research regarding people with disability who use family violence in order to build an evidence base for work in this area. | Response from Department of Families Fairness and Housing (DFFH) | Under consideration |

## Finding into death of Bekkie-Rae Curren

**Keywords:** Family violence, manslaughter, recent separation, homelessness, head injury, housing support, social housing, income support

| Recommendation | Response | Response outcome |
|---|---|---|
| In line with the recommendations of the Economic Inclusion Advisory Committee 2024 Report, the Commonwealth Government should review rates for Australian income support payments, with a particular focus on the needs of women and children experiencing family violence. | Response from Department of the Prime Minister and Cabinet | Accepted in full |
| That the Victorian Government implement the outstanding recommendations outlined by the Legal and Social Issues Committee Inquiry into Homelessness in Victoria and commit to investing in the establishment of adequate crisis accommodation to meet projected demands for victim survivors and perpetrators of family violence who leave or are removed from their home. | Response from Department of Families, Fairness and Housing (DFFH) | Accepted in full |
| That the Victorian Government implement the recommendations outlined by the Inquiry into the rental and housing affordability crisis in Victoria, with special consideration given to building 60,000 new public housing dwellings by 2034, in line with projected demands. | Response from Department of Families, Fairness and Housing (DFFH) | Alternative adopted |
| That the Victorian Government consider alternative ways of expanding social housing stock in Victoria, such as exploring incentives for landlords to lease their property at affordable rates. | Response from Department of Families, Fairness and Housing (DFFH) | Accepted in full |
| That the Victorian Government consider reserving a portion of public housing stock for perpetrators of family violence who have been removed from the family home, with | Response from Department of Families, Fairness | Alternative adopted |

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| the aim of increasing the safety of women and their children. | and Housing (DFFH) | |
| That the Victorian Government, in line with recommendations outlined by The rental and housing affordability crisis in Victoria and the Legal and Social Issues Committee Inquiry into Homelessness in Victoria, include the right to housing in the Victorian Charter of Human Rights and Responsibilities Act 2006 (Vic). | Response from Department of Justice and Community Safety (DJCS) is expected by 17 June 2025. | Awaiting response |

## Finding into death of Samantha Joy Fraser

**Keywords:** Homicide, family violence, family violence intervention order, FVIO breaches

| Recommendation | Response | Response outcome |
|---|---|---|
| That Family Safety Victoria consider the available evidence and consider including re-partnering and pending criminal date for criminal charges brought by the victim as risk factors to be considered in the MARAM. | Response from Department of Families, Fairness and Housing | Under consideration |
| That measures be taken by the APS and RANZCP to introduce family violence mandatory CPD for registered psychologists and psychiatrists to provide for an occupation-specific level of family violence understanding and referrals for further support where a patient/client is identified as experiencing or suspected to be experiencing family violence. | Response from Australian Psychological Society (APS)<br><br>Response from The Royal Australian and New Zealand College of Psychiatrists (RANZCP)<br><br>Response from Psychology Board of Australia | Alternative adopted<br><br>Accepted in full<br><br>Accepted in full |
| That FSV consider how the pilot program currently underway in Bayside, Peninsula and Barwon areas may respond to fixated threat perpetrators. | Response from Department of Families, Fairness and Housing | Accepted in full |

## Finding into passing of Noeline Michelle Dalzell

**Keywords:** family violence, sharp object, multiple offences, FVIO, child protection, support services, MARAM

| Recommendation | Response | Response outcome |
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| 1. That the Victorian Government investigate supplementing and enhancing the CIP to enable the multi-directional flow of information relevant to perpetrator risk among all relevant Departments and agencies in a way that is timely, proactive, complete and automated (where possible and appropriate to manage risk). | Response from Department of Families, Fairness and Housing (DFFH) | Alternative adopted |
| 2. The Victorian Government immediately formalise the sharing of CIP reports by approving Child Protection practitioners as requestors. | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |
| 3. Victoria Police (in conjunction with DJCS) develop a policy to ensure that any victim of family violence or an AFM in an active FVIO case is notified of a court outcome. It is desirable for Victoria Police to notify all victims and AFMs in an active FVIO, however I consider it essential that in cases where an offender is considered high risk, that this notification occur within 48 hours. | Response from Victoria Police | Rejected in full |
| 4. If Recommendation 3 is accepted, the Victorian Government investigate enhancement to the CIP to include a capability that the release of a FV offender (from prison, police cells or directly from a court) triggers an automated notification of that information to all other agencies. | Response from Department of Families, Fairness and Housing (DFFH) | Rejected in full |
| 5. Victoria Police and The Orange Door in two regions as a pilot collaborate to embed advanced family violence practitioners within | Response from Victoria Police | Under consideration<br><br>Under consideration |

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| each FVIU to assess, jointly respond to and manage repeat and/or high-risk family violence matters and improve proactive victim/AFM engagement. I note the complexity of placing a Family Violence Practitioner within the structure of a statutory organisation such as Victoria Police and acknowledge that this will need to be a senior worker with extensive experience and provided with supervision by a specialist family violence service.<br><br>An independent evaluation of the pilot program should be completed within two years of commencing operation in each of the two regions selected. | Response from Department of Families, Fairness and Housing (DFFH) | |
| 6. Victoria Police engage an external independent suitably qualified person to conduct an evaluation of the effectiveness and skillset of the FVIUs. The review ideally should be conducted prior to the rollout of the CPRM to provide valuable benchmarking information to assist in the evaluation of the CPRM program which has been foreshadowed by the Chief Commissioner of Police in his submissions. | Response from Victoria Police | Under consideration |
| 7. DJCS and DFFH take immediate steps to complete work on recommendation 2 of the Multi-Agency Review and identify who is to take the leadership role, including identifying and implementing a central contact person or agency with responsibility for coordinated oversight of family violence perpetrators, affected family members, and associated service providers. Given the rate of family violence perpetrated on First Nations women and children, this approach needs to include First Nations community organisations, | Response from Department of Justice and Community Safety (DJCS)<br><br>Response from Department of Families, Fairness and Housing (DFFH) | Alternative adopted<br><br>Alternative adopted |

