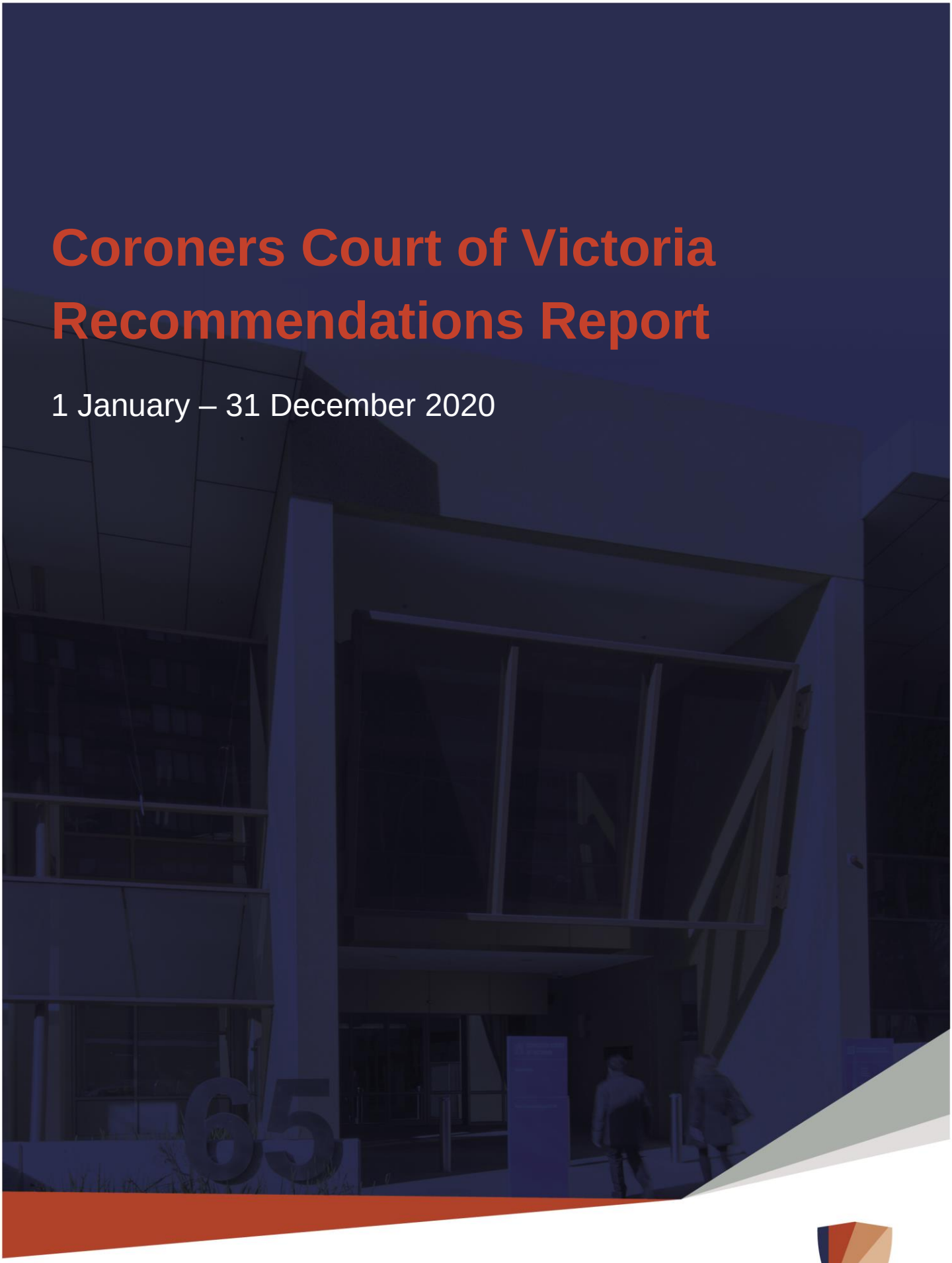
Coroners Court of Victoria Recommendations Report

1 January – 31 December 2020



Coroners Court of Victoria

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Warning

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

Acknowledgement

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

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

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

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

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

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

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

This first edition covers the period from 1 January to 31 December 2020. During this period, coroners made 176 recommendations across 77 findings.

Following these recommendations, the Court received:

- 131 responses stating the recommendation was accepted in full
- 12 responses stating the recommendation was accepted in part or an alternative was proposed
- 21 response stating the recommendation remains under consideration
- 1 response where the recommendation was not accepted

In addition to these:

- 13 responses are still being prepared within the required three-month time frame (awaiting a response)
- 14 responses have not been received within the required time frame (overdue)

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 31 March 2021.

Contents

Suicide

Finding into death of Paul Peterson

Keywords: suicide, mental health, inpatient suicide, inpatient leave procedures, voluntary patient

Recommendation	Response	Response outcome
I recommend that Delmont Private Hospital: Conduct a comprehensive review of the operation of and compliance with the January 2020 Therapeutic Leave Policy and Therapeutic Leave Procedure. The review should be conducted by and independent person and be completed no later than September 2021.	Response from Delmont Private Hospital	Accepted in full
I recommend that Delmont Private Hospital: Consider developing an e-learning or online training module for staff and consultants directed at obligations and compliance with the Therapeutic Leave Policy and Procedure.	Response from Delmont Private Hospital	Under consideration

Finding into death of Jesse Stephen Bird

Keywords: suicide, military, veteran suicide, Australian Defence Force, Post Traumatic Stress Disorder, mental health, incapacity payments, Torres Strait Islander passing, Department of Veteran Affairs, compensation for permanent impairment

Recommendation	Response	Response outcome
I recommend that the Secretary of the Department of Defence consider how the information in its PMKeyS system could be shared with the Coroners Court to: a) enhance Victorian Coroners' ability to identify veteran suicides with a greater degree of accuracy; b) allow investigating Coroners to more effectively direct their investigation to build evidence base for prevention; and c) inform the design and implementation of suicide prevention initiatives.	Response from the Commonwealth Supplementary response from the Commonwealth	Accepted in full
I recommend that the Secretary of the Department of Veteran's Affairs consider implementing a public awareness campaign directed to informing ex-service personnel about the recent reforms undertaken by DVA and encourage veterans to come forward to assist both in reconnecting with them and in building trust and confidence in DVA. Such a campaign ought to be multi-modal, utilising where possible, social media, television, print and radio formats.	Response from the Commonwealth Supplementary response from the Commonwealth	Accepted in full
I recommend that the Minister for Veteran's Affairs and Defence Personnel take the necessary steps to harmonise the legislation governing the veteran's compensation and rehabilitation scheme to: a) ensure that the claims system is 'fit for purpose', reflecting the needs of veterans now and into the future;	Response from the Commonwealth Supplementary response from the Commonwealth	Under consideration

b) reduce complexity in the compensation system by streamlining and simplifying the claims process; c) remove inconsistencies between the Acts to ensure fairness and equity in eligibility and benefits; and d) ensure the legislative framework reflects veteran centric practices.		
I recommend that the Secretary of Department of Prime Minister and Cabinet extend the remit of the proposed National Commissioner to include powers to proactively review and audit DVA processes and to investigate veteran complaints.	Response from the Commonwealth Supplementary response from the Commonwealth	Alternative adopted
I recommend that the Secretary of Department of Prime Minister and Cabinet provide an update to the Coroners Court on the status of the implementation of the proposed National Commissioner within six months, including where relevant, pending or current legislation, specifies as to the scope, remit and functions of the National Commissioner, and information detailing how the National Commissioner's investigation of veteran suicide deaths will sit alongside the coronial functions.	Response from the Commonwealth Supplementary response from the Commonwealth	Accepted in full

