Coroners Court of Victoria Recommendations Report

1 October 2024 – 30 September 2025

28 April 2026

Coroners Court of Victoria

Warning

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

Acknowledgement

The Coroners Court of Victoria (the Court) 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 Court 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 12-month period and the status of responses received.

This ninth edition covers the period from 1 October 2024 – 30 September 2025. During this period, coroners made 239 recommendations across 95 findings.

Following these recommendations, the Court received:

- 147 responses stating the recommendation was accepted in full.
- 55 responses stating the recommendation was accepted in part or an alternative was proposed.
- 64 responses stating the recommendation remains under consideration.
- 18 responses where the recommendation was not accepted.

The report also contains a chapter on overdue responses reported since the first edition of this publication that remain outstanding. There is currently 1 response overdue across 1 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 22 April 2026.

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Suicide

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
To the Office of the Chief Psychiatrist: 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, complex medical history, 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, treatment resistant depression, chronic self-harm, step down care

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	Response from Northern Health	Accepted in full

Safer Care Victoria’s Adverse Patient Safety Event Policy.		

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 Response from Department of Health	Under consideration 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
1(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 (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 Response from Forensicare	Accepted in full Accepted in full
2(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 (b) That Justice Health, in consultation with primary health service providers and Forensicare, develops a clear process to ensure that: a. A prisoner waiting for a non-urgent psychiatric consultation with the forensic mental health service, continues to be monitored and	Response from Department of Justice and Community Safety Response from Forensicare	Accepted in full Accepted in full

reviewed by the primary mental health service provider, to ensure care is escalated to the forensic mental health service when clinically indicated; and 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, that the prisoner be re-reviewed by the primary health service provider.		

Finding into passing of William Gourley

Keywords: Nicotine Replacement Therapy, emergency department, absconding, suicide, mental health, substance use, mental health care, mental health triage, sentinel event

Recommendation	Response	Response outcome
I recommend that Latrobe Regional Health, in consultation with the Victorian Network of Smokefree Health Services Guidance for Managing Nicotine Dependence & Withdrawal in Emergency Care Setting, implement a procedure specific to its emergency department regarding a patient's smoking status, and where clinically indicated, administer an assessment of nicotine dependence and provide appropriate Nicotine Replacement Therapy.	Response from La Trobe Regional Health	Accepted in full
I recommend that Latrobe Regional Health consider adopting William Thomas Gourley's matter as a case study to highlight the importance of a comprehensive triage and of staff responsibilities when identifying and escalating a patient's deterioration, and in circumstances of a patient's departure from the emergency department.	Response from La Trobe Regional Health	Accepted in full
I recommend that the Secretary of the Victorian Department of Health, consider and develop models for educating Victorian healthcare services on the need and utility of Nicotine Replacement Therapy in the context of patient safety and minimising the risk of absconding, and with the view to implement a consistent approach across all Victorian public hospitals.	Response from Department of Health	Alternative adopted

Finding into death of Olivia Alexandra Evans

Keywords: in care, suicide, mental health, young person, paracetamol toxicity, eating disorder, self-harm, ketamine treatment

Recommendation	Response	Response outcome
Whilst I commend the Victorian Government for developing the Victorian Eating Disorders Strategy 2024-2031, I recommend that they commit funding to ensure the development of at-home meal support programs designed specifically for families with children or young people suffering from eating disorders. Such programs should adopt a mental health led response to deliver holistic treatment and strengthen the support to parents or carers.	Response from Department of Health	Accepted in full

Finding into death of Sarah Skillington

Keywords: Postpartum psychosis, in-patient medical treatment, ligature point, risk assessment, observation, communication, training, staffing, mental health, perinatal mental health unit

Recommendation	Response	Response outcome
Ramsay Health Care implement a system to ensure that regular ligature audits are conducted at mental health facilities managed by it in Victoria.	Response from Ramsay Health Care Australia	Accepted in full
Ramsay Health Care review the mental health facilities managed by it to ensure consistency where possible with the clinical guide Improving safety for consumers at risk of harm of ligature published by Safer Care Victoria.	Response from Ramsay Health Care Australia	Accepted in full
Ramsay Health Care provide specific training to nursing staff in the Perinatal Mental Health Unit at Mitcham Private Hospital in relation to postpartum psychosis.	Response from Ramsay Health Care Australia	Accepted in full
Ramsay Health Care provide specific training to nursing staff working in mental health units in how to appropriately respond to finding a patient hanging.	Response from Ramsay Health Care Australia	Accepted in full
Ramsay Health Care review the staffing arrangements on the Perinatal Mental Health Unit at Mitcham Private Hospital to: (a) provide for two nursing staff to be rostered on the unit at all times, one of whom has mental health training and experience; and (b) provide for the Nursing Coordinator to be based in the unit in the event of only one staff member being available due to unplanned leave.	Response from Ramsay Health Care Australia	Alternative adopted

Ramsay Health Care update the Nursing Admission Form to include a heading for family history.	Response from Ramsay Health Care Australia	Accepted in full
Engagement in clinical supervision by nursing staff on the Perinatal Mental Health Unit at Mitcham Private Hospital be actively encouraged and supported by Ramsay Health Care and all obstacles to attendance minimised.	Response from Ramsay Health Care Australia	Accepted in full

Finding into death of JQ

Keywords: young person, suicide, suicidal ideation, mental health, missing person investigation, inert gas

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that the Department of Transport conduct an audit of CCTV coverage at both Melbourne metro and regional railway stations to ensure all stations have appropriate coverage, and that the footage is easily accessible to emergency services.	Response from Department of Transport and Planning	Accepted in full

Finding into death of WB

Keywords: firearm, suicide, financial stress, workplace wellbeing services, employee assistance program, mental health, risk assessment, suicidal ideation, safety planning

Recommendation	Response	Response outcome
With the aim of preventing like deaths and promoting public health and safety, I recommend that Victoria Police implement an audit or checking system to ensure that: (a) member's Schlage card access to police stations is revoked as soon as they no longer have a need to access that station; and (b) codes for digital locks at stations are changed on a regular basis including where staff changeover has occurred.	Response from Victoria Police	Alternative adopted

Finding into death of Andrea Milner

Keywords: Suicide, train death, complex medical history, mental health, chronic suicidal ideation

Recommendation	Response	Response outcome
That Metro Trains Melbourne review and update its CCTV viewing infrastructure to include appropriate labelling of all camera angles and/or a geographical representation.	Response from Safety and People, Metro Trains Melbourne Pty Ltd	Accepted in Full

Finding into death of Mrs R

Keywords: Mental health, police welfare check, mental health, childhood trauma, family violence, suicidal ideation

Recommendation	Response	Response outcome
The Chief Commissioner of Police develop a chapter for the Victoria Police Manual to provide clear and specific guidance to police members to inform their judgment as to the circumstances in which welfare checks are required to be conducted.	Response from Victoria Police	Under consideration

Finding into death of Jamie Nisbet

Keywords: mental health, substance use, hospital admissions, inpatient care, regional triage service, risk assessment

Recommendation	Response	Response outcome
Review its Mental Health Service's escalation policy/protocol for its community mental health team to escalate the above circumstances to mental health senior/leadership for advice on how to address the clinical risks and needs of the client and to ensure appropriate information and training is undertaken to ensure that senior staff are familiar with the policy.	Response from Bendigo Health	Accepted in full
In circumstances where the decision is made to discharge the patient to the care of another practitioner that all reasonable attempts are made to directly contact that practitioner to ensure that they are aware of the patient's current presentation; and	Response from Bendigo Health	Accepted in full
In circumstances where the decision is made to discharge the patient, that the community mental health team or other member of Bendigo Health, contact the patient's family or next of kin about the implications of the decision (subject to the patient's consent to their personal health information being released to their nominated family member / next of kin).	Response from Bendigo Health	Accepted in full

Finding into death of Joshua Gonzalez

Keywords: *Mental Health Act 2014* - section 351, *Mental Health and Wellbeing Act 2022* - section 232, police handover; handover processes, suicide, substance use, mental health crisis, suicidality, CIRT, emergency services

Recommendation	Response	Response outcome
That the Victorian Department of Health (through its Mental Health and Wellbeing Branch, or other appropriate branch) and Victoria Police work in conjunction to develop a universal structured approach for the transmission of essential information upon handover from police of a person in their care and control pursuant to section 232 of the *Mental Health and Wellbeing Act 2022*.	Response from Department of Health Response from Victoria Police	Accepted in full Accepted in full
That the Victorian Department of Health (through its Mental Health and Wellbeing Branch, or other appropriate branch) and Victoria Police work in conjunction to develop the necessary training and tools for police and medical staff to implement the practice of a structured approach for handover from police of a person in their care and control pursuant to section 232 of the *Mental Health and Wellbeing Act 2022* in all cases.	Response from Department of Health Response from Victoria Police	Accepted in full Accepted in full
That Western Health and the Victorian Department of Health (through its Mental Health and Wellbeing Branch, or other appropriate branch) jointly review the practice of allowing only mental health clinicians access to the Mental Health Database with the aim of also permitting access by Emergency Department medical staff where necessary.	Response from Department of Health Response from Western Health	Under consideration Referred to Department of Health's response
That the Victorian Department of Health (through its Mental Health and Wellbeing Branch, or other appropriate branch) review the	Response from Department of Health	Under consideration

practice of allowing only mental health clinicians access to the Mental Health Database, as it may apply for other Victorian health services, with the aim of also permitting access by Emergency Department medical staff where necessary.		