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| and incorporate expertise from those with lived experience. | | |
| 8. Victoria Police make PTMI and MRTs for high-risk family violence offenders accessible to uniform police members who respond to family violence incidents. | Response from Victoria Police | Rejected in full |
| 9. That the Attorney General consider a reference to the VLRC to consider legislative amendment in order to expand the Serious Offenders Act 2018 scheme to encompass serious repeat family violence offenders who pose an ongoing and high risk of violence to AFMs | Response from the office of the Attorney-General | Under consideration |
| 10. DJCS Corrections Victoria work in partnership with Court Services Victoria to investigate a fast-track procedure for processing family violence offenders when they plead guilty to an offence that breaches a CCO imposed for family violence offending. Consideration be given to:<br>• Enabling service of charge-sheet and summons prior to release;<br>• Facilitating an assessment with the offender, where possible, to assess reasons for non-compliance and suggested options for improving compliance (i.e., offender might not have transportation options or housing stability); and<br>• Empowering the judicial officer hearing the plea for the breaching offence to amend the CCO order in any way that the Court considers necessary to mitigate the risk of further offending during the period of delay until the determination of the CCO breach proceeding. Such powers to include for example, geographical exclusion orders. | Response from Department of Justice and Community Safety (DJCS) | Accepted in full |

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| 11. Corrections Victoria implement a digital, non-paper-based system for Corrections warrants that will enable them to be processed without relying on mail or DX. | Response from Department of Justice and Community Safety (DJCS) | Under consideration |

## Finding into death of Thi Minh (Sophie) Nguyen

**Keywords:** Family violence, mixed drug toxicity, suicide, child protection, mental health

| Recommendation | Response | Response outcome |
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| The Victorian Government urgently increase the total quantum of primary prevention funding and prioritise longer term funding across the primary prevention system, including multi-year funding for organisations leading prevention activities, and stable, ongoing funding for Respect Victoria | Response from Department of Families, Fairness and Housing | Accepted in full |
| The Federal Government commit to long term funding for the development and maintenance of critical infrastructure for the primary prevention of violence against women and family violence as well as for those agencies that play a key role in influencing the quality, reach, impact and coordination of prevention activities at a national level, as outlined by Our Watch in Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia. These include:<br><br>a. Our Watch (to provide independent national leadership on primary prevention)<br><br>b. Australia's National Research Organisation for Women's Safety (ANROWS) (to deliver the National Community Attitudes towards Violence against Women Survey and the prevention elements of the national research agenda)<br><br>c. Australian Bureau of Statistics (to deliver the Personal Safety Survey)<br><br>d. Workplace Gender Equality Agency | Response from Department of the Prime Minister and Cabinet | Accepted in full |

# Child/infant deaths

## Finding into passing of XY

**Keywords:** intentional self-harm, human rights, First Nations, minor in care, state care, child protection services, mental health, medical health, housing instability, risk assessment, cultural care, cultural supports, cultural safety, residential care models, support services

| Recommendation | Response | Response outcome |
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| 1. a. That DFFH work towards transitioning all Aboriginal and Torres Strait Islander children and young people in the Victorian child protection system to the care of an ACCO, pending the transfer of decision-making power, authority, control and resources to First Peoples communities as recommended by Yoorrook.<br><br>b. That DFFH, in collaboration with ACCOs including BDAC, ensure that ACCOs are adequately funded and resourced to have the capability and resources to accept section 18 authorisations, including in cases involving Aboriginal and Torres Strait Islander children and young people with complex needs. | Response from Department of Families, Fairness and Housing (DFFH)<br><br>Response from Bendigo and District Aboriginal Co-operative (BDAC) | Under consideration<br><br>Accepted in full |
| 2. That DFFH, Anglicare and other organisations providing services to Aboriginal and Torres Strait Islander children and young persons in out-of-home care (other than ACCOs) review their current policies and practices and implement any changes that are needed to enhance their capacity to provide culturally connected care, including by:<br><br>a. implementing aspects of culture (that can easily be accessed by non-Aboriginal people) such as displaying the Aboriginal and Torres Strait Islander flags, displaying Indigenous artwork, engaging with Aboriginal music and TV, learning | Response from Department of Families, Fairness and Housing (DFFH)<br><br>Response from Anglicare Victoria | Under consideration<br><br>Accepted in full |

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| about Aboriginal food/holidays/language etc;<br><br>b. recognising the deeper levels of culture that are not accessible by non-Aboriginal people and being guided by Aboriginal and Torres Strait Islander people about these – by taking on board advice from ACCOs, Aboriginal practitioners within your organisation and building relationships with the wider Aboriginal community;<br><br>c. employing Aboriginal cultural mentors and having them available to both staff and young people in their care (particularly in residential care);<br><br>d. developing a close relationship with, and being led by the child or young person about their own levels of cultural connection and how they would like to further connect to culture, and providing those opportunities;<br><br>e. having a presence at, and taking children and young people to, public events such as NAIDOC week and National Aboriginal and Torres Strait Islander Children's day; and<br><br>f. providing opportunities for Aboriginal children and young people to connect with community online (for example, via Facebook). | | |
| 3. That ACSASS be sufficiently funded by the Victorian Government to:<br><br>a. enable full compliance with sections 10, 11 and 18 of the CYFA, so that all decision makers at all critical points in time have full and frank access to Aboriginal specialist advice; and<br><br>b. ensure all service providers who have contact with Aboriginal children have free and reliable access to Aboriginal specialist | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |

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| advice, so that no Aboriginal child is placed in a position where they do not have cultural supports around them. | | |
| 4. That DFFH engage with its stakeholders to review their existing training programs so as to ensure that:<br><br>a. all frontline and executive staff employed by agencies that provide child protection, case management and/or residential care services under DFFH's auspices, including but not limited to Anglicare, provide their staff with regular, mandatory cultural awareness and antiracism training covering issues including:<br><br>i. the history of colonisation and in particular the impact of 'protection' and assimilation policies;<br><br>ii. the continuing systemic racism and paternalism inherent in child protection work today that must be identified, acknowledged and resisted;<br><br>iii. the value of First Peoples family and child rearing practice;<br><br>iv. upholding human rights including Aboriginal cultural rights; and<br><br>v. the strength of First Peoples families and culture and culturally appropriate practices; and<br><br>b. such training includes mandatory refresher training; and<br><br>c. such training is designed and delivered by a First Peoples business or consultant on a paid basis. | Response from Department of Families, Fairness and Housing (DFFH)<br><br>Response from Anglicare Victoria | Under consideration<br><br>Accepted in full |
| 5. That DFFH:<br><br>a. review and revise all relevant policies, procedures, guidelines and like documents; and | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |

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| b. review and revise all relevant training courses and programs to improve its workforce's understanding of the importance of cultural plans and improve the quality, timeliness, implementation and monitoring of cultural plans for Aboriginal and Torres Strait Islander children in out-of-home care. In particular, DFFH should ensure that cultural plans:<br><br>c. are individually tailored;<br><br>d. involve the child or young person and their family in their creation and review;<br><br>e. are updated regularly (at a minimum, annually or when placement or other significant circumstances change);<br><br>f. provide a plan to (re)establish or maintain cultural connections, such as contact arrangements with family members, plans for Return to Country with Elders and family members from the same mob group as the child or young person;<br><br>g. include SMART goals with clearly defined accountabilities, either as part of the cultural plan or an actions table supporting the child or young person's case plan; and<br><br>h. include a legible genogram. | | |
| 6. That the DFFH, in consultation with the Attorney General, explore the viability and utility of granting the Children's Court supervisory powers over Aboriginal young people's cultural plans. | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |
| 7. That DFFH:<br><br>a. in consultation with the Department of Health and Bendigo Health, develop and implement more focused Social and Emotional Wellbeing approaches to the | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |

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| treatment of Aboriginal and Torres Strait Islander young people requiring mental health diagnosis and treatment, and do so in consultation with Aboriginal Community Controlled Organisations such as BDAC, and that appropriate and ongoing training be provided to clinical and Child Protection staff to support these approaches;<br><br>b. in consultation with the Department of Health and Bendigo Health, develop and implement systems for the cultural support of Aboriginal and Torres Strait Islander young people admitted to hospital for acute and other mental health episodes, to ensure that Aboriginal health liaison officers are actively made available to the young person at the time of admission and that that cultural connection is available beyond crisis admissions;<br><br>c. in consultation with the Department of Health and Bendigo Health, take appropriate steps to ensure that its practice of offering contact with an Aboriginal Health Liaison Officer upon admission is effected on each occasion that a young Aboriginal or Torres Strait Islander person is admitted with mental health issues.<br><br>d. develop and implement systems to ensure that young Aboriginal and Torres Strait Islander people with acute and/or chronic mental health conditions are provided prompt and ongoing mental health assessment and treatment, and ensure that this is done in ongoing consultation with appropriate Aboriginal input, such as ACCOs like BDAC, and take all steps open to ensure these ACCOs are appropriately funded to enable that work to occur. | Response from Department of Health<br><br>Response from Bendigo Health<br><br>Response from Bendigo and District Aboriginal Co-operative (BDAC) | Under Consideration<br><br>Under consideration<br><br>Accepted in full |
| 8. That Victoria Police: | Response from Victoria Police | Accepted in full |

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| a. make every effort to increase the number and availability of Aboriginal and Torres Strait Islander people it employs;<br><br>b. make every effort to employ Aboriginal and Torres Strait Islander people in SOCITs;<br><br>c. increase the number and availability of Aboriginal liaison staff in its dealings with young Aboriginal sexual assault complainants;<br><br>d. as a matter of policy, when dealing with female Aboriginal sexual assault complainants, make available a female police officer to conduct VAREs and lead contact with the complainant, unless the complainant requests otherwise or it is not practicable;<br><br>e. improve its cultural awareness training as it relates to dealing with female Aboriginal sexual assault victims, including by incorporating reference to 'cultural humility' as described by Dr Krakouer. | | |
| 9. That:<br><br>a. DFFH, in consultation with the Department of Health, clarify respective roles, fund and ensure facilitation of early, intensive and culturally appropriate mental health intervention for young Aboriginal people in its care presenting with complex mental health problems and allegations of sexual assaults.<br><br>b. DFFH continue to fund and develop Aboriginal sexual assault healing services delivered by ACCOs.<br><br>c. DFFH implement practices for appropriately urgent action and follow up with the Department of Health, and/or its service providers, to ensure young Aboriginal people in its care presenting with allegations of sexual assault are | Response from Department of Families, Fairness and Housing (DFFH)<br><br>Response from Department of Health<br><br>Response from Bendigo Health | Under consideration<br><br>Under Consideration<br><br>Accepted in full |