Finding into death of JC

Keywords: suicide, mental health, minor, family violence, child, name of child suppressed, adolescent violence, family violence intervention order, youth crisis accommodation

Recommendation	Response	Response outcome
I recommend that Victoria Police amend the Code of Practice for the Investigation of Family Violence to include guidelines about police-initiated intervention order applications against children and young people, and ensure police are aware of appropriate referral pathways for families experiencing adolescent violence in the home, including alternate accommodation options. The Code of Practice should also prioritise cautions and diversion where appropriate.	Response from Victoria Police	Accepted in full
I recommend that the Secretary of the Department of Health and Human Services and Victoria Police conduct a joint review on the incidence and numbers of youth that are issued with a FVIO and require emergency and short-term crisis accommodation, to identify any areas in Victoria that may be in need of these additional resources. The review should inform funding decisions by the Secretary of the Department of Health and Human Services to provide additional youth crisis accommodation in targeted areas where the demand has been identified.	Response from Department of Health and Human Services	Accepted in full
I recommend that the Secretary of the Department of Health and Human Services consider funding existing specialist youth services to extend their services and support to vulnerable youth to a 24-hour operational model.	Response from Department of Health and Human Services	Accepted in full
I recommend that the Victorian Government and the Secretary of the Department of Health and Human Services explore options to address the legislative anomaly between the Family Violence and Protection Act 2008 (Vic)	Response from Department of Health and Human Services	Accepted in full

and the Children Youth and Families Act 2005 (Vic) in relation to the definition of “child”.		

Finding into death of Kyle Horne

Keywords: suicide, mental health, Autism Spectrum Disorder

Recommendation	Response	Response outcome
The Department of Health and Human Services and the Chief Psychiatrist work with AMAZE to identify opportunities to increase the access by private practitioners, primary care, and public mental health services to information, education and training specific to the risk of suicide for adolescents and adults with Autism Spectrum Disorder especially in the context of relationship breakdown and social stressors.	Response from Amaze Response from the Department of Health and Human Services	Accepted in full

Finding into death of Rachel Mihail

Keywords: suicide, nicotine toxicity, welfare check, Victoria Police, police response

Recommendation	Response	Response outcome
I recommend that the Chief Commissioner of Police consider reviewing the extant processes, policies and procedures applicable to police responding to requests for conducting 'welfare checks' and attendance to tasks similar to the task allocated to SC Smeaton and Constable Squires in this case to include a requirement that the urgency of police response be proportional to the facts made known to police to whom such tasks are allocated and the threat to life evidence by those facts.	Response from Chief Commissioner of Police	Under consideration

Finding into death of AS

Keywords: suicide, combined drug toxicity, mental health, overdose, handover and follow up procedures

Recommendation	Response	Response outcome
Ballarat Health Services ensure that the 'usual practice' of handover is recorded in guidelines and that staff are educated in its importance.	Ballarat Mental Health Services	Accepted in full

Finding into death of Caitlin-Lei Alaya

Keywords: combined drug toxicity, Real Time Prescription Monitoring, SafeScript, welfare check, Victoria Police

Recommendation	Response	Response outcome
I recommend that Victoria Police review and update their policies and procedures pertaining to welfare checks to ensure the inadequacies detailed in this finding are prevented in the future.	Response from Victoria Police	Under consideration

Finding into death of Jolanta Boyd

Keywords: suicide, train, transport, Police Protective Services Officers, PSOs, family violence

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and preventing like deaths, I recommend that Victoria Police update its Protective Services Officers on Transport Networks Policy to include provisions for how PSO's should respond when they are advised of family violence incidents that have not occurred at or in the vicinity of the designated place.	Response from Chief Commissioner of Police	Accepted in full
In the interests of promoting public health and safety and preventing like deaths, I recommend that Barwon Health Service update its Use and Disclosure of Information Procedure, the Family Inclusive Practice Procedure, the Recognizing and Responding to Family Violence Procedure Manual and all other relevant policies and training so that it is explicit that staff must consider the risks of sharing patient health information relating to a victim of family violence with the alleged perpetrator.	Response from Barwon Health	Accepted in full

Finding into death of Ms T

Keywords: suicide, substance dependence, mental health, nicotine withdrawal

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and preventing like deaths, I recommend that Eastern Health review the communication processes both within the emergency department and between emergency department staff and mental health staff to improve the accessibility and reliability of clinical information used by clinicians to make decisions about patients leaving the emergency department while waiting for a mental health assessment.	Response from Eastern Health	Accepted in full
In the interests of promoting public health and safety and preventing like deaths, I recommend that the Victoria Network of Smokefree Healthcare Services and Eastern Health develop and promote a guideline specific to the assessment, prevention and management of withdrawal symptoms from nicotine in patients while in an emergency department.	Response from the Victoria Network of Smokefree Healthcare Services Further response from the Victorian Network of Smokefree Healthcare Services Attachment 1 to VNSHS further response Attachment 2 to VNSHS further response Response from Eastern Health	Accepted in full
In the interests of promoting public health and safety and preventing like	Response from	Accepted in full

deaths, I recommend that Eastern Health review the systems for follow up of patients who leave the emergency department while waiting for a comprehensive mental health assessment, to ensure that they are in line with recommendations from the Department of Health and Human Services and the Chief Psychiatrist.	Eastern Health	

Finding into death of Gordon Malcolm Wallace

Keywords: suicide, poisons and controlled substances

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend the Department of Health and Human Services consider amending the deleterious substances provisions of the Drugs Poisons and Controlled Substances Act 1981 (Vic) to specifically include argon gas.	Response from Department of Health and Human Services	Not accepted

Finding into death of Ms WX
Finding into death of Ms TP
Finding into death of Ms YN
Finding into death of Ms MH

Keywords: South Asian women, vulnerable community, social isolation, cultural and linguistic barriers, suicide

Recommendation	Response	Response outcome
I recommend that the Secretary of the Department of Health and Human Services review current services that support the health and wellbeing of South Asian women in the City of Whittlesea, and consult with relevant service providers and other stakeholders, to identify opportunities to improve South Asian women's access to and engagement with such services.	Response from Department of Health and Human Services	Accepted in full
I recommend that Victoria Police allocate Family Violence Investigation Units to investigations into suspected intentional deaths of women in the City of Whittlesea who are from culturally and linguistically diverse communities, in circumstances where there is any indication that previous family violence incidents may have contributed to the death.	N/A	Awaiting response
I recommend that Victoria Police allocate Family Violence Investigation Units to investigations into suspected intentional deaths of women in the City of Whittlesea who are from culturally and linguistically diverse communities, in circumstances where there is any indication that social isolation may have contributed to the death.	N/A	Awaiting response

Deaths in custody

Finding into death of Darren Brandon

Keywords: death in custody, suicide, corrections, Corrections Victoria, continuity of care