Finding into death of Judith Pollard

Keywords: Voluntary inpatient suicide, mental health, suicidality, hospital admissions, risk assessment, medical treatment, palliative care, lipoid pneumonia

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and with the aim of preventing like deaths, I recommend that Ramsay Health update its 'Risk assessment & Category Observation' policy by mandating that staff complete additional observations and provide guidance regarding staggering observations with the view to prevent patients discerning their frequency.	Response from Ramsay Health (Shepparton Private Hospital)	Accepted in full

Overdose and poisoning

Finding into death of Kim Bartolo

Keywords: Mixed drug toxicity, prescription medication, discharge summary, complex medical history, hip fracture

Recommendation	Response	Response outcome
That Brunswick Private Hospital review its procedures and processes in relation to the formulation and communication of discharge summaries to ensure that they include all relevant information relating to the treatment of a patient arising from the admission (including medication requirements relating to any mental health treatment) and that they are promptly communicated to the patient's General Practitioner.	Response from Brunswick Private Hospital	Accepted in full

Finding into the deaths of Carly Morse, Thomas Vale, Michael Hodgkinson, and Abdul El Sayed

Keywords: Drug overdose, protonitazene, synthetic opioids, novel psychoactive substances (NPS), nitazenes, minor in care

Recommendation	Response	Response outcome
The Department of Health consider the effectiveness of nitazene test strips and whether they can be made available to the community as a measure to reduce unintentional overdose.	Response from The Department of Health	Under consideration

Finding into death of Loreta Maria Del Rossi

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

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 Response from Victorian Poisons Information Centre	Accepted in full Accepted in full

Finding into death of Kathleen Arnold

Keywords: Alcohol toxicity, chronic alcoholism, ethanol, heavy alcohol consumption, alcohol harm reduction, food delivery services, late-night alcohol delivery

Recommendation	Response	Response outcome
That the Secretary of the Victorian Department of Justice and Community Safety consider amending the Liquor Control Reform Act 1998 (Vic), along with any required regulations, as appropriate, to prohibit home delivery of alcohol between 10pm and 10am in Victoria.	Response from Department of Justice and Community Safety	Under consideration
That the Secretary of the Victorian Department of Justice and Community Safety consider amending the Liquor Control Reform Act 1998 (Vic), along with any required regulations, as appropriate, to require a minimum two-hour delay between order and dispatch of alcohol for home delivery in Victoria.	Response from Department of Justice and Community Safety	Under consideration
That the Victorian Government, led by the Victorian Department of Health, develop: (i) a new Alcohol Action Plan; or (ii) a program of work (including specific actions, timeframes, accountabilities, and public reporting on implementation and evaluation) to address alcohol related harms in Victoria.	Response from Department of Health	Accepted in full

Finding into death of Jay Joseph Harrison

Keywords: Homelessness, mixed drug toxicity, mental health, financial stress, inpatient mental health admissions, police contact history, community treatment order, non-compliance, substance use

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	Response from Department of the Prime Minister and Cabinet	Accepted in part
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	Alternative adopted
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.	Response from Department Justice and Community Safety	Under consideration

Finding into death of Emma Louise Terrill

Keywords: Mixed drug toxicity, pain management, prescribing practices, Schedule 8, Schedule 4, complex medical history, mental health, self-harm, substance use, SafeScript

Recommendation	Response	Response outcome
That the Australian Government Department of Health, Disability and Ageing consider increasing the rebate for mental health case conferencing Medicare Benefits Scheme (MBS) item numbers and expanding what is covered by these item numbers to include complex psychiatric conferencing between a GP and psychiatrist in the absence of the patient.	Response from Australian Government Department of Health, Disability and Ageing	Accepted in full

Finding into death of Jonathan Mark Townsend

Keywords: PTSD, substance use, AOD treatment, Department of Veterans Affairs funding, mental health, detox, rehabilitation clinic, hospital discharge, veteran health care

Recommendation	Response	Response outcome
That the Australian Government amend the Department of Veterans' Affairs fee schedule to mitigate the challenges faced by veterans in accessing health care, ensuring that: (i) at a minimum, the revised fee schedule aligns with that of the National Disability Insurance Scheme; and	Response from Department of the Prime Minister and Cabinet	Alternative adopted
(ii) efforts to mitigate supply constraints are prioritised, such as non-fee-for-service components, additional loading, and/or incentive payments, including in areas with few health services for the populations being served.	Response from Department of the Prime Minister and Cabinet	Alternative adopted

Medical

Finding into death of Sheila Quairney

Keywords: Myocardial infarction, missed diagnosis, emergency department presentation

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that St Vincent's Hospital and the Australasian College for Emergency Medicine consider adopting Sheila Marion Quairney's matter as a case study to highlight the importance of a comprehensive primary and secondary assessment and of the consideration of acute coronary syndrome in females who may present atypically.	Response from St Vincent's Hospital Melbourne Response from Australasian College for Emergency Medicine	Accepted in full Accepted in full

Finding into death Robert John Robinson

Keywords: pulmonary thromboembolism, deep vein thrombosis, post-surgical complications, umbilical hernia repair, complex medical history, VTE risk assessment

Recommendation	Response	Response outcome
In the interests of promoting public health and safety, I recommend that Bass Coast Health remind staff members involved in the care of patients of the importance of completing thorough, legible and contemporaneous documentation.	Response from Bass Coast Health	Accepted in full

Finding into death of Michael James Batten

Keywords: complex medical history, valvular heart disease, transoesophageal echocardiogram, aortic stenosis, treatment delay

Recommendation	Response	Response outcome
I recommend that NH update its 'Cardiology Checklist' document to ensure that required follow up appointments are scheduled by the responsible clinician/team.	Response from Northern Health	Accepted in full
I recommend that NH review its Cardiology policies and procedures, to ensure sufficient clarity regarding which clinician/team is responsible for scheduling follow up appointments with patients who undergo a diagnostic procedure, following referral from a Cardiologist.	Response from Northern Health	Accepted in full

Finding into death of Nazlou (Helen) Danildis

Keywords: inpatient, fall, valvular heart disease, falls risk, femur fracture

Recommendation	Response	Response outcome
I recommend that Northern Health review their relevant falls risk mitigation strategies (including relevant policies and procedures) and ensure that the use of any sensor mat alarms require not only proper placement and positioning but should be tested to ensure activation and alarms are operational before implementation with a patient.	Response from Northern Health	Accepted in full

Finding into death of Graeme Dimsey

Keywords: Orthopaedic surgery, sepsis, intellectual disability, diagnostic error, inpatient, complex medical needs, complex medical history

Recommendation	Response	Response outcome
In the interests of public health and safety and with the aim of preventing like deaths, I recommend that Grampians Health conduct a review of the circumstances within which Graeme William Dimsey's death occurred in order to produce guidelines for staff with regard to the assessment and management of patients for whom disability, cognitive impairment, mental health or other conditions contribute to a risk of difficult, unreliable or inconsistent clinical assessment, particularly as it relates to patient history-taking regime and physical examination.	Response from Grampians Health	Accepted in full
In the interests of public health and safety and with the aim of preventing like deaths, I recommend that Grampians Health conduct a review of the scientific literature on the risk of iatrogenic complications of diagnostic joint aspiration and produce evidence-based guidelines, to be developed at a multidisciplinary consultant level, to balance the risk of complication with the risk of missing a diagnosis of joint infection in patients with sepsis where the possibility exists that a joint infection may be implicated.	Response from Grampians Health	Alternative adopted

Finding into death of Barbara Anne Deal

Keywords: Pulmonary embolism, deep vein thrombosis, hospitalised patient VTE, inpatient, complex medical history, chronic pain, spinal fusion, post-surgical complications