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| receiving culturally appropriate mental health intervention.<br><br>d. DFFH develop and implement processes for appropriate support for out-of-home carers who are dealing with young people suffering the mental health effects of sexual assault.<br><br>e. Bendigo Health consider developing and implementing integrated Aboriginal and Torres Strait Islander worker and lived experience workers within the Bendigo health system itself. | | |
| 10. That the Department of Health, DFFH and Bendigo Health coordinate culturally appropriate drug and alcohol support for young Aboriginal and Torres Strait Islander people who present with drug/alcohol misuse, including by adequately funding and liaising with appropriate ACCOs such as BDAC and/or suitable family/community supports. | Response from Department of Families, Fairness and Housing (DFFH)<br><br>Response from Department of Health<br><br>Response from Bendigo Health | Under consideration<br><br>Accepted in part<br><br>Under consideration |
| 11. That DFFH:<br><br>a. in association with its ACCO partners, the Department of Health and Bendigo Health, urgently consider how existing mental health services and new mental health service options could be developed to provide care that is accessible to and culturally appropriate for Aboriginal and Torres Strait Islander young people with complex mental health needs;<br><br>b. offer funded mental health first aid training for all out-of-home carers, or, at minimum, for out-of-home carers caring for children and young people with mental health concerns, and make such training available in accessible locations in regional Victoria. | Response from Department of Families, Fairness and Housing (DFFH)<br><br>Response from Department of Health<br><br>Response from Bendigo Health | Under consideration<br><br>Under Consideration<br><br>Under consideration |

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| 12. That:<br><br>a. DFFH develop measures to improve coordination between stakeholders in the development and implementation of safety plans, with a particular cultural emphasis where safety plans concern Aboriginal and Torres Strait Islander young people; and<br><br>b. DFFH and service providers ensure that any 'line of sight monitoring' policies mandate consideration by carers of compelling surrounding circumstances, such as patterns of escalation in suicidality risk, risk of exposure to identified triggers of a self-harm event, and the young person's recent behaviour and affect | Response from Department of Families, Fairness and Housing (DFFH)<br><br>Response from Anglicare Victoria | Under consideration<br><br>Rejected in full |
| 13. That DFFH ensure that kinship carers:<br><br>a. have access to training, support, and services that are appropriate to their circumstances;<br><br>b. are aware of and receive assistance accessing financial supports; and c. are aware of the existence of the Care Support Help desk and how to access it. | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |
| 14. That:<br><br>a. the KEYS or like model of residential care services continue to be rolled out in regional Victoria and that such services for young Aboriginal and Torres Strait Islander people be developed in consultation with ACCOs such as BDAC;<br><br>b. ACCOs be prioritised as the preferred organisation to deliver residential care in the tender process for allocating funding, with quality of care and best practice outcomes given a higher priority | Response from Department of Families, Fairness and Housing (DFFH)<br><br>Response from Bendigo and District Aboriginal Co-operative (BDAC) | Under consideration<br><br>Accepted in full |

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| than economic rationalisation in the tender process. | | |
| 15. That DFFH extend AFLDM referral powers to organisations providing contracted case management services to DFFH and to ACCOs exercising delegated powers pursuant to section 18 of the CYFA. | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |
| 16. Noting the Yoorrook Justice Commission's recommendation that the Victorian Government 'transfer decision making power, authority, control and resources to First Peoples, giving full effect to self-determination in the Victorian child protection system', I recommend that DFFH significantly upscale the capability, competence and support of all persons working within the child protection system to ensure that they are able to: 241<br><br>a. comply with sections 10, 11, 12, 13 and 14 of the Children, Youth and Families Act 2005;<br><br>b. adopt a relational approach to child protection work which prioritises the practitioner's ability to relate to the child and their families over compliance-driven measures; and<br><br>c. engage in effective case management and case planning, including long-term planning and transition planning.<br><br>In particular for this purpose, DFFH should:<br><br>d. review and revise all relevant policies, procedures, guidelines and like documents;<br><br>e. review and revise all relevant training courses and programs; and<br><br>f. ensure, to the greatest extent possible, that it has appropriate staffing levels and is able to retain | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |

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| experienced child protection practitioners. | | |
| 17. That DFFH review and revise its relevant training courses and programs with a focus on improving Child Protection Practitioners' skills in engaging with children and young people, so as to hear, acknowledge, understand and give weight to a child's experience and expressed views in their subsequent decisions and actions. | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |

## Finding into death of PJQ

**Keywords:** State care, transition to independent living, accommodation, exposure to family violence, child protection, Permanent Care Order, Protective Care Order, mixed drug toxicity

| Recommendation | Response | Response outcome |
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| That the Department of Families, Fairness and Housing incorporate a guideline in its risk assessment framework which is directed toward the risk assessment process to be applied when considering the suitability of short-term accommodation options for children whose Care by Secretary Order is shortly due to expire, which:<br><br>(a) promotes flexibility; and<br><br>(b) recognises the importance of safe and stable accommodation during this critical transition period. | Response from Department of Families, Fairness and Housing (DFFH) | 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 |
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| 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 |
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| All amusement structures, which are considered plant under relevant regulations, be design registered; | Update from the Minister for Worksafe and the TAC<br><br>Response from the Minister for Worksafe and the TAC | Accepted in full |
| 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; | Update from the Minister for Worksafe and the TAC<br><br>Response from the Minister for Worksafe and the TAC | Accepted in full |
| 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; | Update from the Minister for Worksafe and the TAC<br><br>Response from the Minister for Worksafe and the TAC | Accepted in full |
| 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. | Update from the Minister for Worksafe and the TAC<br><br>Response from the Minister for Worksafe and the TAC | Accepted in full |
| The operator of an amusement ride be required to carry the plant's | Update from the Minister for | Accepted in full |

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| manual and logbook with the item of plant at all times; | Worksafe and the TAC<br><br>Response from the Minister for Worksafe and the TAC | |
| The requirement that items of plant be registered should be reintroduced and apply to all amusement structures operating in Victoria; | Update from the Minister for Worksafe and the TAC<br><br>Response from the Minister for Worksafe and the TAC | Accepted in full |
| The operator of an amusement ride be required to record and maintain details of training and certification of the operator of an amusement ride; | Update from the Minister for Worksafe and the TAC<br><br>Response from the Minister for Worksafe and the TAC | Accepted in full |
| 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 | Update from the Minister for Worksafe and the TAC<br><br>Response from the Minister for Worksafe and the TAC | Accepted in full |
| 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. | Update from the Minister for Worksafe and the TAC<br><br>Response from the Minister for Worksafe and the TAC | Accepted in full |

