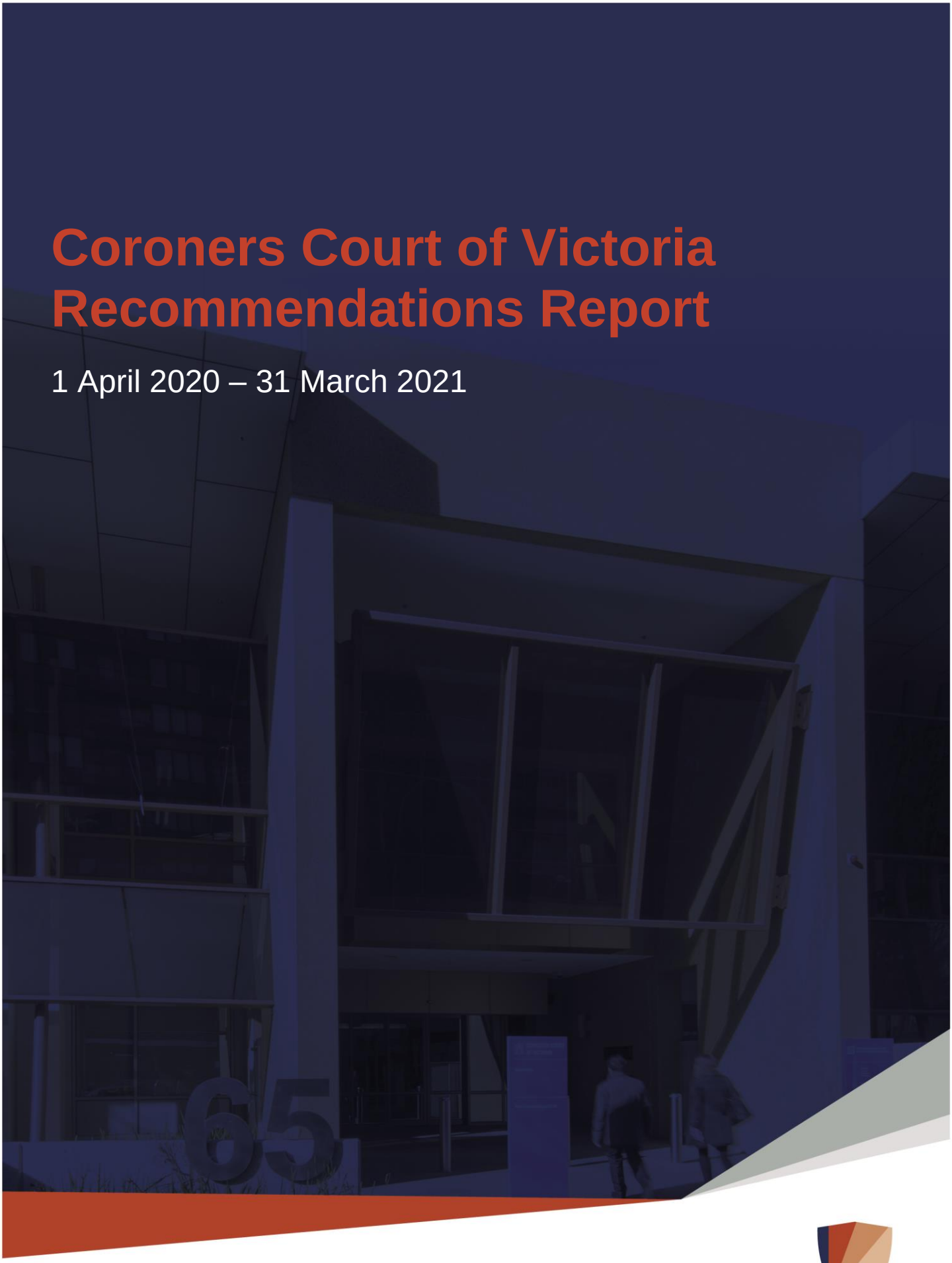
Coroners Court of Victoria Recommendations Report

1 April 2020 – 31 March 2021



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 second edition covers the period from 1 April 2020 to 31 March 2021. During this period, coroners made 183 recommendations across 85 findings.

Following these recommendations, the Court received:

- 128 responses stating the recommendation was accepted in full
- 18 responses stating the recommendation was accepted in part or an alternative was proposed
- 35 responses stating the recommendation remains under consideration
- 8 responses where the recommendation was not accepted

In addition to these:

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

The report also contains a chapter on overdue responses reported since the first edition of this publication that remain outstanding. There are currently three responses overdue across two recommendations in this category.