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and reducing like deaths, I recommend that Healthscope consult the 'Victorian sentinel event guide (Version 2)' published by Safer Care Victoria and provide education to its clinicians on their responsibility to identify, report and investigate patient deaths which constitute sentinel events.	Response from Melbourne Private Hospital (Healthscope)	Accepted in full

Finding into death of Alan Deem

Keywords: Coronary artery angioplasty, coronary artery dissection, occlusion, inter-hospital transfer delay, deficient medical records, intercranial bleeding, post-surgical complications

Recommendation	Response	Response outcome
I recommend that Western Health determine whether the delay in the referral was exacerbated by the lack of documentation or medical records; and	Response from Western Health	Accepted in full
I recommend that Western Health develop and implement measures to ensure referrals are expedited or completed in a timely manner; and	Response from Western Health	Under consideration
I recommend that The Royal Melbourne Hospital develop and implement a process to ensure that their clinicians comply with their own record-keeping policy(ies); and	Response from Melbourne Health (Royal Melbourne Hospital)	Rejected in full
I recommend that The Royal Melbourne Hospital develop a toolkit to facilitate their clinicians' compliance with the own policy(ies); and further	Response from Melbourne Health (Royal Melbourne Hospital)	Rejected in full
I recommend that the Victorian Department of Health encourage and facilitate the roll-out of CareSync Exchange system or program with a functionality to facilitate inter-hospital transfer documentation where the referring hospital is able to write a referral to which the receiving hospital is able to respond in real time.	Response from The Department of Health	Accepted in part

Finding into death of Caroline McCormack

Keywords: medication administration error, chronic obstructive airways disease, inpatient, complex medical history, chronic illness, pharmacy error, dispensing error

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that the Pharmacy Guild of Australia consider a means by which hospital discharge medication list could be provided directly to a patient's regular or community pharmacy, particularly where that patient relies on a Webster-pak or similar dose administration aid.	Response from The Pharmacy Guild of Australia	Accepted in part

Transport and Road Safety

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	Accepted in full

Finding into death of Grant Dimitrijevic

Keywords: Motor vehicle incident, wandering livestock, public road, cow, collision

Recommendation	Response	Response outcome
In the interests of public health and safety and with the aim of preventing similar deaths, I recommend that the Department of Transport and Planning collaborate with all the relevant stakeholders and/or authorities to develop reporting or information sharing mechanisms when any of the stakeholders and/or authorities receive or are investigating reports of wandering livestock in the Moriac area.	Response from Department of Transport and Planning	Accepted in full

Finding into death of Jürg-Peter Styner

Keywords: Motor vehicle incident, international tourist driver, head-on collision, isolated rural area

Recommendation	Response	Response outcome
That the Secretary to the Department of Transport and Planning: A. Reduce the speed limit to 80 km/h on the bends on this stretch of road which do not qualify for centre line marking by virtue of having less than 6.2 metres of bitumen road available at that point; and	Response from Department of Transport and Planning	Alternative adopted
B: Install 'Drive on left side of Road' signs along the increasingly popular Silo Art trail, so as to assist international visitors.	Response from Department of Transport and Planning	Rejected in full

Finding into death of Frank Baker

Keywords: Bellarine Highway, motor vehicle collision, loss of control, poor road condition, poor road surface, wet weather

Recommendation	Response	Response outcome
In the interest of public safety, to prevent further death and injuries, I recommend that the Secretary Department of Transport and Planning immediately prioritise the resurfacing of the westbound lanes of Bellarine Highway in Wallington (between Curlewis Road and Fenwick Street), Victoria.	Response from Department of Transport and Planning	Accepted in full
If not already undertaken, the resurfacing of this section of the Bellarine Highway should be completed before the rains of winter 2025, to avoid another prolonged period of hazardous road conditions along this section of the road, in particular in the wet.	Response from Department of Transport and Planning	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 Response from Department of Transport and Planning	Rejected in full 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 Response from Greater Dandenong Council	Alternative adopted Alternative adopted

Finding into death of Moustafa Aboueid

Keywords: private electric scooters, e-scooters, high power output, design and performance, permitted use, regulation, importation, speed hump, head injury

Recommendation	Response	Response outcome
With a view to supporting Victorian road safety legislation (and the road safety legislation of other states and territories) which prohibits the use of high power / high speed e-scooters on public roads, the Secretary of the Department of Infrastructure, Transport, Regional Development, Communications and the Arts: (a) review the conclusion that e-scooters capable of speeds higher than 25 km/h are not road vehicles for the purposes of the *Road Vehicles Standards Act 2018*; (b) consider a ban on the importation of high power / high speed e-scooters, save for individual instances on an exemption basis where a proper use case can be established and; (c) consider a ban on the sale within Australia of high power / high speed e-scooters, save for individual instances on an exemption basis where a proper use case can be established.	Response from Department of Infrastructure, Transport, Regional Development, Communications, Sport and the Arts	Under consideration
That the Victorian Minister for Transport and Planning seek to introduce amendments to Part 6A of the *Road Safety Act 1986* to provide for the forfeiture of high power / high speed e-scooters that do not fall within the exemption to not be a motor vehicle within the meaning of the *Road Safety Act 1986*, if used on a public road or road related area.	Response from Department of Transport and Planning	Under consideration

Finding into death of Nitin Prabhu

Keywords: E-bicycle, e-bike, motorcycle, regulation, head injury, collision

Recommendation	Response	Response outcome
With the aim of improving public health and safety and preventing like deaths, I recommend that Victoria Police obtain a dynamometer capable of testing e-bicycles and similar vehicles to determine whether they comply with Victorian regulations, including in instances where those vehicles are substantially damaged in an incident.	Response from Victoria Police	Rejected in full
With the aim of improving public health and safety and preventing like deaths, I recommend that representatives of Victoria Police, the Victorian Department of Transport and of VicRoads convene to discuss the issue of non-compliant e-bicycles. Specifically, this conference ought to be used to consider methods to identify noncompliant e-bicycles, including those which may seem radical – such as requiring the registration of all e-bicycles.	Response from Victoria Police Response from Department of Transport and Planning	Accepted in full Accepted in full

Finding into death of Sharon O’Neill

Keywords: motor vehicle incident, motor scooter, training, training facility, motorcycle learner beginner course, collision, wire mesh fence, learner rider

Recommendation	Response	Response outcome
That the Department of Transport and Planning implement the recommendations detailed at section 6.3.1 of the review by Safe System Solutions Pty Ltd dated 18 July 2024 (titled Motorcycle Training Assessment Facility/Equipment Review) in respect of amendments to its Business Procedures Manual to require appropriate containment devices at motorcycle rider training facilities	Response from The Department of Transport and Planning	Accepted in full

Finding into Nancy Doreen Hay

Keywords: motorised mobility scooter, collision, tram

Recommendation	Response	Response outcome
That by September 2025, Yarra Trams and the DTP complete the current network-wide assessment of legacy tram stops that may require safety modifications.	Response from The Department of Transport and Planning Response from Yarra Trams	Accepted in full Accepted in full

Finding into death of Takamasa Takeda

Keywords: Motor vehicle collision, pedestrian, horse riding, road crossing, cannabis, THC, track rider, head injury

Recommendation	Response	Response outcome
I recommend that VicRoads and the Transport Accident Commission consider updating their public education materials in relation to cannabis use and driving to reflect the longer-term effects on driving risk beyond the immediate psychoactive phase.	Joint response from Department of Transport and Planning and Transport Accident Commission	Accepted in full

Finding into death of Robin Banks

Keywords: Fitness to drive, elderly driver, motor vehicle incident, head-on collision, slow speed, medical complications

Recommendation	Response	Response outcome
That the Secretary, Department of Transport and Planning develop a public education and awareness campaign about the importance of understanding the fitness to drive guidelines and obligations on individuals to inform VicRoads of any medical conditions that may impair their fitness to drive	Response from Department of Transport and Planning	Accepted in full
That the public education and awareness campaign also addresses the need to ensure the general community is aware of the process for reporting concerns about a person's fitness to drive to VicRoads, including information that such reports can be made anonymously.	Response from Department of Transport and Planning	Accepted in full

Finding into death of Steven Parlby

Keywords: Fitness to drive, driving assessments, motor vehicle incident, driver licence suitability

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 Secretary of the Department of Transport and Planning consider adopting a framework which required medical practitioners to submit a report to VicRoads when they form the belief that a person is not medically fit to drive.	Response from Department of Transport and Planning	Under consideration

Deaths in custody

Finding into passing of Michael Suckling

Keywords: death in custody, custodial healthcare system, obesity, cardiomegaly, natural causes, Ravenhall Correctional Centre