## 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 |
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| 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 |

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| 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 |
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| 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 |

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| 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 |

## Finding into death of Siya Yogin Patel

**Keywords:** Medicare ineligible, neonate, newborn assessments, dehydration, insufficient feeding, telehealth, Maternal and Child Health services, palliative care, communication breakdown

| Recommendation | Response | Response outcome |
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| That the Minister for Health and Aged Care, The Hon Mark Butler, make an Order pursuant to subsection 6(1) of the Health Insurance Act 1973 (Cth) to the effect of declaring that babies born in Australia who, but for the Order, would not be an eligible person, shall be treated as an eligible person for the purposes of the same Act. | The Minister for Health and Aged Care was invited to respond by 28 November. The minister is not required to respond, and no response has been received to date. | Awaiting response |
| That Mercy Health provide a hard copy of the discharge summary to new parents at discharge to include in the My Health Learning and Development book (Green Book) | Response from Mercy Health | Accepted in full |

## Finding into death of Noah Andrew Souvatzis

**Keywords:** Meningitis, paediatric, hospital discharge, parent and carer escalation, locum doctors, regional health care, sentinel event, toddler, health care, ViCTOR

| Recommendation | Response | Response outcome |
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| That the Australian Commission on Safety and Quality in Health Care consider incorporating a question to be asked by clinicians about parental and carer concerns as a core vital sign in paediatric patients and recommend free text space to document these concerns. | Response from Australian Commission on Safety and Quality in Health Care | Accepted in full |
| That Safer Care for Kids consider incorporating a question to be asked by clinicians about parental and carer concerns into the ViCTOR chart as a routine vital sign with associated free text spaces to document these concerns. | Response from Safer Care | Accepted in full |

## Finding into death of Frankie Skye Foulkes

**Keywords:** Complex medical needs, child car restraints, lie-flat car restraints, product safety regulations, infant, non-standard car seat, spinal muscular atrophy

| Recommendation | Response | Response outcome |
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| That the Victorian Government consider amending the Road Safety Road Rules 2017 to include a specific authorisation within rule 267 for the use of an alternative restraint in circumstances where, by virtue of a disability or medical condition, a child is exempted from wearing a seatbelt or being placed in an approved child restraint or booster seat. | Response from Department of Transport and Planning | Accepted in full |
| That Standards Australia consider granting an exemption to AS/NZS 4370:2013 to the Royal Children's Hospital for the use of the Jane Matrix lie-flat car restraint in its lie-flat car restraint pilot. | Response from Standards Australia | Alternative adopted |
| That the Australian Competition and Consumer Commission commence a review of mandatory standards regarding child restraint systems for use in motor vehicles, in consultation with relevant expert stakeholders such as Mobility and Accessibility for Children in Australia Ltd, the Royal Children's Hospital, Transport Accident Commission (TAC), the Department of Transport and Planning, and interstate equivalents, for the purpose of:<br><br>a. developing standards that ensure the adequate testing and safety of special purpose car restraints; and<br><br>b. revising existing standards to facilitate the availability of a broader range of car restraints in Australia which meet the needs of children with complex medical conditions and/or disability. | Response from Australian Competition and Consumer Commission (ACCC) | Accepted in full |

## Finding into death of Nihal Singh Hundal

**Keywords:** Drowning, child, septic tank, unsecured septic tank lid, septic tank safety, child resistant safety screen

| Recommendation | Response | Response outcome |
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| I recommend the Victorian Building Authority investigate how they might introduce a Certificate of Compliance system for all septic tanks in the state. As part of this investigation, I further recommend that the Victorian Building Authority consider mandating the installation of child resistant screen devices on all septic tanks in Victoria. | Response from Victorian Building Authority | Accepted in full |

## Finding into death of Makayla Lee Wadeson

**Keywords:** streptococcus pneumoniae, candida albicans pneumonia, empyema, pulmonary thromboembolism, deep vein thrombosis, complex medical history, child, emergency department, hospital discharge, immunosuppression, ViCTOR

| Recommendation | Response | Response outcome |
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| That GV Health use ViCTOR charts to record all observations in paediatric cases including observations taken at triage in the emergency department. | Response from Goulburn Valley Health | Accepted in full |
| That GV Health make changes to their electronic medical record to ensure current medical diagnoses and medications are easily accessible to all users who open the record. | Response from Goulburn Valley Health | Accepted in full |

## Finding into passing of Baby LT

**Keywords:** Aboriginal patient, Aboriginal Health Liaison Officer, child protection, pneumonia, Portland Hospital, culturally appropriate care, patient transfer, post-natal care, healthcare coordination and communication, infant, Portland District Health Urgent Care Centre, Warrnambool Base Hospital, vulnerable children, intensive support, Enhanced MCHN (EMCHN) service, Yoorrook Justice Commission

| Recommendation | Response | Response outcome |
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| I recommend that Child Protection, through the Aboriginal Unborn Child Report Working Group, develop and implement guidelines for working with pregnant Aboriginal women who are reported to Child Protection or are referred to the Orange Door or Child FIRST. These guidelines should be informed by the relevant findings of the Yoorrook Justice Commission. | Response from Department of Families, Fairness and Housing (DFFH) | Alternative adopted |