Recommendation	Response	Response outcome
Recommendations to all institutional Parties: To enhance existing continuity of care, the various custodial health stakeholders train their staff about what information on their systems is visible to other stakeholders.	Forensicare - Thomas Embling Hospital Chief Commissioner of Police Department of Justice and Community Safety	Accepted in full
Recommendations to all institutional Parties: Given that forensic clinicians have indicated that they would be most assisted by being able to obtain all necessary information from a single database, the interested institutional parties in this inquest, and such other stakeholders as they determine necessary for an effective review process, including but not limited to Justice Health, should meet to consider the viability of such an innovation, and report back to me once they have done so.	Forensicare - Thomas Embling Hospital Chief Commissioner of Police Department of Justice and Community Safety	Accepted in full by Forensicare Under consideration by Chief Commissioner of Police Accepted in full by Department of Justice and Community Safety
Recommendation to Corrections Victoria and Forensicare: That CV and Forensicare ensure that, upon the arrival of a prisoner at a prison, the appropriate reception staff promptly note and act upon any custodial management issues recorded on the accompanying documentation in a timely fashion, including by capturing life threatening health, suicide or self-harm risk issues in JCare, or otherwise bringing it to the attention of the appropriate clinical staff working at the	Forensicare - Thomas Embling Hospital Department of Justice and Community Safety	Accepted in full

prison. This a should include a timely remedial mechanism for admission documentation which arrives after the prisoner has been through the reception processes.		
Recommendations to the Chief Commissioner of Police: Whilst a suspect remains self-represented, contact details of identified support people must be passed along to each subsequent informant and the ultimate prosecutor, so that prosecutor is able to assist the Court in the manner it will expect.	Chief Commissioner of Police	Accepted in full
Recommendations to the Chief Commissioner of Police: In recognition of the inherent vulnerability of people taken into Police custody, the Commissioner revisit the relevant parts of the Victoria Police Manual with a view to ensuring all relevant information in the possession of Victoria Police is conveyed to the police prosecutor.	Chief Commissioner of Police	Accepted in full
Recommendations to the Chief Commissioner of Police: That police custodial officers be directed that, upon receipt of remand documentation for a prisoner issued by a court, that they immediately note and act upon any custodial management issues noted on the documentation, including by bringing any health or suicide or self-harm risk issues to the notice of CHS.	Chief Commissioner of Police	Accepted in full
Recommendations to the Chief Commissioner of Police: That Chief Commissioner of Police ensure that current and future health care providers and administrators receive training on how the applicable continuity of care policies are to be complied with whilst they fulfil their respective responsibilities.	Chief Commissioner of Police	Accepted in full

Recommendations to the Chief Commissioner of Police: That CHS implement a procedure for the electronic transfer of HEALTHe records upon the handover of a prisoner from police custody to a prison, whenever the transfer occurs.	Chief Commissioner of Police	Accepted in full

Finding into death of Travis Fernandez

Keywords: suicide, corrections, death in custody, Dhurringile, hanging, surgically repaired jaw fracture, failed bony union, pain and medical management in custody

Recommendation	Response	Response outcome
That Justice Health collaborate with custodial health care providers to collect data on the reason(s) prisoners refuse medical treatment or refuse to attend specialist appointments to better inform further improvements to the custodial healthcare system.	Response from Department of Justice and Community Safety Further response from Department of Justice and Community Safety	Accepted in full
That Corrections Victoria collaborate with Justice Health and custodial health care providers to establish a common approach to what may constitute 'special circumstances' warranting transfer for secondary and tertiary healthcare other than via Port Phillip Prison, and ensure that primary healthcare providers (in particular) are aware that this facility exists and when it may be recommended.	Response from Department of Justice and Community Safety Further response from Department of Justice and Community Safety	Accepted in full
That St Vincent's Correctional Health consult with Justice Health and consider revising the policy of removing prisoner patients from the outpatient waiting lists after two consecutive appointment cancellations since, at present, information about why an appointment was cancelled or by whom does not appear to be meaningfully collated.	Response from Department of Justice and Community Safety Further response from Department of Justice and Community Safety Response from St Vincent's Hospital	Accepted in full
That Rumbalara Aboriginal Co-operative Limited consider revising its Medical History Questionnaire to	Response from Rumbalara Aboriginal Co-operative Limited	Accepted in full

include a field, preferably on the first page of the document, to ensure that information relating to ‘previous/recent dental surgery’ (or similar) is captured.		

Finding into the death of Tanya Day

Keywords: Aboriginal and Torres Strait Islander passing, death in custody, fall, public drunkenness, police response

Recommendation	Response	Response outcome
To: The Attorney General, The Honourable Jill Hennessey: I recommend that the offence of public drunkenness be decriminalised and that section 13 of the *Summary Offences Act 1966* be repealed.	Response from the Honourable Jill Hennessey, Attorney General	Accepted in full
To: The Attorney General, The Honourable Jill Hennessey: I recommend legislative amendment to the *Coroners Act 2008* that the coroner in charge of a coronial investigation may give a police officer direction concerning investigations to be carried out for the purpose of an inquest or investigation into a death being investigated by the coroner, thus legislatively recognising the role of the Coronial Investigator.	Response from the Honourable Jill Hennessey, Attorney General	Under consideration
To: The Chief Commissioner, Victoria Police: I recommend that the Victoria Police Manual Rules and Guidelines be amended to include a falls risk assessment as part of the detainee risk assessment for each person in custody who appears to be affected by alcohol or drugs or illness.	Response from the Chief Commissioner of Victoria Police	Under consideration
To: The Chief Commissioner, Victoria Police: I recommend that there be a review of training and education within Victoria Police regarding the findings and recommendations of the Royal Commission into Aboriginal Deaths in Custody to ensure knowledge and appropriate compliance.	Response from the Chief Commissioner of Victoria Police	Accepted in full

To: The Chief Commissioner, Victoria Police: I recommend training be implemented for all Victoria Police custody staff regarding the Victoria Police Manual Rules, Guidelines and local police station Standard Operating Procedures regarding the mandatory requirements applicable for the safe management of persons in police care or custody.	Response from the Chief Commissioner of Victoria Police	Accepted in part
To: The Chief Commissioner, Victoria Police: I recommend training be implemented within Victoria Police regarding the medical risks of individuals affected by alcohol.	Response from the Chief Commissioner of Victoria Police	Accepted in part
To: The Chief Commissioner, Victoria Police: I recommend Victoria Police request the Victorian Equal Opportunity and Human Rights Commission to conduct a section 41(c) review of the compatibility of its training materials with the human rights set out in the Charter.	Response from the Chief Commissioner of Victoria Police	Accepted in full
To: The Chief Executive Officer, V/Line: I recommend V/Line review training materials to include input from the Aboriginal and Torres Strait community about unconscious bias and to provide training to staff as to how to reduce the impact of unconscious bias in decision making.	Response from V/Line Corporation	Accepted in full
To: The Chief Executive Officer, V/Line: I recommend V/Line request the Victorian Equal Opportunity and Human Rights Commission to conduct a section 41(c) review of the compatibility of its training materials with the human rights set out in the Charter.	Response from V/Line Corporation	Accepted in full

To: The Secretary, Department of Justice and Community Safety: I recommend that the current volunteer model for the Aboriginal Community Justice Panel be reviewed as to its effectiveness in providing protection for Aboriginal people in custody and that this review include a clarification of the services offered by the Aboriginal Community Justice Panel with both Victoria Police and the Victorian Aboriginal Legal Service.	Response from the Department of Justice and Community Safety	Accepted in full

Deaths in care

Finding into death of Anthony Churches

Keywords: cyanide toxicity, poisoning, absconding

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

Finding into death of Janet Foster

Keywords: mixed drug toxicity, opioids, Victoria Police, welfare checks, mental heath

Recommendation	Response	Response outcome
I recommend the Chief Commissioner of Police consider reviewing the processes, policies and procedures for conducting welfare checks, with particular reference to the urgency with which welfare checks are conducted and the application of existing VPM Procedures and Guidelines.	Response from Chief Commissioner of Police	Under consideration

Finding into death of Damon Brendon Amiet

Keywords: Involuntary psychiatric patient, complex presentation including chronic suicidality, impulsivity, absconding, polysubstance use, risk assessment, clinical observation guideline, suicide.