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

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

The status of responses received is accurate at 30 June 2021.

Contents

Suicide

Finding into death of Christopher Ritson

Keywords: hypoxic ischaemic encephalopathy, suicide, mental health

Recommendation	Response	Response outcome
I recommend that Maroondah Hospital clearly assess the utility of mental health assessments being undertaken by telephone, vis-à-vis face-to-face, and limit the use of such contact to circumstances when contact by telephone has been identified to be adequate.	Response from Eastern Health Attachment 1 Psychiatric Phone Triage Guideline Attachment 2 State-wide Mental Health Triage Scale	Rejected in full
Further I recommend that Maroondah Hospital investigate whether in this case the period of time that elapsed between 7 March and 12 March 2020 was a result of the systematic failure to which Dr Starke referred and if that is found to be the case that it take the steps necessary to prevent a repetition of that systematic failure. I also recommend that if such an investigation does not reveal a systematic failure and that the reason identified for the 5 day delay between 7 march and 12 March 2020 be clearly and practically addressed by the hospital so as to ensure that such a delay does not occur again.	Response from Eastern Health Attachment 1 Psychiatric Phone Triage Guideline Attachment 2 State-wide Mental Health Triage Scale	Accepted in full

Finding into death of Mitchell James Dowling

Keywords: suicide, mental health

Recommendation	Response	Response outcome
That the Australian Psychological Society (APS) and other peak bodies representing psychologists, including the Australian Clinical Psychology Association (ACPA) and the Australian Association of Psychologists (AAP) advise their members that when treating young adults, unless clear reasons contraindicate such action, they provide the patient with written information relevant to the diagnosis which can be provided to the patient's family, friends and/or supports. In particular the information should include information about future symptoms which may indicate a relapse and the need for further therapy.	Response from The Australian Clinical Psychology Association Response from Australian Association of Psychologists Inc Response from Australian Psychological Society	Accepted in full Accepted in full Accepted in full
That the APS, ACPA and AAP advise their members that when treating young adults in relation to self-harm and suicide issues that, unless clear reasons contraindicate such actions, management should include exploring the option for the patient approving/consenting for the psychologist to directly consult with the patient's parent or a parent or partner about the patient's condition and that which may be needed to support the patient.	Response from The Australian Clinical Psychology Association Response from Australian Association of Psychologists Inc Response from Australian Psychological Society	Accepted in full Accepted in full Accepted in full
That the APS, ACPA and AAP advise their members that when treating young adults, unless clear reasons contraindicate such action, management should include establishing whether the patient has discussed the subject of treatment and any diagnosis with family, friends and/or supports and, if not, encourage and potentially provide strategy for such discussion with a view to such	Response from The Australian Clinical Psychology Association Response from Australian Association of Psychologists Inc Response from Australian	Accepted in full Accepted in full Accepted in full

supports aiding treatment.	Psychological Society	
That the APS, ACPA and AAP advise their members that when treating young adults, if the involvement of psychiatric care is considered appropriate, clear advice is provided as to how to access such care and the patient's general practitioner is promptly notified regarding the recommendation in order to further facilitate access to such care.	Response from The Australian Clinical Psychology Association Response from Australian Association of Psychologists Inc Response from Australian Psychological Society	Accepted in full Accepted in full Accepted in full
That the APS, ACPA and AAP remind their members that, regardless of their ongoing duty of confidentiality to deceased patients, that there is a specific exemption contained in Health Privacy Principle 2.4 of the Health Records Act 2001 (Vic) which states that: "a health service provider may disclose health information about an individual to an immediate family member of the individual if: (ii) the disclosure is made for compassionate grounds.	Response from The Australian Clinical Psychology Association Response from Australian Association of Psychologists Inc Response from Australian Psychological Society	Accepted in full Accepted in full Accepted in full

Finding into death of Brett McDonnell

Keywords: suicide

Recommendation	Response	Response outcome
I recommend that the Corrections Victoria obtain detailed relevant professional advice about the adequacy and effectiveness of the "Suicide and Self-harm Risk Screening Suite" together with the qualifications and training of those who administer it as well as the manner in which it is administered with a view to improving insight into the state of mind of those upon whom the Screening Suite is conducted specifically in relation to the likelihood of proximate suicide and self-harm risk. Such advice ought to contemplate the best way to maximise effectiveness and efficiency and consider the utility of recommending a minimum time-period over which the Screening Suite ought to be administered and periodic 'refresher' training.	Response from Department of Justice and Community Safety	Accepted in full