Recommendation	Response	Response outcome
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	Accepted in part
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	Accepted in full
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	Accepted in full

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	Under consideration
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: 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. 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	Alternative adopted
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: a) clear referral criteria for identification of complex cases and inclusion in complex case management meetings; 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 there patient has at least one comorbidity, unless otherwise clinically indicated;	Response from Department of Justice and Community Safety	Accepted in full

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.		
That Justice Health mandates a requirement for primary health service providers in prisons that: a) a prisoner who is prescribed psychotropic medication should be screened for cardiometabolic risks; and 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	Accepted in full
That Justice Health makes modifications necessary in J-Care to allow for the following: a) Inclusion of details in J-Care that indicate the full name, role, discipline and employer of clinicians; b) Add in fields or drop-down options to accurately record reasons for non-attendance; c) Development of fields to record height, weight, waist circumference and calculation of BMI;	Response from Department of Justice and Community Safety	Accepted in full
That Justice Health explore the feasibility of developing the following: a) a prompt for cardiometabolic monitoring in relation to patients on psychotropic and other weight-gaining medications; and 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	Under consideration

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	Accepted in full
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 Response from St Vincent's Hospital Melbourne Response from Forensicare	Accepted in full Accepted in full Accepted in full
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 Response from St Vincent's Hospital Melbourne Response from Forensicare	Accepted in full Accepted in full Accepted in full
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 minimum of one full-time equivalent AHW at every prison in Victoria.	Response from Department of Justice and Community Safety Response from GEO Group Response from St Vincent's Hospital Melbourne	Accepted in full Accepted in full Accepted in full
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 Response from St Vincent's Hospital Melbourne Response from Forensicare	Accepted in full Accepted in full Accepted in full

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 Response from St Vincent's Hospital Melbourne Response from Forensicare	Accepted in full Accepted in part Accepted in full
That Health Service Providers develop a policy or operating 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 GEO Group Response from St Vincent's Hospital Melbourne Response from Forensicare	Accepted in full Accepted in part Accepted in full
That Health Service Providers consider developing additional KPI measurements that are outcome focussed rather than quantitative measurements.	Response from GEO Group Response from St Vincent's Hospital Melbourne Response from Forensicare	Accepted in part Accepted in part Accepted in full
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 Response from St Vincent's Hospital Melbourne Response from Forensicare	Accepted in part Accepted in part Accepted in full
That GEO educates its correctional staff about appropriate referral pathways for prisoners facing mental health or medical issues,	Response from GEO Group	Accepted in full

including clarifying the role and function of the key clinician		
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
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 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	Under consideration

Finding into passing of Heather Calgaret

Keywords: in custody, health care, suboxone, parole, prison health care, vulnerable person, chronic health care plan, mental health, cultural safety

Recommendation	Response	Response outcome
I recommend that Justice Health investigate and establish appropriate measures to ensure that: a. women who give birth in custody, or proximate to their remand into custody, are adequately screened and monitored for post-natal mental health symptoms and treated with appropriate post-natal care; and b. consider establishing an automatic referral to Forensicare for assessment.	Response from Department of Justice and Community Safety	Accepted in full
I recommend that Justice Health investigate and establish appropriate measures to ensure that: a. women who are refused access to the Living with Mum Program, are adequately supported following the removal of their newborn, and b. consider establishing an automatic referral to Forensicare for assessment.	Response from Department of Justice and Community Safety	Accepted in full
I recommend that Justice Health make modifications necessary for JCare to allow for the following: a. weights and girths of prisoners to be entered as a specific entry on JCare; and b. an alert for significant weight increases be highlighted on JCare for clinicians.	Response from Department of Justice and Community Safety	Accepted in part
I recommend that Justice Health engage with government and stakeholders to improve access to	Response from Department of	Under consideration

psychological services for women at DPFC.	Justice and Community Safety	
I recommend that Justice Health collaborate with health service providers to ensure that commitments under the 2023 Quality framework and other applicable health standards are consistent with the following outcomes, a. the scheduling of multi-disciplinary reviews for patients with complex health needs in order to treat and monitor their care holistically; b. the scheduling of regular pharmacological reviews for patients who are prescribed multiple medications and/or have complex health presentations; c. that health service providers conduct baseline testing of patients, including weight and BMI measurements, before commencing psychotropic medication; d. that chronic health care plans are properly documented upon recognition of a patient's eligibility for a chronic health care plan. Proper documentation includes identification of treatment plans, reporting on progress of treatment plans and regular oversight and review of plans; and f. identification and intervention to address ongoing deterioration of a patient's physical and/or mental health.	Response from Department of Justice and Community Safety	Accepted in full
I recommend that Justice Health, a. continue to explore ways to develop an in-reach model for Aboriginal Community Controlled Health Organisations to provide primary healthcare services to Aboriginal people in custody; b. engage with Aboriginal Community Controlled	Response from Department of Justice and Community Safety	Accepted in full

Health Organisations to co-design auditing tools and processes to develop an independent and robust oversight and accountability system for all providers of prison healthcare (both public and private).		
I endorse the following recommendations made to DJCS and other key departments in the Ombudsman's Report made aimed to: a. involve Aboriginal Community-Controlled Organisations in the design and delivery of holistic custodial services that are culturally safe and responsive to Aboriginal people, culture and rights; b. increase Justice Health's capacity to oversight the delivery of culturally responsive healthcare to Aboriginal people by developing and implementing a capability building plan; c. consider ways to vary the current custodial primary health contracts to provide oversight that is more culturally safe and responsive to Aboriginal people; d. develop an audit framework to regularly assess the clinical effectiveness and cultural responsiveness of healthcare delivery to Aboriginal people across all Victorian prisons; and e. invest in education and training to increase the number of Aboriginal health professionals in Victoria and better support their career development.	Response from Department of Justice and Community Safety	Accepted in full
I recommend that DJCS investigate ways to ensure that the parole application process, including the availability of required treatment programs, is consistent with, a. the Commissioner's Requirement 2.6.1 – Parol Application Process,	Response from Department of Justice and Community Safety	Accepted in full

which requires that the parole application process must occur in a timely manner and not prevent or delay the APB's consideration of a prisoner for parole; b. the commitment to reduce over-representation of Aboriginal and Torres Strait Islander people in Victorian custodial settings; c. the principles of Aboriginal self-determination in the custodial setting ; d. Recommendation 244 of the RCIADC; and e. The right to equality under the Charter of Human Rights of Responsibilities, particularly with respect to access to required treatment programs for women.		
I recommend that DJCS explores ways to ensure that Aboriginal and Torres Strait Islander parole applicants are assigned an Aboriginal Case Manager.	Response from Department of Justice and Community Safety	Accepted in full
I recommend that DJCS, in consultation with the Naalamba Ganbu Nerrlinggu Yilam (the Yilam), explore ways to improve support for Aboriginal and Torres Strait Islander parole applicants to help navigate the parole application process, and improve justice outcomes for those prisoners.	Response from Department of Justice and Community Safety	Accepted in full
I recommend that DJCS, in consultation with the Yilam, give consideration to raising through the Aboriginal Justice Forum, concerns about the potential for the parole application process to undermine the integrity of sentences, and potentially reduce the availability of a period of supervision while on parole, which is an essential component to the management of community safety and the rehabilitation of a prisoner.	Response from Department of Justice and Community Safety	Under consideration

I endorse the Justice Review recommendations that Corrections and Justice Services update relevant Practice Guidelines to: a. Require Parole Officers to engage with Forensic Intervention Services to ensure they have up to date information about program availability both in custody and the community prior to the prisoners Earliest Discharge Date. b. Clarify that, in circumstances where a prisoner has requested to complete treatment programs in the community and Forensic Intervention Services has advised that the treatment is available, a Parole Officer can progress the Parole Suitability Assessment to the Adult Parole Board for consideration. c. Require Parole Officers to engage with their Principal Practitioner on prisoner requests relating to a parole application (including an application for a Parole Suitability Assessment) and document the rationale and outcome of such requests within the Offender Management File. d. Require Parole Officers to promptly respond to prisoner requests made in relation to a parole application (including an application for a Parole Suitability Assessment) and explain the outcome to the prisoner.	Response from Department of Justice and Community Safety	Accepted in part
I recommend that Justice Health continue to work with health service providers to ensure that all staff, including all agency staff, are adequately trained in all relevant prison processes, including responses to a Code Black and the use of emergency equipment on site, prior to the commencement of employment and that regular.	Response from Department of Justice and Community Safety	Accepted in full