Recommendation	Response	Response outcome
That the Department of Health and Human Services consider the feasibility of establishing long-term residential, rehabilitation-focussed mental health treatment facilities that are appropriately resourced to provide intensive care and meet demand for such services in the Victorian community.	Response from Department of Health and Human Services	Accepted in full

Finding into death of Harley Larking

Keywords: Aboriginal and Torres Strait Islander passing, mental health, inpatient care, risk management, absconding, suicide

Recommendation	Response	Response outcome
To the Director, Northern Health: That the system for responding to identified environmental risks to patients in the psychiatric units include prioritising of corrective or ameliorating actions and in circumstances where the risks are not managed in a timely way, require escalation to the govern	Response from Northern Health	Accepted in full
To the Director, Melbourne Health: That policy and procedures for the monitoring of involuntary patients are reviewed to be in line with the Department of Health 2013 Nursing observation through engagement in psychiatric inpatient care, with particular focus on any predictability of the frequency, timing and duration of nursing observations and the requirements for contemporaneous documentation of the observations.	Response from North Western Mental Health	Accepted in full
To the Director, Melbourne Health: That a secure electronic transmission process be implemented to replace the facsimile system (which existed at the time of Mr Larking's death) so that North Western Mental Health Service can initiate and complete a missing patient notification to Epping Police Station by telephone and contemporaneously in writing.	Response from North Western Mental Health	Under consideration
To the Director, Melbourne Health: That North Western Mental Health Service enter both actual and attempted absconding instances in Riskman and reconcile instances of absconding with the records of Victoria	Response from North Western Mental Health	Accepted in full

Police to determine areas for clarification including when to record incidents of absconding by compulsory patients in Riskman.		
To the Director, Melbourne Health: That North Western Mental Health Service specify that in circumstances where a compulsory inpatient absconds for more than 15 minutes (and in the absence of the treating psychiatrist's contemporaneously documented rationale otherwise), that Victoria Police are notified, and the instance and its outcome are recorded in Riskman.	Response from North Western Mental Health	Accepted in full
To the Director, Melbourne Health: That the policies at Melbourne Health as they relate to missing persons be reviewed and rationalised so that they are written in plain English, are consistent across facilities and clear regarding steps required to be followed and in what timeframes.	Response from North Western Mental Health	Accepted in full
To the Director, Melbourne Health: That staff be regularly trained about those policies (such as the missing/absconded person policy) and regular-audits are undertaken to ensure North Western Mental Health Service is confident their staff are taking the required and appropriate action in reporting to external agencies to minimise risk to the patient.	Response from North Western Mental Health	Accepted in full
To the Director, Melbourne Health: That North Western Mental Health Service implement Aboriginal cultural competency training for all inpatient psychiatric staff that includes a focus on working with Koori workers, how to facilitate their role within the unit, develops an understanding of the benefits to the Aboriginal patient and their family from involving Koori Workers, and promotes culturally	Response from North Western Mental Health	Accepted in full

informed treatment planning.		
To the Office of Chief Psychiatrist: That the Office of the Chief Psychiatrist review other public mental health service inpatient units that may not have an Aboriginal mental health liaison officer, with a view to encouraging the embedding of the principles and practice of cultural competence in the provision of mental health services to Aboriginal and Torres Strait Islander patients.	The Office of the Chief Psychiatrist was expected to respond by December 2020.	Response overdue

Finding into death of Zakiya Crystal Lisa Thomas

Keywords: youth suicide, Aboriginal and Torres Strait Islander passing, mental health support and resources, cultural training

Recommendation	Response	Response outcome
I recommend that the Child Protection and ACSASS consider reviewing their systems for enabling joint input and engagement with vulnerable Aboriginal youth in their catchment areas upon notification of an incident. A protocol should be established to ensure that any investigations involving Aboriginal youth is not completed without input of both services.	Response from Child Protection, Department of Health and Human Services and the Victorian Government	Under consideration
I further recommend that the Victorian Government, Child Protection and MDAS should consider the high rate of Aboriginal youth suicides in the Mildura region in future planning with respect to the allocation of resources and provision of services to the Mildura community and in dealing with cases such as this one.	Response from Child Protection, Department of Health and Human Services and the Victorian Government	Accepted in full
I recommend that CAMHS review their current policies and training for mental health practitioners, specifically their family violence risk assessments, information sharing with relevant agencies and family violence safety planning for patients who disclose family violence in the home environment.	Response from Mildura Base Hospital	Accepted in full
I also recommend that the MBH review their current policies and training for all clinicians and health practitioners to refer patients who identify as Aboriginal or Torres Strait Islander to the internal Aboriginal Health Unit at the MBH to enable additional cultural support and advocacy upon admission or discharge. I further recommend that the current policies and procedures at the MBH be reviewed to incorporate cultural training to improve support	Response from Mildura Base Hospital	Accepted in full

provided by hospital staff to patients who identify as Aboriginal or Torres Strait Islander.		
I recommend that MDAS consider the following: a) A partnership with the Youth Affairs Council Victoria and the Koorie Youth Council to develop an Aboriginal youth mentoring program (Marram Nganyin) in the Mildura region. I note that in October 2017 the Victorian Government announced the Balit Murrup: Aboriginal Social and Emotional Wellbeing Framework and allocated an additional $1.8 million dollars in funding to extend the Aboriginal youth mentoring program. I confirm that MDAS started a Family Wellbeing Program in 2016 that runs over 12 weeks to help vulnerable individuals with self-reflection, relationships and building leadership skills. The Family Wellbeing Program would benefit from additional funding through the Victorian Government to continue its success amongst Aboriginal Youth in Mildura. b) Development of a similar program to Fresh Tracks, an initiative developed by Geelong-based Wauthorong Aboriginal Cooperative that uses a service model applied to clients with a high degree of complex needs and lower rates of attending clinical care.	Response from Mallee District Aboriginal Services	Under consideration

Aged care

Finding into death of Irene Florence Curran

Keywords: aged care, inadequate medical management

Recommendation	Response	Response outcome
I recommend Ballarat Health Services reassess their system for ensuring discharge summaries are drafted and sent out to relevant recipients in a timely manner, which I consider to be within the 24-hour period post discharge.	Ballarat Health Services were expected to respond by October 2020.	Response Overdue
I recommend Ballarat Health Services extend the importance of completing discharge summaries within a timely manner hospital wide, rather than those solely on orientation.	Ballarat Health Services were expected to respond by October 2020.	Response Overdue
I recommend Hepburn Health - Trentham Aged Care discuss concerns relating to patient transfer on public holidays with Ballarat Health Services. Namely, that a memorandum of understanding is agreed upon to ensure the health and safety of future patients.	Response from Central Highlands Rural Health	Accepted in full
I recommend Hepburn Health - Trentham Aged Care reassess the workings of their iCare® medication management system to ensure there is capability to enter medication prompts in the event that dispensation through a pharmacy is not required.	Response from Central Highlands Rural Health	Accepted in full

Finding into death of Annie Chettle

Keywords: aged care, subdural haemorrhage, risk assessment

Recommendation	Response	Response outcome
I recommend that Kirkbrae update their relevant policies and procedures to reflect the need and/ or allow PCAs to make instantaneous risk assessments and defer undertaking high risk activities with vulnerable residents when insufficient staff are available.	Response from Kirkbrae Presbyterian Homes	Accepted in part

Finding into death of Dorothy Nelson

Keywords: aged care, choking

Recommendation	Response	Response outcome
I recommend annual drills for staff around responding to a choking incident be included as part of First Aid Response training at all residential aged care facilities, including those at Kerala Manor.	Response from Kerala Manor	Accepted in full
I recommend all staff at Kerala Manor receive education in assisting residents with eating at mealtimes, including how to manage the safe delivery of modified texture foods.	Response from Kerala Manor	Accepted in full
I recommend that Kerala Manor submit their policy, RHL-D26 CHOKING, for review and amendment by an AHPRA approved third party provider to give guidance on best practice for the management of a choking event	Response from Kerala Manor	Accepted in full