## Finding into deaths of Child 1, Child 2, Child 3, Child 4

**Keywords:** Filicide, Family violence, Child Protection, Victoria Police, Corrections; Cluster Inquest

| Recommendation | Response | Response outcome |
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| 1. a) Compliance with Child Protection's obligations to consult with ACSASS, and to produce cultural plans, and be sufficiently monitored that non-compliance trigger oversight and enforcement of such obligations (whether through SAFER or other oversight mechanisms).<br><br>b) DFFH and VACCA to publish an update about the outcome of the Aboriginal-led State-wide Cultural Planning Forum, and any outcomes relevant to these findings.<br><br>c) The Court endorses Recommendation one of the Yoorrook report and that Aboriginal-controlled organisations be funded sufficiently to be able to meet the demand to undertake these roles. | Response from Department of Families, Fairness and Housing (DFFH)<br><br>Response from Victorian Aboriginal Child Care Agency (VACCA) | Under consideration<br><br>Accepted in part |
| 2. That Child Protection, as part of the work they are doing to reform and improve Child Protection Manual, incorporate easy access to a singular policy and simple tool relevant to cumulative harm assessment being undertaken. | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |
| 3. a) That DFFH engage a suitably qualified consultant or an internal person to conduct a review of the operation and effectiveness of the SAFER Framework with particular reference to its identification and assessment of risk associated with a parent entering a relationship with a new partner or any other person who is regularly in the house.<br><br>b) That DFFH publicly report on the implementation and evaluation of the SAFER framework. | Response from Department of Families, Fairness and Housing (DFFH) | Alternative adopted |

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| c) That DFFH ensure mandatory training for protective workers and supervisors incorporate a positive obligation on staff to be assessing the risk of any new partner that may potentially have any contact with the subject children, whether they are residing in the home or not, and incorporate assertive engagement such that the risk assessment is always prioritised, even when it may impinge upon the parent and partner's privacy. | | |
| 4. a) That Child Protection undertake an impact evaluation of SAFER broadly, and to include the terms as set out in recommendation 13 of the Yoorrook Report, noting my earlier recommendation at 3(a)<br><br>b) Professional development reinforcing the importance of entering data into the CRIS system, and systems for oversight to ensure mandatory tasks are completed in a timely fashion and the system can be easily audited for compliance be expedited. | Response from Department of Families, Fairness and Housing (DFFH) | Accepted in full |
| 5. Child Protection update current policy regarding consequences of non-engagement with voluntary services including consideration of re-report or not closing until engagement has been confirmed with Child Protection. In the event of non-engagement, focus on risk assessment and mitigation should be prioritised. | Response from Department of Families, Fairness and Housing (DFFH) | Alternative adopted |
| 6. That the 'Unborn Child Reports – advice' clarify the circumstances that will mandate that a case conference be convened and include advice that Child Protection seek to identify and address any material or practical needs of the parents prior to birth. | Response from Department of Families, Fairness and Housing (DFFH) | Under consideration |
| 7. a) The Victorian Government develop a further workforce (beyond | Response from Department of | Accepted in part |

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| 2024) plan to address the workforce challenges currently facing the whole of the community and social service sectors in Victoria, including appropriate caseloads, for and attrition rates of Child Protection practitioners.<br><br>b) In consultation with the sector, the Victorian Government review the relevant Enterprise Agreement governing Child Protection Practitioners with the view of assessing the adequacy of current wage and leave entitlements, ensuring they are competitive within the industry and that conditions and wage progression is attractive to staff.<br><br>c) The Victorian Government explore new or consider expanding current opportunities to increase the pipeline of workers entering the social service industry, consideration should be given to traineeship models, expanding the Shift to Social Work or like programs, paid study and free tuition.<br><br>d) The Victorian Government expand the Shift to Social Work program to increase intake and encourage the recruitment of social workers in Victoria. This program should also be extended to include the Bachelor of Social Work.<br><br>e) The Department of Families, Fairness and Housing publicly report on the progress of the Child Protection Workforce Strategy 2021–2024 and upon its completion, undertake an evaluation of the effectiveness of this strategy, and make the findings of this evaluation public. | Families, Fairness and Housing (DFFH) | |

## Finding into passing of RDZ

**Keywords:** Paediatric, constipation, rural, Aboriginal patient, bowel obstruction, child, triage assessment, Aboriginal Liaison Officer referral, cultural safety, post-surgical complications

| Recommendation | Response | Response outcome |
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| That the Pharmaceutical Benefits Advisory Committee consider liquid paraffin and/or other lubricant laxatives for recommendation to be added to the Pharmaceutical Benefits Scheme for use in chronic constipation or faecal impaction not adequately controlled with first line interventions such as bulk-forming agents. | Response from Pharmaceutical Benefits Advisory Committee (PBAC) | Accepted in full |

# Drowning

## 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 |
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| 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 |
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| 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 |

## Finding into death of JV

**Keywords:** Drowning, pumping station, weir, swimming, strong current, dam wall, back eddy, signage, safety warning

| Recommendation | Response | Response outcome |
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| The Tyers River at Tyers River Pumping Station is reportedly a popular local swimming location. The conditions there on the day of Kaleb's death were hazardous. Detective Acting Senior Sergeant Shane Wakker observed the turbulence and a strong back eddy. Senior Constable Bradley Prior noted that the area around Tyers River Pumping Station was freely accessible, with no signage to indicate potential danger relating to swimming or the water current. With the intention to prevent similar deaths, I recommend that the Secretary, Department of Energy, Environment and Climate Action undertake a review of water safety at the Tyers River proximal to Tyers River Pumping Station to establish whether any new countermeasures could be put in place to reduce the risk to swimmers of drowning. While I do not prescribe the form of the review, I note that organisations such as Victoria Police and Life Saving Victoria may have expertise and insights to contribute. | Response from Department of Energy, Environment and Climate Action (DEECA) | Accepted in full |

## Finding into death of Frank Mellia

**Keywords:** Drowning, river waters, alcohol intoxication, Yarra River, Warrandyte, swimming proficiency, inland waterways

| Recommendation | Response | Response outcome |
|---|---|---|
| That Parks Victoria review the signage warning the public of river hazards in the Warrandyte River Reserve and particularly, the Taroona Reserve. Among the hazards identified, the signage should warn of the danger of alcohol or drugs in combination with use of the river. | Response from Parks Victoria | Alternative adopted |