Finding into death of Jack David Watson

Keywords: suicide, asphyxiation, mental health, inert gas

Recommendation	Response	Response outcome
I recommend that Ballarat Health Services amend the section "Transfer between another Area Mental Health Services - Community Services" of the Patient Transfer Protocol to explicitly require that the referral discussion address a recommended timeframe for the receiving service to see the patient, including the relative urgency of a face-to-face interview as opposed to telephone contact. These matters should also be documented in the information sent to the receiving health service.	Response from Ballarat Health Services	Accepted in full

Finding into death of Stanley Weaver

Keywords: suicide, family violence, mental health

Recommendation	Response	Response outcome
I recommend that Victoria Police review the relevant Victoria Police Manual and Guidelines to ensure that there is clear and consistent guidance regarding suspect welfare management in relation to family violence perpetrators. Suspect welfare management should be considered in all interactions between Victoria Police and family violence perpetrators, including during the service of family violence related documentation. This guidance should be included in the updated Code of Practice for the investigation of Family Violence and be reflective of the advice already provided in the Code of Practice for the investigation of Sexual Crime.	Victoria Police was expected to respond by 18 June 2021.	Overdue

Finding into death of Nguyen Pham Dinh Le

Keywords: suicide, international student, mental health, support

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 takes on the role of leading and coordinating efforts to support mental health and wellbeing of international students studying in Victoria, and to ensure international students can access mental health treatment.	Response from Department of Health	Accepted in full

Finding into death of Daniel Patrick Frawley

Keywords: motor vehicle collision, CTE, mental health, head trauma, suicide

Recommendation	Response	Response outcome
That the Australian Football League actively encourages players and, their legal representatives after their death, to donate their brains to the Australian Sports Brain Bank in order to make a meaningful contribution to research into Chronic Traumatic Encephalopathy and thereby improve the safety of future generations of footballers and others engaged in contact sports.	Response from Australian Football League	Accepted in full
That the Australian Football League Players' Association actively encourages players and, their legal representatives after their death, to donate their brains to the Australian Sports Brain Bank in order to make a meaningful contribution to research into Chronic Traumatic Encephalopathy and thereby improve the safety of future generations of footballers and others engaged in contact sports.	Response from Australian Football League Players' Association	Accepted in full

That, in order to enhance research into CTE, the State Coroner and the Director of the Victorian Institute of Forensic Medicine, ensure that, as far as possible, coronial processes and practices: (i) Recognise that currently, CTE can only be diagnosed at autopsy and requires a careful brain examination and sampling of the appropriate areas of the brain for histological and immunohistochemical assessment to determine whether the pathological changes ascribed to CTE are present. (ii) Improve timely identification of cases in which there is a history of head trauma, be that major trauma or minor repetitive trauma, such as may be sustained in sporting activities, so that consideration of the need for an autopsy can be appropriately informed. (iii) While brain examination and tissue sampling needs to be adequate for CTE assessment and this is ideally achieved by retention of the brain for examination in an appropriate centre, such as the Australian Sports Brain Bank, this option may not be acceptable to the senior next of kin. Therefore, a histological brain sampling protocol should be developed to ensure that appropriate sections are available to allow adequate assessment for the presence or absence of CTE changes without the need for long term retention of the whole brain.	Response from Coroners Court of Victoria Response from Victorian Institute of Forensic Medicine	Accepted in full Accepted in full

Finding into death of Julie Ann Lindsay

Keywords: mental health, suicide, firearm, mental health services, general practitioners, rural

Recommendation	Response	Response outcome
Given the increased access to firearms in regional and rural areas, and their lethality as a means of suicide, I recommend that the College of General Practitioners targets promotion of their comprehensive website education about suicide prevention to General Practitioners who treat patients in regional and rural areas.	Response from Royal Australian College of General Practitioners	Accepted in full

Finding into the death of Mr P

Keywords: suicide, firearms licence, clinical guidelines, gun ownership, mental health