I recommend that Justice Health audit all health service providers to identify that emergency medical equipment is regularly checked and maintained in good working order to ensure functionality and reliability during incident responses.	Response from Department of Justice and Community Safety	Accepted in full
I recommend that Justice Health work with health service providers to ensure that all staff, including all agency staff, and officers receive training in drug overdoses and the administration of naloxone.	Response from Department of Justice and Community Safety	Accepted in full
I recommend that Justice Health work with health service providers to provide and reinforce clear practical training to all staff on basic life support processes, escalating care and emergency management in the prison environment. Practical resources, such as lanyards, and posters, should be developed and disseminated throughout prisons.	Response from Department of Justice and Community Safety	Accepted in full

Finding into death of Brent Reker

Keywords: in custody, suicide, prisoner transfer, suicide, self-harm, suicide and self-harm history (SASH), cell barricade, cell cameras, remote viewing, mental health

Recommendation	Response	Response outcome
That, in order to promote an increased awareness by custodial managers and custodial officers of the essential details of previous episodes of suicidal or self-harming behaviour by a prisoner, and to prominently convey meaningful context associated with a SASH rating, the Secretary to the Department of Justice and Community Safety: (a) review the manner in which the details of previous episodes of suicidal or self harming behaviour are contained in a prisoner's Individual Management File and other prisoner information systems intended for use by custodial officers, with the aim of making this information more prominent in an operational setting; and (b) require prison operators to review the training provided to custodial supervisors and custodial officers to reinforce the need for a thorough examination of prisoner information relating to any SASH rating, in order to properly inform prisoner assessment processes and relevant operational decisions concerning the prisoner.	Response from Department of Justice and Community Safety	Accepted in full
That, in order to promote an increased awareness by custodial managers and custodial officers of the essential details of previous episodes of suicidal or self-harming behaviour by a prisoner, and to prominently convey meaningful context associated with a SASH rating, GEO Group Australia Pty Ltd:	Response from GEO Group	Accepted in full

(a) review the manner in which the details of previous episodes of suicidal or self harming behaviour are contained in GEO prisoner information systems with the aim of making this information more prominent in an operational setting; and (b) review its training of custodial supervisors and custodial officers to reinforce the need for a thorough examination of prisoner information relating to any SASH rating, in order to properly inform prisoner assessment processes and relevant operational decisions concerning the prisoner.		
That, in order to permit remote viewing of the interior of a cell in the event a prisoner blocks direct physical means of seeing inside the cell, the Secretary to the Department of Justice and Community Safety require prison operators to install a video camera (or cameras) in every management unit cell.	Response from Department of Justice and Community Safety	Rejected in full
That the Secretary to the Department of Justice and Community Safety require prison operators to: (a) have available in all units in prisons, a borescope camera (or similar technology) for use by custodial officers as an alternate or emergency means of seeing inside a barricaded cell; and (b) adequately train custodial officers in the use of the borescope camera (or whatever similar technology may be adopted)	Response from Department of Justice and Community Safety	Accepted in full

Aged care

Finding into death of Sylvie Burton

Keywords: Food bolus, aged care, acute upper airway obstruction, complex medical needs

Recommendation	Response	Response outcome
(That Regis Mornington (Regis Aged Care) ensure that all staff receive training and guidance to identify and appropriately respond to residents experiencing severe difficulty breathing due to a mild or severe obstruction of the airway due to a foreign body like a food bolus. This includes updating and/or developing appropriate choking hazard policies and procedures.	Response from Regis Aged Care	Accepted in full
That Regis Mornington (Regis Aged Care) ensure that all relevant staff that require first aid training certification have up to date refresher training that including responding to a choking adult or child.	Response from Regis Aged Care	Accepted in full

Family Violence

Finding into death of Ms KSQ

Keywords: Family violence, suicide, misidentification of primary aggressor, mental health, police contact, Family Violence Safety Notice, FVSN, Family Violence Intervention Order, FVIO, MARAM framework

Recommendation	Response	Response outcome
That the Department of Families, Fairness and Housing resource an expansion of co-responder programs, such as the Alexis Family Violence Response Model, across Victoria.	Response from Department of Families, Fairness and Housing	Alternative adopted

Finding into death of TCW

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

Recommendation	Response	Response outcome
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	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	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	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	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	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	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	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 and Housing	Alternative adopted

the aim of increasing the safety of women and their children.		
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	Under Consideration

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 Response from The Royal Australian and New Zealand College of Psychiatrists Response from Psychology Board of Australia	Alternative adopted Accepted in full 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
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	Alternative adopted
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	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	Rejected in full
5. Victoria Police and The Orange Door in two regions as a pilot collaborate to embed advanced	Response from Victoria Police	Under consideration

family violence practitioners within 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. 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	Under consideration
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 Response from Department of Families, Fairness and Housing	Alternative adopted Alternative adopted

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 Attorney-General's office	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: • Enabling service of charge-sheet and summons prior to release; • 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 • 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	Accepted in full

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	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
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: a. Our Watch (to provide independent national leadership on primary prevention) 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) c. Australian Bureau of Statistics (to deliver the Personal Safety Survey) d. Workplace Gender Equality Agency	Response from Department of the Prime Minister and Cabinet	Accepted in full

Finding into death of ZSQ

Keywords: Intimate partner homicide, family violence, mental health, substance use, family violence safety notice (FVSN), family violence intervention order (FVIO), co-responder programs

Recommendation	Response	Response outcome
That the Department of Families, Fairness and Housing and The Hon. Natalie Hutchins, Minister for the Prevention of Family Violence provide funding for the expansion of co-responder programs across Victoria, noting the numerous coronial recommendations and comments made about the benefits of co-responder models.	Response from Department of Families, Fairness and Housing	Accepted in part
That Corrections Victoria and investigate and implement a system to create real-time (or near real-time) notifications to Victoria Police when offenders are released from prison, to improve risk assessment and management strategies.	Response from Department of Justice and Community Safety (DJCS)	Alternative adopted

Finding into death of JNY

Keywords: Homicide, family violence, child protection, family violence intervention order (FVIO), personal safety intervention order (PSIO), systems abuse, MARAM, SOCIT, branding, sexual coercion/exploitation

Recommendation	Response	Response outcome
That Family Safety Victoria consider how best to integrate the evidence of branding and sexual coercion/exploitation demonstrated by this case and other research into the MARAM, its tools and training.	Response from Department of Families, Fairness and Housing	Under Consideration

Finding into death of HBG

Keywords: Family violence, intimate partner homicide, gambling, financial stress

Recommendation	Response	Response outcome
That the Department of Justice and Community Safety implement Recommendation 17c and d of the Rapid Review, namely: 17. The Commonwealth and state and territory governments to work with industries that are well positioned to prevent DFSV [Domestic, Family and Sexual Violence], including homicide, with a focus on alcohol and gambling industries in addition to media and pornography. This includes reviewing and strengthening alcohol and gambling regulatory environments to prioritise the prevention of gender-based violence. This should include: c. stronger restrictions leading to a total ban on advertising of gambling (Commonwealth and states and territories); d. examining the density of electronic gaming machines, and use of online gambling, in relation to the prevalence of DFSV across different populations and communities (Commonwealth and states and territories).	Response from Department of Justice and Community Safety	Alternative adopted

Finding into death of DCF

Keywords: Family violence, intimate partner homicide, mental health, family violence intervention order (FVIO), misidentification predominant aggressor, MARAM

Recommendation	Response	Response outcome
That Victoria Police fully implement recommendation 5 of the FVRIM December 2021 report, Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor, specifically to "Trial a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent (and possible for other targeted cohorts) before it is committed to Victoria Police's LEAP database." The review of Family Violence Reports should occur by police and members of the specialist family violence sector together. Victoria Police should work with Family Safety Victoria to implement this recommendation	Response from Department of Families, Fairness and Housing Response from Victoria Police	Accepted in full Accepted in full

Finding into death of William Charles Heddergott

Keywords: Family violence, adult safeguarding, disability, mental health, MARAM

Recommendation	Response	Response outcome
That the Department of Families, Fairness and Housing engage with the Commonwealth Government in relation to the prescription of Commonwealth Government entities such as the National Disability Insurance Agency (NDIA) and the NDIS Quality and Safeguards Commission as Information Share Entities (ISEs) under the Family Violence Information Sharing Scheme (FVISS) and in respect of the Multi Agency Risk Assessment and Management Framework (MARAM).	Response from Department of Families, Fairness and Housing	Under consideration
That the Psychology Board of Australia work with the Australian Psychological Society to implement mandatory family violence training and CPD for Australian psychiatrists.	Response from Psychology Board of Australia Response from Australian Psychological Society	Alternative adopted Accepted in part
That the Royal Australian and New Zealand College of Psychiatrists work with the Medical Board of Australia to implement mandatory family violence training and CPD for Australian psychiatrists.	Response from Medical Board of Australia Response from Royal Australian and New Zealand College of Psychiatrists	Alternative adopted Under consideration