## Finding into death of Munif Mohammed

**Keywords:** Boating Accident; Marine Incident; Drowning; Port Phillip Bay; Seaworthy Inspections; Practical Boat Licensing; Boarding Ladders

| Recommendation | Response | Response outcome |
|---|---|---|
| I recommend that Safe Transport Victoria explores potential models for a recreational vessel seaworthy inspection and certificate regime to assess the already legislated prescribed conditions under regulation 27 of the Marine Safety Regulations 2023 (Vic) as a means of ensuring the seaworthiness of vessels at points of registration, transfer of ownership, and after any modification of the vessel. | Response from Department of Jobs, Skills, Industry and Regions (DJSIR) | Rejected in full |
| I recommend that Safe Transport Victoria considers the introduction of practical training and assessment as part of the Victorian marine licencing regime analogous to regimes already in existence in other Australian States. | Response from Department of Jobs, Skills, Industry and Regions (DJSIR) | Rejected in full |
| I recommend the Minister for Outdoor Recreation of the Department of Jobs, Skills, Industry and Regions77 amend the Marine Safety Regulations 2023 (Vic) to mandate boarding ladders or other similar means of reboarding a vessel from the water in vessels with a freeboard greater than 0.3 metres, irrespective of the size of the vessel. | Response from Department of Jobs, Skills, Industry and Regions (DJSIR) | Rejected in full |

## Finding into death of Jack Mitchell Bird

**Keywords:** drowning, boat, Lake Mulwala, life jacket, flotation device, fishing, fall overboard, dead man switch, watercraft

| Recommendation | Response | Response outcome |
|---|---|---|
| That the New South Wales State Government consider mandating life jackets/personal floatation devices for all people on and/or operating a boat or other vessel. | Response from Transport for NSW | Under consideration |

## Finding into death of Alison Debra Johns

**Keywords:** Child drowning, Lake Nagambie, water safety, supervision, inland waterways, Life Saving Victoria

| Recommendation | Response | Response outcome |
|---|---|---|
| I recommend under section 72(2) of the Act that Strathbogie Shire Council consult with the Victorian Water Safety Coordination Forum, Life Saving Victoria and any other appropriate body, to ensure appropriate safety measures are in place at Blayney Reserve on Lake Nagambie (including appropriate signage, depth warnings, fencing or other identified safety measures) to promote the safety of those engaging in recreational water activities such as swimming. | Response from Strathbogie Shire Council | Accepted in full |

## Workplace

### Finding into death of Kevin John Harris

**Keywords:** workplace injury, pulmonary thromboembolism, deep vein thrombosis, knee injury

| Recommendation | Response | Response outcome |
|---|---|---|
| In the interests of promoting public health and safety and with the aim of preventing like deaths, I recommend that the Royal Australian College of General Practitioners consider the creation and publication of a clinical guideline for the diagnosis, prophylaxis and treatment of venous thromboembolism for patients in the general practice setting. | Response from the Royal Australian College of General Practitioners | Rejected in full |

## 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:<br><br>a) recognising the acute signs and symptoms of concussion and head trauma; | Response from Australian Football League (AFL)<br><br>Response from Australian Football League Players' Association (AFLPA) | Accepted in Full<br><br>Accepted in Full |

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| b) responding and managing concussion and head trauma; and<br><br>c) understanding the short and long-term risks of concussion and repeated head trauma. | | |
| The AFL:<br><br>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;<br><br>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;<br><br>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;<br><br>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<br><br>e) in developing this accessible and informative educational material that further consideration be given to how that educational material can be adopted at all community levels and in all environments in which | Response from Australian Football League (AFL) | Accepted in Full |

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| 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 AFL and AFLW clubs and using the data for clinical research purposes. | Response from Australian Football League (AFL) | Under Consideration |

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| 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)<br><br>Response from Australian Football League Players' Association (AFLPA) | Accepted in Full<br><br>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)<br><br>Response from Australian Football League Players' Association (AFLPA) | Accepted in Full<br><br>Accepted in Full |
| The Commonwealth Department of Health facilitate the adequate | Response from Australian | Accepted in Full |

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| funding of brain banks nationally. | Government Department of Health and Aged Care | |
| 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)<br><br>Response from Australian Football League Players' Association (AFLPA) | Accepted in Full<br><br>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 in research on the brain health of professional boxers overtime. | Response from Department of Jobs, Skills, Industry and Regions (DJSIR) | Under Consideration |

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| As part of the regulatory review, the DJSIR and the Board:<br><br>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<br><br>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 | Response from Department of | Accepted in Full |

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| 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. | Jobs, Skills, Industry and Regions (DJSIR) | |
| The Board and DJSIR on advice from the Medical Advisory Sub-Committee (MASC):<br><br>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<br><br>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 |

## Finding into death of Giovanni Castillo Garbanzos

**Keywords:** Drowning, commercial fishing boat, AMSA, personal flotation device, lifejacket, Marine Safety (Domestic Commercial Vessel) National Law Act 2012, large wave, open deck, not recovered, overboard, wet weather gear, inclement weather, safety, workplace

| Recommendation | Response | Response outcome |
|---|---|---|
| AMSA (consistent with the recommendation in the Batchelor and Bugeja report February 2003) lead, in collaboration with the seafood industry and the manufacturers of PFDs:<br><br>• a review of existing PFDs currently available in the market to determine suitability for use by commercial fisherman;<br><br>• if existing PFDs are found not suitable for use by commercial fisherman encourage and work with the manufacturers of PFDs to design a suitable PFD that would be acceptable to commercial fishermen and compatible with the appropriate Australian Standard; and<br><br>• engage with the Australia New Zealand Safe Boating Education Group and other industry stakeholders to raise awareness of and support for this work. | Response from Australian Maritime Safety Authority (AMSA) | Alternative adopted |