Recommendation	Response	Response outcome
Victoria Police develop a framework for determining whether a person with a history of or current mental illness and suicidality is a fit and proper person to hold a firearm licence under the Firearms Act, in consultation with the Royal Australian and New Zealand College of Psychiatrists and the Royal Australian College of General Practitioners; and	Response from Royal Australian College of General Practitioners Response from Royal Australian and New Zealand College of Psychiatrists Response from Victoria Police	Rejected in full Under consideration Accepted in full
As part of the development of that framework, the Royal Australian and New Zealand College of Psychiatrists and the Royal Australian College of General Practitioners develop a set of clinical guidelines regarding assessing fitness to own a firearms licence and firearms in people with a history of or current mental illness and suicidality.	Response from Royal Australian College of General Practitioners Response from Royal Australian and New Zealand College of Psychiatrists	Rejected in full Under consideration

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 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 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	Response from Eastern Health	Accepted in full

Department of Health and Human Services and the Chief Psychiatrist.		

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	Rejected in full

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.	Victoria Police was expected to respond by 5 March 2021	Overdue
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.	Victoria Police was expected to respond by 5 March 2021	Overdue

Deaths in custody

Finding into death of Gary Hietanen

Keywords: death in custody, Aboriginal and Torres Strait Islander passing, combined drug toxicity

Recommendation	Response	Response outcome
1. G4S commission independent research into the safest efficient way to dispense medication to prisoners in the Borrowdale Unit of Port Phillip Prison incorporating consideration of: a) 'Trap-to-trap' dispensation and alternatives including but not limited opening cell doors to dispense medication, b) Dispensing medication directly to prisoners form a central point in the Unit; and c) Whether different dispensation methods ought to be used for different prisoners taking into account the nature of the medication being dispensed and each prisoner's history of medication and drug use and abuse.	Response from Port Phillip Prison	Alternative adopted
2. G4S reiterate to staff undertaking the 'lock-down' of the Borrowdale Unit that a verbal, spoken response must be obtained from each and every prisoner. If such a response is not forthcoming from an enquiry made through the 'trap', the cell door is to be opened and a verbal response then obtained from the prisoner.	Response from Port Phillip Prison	Accepted in full

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 Under consideration Accepted in full
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 prison. This a should include a timely remedial mechanism for admission	Forensicare - Thomas Embling Hospital Department of Justice and Community Safety	Accepted in full Accepted in full

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	Chief Commissioner	Accepted in full

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.	of Police	

Finding into 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	Response from the	Accepted in part

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.	Chief Commissioner of Victoria Police	
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 Islander 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 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.	Overdue

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.	Response from Ballarat Health Services	Accepted in part
I recommend Ballarat Health Services extend the importance of completing discharge summaries within a timely manner hospital wide, rather than those solely on orientation.	Response from Ballarat Health Services	Accepted in part
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 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 Teresa Mancuso

Keywords: family violence, FVIO, police response

Recommendation	Response	Response outcome
Victoria Police amend the current Code of Practice for the Investigation of Family Violence and the current Victoria Police Manual Policy Rules - Family Violence to provide clear instructions to Victoria Police members responding to reports of family violence incidents received via telephone and make a reference to updated VPM - Crime and events reporting.	Victoria Police was expected to respond by 10 June 2021.	Overdue

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 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 enhance the assessment of risk.	Response from Department of Justice and Community Safety	Accepted in full

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.	Family Safety Victoria was expected to respond by 20 February 2021	Overdue

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.	Family Safety Victoria was expected to respond by 20 February 2021	Overdue

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 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; iii. Explore the problems associated with a reliance on alcohol to manage	Response from Department of Health and Human Services and Family Safety Victoria	Under consideration

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.		
The 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 death of Ora Holt

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

Recommendation	Response	Response outcome
That the Royal Australian College of General Practice (RACGP) should review the currency of the 2008 Abuse and violence, Working with our patients in general practice guiding document and documents that reference it. After development of the above document, the RACGP should work with Primary Health Networks and local family violence hubs to provide awareness and education for members.	RACGP was expected to respond by 26 September 2020	Overdue
The RACGP should also develop guidance and examples of an index of suspicion for general practitioners who are working with potential perpetrators of family violence	RACGP was expected to respond by 26 September 2020	Overdue