Finding into death of Adele Di Quinzio

Keywords: Immobility, pressure wounds, pressure injuries, decubitus ulcers, aged care, prevention strategies, supported residential services

Recommendation	Response	Response outcome
I recommend that the Mr Jinson Thomas, Proprietor of Adare SRS develop and implement a policy, procedure or guideline about the prevention, identification and management of pressure injuries in their residents (and train staff accordingly).	Response from Adare SRS	Accepted in full
I recommend that Kym Peake, Secretary of DHHS regularly monitor Adare SRS in relation to their service delivery to their residents relevant to the prevention, identification and management of pressure injuries to their residents.	Response from Department of Health and Human Services	Accepted in full
I recommend that Ms Kym Peake, Secretary of the Department of Health and Human Services develop and distribute educational material to Supported Residential Services with the aim to inform them about the importance of the prevention, identification and management of pressure injuries in their residents.	Response from Department of Health and Human Services	Accepted in full
I recommend that Adjunct Professor David Plunkett, Chief Executive Officer of Eastern Health, Maroondah Hospital arrange to provide refresher training to staff responsible for admitting and discharging patients to ensure that they are aware of the differences in types of aged care facilities; such as the difference between a nursing home and supported residential service and their respective levels of care.	Response from Eastern Health	Accepted in full

Finding into death of Annette Douglass

Keywords: death in care, aspiration, aged care, disability, aspiration pneumonia, Alzheimer's disease, Down syndrome, Trisomy 21, Residential Aged Care Facility, seizure management, phenytoin, medication management, medication unavailability

Recommendation	Response	Response outcome
I recommend that the General Manager of TLC Homestead Lakes, arrange for the TLC Aged Care Medication management policy and procedure to be amended to include instruction for staff on urgent management of the following issues: a) Non-supply/non-availability of medications from a pharmacy; and b) Communication with the GP/prescribing doctor about missed doses of essential medications.	Response from Homestead Estate	Accepted in full
I recommend that Homestead Lakes RACF provide internal education to all staff responsible for dispensing and supervision of medication administration to residents regarding recommendation one.	Response from Homestead Estate	Accepted in full
I recommend that Homestead Lakes RACF review the need for internal pharmacology education of essential medications for all staff responsible for dispensing and supervision of medication administration to residents.	Response from Homestead Estate	Accepted in full

Family violence

Finding into death of Brittany Harvie

Keywords: Intimate partner homicide; family violence; death resulted directly from injury; unexpected; violent; not from natural causes; multiple blunt force trauma

Recommendation	Response	Response outcome
I RECOMMEND that the Victoria Police and the Victorian Department of Justice and Community Safety update their policies and procedures for information sharing to ensure that when an offender under the supervision of Youth Justice is arrested or is the subject of a family violence investigation, Victoria Police provide this information to Youth Justice so that current and accurate risk assessments of offenders under the supervision of Youth Justice can be completed. This system should replicate the efficiencies and effectiveness of the L17 referral notification process and should provide for timely sharing of relevant information for all agencies to assess risks. It would be preferable that this be achieved through the development of an automated system to ensure a reduction in data entry errors and increase the efficiency of information flow between the relevant agencies.	Response from Victoria Police Response from Department of Justice and Community Safety	Accepted in full
I RECOMMEND that the Victorian Department of Justice and Community Safety review their policies and procedures to ensure that Youth Justice offenders who attend counselling programs funded or operated by Youth Justice or Justice Health accurately record and utilise an appropriate family violence risk assessment tool when assessing a youth offender's current or future risk of harm to self or others. These assessments should draw upon relevant family violence information shared within the CISS and FVISS to	Response from Department of Justice and Community Safety	Accepted in full

enhance the assessment of risk.		
I further RECOMMEND that the Victorian Department of Justice and Community Safety should also review the training and professional development of mental health practitioners who staff any programs funded or operated by Youth Justice or Justice Health to ensure they are adequately trained to identify and manage family violence risk for their clients.	Response from Department of Justice and Community Safety	Accepted in full

Finding into death of Mrs K

Keywords: Family violence, homicide, non-accidental injuries

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

Finding into death of Baby S

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

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

Finding into death of Mrs FS

Keywords: Family violence, homicide, non-accidental injuries

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

Finding into death of Mr. A

Keywords: Family Safety Victoria, Blue Knot Foundation, family violence, men, mental health, behaviour change program

Recommendation	Response	Response outcome
Family Safety Victoria work with the Blue Knot Foundation to review the behaviour change program for opportunities to embed trauma-informed principles and practices.	Response from Department of Health and Human Services and Family Safety Victoria	Alternative adopted
To improve the safety of the men who engage in family violence behaviour change programs, the Family Safety Victoria Minimum Standards should include: i. Active and explicit discussion about suicidal thinking in the program interventions and material; ii. Assessment for suicide risk at entry and regular review throughout the program; iii. Use of a screening tool for a mood disorder as part of assessment; and iv. Include as part of the program, a mental and physical health focus with connection to a participant's local general practitioner.	Response from Department of Health and Human Services and Family Safety Victoria Response from Department of Health and Human Services and Family Safety Victoria attachment 1	Accepted in full
Department of Health and Human Services: To reduce the suicide of men through the promotion of help-seeking, develop public awareness raising strategies that: i. Are inclusive of all men and promote early help-seeking as normal and appropriate; ii. Target times in a man's life when he is likely more vulnerable, including relationship breakdowns, and advice of what services are available and how to access them;	Response from Department of Health and Human Services and Family Safety Victoria	Under consideration

iii. Explore the problems associated with a reliance on alcohol to manage distress and such things as sadness, poor sleep and increased stress; and iv. Promote addiction services to men as an accessible and appropriate option in circumstances when substance use is contributing to anger, aggression and violence.		
Department of Health and Human Services: To increase the engagement of men with social services and practitioners, develop advice for the community of ways to increase both the appeal of, and engagement with services by men.	Response from Department of Health and Human Services and Family Safety Victoria	Under consideration
The Department of Health and Human Services and Family Safety Victoria work together with organisations who provide behaviour change programs for men, professional bodies, social services, mental health services, and with particular emphasis on involvement of general practitioners and addiction services, develop practical information about the relationship between angry behaviours, violence and associated suicide risk. The information should focus on practical interventions and strategies for men who have anger and/or with angry behaviours and include when and where to seek specialist advice.	Response from Department of Health and Human Services and Family Safety Victoria	Accepted in full

Finding into the death of Ora Holt

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

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

Overdose and poisoning

Finding into death of Gemma Loryn Redding

Keywords: combined drug toxicity, opioids, overdose education, naloxone programs

Recommendation	Response	Response outcome
I recommend that the Department of Health and Human Services consider expanding its heroin focused overdose education and naloxone programs to those, including their immediate family members prescribed strong opioids such as methadone, physeptone and similar drugs and their families.	Response from Department of Health and Human Services	Under consideration

Finding into death of Mr P

Keywords: synthetic cannabinoids, heart health

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that the Victorian Department of Health and Human Services review how education regarding synthetic cannabinoids is disseminated to health services and, if deemed appropriate and necessary, develop a training package or similar resource for clinicians to equip them to have conversations with patients about synthetic cannabinoid risks and harm reduction.	Response from Department of Health and Human Services	Accepted in full

Finding into death of John Alexander King

Keywords: mental health, emergency department, overdose

Recommendation	Response	Response outcome
To enhance the suite of improvements already made, I recommend that Eastern Health considers the use of video conferencing at Box Hill Hospital ED and Maroondah Hospital ED to enable clinicians to access specialist mental health clinicians to assess patients in the ED when specialist mental health clinicians are unavailable at their campus.	Response from Eastern Health	Accepted in full