# 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:<br><br>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;<br><br>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).<br><br>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 | Accepted in part |
| 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:<br><br>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 |

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| concentration of 100%. The equipment should also facilitate oxygen enriched artificial ventilation of a non-breathing patient.<br><br>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 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 |

## Finding into death of George Diamond

**Keywords:** acute chronic subdural haemorrhage, boxing, sparring, training, gym, medical management, amateur boxing, contact sport, brain injury, head trauma

| Recommendation | Response | Response outcome |
|---|---|---|
| As part of DJSIR's regulatory review, being undertaken by KPMG, consideration should be given to including:<br><br>a) the requirements for an individual to be cleared before commencing amateur boxing/combat sports for the first time, and before returning to amateur boxing/combat sports following an injury, including whether this clearance should be obtained from a medical practitioner certified to do so; and<br><br>b) as part of this review, consideration should be given to whether the current VABL Certificate of Fitness form should be enhanced, with more information given to medical practitioners. | Response from Secretary, Department of Skills, Jobs, Industry and Regions (DJSIR)<br><br>Response from KPMG | Accepted in full<br><br>Accepted in full |
| The Neurosurgical Society of Australasia, the Royal Australian College of General Practitioners (RACGP), in conjunction with Australasian College of Sport and Exercise Physicians (ACSEP) should consider developing appropriate mandatory training for medical practitioners in relation to providing medical clearance for individuals to commence and return to boxing and other combat sports. | Response from Royal Australian College of General Practitioners (RACGP)<br><br>Response from Neurosurgical Society of Australasia (NSA)<br><br>Response from Australasian College of Sport and Exercise Physicians (ACSEP) | Alternative adopted<br><br>Alternative adopted<br><br>Accepted in full |
| The Neurosurgical Society of Australasia, Royal Australian College of General Practitioners (RACGP) and the Australasian College for Emergency Medicine | Response from Royal Australian College of General Practitioners (RACGP) | Rejected in full |

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| (ACEM), consider developing guidelines to be followed in respect of patients presenting with mild head injuries but resulting from potentially dangerous mechanisms and which fall outside the scope of the Canadian CT Head Injury/Trauma Rule (CT Head Rule) and also include the appropriate threshold for undertaking a CT Scan or MRI of a person's brain where injury has occurred in a boxing or mixed martial arts context. | Response from Neurosurgical Society of Australasia (NSA)<br><br>Response from Australasian College for Emergency Medicine (ACEM) | Rejected in full<br><br>Rejected in full |

# Accidents

## Finding into passing of Jesse Lee Christopher Edwards

**Keywords:** prone restraint asphyxia, physical altercation, security officer, restraint, face-down prone position, training

| Recommendation | Response | Response outcome |
|---|---|---|
| That Victoria Police Licensing & Regulation Division (LRD) establish a requirement that prior to licence renewal, existing security licence holders must undertake refresher training with an LRD-approved Registered Training Organisation, including with regard to the safe use of restraint techniques and the risks of positional asphyxia | Response from Victoria Police | Accepted in full |

## Finding into death of Maurice Wayne Matthews

**Keywords:** mechanical asphyxia, crush injury, car, vehicle, retired mechanic, jack, uneven ground, raised vehicle, at-home vehicle maintenance, DIY

| Recommendation | Response | Response outcome |
|---|---|---|
| With the aim of preventing like deaths and promoting public health and safety, I recommend that the ACCC consider renewing or creating a new educational campaign focussing on the safety in DIY motor vehicle maintenance and repairs. | Response from Australian Competition & Consumer Commission (ACCC) | Accepted in full |
| (ii) With the aim of preventing like deaths and promoting public health and safety, I recommend that WorkSafe Victoria consider again collaborating with the ACCC in its campaigns to promote safe DIY vehicle maintenance. | Response from Australian Competition & Consumer Commission (ACCC)<br><br>Response from WorkSafe | Accepted in full<br><br>Accepted in full |

## Finding into death of Ryleigh James Pallot

**Keywords:** cliff collapse, falling rocks, remote location, beach access, Addiscot Beach, Air Ambulance Victoria, Mobile Intensive Care Ambulance, Helicopter Emergency Medical Services, signage, rock fall, ranger patrols, safety, risk mitigation

| Recommendation | Response | Response outcome |
|---|---|---|
| I recommend that the Department of Energy, Environment and Climate Action (DEECA), Parks Victoria and GORCPA consider developing and implementing a state-wide rockfall and landslide assessment and management policy, which includes consideration of implementing risk mitigation commensurate with the level of risk. | Response from Great Ocean Road Coast and Parks Authority (GORCPA)<br><br>Response from Department of Energy, Environment and Climate Action (DEECA)<br><br>Response from Parks Victoria | Accepted in full<br><br>Accepted in full<br><br>Accepted in full |
| I recommend that Parks Victoria consider amending the new signage at Addiscot Beach to state that a cliff collapse has led to injury and death to reinforce the danger posed to visitors from cliff collapse. | Response from Parks Victoria | Under consideration |

# Missing Persons

## Finding into death of Colleen Mary South

**Keywords:** Missing person, police search, transfer of interstate investigation, police dog squad, tracking, Bunguluke Reserve, search and rescue capability

| Recommendation | Response | Response outcome |
|---|---|---|
| Victoria Police continue its assessment to consider the practicality and viability of establishing a Human Remains Detection Dog Capability within the Dog Squad; and | Response from Victoria Police | Accepted in full |
| In the meantime, Victoria Police liaise with New South Wales Police to utilise the resources of its Human Remains Detection Dog training facility. | Response from Victoria Police | Accepted in full |

# Homicide

## 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 | Response from Department of Justice and Community Safety (DJCS) | Accepted in full |

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| assessments in situations where the offender has contact with an 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 15 month period. This edition includes the period between 1 September 2023 – 31 August 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 |