Finding into death of GVY

Keywords: Family violence, coercive control, recent separation, recent intervention order, fixated threat, intimate partner homicide, support services, personal safety device, risk assessment, MARAM

Recommendation	Response	Response outcome
That Respect Victoria invest in researching possible interventions with the 'fixated threat' cohort of intimate partner homicide offenders, with a focus on identifying opportunities for primary prevention and early intervention. This research should consider the role of trauma on the decision to use family violence and explore opportunities to strengthen system capacity to engage, where appropriate, with 'fixated threat' individuals in addressing and dismantling the choice to use violence. Research into early intervention with this cohort should explore the health settings as a point of intervention with these individuals and how to mobilise health settings to identify and respond to these individuals.	Response from the Department of Families, Fairness and Housing	Alternative adopted
That Family Safety Victoria review avenues to rectify delays in specialist family violence services contacting people who use violence and implement any appropriate strategies to improve same.	Response from the Department of Families, Fairness and Housing	Under consideration

Finding into passing of Helena Broadbent

Keywords: Family violence, dangerous driving, motor vehicle incident, separation, pregnancy, family violence intervention order (FVIO), MARAM, child protection

Recommendation	Response	Response outcome
I endorse and support Recommendation 13 (e) of the Commonwealth Government's Rapid Review of Prevention Approaches to domestic, family and sexual violence (DFSV), Unlocking the Prevention Potential. I recommend the Department of Premier and Cabinet (or another suitable department) establish a mechanism or entity for independent oversight and accountability of police response and management of family violence, ensuring they are resourced to undertake prompt and thorough reviews as necessary. This should be civilian-led and sit outside Victoria Police. Given the over-representation of First Nations women who experience family violence, I therefore recommend that such a mechanism should be developed in consultation with Aboriginal organisations such as the VALS.	Response from The Department of Premier and Cabinet	Under consideration
That Family Safety Victoria make the following changes to the Flexible Support Package: a) Ensuring that all FSP providers comply with consistent and comprehensive guidelines, removing situations in which "some providers appear to be more lenient than others", in particular, that updates to packages are not discouraged or disallowed, providing they comply with the guidelines. b) Exploring enhancements to the FSP online portal to make it more	Response from Department of Families, Fairness and Housing (Family Safety Victoria)	Under consideration

user-friendly and transform it into an end-to-end platform, rather than relying on email correspondence between FSP providers and case managers. c) Require all case managers who assist victim-survivors to access FSPs to be trained in trauma-informed care and practice, to better support people who have experienced family violence.		

Finding into death of FCP

Keywords: Family violence, drowning, mental health, suicide, substance use, suicidality, identification of predominant aggressor, MARAM

Recommendation	Response	Response outcome
a) That Victoria Police update their policies and documents to require members to document the reason for their decision to assign the roles of AFM and respondent and document the conversation(s) held with the respective parties/other witnesses when attending family violence incidents where the roles of AFM and respondent are not clear.	Response from Victoria Police	Accepted in full
b) That Victoria Police amend the Code of Practice, Victoria Police Manual and the new Predominant Aggressor Practice Guide to provide further information on the specific risk of misidentifying women with mental illness as primary aggressors when they do not present as 'ideal victims' due, for example, to: i. Perceived aggression, agitation or erratic behaviour ii. Substance use or lack of calm cooperation with police iii. Use of violent resistance, including self-defence.	Response from Victoria Police	Accepted in full
c) That Victoria Police fully implement recommendation 5 of the FVRIM December 2021 report, Monitoring Victoria's family violence reforms: Accurate identification of the predominant aggressor, specifically to "Trial a review process, involving the specialist family violence sector, for any Family Violence Report where a woman is identified as a respondent (and possible for other targeted cohorts) before it is committed to Victoria Police's LEAP database."	Response from Victoria Police	Rejected in full

The review of Family Violence Reports should occur by police and members of the specialist family violence sector together.		

Finding into death of RFV

Keywords: Family violence, homicide, substance abuse, familial relationship, substance use, elderly person

Recommendation	Response	Response outcome
That Victoria Police consider the importance of upskilling members in working with elderly people who experience family violence, as part of their review into family violence policies and procedures.	Response from Victoria Police	Accepted in full

Finding into death of Jessica Geddes

Keywords: Family violence, intimate partner homicide, mental health, begging, homelessness, substance use, family violence intervention order (FVIO), support services, co-responder model

Recommendation	Response	Response outcome
That Victoria Police develop welfare-oriented approaches to people who beg. In doing so, I recommend that the Victorian Government consider investing in a co-responder model which would see police members partner with community welfare practitioners when responding to reports of begging. I also recommend that Victoria Police develop a protocol/practice guideline to dissuade members from using a criminal response to people who beg and that encourages members to inquire as to the persons' needs and safety and offer referrals to welfare services.	Response from Victoria Police	Accepted in part
That Victoria Police and Department of Families, Fairness and Housing provide funding to implement Recommendation 5 in my Finding into the passing of Noeline Dalzell, as follows: Victoria Police and The Orange Door in two regions as a pilot collaborate to embed advanced family violence practitioners within 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. An independent evaluation of the pilot program	Response from Victoria Police Response from The Department of Families Fairness and Housing	Accepted in part Under consideration

should be completed within two years of commencing operation in each of the two regions selected.		

Finding into death of Monique Lezsak

Keywords: Homicide, intimate partner violence, coercive control, recent separation, support services, children bereaved by homicide

Recommendation	Response	Response outcome
That the Department of Families, Fairness and Housing and Family Safety Victoria work with and resource bodies such as Respect Victoria and Safe and Equal to deliver a public campaign to resource the broader community, beyond service providers, to better understand the risks that perpetrators of family violence pose, including in the absence of physical violence. This campaign should consider how to reach the broadest possible audience including through education, health, local community, sports and faith groups. The campaign should enhance awareness of fatality risks posed by those who use coercive and controlling behaviour, factors that may increase risk (such as in the context of separation) - and should include clear information to victims, friends, family and bystanders as to services available to help keep them safe.	Response from The Department of Families, Fairness and Housing	Accepted in full
That the Minster for Prevention of Family Violence provide funding for a service designed to provide support to children and young people (and their carers) bereaved by homicide.	Response from The Department of Families, Fairness and Housing	Under consideration

Finding into death of Ms HRZ

Keywords: Family violence, sexual abuse, physical abuse, culturally and linguistically diverse (CALD) persons, human rights, violence against women, Convention on the Elimination of All Forms of Violence Against Women

Recommendation	Response	Response outcome
That the Victorian Department of Justice and Community Safety consider the Broadmeadows Community Legal Service's submission to the Royal Commission into Family Violence and conduct sector-wide consultation and research about the feasibility of the same (specifically, to seek feedback from and conduct consultation with the family violence sector regarding the feasibility of the use of Applicant and Respondent Workers' risk assessments by the Magistrates Court of Victoria). Feedback should be obtained from (but not limited to) Applicant and Respondent workers, specialist family violence staff, Magistrates, Victoria Police and Victoria Legal Aid.	Response from The Department of Justice and Community Safety	Under consideration
That the Victorian Government review 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, to assess whether current funding levels meet needs in this space.	Response from The Department of Families, Fairness and Housing	Accepted in full
That the Victorian Government reaffirm its commitment to funding the development and implementation of a Sexual Violence Strategy, as outlined in the Victorian Law Reform Commission (VLRC) 2021 report, *Improving the Justice System Response to Sexual Offences* and provide a timeframe for its completion. As part of the	Response from The Department of Families, Fairness and Housing	Under consideration

Sexual Violence Strategy, the Victorian Government should: a) Develop a coordinated, community-wide approach to preventing sexual offending which includes investment in the development, delivery and evaluation of initiatives focused on the primary prevention of sexual violence by specialist sexual assault services and other relevant experts (including inTouch); and b) Consider the circumstances and comments contained within this finding with respect to any future investments in the expansion of: (i) Multi-Disciplinary Centres; (ii) Specialist Sexual Assault Services; and (iii) culturally responsive support for victim survivors of sexual violence.		
That the Commonwealth 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: a. Our Watch (to provide independent national leadership on primary prevention) 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)	Response from The Department of the Prime Minister and Cabinet	Accepted in full

c. Australian Bureau of Statistics (to deliver the Personal Safety Survey) d. Workplace Gender Equality Agency.		
That the Commonwealth Government work closely with the family violence sector to ensure the family violence funding allocated in the 2024 federal budget and future budgets provides appropriate and adequate support for migrant and refugee women experiencing family violence, including through investment in targeted prevention programs.	Response from The Department of the Prime Minister and Cabinet	Accepted in full