Missing persons

Finding into death of Barry Scott Collins

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

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

Finding into death of Matthew Fitzpatrick

Keywords: Victoria Police, Family Liaison Officers, missing person, search

Recommendation	Response	Response outcome
The issue of the obvious tension between the family and police members was recognised by the reviewers and a recommendation made that Victoria Police develop and implement a policy where trained Family Liaison Officers liaise with family members in some situations, including searches, for missing persons. Apparently, such an initiative was implemented in the United Kingdom several decades ago and the proposal is to a adopt a similar protocol here. I do not know whether the recommendation of the review committee has been adopted and implemented by Victoria Police. However, I support the proposal and if not yet implemented adopt the recommendations of the reviewers.	Chief Commissioner of Police	Accepted in full

Medical

Finding into death of Francis Stewart

Keywords: medical, adrenal crisis, hospital, adrenal insufficiency, hypopituitarism, steroid replacement therapy, infection, sepsis

Recommendation	Response	Response outcome
I recommend that the ROYAL AUSTRALASIAN COLLEGE OF GENERAL PRACTITIONERS develop and distribute a guidance sheet to their practitioners that: i. reminds practitioners about the risk of adrenal crisis, the nonspecific nature of symptoms and presentations preceding a crisis, the importance of prompt recognition and treatment to reduce its associated morbidity and mortality and the need to adjust medication during periods of stress and illness; ii. Promotes the implementation and use of medical record software that prominently highlights medical alerts for conditions such as adrenal insufficiency when the file is opened to make the information clear to any doctor or nurse at the practice; iii. Highlights the need for general practitioners to ensure that patient's relatives, friends and/or carers are educated about adrenal insufficiency, the signs and symptoms of adrenal insufficiency, and preventative measures that should be undertaken to mitigate against the risk of an adrenal crisis, particularly during periods of stress and illness; iv. Promotes the benefits of seeking specialist input regarding the management of adrenal insufficiency during periods of illness or stress.	Response from Royal Australian College of General Practitioners	Accepted in full
I recommend that the ROYAL AUSTRALASIAN COLLEGE OF	The Royal Australasian College	Response overdue

PHYSICIANS - ENDOCRINOLOGY: develop and distribute a guidance sheet for endocrinologists to advise them that when providing a 'stress cover letter' or 'sick day management letter' to a patient with adrenal insufficiency, that a copy should also be provided to the patient's treating general practitioner and the patient's family and/or carer;	of Physicians was expected to respond by 11 Sept 2020	
I recommend that the ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS - ENDOCRINOLOGY: Develop, implement and promote an awareness campaign to remind and inform general practitioners and other health professionals about the risk of adrenal crisis, the nonspecific nature of symptoms and presentations preceding a crisis, and the importance of prompt recognition and treatment to reduce its associated morbidity and mortality.	The Royal Australasian College of Physicians was expected to respond by 11 Sept 2020.	Response overdue

Finding into death of Ward Harker

Keywords: suspected homicide, palliative care, hospital, clinical aggression

Recommendation	Response	Response outcome
I recommend that Alfred Health's Clinical Aggression, Code Grey and Restrain Committee conduct review of Alfred Health's response to the incident - so that any improvements to the security system may be identified and, where appropriate, incorporated into Alfred Health's guidelines and relevant training programs including protocols for training staff to deal with potential crime scenes.	Alfred Health was expected to respond by 12 May 2020. The effects of COVID-19 have caused a delay and a response is expected after August 2020.	Response overdue

Finding into death of Valerie Fraser

Keywords: palliative care

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

Finding into death of Nicola Deleo

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

Recommendation	Response	Response outcome
Austin Health consider amending their 'Austin Health Outpatient Referral Form' template to include a specific field for allergies (or an alternate measure) to increase the likelihood of the template capturing all essential information when GP clinic patient summaries are imported.	Response from Austin Health	Accepted in full

Finding into death of Ian Dunlop*

Keywords: medical, post-surgical complications, hospital, pericarditis, escalation of care

Recommendation	Response	Response outcome
That, as soon as is practicable, Donvale provide the Court with their Recognising and Responding to Clinical Deterioration policy, as revised following the discussion by their Medical Advisory Committee Meeting scheduled for 20 March 2019.	Donvale Rehabilitation Hospital	Accepted in full

* Since the making of this recommendation, this matter has been re-opened for further investigation

Finding into death of Jessica Higgins*

Keywords: Opioid toxicity, opioid rotation, low-dose ketamine infusion

Recommendation	Response	Response outcome
Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation connected with the death: That the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists include in their forthcoming guidelines on ketamine infusion specific guidance on post-discharge planning that addresses how to communicate clinical decision-making surrounding changes in dosage of opioid medication and what information will be required before making any such changes.	Response from the Faculty of Pain Medicine	Alternative adopted

* Since the making of this recommendation, this matter has been re-opened for further investigation

Finding into death of Alma Honeychurch

Keywords: medical, airway obstruction, cardiac arrest

Recommendation	Response	Response outcome
That Safer Care Victoria, in consultation with AV and ARV, provide education to rural and remote Emergency Departments and Urgent Care Centres on the role and responsibilities of ARV.	Response from Safer Care Victoria	Accepted in full
That Castlemaine Health review and clarify its Hospital Transfer Procedure's referral pathways to ARV and AV, so as to ensure critically unwell patients are transported as safely as possible.	N/A	Awaiting response
That Castlemaine Hospital revisit its case review report in this matter, so as to reassess issues regarding staff communication and education on upper airway obstruction.	N/A	Awaiting response

Finding into death of John Hayle

Keywords: patient transfer, recognition of deteriorating health, healthcare delay

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that Frankston Hospital of Peninsula Health undertake a review of John Hayle's death with particular emphasis on the delayed recognition of his deteriorating health, including difficulties in the transfer of patients between health services and any preventative measures that may be instigated to prevent these delays and difficulties in the future.	Response from Peninsula Health	Accepted in full

Finding into death of Ronald Wood

Keywords: aged care, pulmonary embolus

Recommendation	Response	Response outcome
I recommend that Peninsula Health expand all relevant clinical practice guidelines to require that, when patients at risk of VTE are discharged from hospital, both the patient and their general practitioner receive written guidance on anticoagulation. This should be done in accordance with Quality Statements 3, 4, and 7 of the Australian Commission on Safety and Quality in Health Care Clinical Care Standard on Venous Thromboembolism Prevention (October 2018).	Response from Peninsula Health	Accepted in full

Workplace

Finding into death of D M

Key words: fertiliser spreader, machinery, farm worksites, WorkSafe, children

Recommendation	Response	Response outcome
I recommend that WorkSafe Victoria, in consultation with Victorian Farmers Federation, consider engaging with farming families and/or conducting a public awareness campaign aimed at farming families highlighting the risks of having children on the farm worksite while undertaking work and incorporating how to keep children safe on farms.	Response from WorkSafe Victoria	Accepted in full

Finding into death of Gavin Boyd

Keywords: WorkSafe, electrocution, powerlines

Recommendation	Response	Response outcome
WorkSafe distribute an industry-wide release setting out the lessons learnt, and the initiatives undertaken by the employer and the farm owner in this case, in order to reduce the risk of electrocution by overhead power lines.	Response from WorkSafe Victoria	Accepted in full

Transport and Road Safety

Finding into death of Samuel Alexander Chilton

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

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

Finding into death of Julie-Ann Margaret Johnston

Keywords: pedestrian, road safety, motor vehicle collision, bus terminus, transport hub, pedestrian safety