Overdose and poisoning

Finding into death of Diane Maria Hillgrove

Keywords: mixed drug toxicity, chronic pain, SafeScript

Recommendation	Response	Response outcome
In order to reduce the risk of harm associated with pregabalin, the Victorian Department of Health and Human Services consider the inclusion of pregabalin in the scope of drugs monitored in the Safe Script real-time prescription monitoring scheme.	Response from Minister for Health	Accepted in full

Finding into death of Shae Harry Paszkiewicz

Keywords: combined drug toxicity, heroin, naloxone, custodial health, prisoner health

Recommendation	Response	Response outcome
That the Victorian Department of Health adopt formal responsibility for improving health outcomes and reducing drug-related mortality among people who are released from prison.	Response from Department of Health	Alternative Adopted
That the Victorian Department of Health convene a formal advisory group to guide the identification, prioritisation, implementation and evaluation of policies and programs to reduce drug-related mortality among people who are released from prison. This advisory group should include representatives from government departments and nongovernment organisations whose work intersects with support of people leaving prison, as well as academic experts.	Response from Department of Health	Accepted in full
That the Victorian Department of Health collaborate with the Victorian Department of Justice and Community Safety to link information they hold on all people who enter Victoria's prison system, with a view to producing accurate and timely information on these people and their health outcomes including death within 10 years of release from prison. This information should be collated in consultation with the advisory group (see Recommendation Two) and should be publicly reported on (at least) an annual basis, as well as being made available to researchers who are engaged in efforts to improve these health outcomes.	Response from Department of Health Response from Department of Justice and Community Safety	Accepted in full Accepted in part
That the Victorian Department of Justice and Community Safety should immediately introduce a take-home naloxone program (including training in	Response from Department of Justice and Community Safety	Accepted in part

overdose awareness and naloxone administration) to be made available to all people in Victorian prisons who have a history of opioid use and who are preparing to exit prison.		

Finding into death of AAC

Keywords: combined drug toxicity, pregabalin, dihydrocodeine, tramadol, temazepam, lorazepam, obesity, accidental overdose

Recommendation	Response	Response outcome
I acknowledge the Department's response to Coroner Gebert's recommendation. I trust that the Department and the SafeScript Expert Advisory Group are abreast of coroners' concerns about pregabalin given its now established and ongoing contribution to Victorian overdose deaths. Nevertheless, given my obligation as a coroner to contribute to a reduction in the number of preventable deaths in Victoria, I recommend that the Victorian Department of Health review the circumstances of AAC death, and particularly the apparent ease with which he presented to multiple clinics, registered as a patient under false names and was prescribed significant quantities of drugs implicated in his death - pregabalin, tramadol, temazepam and lorazepam. Such review should include a re-consideration of the case for adding pregabalin to the list of medicines monitored through the SafeScript system and any other measures that could enhance patient safety in this regard.	Response from Department of Health	Accepted in full

Finding into death of 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.	Response from Victoria Police	Under consideration

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 Josephine Helen Clarke

Keywords: subdural haemorrhage, fall, inpatient rehabilitation

Recommendation	Response	Response outcome
Monash Health review its falls related guidelines and other supporting documents to clarify ambiguous terms or instructions including, but not limited to, 'constant supervision' and 'N/A'	Response from Monash Health Attachment 2 - Preventing Falls and harm from falls Attachment 3 - Delirium and Dementia Attachment 4 - Medical Falls risk assessment	Accepted in full
Monash Health review its falls related guidelines and other supporting documents so that a patient's cognitive issues are more clearly identified and documented in order to inform the individual risk mitigation and intervention strategies to be put in place	Response from Monash Health Attachment 2 - Preventing Falls and harm from falls Attachment 3 - Delirium and Dementia Attachment 4 - Medical Falls risk assessment	Accepted in full
Monash Health review how the application and implementation of falls prevention mitigation and intervention strategies are recorded for individual patients with a view to providing consistent care	Response from Monash Health Attachment 2 - Preventing Falls and harm from falls Attachment 3 - Delirium and Dementia Attachment 4 - Medical Falls risk assessment	Accepted in full

Monash Health review how consumers and their families are informed of falls prevention mitigation strategies and interventions with a view to reducing ambiguity	Response from Monash Health Attachment 2 - Preventing Falls and harm from falls Attachment 3 - Delirium and Dementia Attachment 4 - Medical Falls risk assessment	Accepted in full

Finding into death of Robert Gerard Dimattina

Keywords: aspiration pneumonia, surgical procedure, colorectal surgery, NGT insertion