Finding into death of DRF

Keywords: Family violence, adult safeguarding, elder abuse, disability, culturally and linguistically diverse (CALD) communities, care and support needs

Recommendation	Response	Response outcome
That Victoria Police consider the possibility of modifying their body worn camera (BWC) units in collaboration with the relevant manufacturer(s) to emit an audible alert tone that reminds officers that their unit is muted.	Response from Victoria Police	Accepted in full
Or, in the alternative, that Victoria Police amend section 3.7 of the Victoria Police Manual – Body worn cameras to state that members must not mute body worn cameras during phone calls or other forms of contact with other police members, including supervisors, while responding to an incident that has required BWC activation.	Response from Victoria Police	Under consideration

Finding into death of Shirley Annette Kidd

Keywords: Family violence, past trauma, parricide, substance use, mental health, historical child abuse

Recommendation	Response	Response outcome
The Family Safety Victoria work with the Department of Families, Fairness and Housing to review and adequately resource statewide programs for recovery from family violence, including ensuring accessible programs tailored to the specific needs of young people.	Response from The Department of Families, Fairness and Housing/ Family Safety Victoria	Under consideration

Finding into death of PLM

Keywords: Family violence, homicide, homelessness, former partner, support services

Recommendation	Response	Response outcome
That the Victorian Government work with the Commonwealth Government to expand the MARAM framework to include NDIS service providers in Victoria and make them MARAM-prescribed entities.	Response from Department of Families, Fairness and Housing Response from Prime Minister and Cabinet	Under consideration Under consideration
That Victoria Police update its bail decision making policies/guidelines to note that the presence of an intervention order is not automatically considered a mitigating factor when deciding whether to bail an offender, particularly where there is a history of breaching intervention orders, bail and/or court orders. The decision-maker should consider the party's history of compliance with the order and/or bail as part of the decision-making process	Response from Victoria Police	Accepted in full

Finding into death of EDH

Keywords: Family violence, gendered violence, overdose, identification predominant aggressor, substance use, mental health, trauma, controlling behaviour, family violence intervention order (FVIO)

Recommendation	Response	Response outcome
That Safe and Equal update Code of Practice: Principles and Standards for Specialist Family Violence Services for Victim-Survivors or a similar practice guiding document to include: 1. clear instructions not to allocate workers to clients who they know personally, including family friends and acquaintances 2. clear guidance on what workers should do if they identify that they know a client personally after a referral has been made to them 3. clear guidance on how services should manage referrals where the client has a personal association with all available workers.	Response from Safe and Equal Australia	Rejected in full

Finding into death of Stephen O'Brien

Keywords: Family violence, elder abuse, undiagnosed mental illness, unreported family violence, MARAM

Recommendation	Response	Response outcome
That the Victorian Government implement the recommendation from Mind Australia in their submission to the RCVMHS by developing mechanisms that assist in identifying 'hidden' mental health carers and families that do not rely on self-identification. This could be through GPs, community health centres, My Aged Care, primary health networks, schools and other educational settings and workplaces.	Response from Department of Health	Accepted in part
That the Victorian Government implement the submission by Seniors Rights Victoria and the Council on the Aging to the Inquiry into Capturing Data on Family Violence Perpetrators, namely, to raise awareness through targeted campaigns and greater investment in community education to educate older people about the various forms of elder abuse and the importance of seeking help, providing clear information on where and how to get assistance to empower them to report abuse, thus improving data collection and enabling timely intervention.	Response from Department of Families, Fairness and Housing	Under consideration
That the Victorian Government fund pilot programs of integrated response models of care specifically for both victim survivors and perpetrators of elder abuse, given the barriers to engage with support for this type of family violence.	Response from Department of Families, Fairness and Housing	Under consideration

Finding into death of CFT

Keywords: Adult safeguarding, vulnerable adults, adults with disability, at-risk adults, guardian advocate, familial relationship, neglect

Recommendation	Response	Response outcome
1. That the Office of the Public Advocate whenever they become aware of any allegations of neglect or abuse of a represented persons where a guardianship and administrative order is made by VCAT conduct a thorough investigation. This investigation could be carried out by the Office of the Public Advocate or another agency at their request. The outcome of the investigation should inform the guardian advocate's decision-making, where appropriate.	Response from the Office of the Public Advocate	Alternative adopted
2. When implementing the VAGO recommendation that the Office of the Public Advocate "review and update its guidance about allocating orders and balancing the risk of harm when making decisions", the Office of the Public Advocate should review their training, policies, procedures and guidelines to ensure guardian advocates have the guidance and skills necessary to appropriately assess the risks of harm to represented people which may emanate from neglect and unmet care needs.	Response from the Office of the Public Advocate	Accepted in full
3. That the Victorian Government make available appropriate funding to the Office of the Public Advocate to enable it to implement all of the recommendations from the VAGO report	Response from the Office of the Public Advocate Response from Department of Justice and Community Safety	Accepted in full Accepted in full
4. The Victorian Government implement as a priority, adult safeguarding legislation to establish adult safeguarding functions	Response from Department of Families Fairness and Housing	Under consideration

including but not limited to the assessment and investigation of, and coordination of responses to allegations of abuse, neglect, and exploitation of at-risk adults.		
5. In framing legislation, the Victorian Government review the circumstances of CFT's passing and similar cases together with the safeguarding recommendations of the ALRC, the OPA and the DRC.	Response from Department of Families Fairness and Housing	Under consideration
6. That any new adult safeguarding agencies be adequately funded by the Victorian Government to function in an effective manner.	Response from Department of Families Fairness and Housing	Under consideration
7. That the Victorian Government, when establishing a new safeguarding agency, should ensure that the agency works cooperatively with other service providers to facilitate the timely provision of, or changes to, the support services provided to at-risk adults.	Response from Department of Families Fairness and Housing	Under consideration
8. That the Victorian Government introduce legislation to permit an adult safeguarding agency to receive and share information in a timely manner, including information about neglect, with police, healthcare entities, government departments, the Office of the Public Advocate and any other agencies involved.	Response from Department of Families Fairness and Housing	Under consideration
9. That the Victorian Government implement the recommendation of the Office of the Public Advocate, namely, to build the capacity of mainstream service providers to be able to identify and respond to the abuse of at-risk adults.	Response from Department of Families Fairness and Housing	Under consideration
10. That the Victorian Government make funding available for regular community awareness, media engagement and education campaigns about any new adult	Response from Department of Families Fairness and Housing	Under consideration

safeguarding function, as suggested by the Disability Royal Commission.		

Finding into death of CM

Keywords: Suicide, family violence, service interactions, Victorian Systemic Review of Family Violence Deaths (VSRFVD), mental health, substance use, MARAM

Recommendation	Response	Response outcome
That the Victorian Government fund further research into the link between family violence and suicide.	Response from Department of Families, Fairness and Housing	Under consideration
That Austin Health further consider the integration of risk 'flags' or other notifications into and across their patient record system where serious risk of family violence has been identified.	Response from Austin Health	Accepted in full
That the Victorian Government resource an expansion of co-responder programs across Victoria.	Response from Department of Families, Fairness and Housing	Under consideration

Child/infant deaths

Finding into death of Tasman Tribe

Keywords: Neonate, PPROM, emergency caesarean, traumatic head injury, birth complications, PIPER

Recommendation	Response	Response outcome
That Barwon 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 Barwon Health	Alternative adopted

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
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 death of Amir Iran

Keywords: neonate, pediatric, inpatient, intensive care unit, respiratory disorder, diagnostic delay, atypical presentation, surfactant

Recommendation	Response	Response outcome
That the Royal Women's Hospital, PIPER and Safer Care Victoria review their guidelines relating to surfactant to ensure prompt administration to newborns who require intubation for respiratory distress and that initial and repeat doses accord with the latest available evidence bearing in mind interstate and European guidelines and the manufacturer's user guide.	Response from Royal Children's Hospital Response from Royal Women's Hospital Response from Safer Care Victoria	Accepted in full Accepted in full Accepted in full
That parents of newborns be informed of the importance of and encouraged to notify carers in relation to any changes in colour or breathing, supported by visual signs to aid education.	Response from Royal Women's Hospital	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
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	Alternative adopted