Recommendation	Response	Response outcome
I recommend that the Secretary of the Department of Transport, work with the Executive Director of Metro Trains Melbourne and the Coordinator of Engineering Services and Strategy at Maroondah City Council to conduct a safety audit of the bus terminus at Croydon Railway Station to determine whether there are any additional safety measures, such as speed humps or give way signage, that are suitable to improve and ensure the safety of pedestrians at Croydon Railway Station.	Response from Department of Transport Response from Maroondah City Council	Accepted in full Extension granted for Metro Trains Response

Finding into death of Gregory Hulands

Keywords: motor vehicle collision, road safety, road maintenance, road safety

Recommendation	Response	Response outcome
I recommend that, informed by appropriate input from Victoria Police, VicRoads undertake an assessment of the condition of Calder Alternative highway near Fentons Lane, Ravenswood including the adequacy of signage and road safety barriers applicable to traffic travelling in a north west and south east direction. I further recommend that VicRoads make any necessary changes to signage and road safety barriers that this review identifies as being desirable.	Response from Department of Transport	Accepted in full

Finding into death of Scott Fewson

Keywords: motor vehicle collision, motorcycle, road safety

Recommendation	Response	Response outcome
I recommend that, informed by appropriate input from Victoria Police, VicRoads undertake an assessment of the condition of Princetown Road- between Ford's Road and Melrose Road including the adequacy of signage and road markings applicable to traffic travelling south and around the right-hand bend immediately before Princetown Road crosses Melrose Road. I further recommend that VicRoads make any necessary changes to road marking and signage that this review identifies as being desirable.	Response from Regional Roads Victoria	Accepted in full

Finding into death of Bernice Northover

Keywords: motor vehicle collision, road safety

Recommendation	Response	Response outcome
I recommend that, VicRoads immediately install 'road infrastructure' at the intersection of Wellington and Berwick Roads Narre Warren so as to substantially increase the safety of that intersection for all road users.	Response from VicRoads	Accepted in full
I recommend that VicRoads immediately undertake an urgent comprehensive assessment of the condition, design and function of the intersection of Wellington Road and Berwick Road, Narre Warren East with a view to urgently making changes to increase its safety for all road users. I further recommend that as soon as is practicable VicRoads implement the findings of the review and that the measures put in place as a result of recommendation number 1 remain in place until the findings of the review are implemented.	Response from VicRoads	Accepted in full

Finding into death of KJE

Keywords: motor vehicle collision, road safety, motorcycle

Recommendation	Response	Response outcome
I recommend that, VicRoads immediately assess the need for a sign, the nature of which is a matter for VicRoads, to be installed appropriately at or near the intersection of Flockhart Street and Elsworth Street West, Mount Pleasant warning road users turning right from Flockhart Street into Elsworth Street West if they have inadvertently turned into the west-bound lane. I further recommend that if such assessment identifies a need for such signage that temporary signage be immediately installed until permanent signage can be erected.	The Department of Transport was expected to respond by October 2020.	Response overdue

Finding into death of Norman MacKenzie

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

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

Finding into death of Keith Sharp

Keywords: motor vehicle collision, patient transport, emergency department

Recommendation	Response	Response outcome
I recommend the Albury Wodonga Health Safety and Quality Department repeat their investigation with an external expert in emergency department trauma process management in order to identify better opportunities for system improvements.	Response from Albury Wodonga Health	Accepted in full

Finding into death of Marek Koziol

Keywords: pedestrian, motor vehicle, head injury, vision impaired, Guide Dogs Victoria

Recommendation	Response	Response outcome
That Guide Dogs Victoria consider incorporating into their training programs strategies to address the challenges associated by some modern motor vehicles that emit lower noise levels and to visually impaired people as they move around in public, whether assisted by guide dogs or otherwise.	Guide Dogs Victoria was expected to respond by October 2020.	Response overdue

Finding into death of Christina Maree Chamberlain

Keywords: motor vehicle, collision, road safety, safety barriers

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that the Department of Transport review the circumstances of this collision, in particular the location, as identified by Leading Senior Constable Rohan Clapham of Victoria Police, with the view to install safety barriers along the road.	Response from Department of Transport	Accepted in full

Finding into death of Cameron Andrew MacLellan

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

Recommendation	Response	Response outcome
With the aim of promoting public health and safety, I repeat my recommendation that consideration be given by the Secretary of the Department of Transport to adopting a framework requiring mandatory reporting to VicRoads when a medical practitioner forms an opinion that a person with a permanent or long-term injury or illness, is not or may not be medically fit to drive.	Response from Department of Transport	Under consideration

Finding into death of Jason Devon Trevin Pinto Jayawardena

Keywords: road safety, maintenance, speed limit, motor vehicle, bend

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that Cardinia Shire Council erect signage in both directions of Bessie Creek Road, Nar Nar Goon North Victoria 3812 advising of the upcoming sweeping bend and mandating a reduction in speed.	Response from Cardinia Shire Council	Accepted in part
With the aim of promoting public health and safety and preventing like deaths, I recommend that Cardinia Shire Council review the statistical data associated with this stretch of road in light of the death of Jason Devon Trevin Pinto Jayawardena and consider reducing the speed limit along the length of Bessie Creek Road, Nar Nar Goon North Victoria 3812 from 100 km/h to 80km/h.	Response from Cardinia Shire Council	Accepted in part

Finding into death of Antoine Alam

Keywords: pedestrian, motor vehicle collision

Recommendation	Response	Response outcome
I recommend that the City of Greater Geelong and VicRoads review pedestrian safety along Thompson Road, North Gelong, and consider installing pedestrian crossings or traffic refuges between the bus stops on the east and west sides of the road.	Response from the City of Greater Geelong Response from the Department of Transport	Accepted in full

Finding into death of AC

Keywords: motor vehicle collision, road safety, speed limit

Recommendation	Response	Response outcome
That VicRoads consider reducing the speed limit on the unsealed section of Kulkyne Way, Colignan, approaching Hattah National Park, to 80 kilometres per hour.	VicRoads was expected to respond by mid-March 2021.	Response overdue

Aviation

Finding into death of Donald Ernest Hateley
Finding into death of Dianne Bradley
Finding into death of Ian Chamberlain
Finding into death of Daniel Flinn

Keywords: aviation, SARTIME, Visual Flight Rules pilot, accident, General Aviation, safety

Recommendation	Response	Response outcome
I recommend that the Civil Aviation Safety Authority mandates the use of a SARTIME for all Visual Flight Rules flights over water.	The Civil Aviation Safety Authority was expected to respond by May 2020	Response overdue
I recommend that the Civil Aviation Safety Authority increase Instrument Flight Rule training and regency requirements for Private Pilot Licence candidates and holders, for the purpose of, but not necessarily limited to, further education for candidates on the fatal dangers of inadvertent entry into Instrument Meteorological Conditions.	The Civil Aviation Safety Authority was expected to respond by May 2020	Response overdue

Drowning

Finding into death of Yik Sua Hong

Keywords: drowning, rock fishing, recreation

Recommendation	Response	Response outcome
I recommend that Life Saving Victoria work with the Victorian government and other related water safety organisations to continue to educate and increase education among Victorians and the Culturally and Linguistically Diverse community regarding the dangers of rock-fishing and relevant safety initiatives to reduce risk.	Response from Life Saving Victoria	Accepted in full
I recommend that the Victorian Minister for Agriculture, The Hon. Jaclyn Symes, study the progress of the New South Wales government's mandatory requirement for rock fishers to wear personal flotation devices and implement similar laws in Victoria if the strategy appears successful.	Response from Victorian Fisheries Authority	Accepted in full