Recommendation	Response	Response outcome
That the Royal Australian College of Surgeons (RACS) use a de-identified version of this case as an educative tool to remind its members of the uncommon and unexpected severe risks associated with NGT insertion.	RACS was expected to respond by 5 May 2021.	Overdue

Finding into death of Ian Fraser

Keywords: retroperitoneal haemorrhage, anticoagulants, congestive heart failure, useability of electronic medical records

Recommendation	Response	Response outcome
1(a) I recommend the Therapeutic Goods Association consider: Reassigning the risk-level assigned to EMRs (specifically, the electronic prescribing component) to a risk level that requires assessment of and compliance with a usability standard. These standards should be developed in conjunction with key stakeholders (for example, the Australian Commission of Safety and Quality in Health, state government health departments, safety departments, and state government digital health officers, and relevant overseas agencies) (b) I recommend the Therapeutic Goods Association consider: developing pathways for users to report adverse events involving software as a medical device (including but not limited to electronic medical records) similar to the publicly accessible pathways that already exist for medical devices, medicines and vaccines c) I recommend the Therapeutic Goods Association consider assessing the EMR vendor improvements in response to incidents for usability and shared with other health services (d) I recommend the Therapeutic Goods Association consider developing promotional material for this pathway similar to those that already exist for medical devices, medicines and vaccines.	Response from the Australian Commission of Safety and Quality in Health Care The TGA was expected to respond by 5 June 2021	Accepted in full Overdue
2. I also recommend that Safer Care Victoria promote the Therapeutic Goods Association's reporting pathway to both health-service safety departments and clinicians.	Response from Safer Care Victoria	Accepted in full

Finding into death of Carl David Waldon

Keywords: medical, hospital, intracerebral haemorrhage

Recommendation	Response	Response outcome
In the interests of public health and safety and preventing like deaths, I recommend that the Monash Clinical Council supports the proposed Hospital-wide anticoagulant stewardship program.	Response from Monash Health	Accepted in full

Finding into death of Mrs L

Keywords: neutropenic sepsis, multiple organ failure, chemotherapy, capecitabine toxicity, availability of antidote

Recommendation	Response	Response outcome
That the Peter MacCallum Cancer Centre and the Medical Oncology Group of Australia make a submission to the Medical Services Advisory Committee to consider the feasibility of finding DPYD testing for all patients prior to commencement of fluoropyrimidines in Australia and to determine the support required to implement a DPYD testing program to remove the major barrier of cost to testing and provide oncologists and patients the choice to undertake DPYD testing when clinically indicated.	Response from Peter MacCallum Cancer Centre Response from Medical Oncology Group of Australia Incorporated	Under consideration Rejected in full

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.	Response from Castlemaine Health Attachment to response from Castlemaine Health	Accepted in full
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.	Response from Castlemaine Health Attachment to response from Castlemaine Health	Accepted in full

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 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 the death of Scott Adams

Keywords: motor vehicle collision, motorised bicycle

Recommendation	Response	Response outcome
VicRoads, The Transport Accident Commission, The Vehicle Safety Standards Bureau, Victoria Police, Bicycle Industries Australia, consider the circumstances in which Scott Adams died as set out in this Finding and individually and together assess the adequacy of the current regulation of the motorisation of bicycles and their use including the ready availability of conversion kits taking into account the actual power provided by such kits vis-à-vis any purported power they provide with a view to improving public safety and the safety of people riding such bicycles.	Response from Department of Transport Victoria Police is expected to respond by 14 July 2021	Accepted in full Awaiting response

Finding into death of Walentyna Huczyk

Keywords: motor vehicle collision, mobility scooter, motorised scooter

Recommendation	Response	Response outcome
I recommend that the Victorian Department of Transport implement a targeted public awareness campaign to highlight the risks associated with motorised mobility scooters as a potential traffic hazard.	The Department of Transport is expected to respond by 30 June 2021	Awaiting response

Finding into death of Jason Gilham
Finding into death of Bradley Dobney

Keywords: transport and road safety, barriers, water hazards

Recommendation	Response	Response outcome
Using the risk-based 'safe system approach', the Department of Transport should conduct a review of Victorian roads in the vicinity of 'bodies of water', to identify and consider whether safety barriers should be installed or extended to protect against potential water hazards.	Response from Department of Transport	Alternative adopted

Finding into death of Joshua Luke Ackaoui

Keywords: traumatic haemothorax, motorcycle collision, motor vehicle collision, transport, road safety