Finding into passings of Child 1, Child 2, Child 3, Child 4

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

Recommendation	Response	Response outcome
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). 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. 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 Response from Victorian Aboriginal Child Care Agency	Under consideration 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	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. b) That DFFH publicly report on the implementation and evaluation of the SAFER framework.	Response from Department of Families, Fairness and Housing	Alternative adopted

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) 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	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	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	Under consideration
7. a) The Victorian Government develop a further workforce (beyond	Response from Department of	Accepted in part

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. 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. 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. 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. 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	

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
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	Accepted in full

Finding into death of Baby M

Keywords: Perinatal asphyxia, cord compression, neonatal resuscitation, training

Recommendation	Response	Response outcome
That Safer Care Victoria consider requiring Victorian health services to ensure that staff who attend deliveries undertake neonatal resuscitation training and that this training include high-fidelity simulation training.	Response from Safer Care Victoria	Accepted in part

Finding into passing of GFD

Keywords: Malnutrition, family violence, vulnerable infant, support services

Recommendation	Response	Response outcome
That the Department of Health work with the Municipal Association of Victoria (MAV) and all local councils and associated MCHNs to review their policies to ensure that they all have documented processes of follow-up and assessment where a family has previously been engaged with EMCHN and then disengages.	Response from Department of Health Response from Municipal Association of Victoria	Accepted in full Accepted in part

Finding into death of Baby E

Keywords: Home birth, water birth, free birth, prolonged labour, birthing pool, meconium inhalation, inflammatory response, bacterial infection

Recommendation	Response	Response outcome
That the Department of Health update relevant websites, including the Better Health Channel, with Safer Care Victoria's 'Guidance: Water for labour and birth' and RANZCOG's best practice statement 'Water immersion during labour and birth'.	Response from Department of Health	Accepted in part

Finding into death of Aluel Ajak

Keywords: Public housing, child, disability, risk of absconding, housing transfer application, home modifications, motor vehicle incident

Recommendation	Response	Response outcome
That Homes Victoria review their guidelines for the processing of priority access transfer applications to require that they be given particular urgency in circumstances where they are made aware that the location and/or configuration of the property creates a specific risk of serious harm to an occupant	Response from Department of Families Fairness and Housing	Accepted in full
That the National Disability and Insurance Agency review its guidelines for processing requests for housing improvements for Victorian participants to require prompt and active liaison and coordination with Homes Victoria.	Response from National Disability Insurance Agency	Accepted in full

Finding into death of Baby Sidney

Keywords: Infant death; foetal head impaction, caesarean section, vaginal delivery, complications of childbirth

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 Women's Hospital implement ongoing training to medical staff to appropriately identify risks and address difficulties from disimpaction of the foetal head during deliveries.	Response from The Royal Women's Hospital	Accepted in full

Finding into the passing of Child A

Keywords: Family violence, child protection, child homicide, head injury

Recommendation	Response	Response outcome
That the Victorian Government expand funding for the Dardi Munwurro program across Victoria to support First Nations men to address their use of violence regardless of their location.	Response from Department of Families, Fairness and Housing	Under consideration
I recommend the Victorian Government continue to work with the Commonwealth Government to strengthen multi-agency responses to family violence in Victoria.	Response from Department of Families, Fairness and Housing	Under consideration

Drowning

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	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	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	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

Finding into death of Ying Sun

Keywords: Drowning, signage, hazard warning, tourist, rocks, remote location, Cape Schanck

Recommendation	Response	Response outcome
That Parks Victoria consider the installation of additional signage at the end of the boardwalk towards Black Rock Beach. This additional signage should remind visitors and warn them of the hazards present in the area and the need for caution around the water and rocks.	Response from Parks Victoria	Accepted in full
That Parks Victoria consider updating all hazard warning signage in the area with QR codes to link to information on the Parks Victoria website that is available in multiple languages to ensure international visitors have access to relevant information in their own languages.	Response from Parks Victoria	Alternative adopted

Finding into death of Remy Da Silva

Keywords: Gunnamatta Beach, drowning, BeachSafe, interactive signage, strong winds, unpatrolled beach, rip, rough ocean conditions, large waves

Recommendation	Response	Response outcome
Life Saving Victoria conduct a site-specific risk assessment at Gunnamatta Beach to explore the most effective drowning mitigation strategies for that particular location	Response from Life Saving Victoria	Alternative adopted
Life Saving Victoria, Parks Victoria, and Surf Living Australia continue to promote the Beachsafe app and website, including by installing infrastructure to support QR code access to information on site at Victorian beaches.	Response from Life Saving Victoria Response from Surf Life Saving Australia Response from Parks Victoria	Accepted in full Accepted in full Accepted in full
Parks Victoria explore the feasibility of interactive signage with up-to-date safety information at Gunnamatta and other high risk Victorian beaches.	Response from Parks Victoria	Alternative adopted

Finding into death of Cienna Ros'Se Jervies

Keywords: Drowning, Ocean Grove Beach, safety signage, water safety, rip, rough conditions, large waves

Recommendation	Response	Response outcome
That Emergency Management Victoria consider developing a resource similar to NSW's Practice Note 15: Water Safety under the Victorian Statement Emergency Plan with a view to clarifying, coordinating and strengthening the water safety functions and responsibilities of Victorian water safety duty holders.	Response from Emergency Management Victoria	Under consideration

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

Recreational activities

Finding into death of Mathew Farrell

Keywords: Light sports aircraft, recreational aviation, flight training, pilot certification, pilot endorsements, human factors, spatial disorientation, icing, loss of control in flight, Approved Self-Administrating Aviation Organisations, investigator conflict of interest

Recommendation	Response	Response outcome
That CASA review the conduct of RAAus during this investigation and inquest, including the conduct of its officers and key personnel.	Response from Civil Aviation Safety Authority	Accepted in full
That CASA facilitates amendments to Section 2.13 of the RAAus Flight Operations Manual: (a) to clarify the aeronautical experience that may constitute “recognised flight time” according to each aircraft type or group for which the experience is required; (b) to clarify the aeronautical experience required for endorsements; (c) where flight testing is required for a particular endorsement, to clarify whether such flight testing may be conducted concurrently with flight testing required for pilot certification or other endorsements.	Response from Civil Aviation Safety Authority	Accepted in full
That CASA facilitates amendments to the RAAus Flight Operations Manual to include a definition of “aeroplane” consistent with the definition found in the Civil Aviation Safety Regulations 1998, and a definition of “aircraft” consistent with the definition found in the Civil Aviation Act 1988.	Response from Civil Aviation Safety Authority	Accepted in full
That RAAus develops standardised training records for use by RAAus flight instructors which: (a) permit detailed auditing of the training delivered by RAAus	Response from Recreational Aviation Australia Inc	Under consideration

flight instructors to student pilots or pilots seeking endorsements; (b) are in a form approved by CASA; and (c) must be used by all RAAus flight instructors in all instances.		
In light of the declaration by RAAus that it will no longer investigate fatal accidents involving RAAus registered aircraft, that the ATSB should investigate all fatal accidents involving such aircraft.	Response from Australian Transport Safety Bureau	Rejected in full

Finding into death of Harold Clayton

Keywords: Boating accident, seaworthy inspections, carbon monoxide alarm, generator, confined space

Recommendation	Response	Response outcome
To the Safe Transport Victoria, I recommend that potential models are explored 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	Rejected in full
To Energy Safe Victoria, I recommend that legislation be developed under the Gas Safety Act 1997 to mandate the installation of a gas detecting system on vessels in a position to alert occupants of high levels of carbon monoxide and other toxic gases and that it coordinates with Standards Australia to amend AS 1799.1 (2021, Small craft, Part 1: General requirements for power boats) in accordance with this legislation.	Response from Energy Safe Victoria	Alternative adopted

Accidents

Finding into death of Dustin Buckley

Keywords: firearm, accident, gunshot wound, unintentional, young person

Recommendation	Response	Response outcome
That the Attorney-General consider amendments to Crimes Act 1958 (Vic), Firearms Act 1996 (Vic) and/or the Firearms Regulations 2018 (Vic) to address the following issues: a) Creation of an offence prohibiting the pointing of a firearm at another person's face/head. b) Changes to the supervision of junior firearms licence holders so that an adult licence holder can only supervise one junior licence holder at one time. c) Requirement for a person involved in a fatal or serious firearms incident to undergo mandatory drug and alcohol testing.	Response from Minister for Police	Under consideration

Responses overdue by more than 12 months

Each edition of the CCOV Recommendations Report covers a 12-month period. This edition includes the period between 1 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

Keywords: 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