Finding into death of Mr L

Keywords: drowning, recreation, tourist

Recommendation	Response	Response outcome
That the OCC ensure adequate risk measures (including but not limited to signage and public awareness messaging for tourists) are undertaken in relation to the coastline it manages to address the potential for drowning in public spaces.	N/A	Awaiting response
That these measures should be re-assessed at appropriate intervals to ensure that they remain best practice and in line with relevant standards.	N/A	Awaiting response
That water safety measures be undertaken in consultation with industry experts/stakeholders, such as Life Saving Victoria (the recognised peak water safety agency in Victoria), and form part of the Coastal and Marine Management Plans required to be prepared under the Coastal and Marine Policy 2020.	N/A	Awaiting response

Finding into death of Richard Lyon

Keywords: drowning, dam, water safety, fencing

Recommendation	Response	Response outcome
I recommend Frankston City Council ensure there is a regular inspection and maintenance regime of the dam and its fencing, to improve public safety in the area and minimise the occurrence of similar events in future.	Response from Frankston City Council	Accepted in full

Finding into death of Swee Chuan Ho

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

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

Finding into death of Xu Zhou

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

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

Finding into death of Amanda Bourke

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

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

Recreational Activities

Finding into death of Mr ST

Keywords: motor vehicle maintenance, safety, head injury, jack failure

Recommendation	Response	Response outcome
With the aim of preventing injuries and deaths in similar circumstances, I recommend that the ACCC consider renewing its national 'Safe Summer' campaign with a view to including DIY motor vehicle repairs and maintenance, and review its strategies for disseminating information involved in the campaign.	Response from the Australian Competition & Consumer Commission	Accepted in full
I also recommend that WorkSafe Victoria consider once again collaborating with the ACCC in its campaign to promote safety precautions for DIY vehicle maintenance.	Response from the Australian Competition & Consumer Commission	Accepted in full

Child/infant deaths

Finding into death Infant A

Keywords: blind cords, infant, Consumer Affairs Victoria

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

Finding into death of Baby AA

Keywords: Herpes Simplex Virus, Neonatal Herpes Simplex Virus, Disseminated Herpes Simplex Virus, hospital pathology, coagulation studies, abnormal pathology, escalation and transfer of neonatal care, escalation pathways

Recommendation	Response	Response outcome
I recommend that the Northern Hospital consult with Victorian paediatric tertiary hospitals such as the Royal Children's Hospital and the Monash Children's Hospital in relation to the process of alerting clinicians of abnormal/unexpected coagulation results in children aged under 12 years, and what is to occur in the event of contaminated or unreliable results. This can then be compared to the Northern Hospital policy to ensure it is in line with standard practice in Victoria, and updates made if required.	Response from Northern Health	Accepted in full

Finding into death of Cai Wheeler-Trow

Keywords: infant death, head injury, complications during labour, assisted delivery, forceps, subgaleal haemorrhage, birth injury, detection and management of subgaleal haemorrhage

Recommendation	Response	Response outcome
I recommend the Royal Australian and New Zealand College of Obstetricians and Gynaecologists amend the guideline: Prevention, detection, and management of subgaleal haemorrhage in the newborn, which is currently under review, to include a section on the importance of assessing head circumference and scalp observations to assist to identify the development of a subgaleal haemorrhage after an instrumental birth.	N/A	Under consideration
I recommend the Royal Australasian College of Physicians incorporate the current state of knowledge obtained from paediatric clinical practice, peer review studies such as Colditz et al, any other relevant studies and coronial findings and develop a guideline to assist paediatricians with the identification, management and treatment of subgaleal haemorrhages in newborns.	N/A	Under consideration
I recommend the Royal Children's Hospital PIPER service continue to develop and implement the ability to video conference with a referring hospital to facilitate visualisation of a baby's condition, and to assist with the assessment and management of a baby. Further, in the interim, I would urge the hospital to consider the use of the video capacity of clinician's mobile phones, laptops and/or iPad until other compatible information technology can be developed and implemented.	Response from Paediatric Infant and Perinatal Emergency Retrieval and Royal Melbourne Hospital	Accepted in full

Finding into death of Baby M

Keywords: drowning, infant death, pool fence, safety

Recommendation	Response	Response outcome
I recommend that Committee CS-034, Safety of Private Swimming Pools, of Standards Australia consider whether amendments should be made to Australian Standard 1926.1 to ensure that pool gate hinges are resistant to degradation over time, particularly in conditions of disuse, by requiring either: (a) that certain grades of materials be used in spring-based self-closing hinges; or (b) that self-closing gate hinges employ a prescribed class of mechanisms.	Response from Standards Australia	Under consideration

Finding into death of HB

Keywords: Child with complex medical needs, malnourished child, total parenteral nutrition, PEG feeding, seizure disorder, epilepsy, Lennox Gastaut syndrome, DHHS, Child Protection, ChildFIRST, Disability Client Services

Recommendation	Response	Response outcome
Conscious that policy is a matter for the government and should not be dictated by isolated or extreme circumstances, the level of risk to a child such as HB can never be properly determined without a comprehensive understanding of her vulnerabilities and needs at the very least and, optimally, an appraisal of her current medical condition, preferably informed by a contemporary medical assessment. If this is beyond the current Child Protection paradigm, then I recommend that the Minister for Health and Humans Services considers modifying the paradigm to make special provision for vulnerable children like HB, analogous to initiatives for high-risk infants and high-risk adolescents where they exist, to ensure they remain visible to Child Protection.	Response from Department of Health and Human Services	Accepted in full

Finding into death of Angel Hensgen

Keywords: paracetamol toxicity, child death, student wellbeing, self-harm

Recommendation	Response	Response outcome
That the Department of Education and Training review the compliance and competency of teachers and staff at Red Cliffs Secondary School with the mandatory reporting online training and their obligations.	Response from Department of Education and Training	Accepted in full
That the Department of Education and Training develop a guide to assist schools' responses when they become aware of a possible relationship between a child who is not of the age of consent and an older student.	Response from Department of Education and Training	Accepted in part
That the Department of Education and Training work with Red Cliffs Secondary College and Irymple Technical College to establish a process to manage requests by a student supported by family/carers to transfer between schools that will ensure the best interests of the child are prioritised.	Response from Department of Education and Training	Accepted in full
That Red Cliffs Secondary College review any policy relating to its management of self-harm by students and, if necessary, amend it to ensure it provides guidance about how risk of suicide and/or self-harm should be assessed and in what circumstances a student should be referred to a mental health service.	Response from Department of Education and Training	Accepted in full
That Red Cliffs Secondary College review and amend if necessary, any Wellbeing policy or procedure to ensure that each student's wellbeing is assessed and interventions implemented holistically, rather than episodically, and provide guidance about responding to students refusing help to ensure his or her wellbeing is	Response from Department of Education and Training	Accepted in full

optimised.		
That the Therapeutic Goods Administration consider mandating a reduction of the number of doses sold in each box of modified release paracetamol products to minimise the risk of overdose.	Response from Therapeutic Goods Administration	Under consideration

Finding into death of Baby S

Keywords: infant, hospital, lotus birth, sepsis, vaginal seeding

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that Safer Care Victoria Maternity and Newborn Clinical Network groups formulate clinical practice guidelines or consensus statements in relation to lotus birth and vaginal seeding in consultation with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Consultative Council of Obstetric and Paediatric Mortality and Morbidity, and other relevant experts.	Response from Safer Care Victoria	Accepted in full
With the aim of promoting public health and safety and preventing like deaths, I recommend that Eastern Health services institute a review of new or alternative practices by a clinically relevant hospital committee, which include experienced senior medical staff, to thoroughly assess new or alternative practices for their risks and evidence basis and ultimately approve whether the new practice should be allowed to proceed.	Response from Eastern Health	Accepted in part

Finding into death of Baby C

Keywords: myocarditis, viral infection, emergency department, triage

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

Homicide

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

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

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

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

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