Recommendation	Response	Response outcome
In the interest of promoting public safety and preventing like deaths, pending the duplication of Hallam Road, I recommend that VicRoads and the Casey City Council review the circumstances of Mr Ackaoui's death and consider the need for interim remediation of road infrastructure in the vicinity of the collision by: (i) facilitating right turns from Centre Road onto Hallam Road whether by the installation of traffic controls signals or otherwise; or	Response from Casey City Council Response from Department of Transport	Under consideration Under consideration
(ii) converting the broken white dividing line to a single unbroken white line, thus prohibiting U-turns altogether; or	Response from Casey City Council Response from Department of Transport	Accepted in full Accepted in full
(iii) by signage or other means, encouraging drivers intending to turn right from Centre Road onto Hallam Road, to use existing traffic-signal controlled intersections such as the intersection of Hallam Road and Pound Road, to safety negotiate a route north.	Response from Casey City Council Response from Department of Transport	Under consideration Under consideration

Finding into the death of Mr R

Keywords: motor vehicle incident, unsecured load

Recommendation	Response	Response outcome
That the Indigo Shire Council consider installing advisory speed sign(s) at an appropriate location at the bend near the intersection of Sandy Creek Road and Reserve Road, Sandy Creek, recommending a maximum speed limit of 80 km/h	Indigo Shire Council was expected to respond by 19 May 2021.	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 Response from Department of Transport and Metro Trains	Accepted in full Accepted in full Accepted in full

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.	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 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 15 October 2020.	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 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 1 March 2021.	Overdue

Drowning

Finding into death of Ehren Hyde

Keywords: drowning, sailing accident, recreational activities

Recommendation	Response	Response outcome
I recommend that Transport Safety Victoria engage with Victorian sailing and yacht clubs to promote the 'Prepare to Survive: Know The Five' campaign, and encourage boaters or paddlers to enact the five steps, particularly when boating or paddling alone. Such a campaign may be multimodal, utilising where possible, social media, flyers or posters at sailing or yacht clubs, and articles or advertisements in sailing club newsletters.	Transport Safety Victoria is expected to respond by 30 June 2021	Awaiting response
I recommend that Transport Safety Victoria liaise with the Department of Economic Development, Jobs, Transport and Resources to explore the possibility and feasibility of legislative amendment to require EPIRBs or PLBs to be carried by the operators of recreational vessels (regardless of the classification of waterway or distance offshore) in high risk situations, including when operating alone.	Transport Safety Victoria is expected to respond by 30 June 2021	Awaiting response

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.	Response from Great Ocean Road Coast and Parks Authority	Under consideration
That these measures should be re-assessed at appropriate intervals to ensure that they remain best practice and in line with relevant standards.	Response from Great Ocean Road Coast and Parks Authority	Under consideration
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.	Response from Great Ocean Road Coast and Parks Authority	Rejected 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.	Mornington Peninsula Shire Council was expected to respond by 29 December 2020	Overdue

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 18 November 2020.	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 Allan McFarlane

Keywords: cardiac arrest, near drowning, boating accident

Recommendation	Response	Response outcome
For a number of years this Court has made recommendations with regard to prevention opportunities in boating related incidents. Most recently, after the death of Graham Hill, Coroner Michelle Hodgson recommended " ... that Transport Safety Victoria consider introducing requirements that all boats be fitted with a_ manual or electrical pumping mechanism to all bilge areas ... ". I support Coroner Hodgson's recommendation and add that I concur with the Water Police Squad's advocation for all boats fitted with electrical bilge pumps in enclosed bilge areas to have automated switches or floats, or alarms if a manual bilge exists.	Response from Transport Safety Victoria	Under consideration
Since 2010, the Water Police Squad has consistently campaigned for 'seaworthy' inspections at the time of registration and acquisition or transfer of vessel ownership. The absence of a vessel inspection process to Victoria tragically means that old and/or modified vessels are usually only detected as unsafe or unsuitable post incident. My fellow coroners have enduringly supported the implementation of such a system; however, one is yet to be developed. For this reason, I encourage Transport Safety Victoria to explore the possibility of implementing a system of vessel inspections, akin to roadworthy inspections, to improve marine safety.	Response from Transport Safety Victoria	Under consideration

Furthermore, I recommend that as part of seaworthy inspections, builders plates are retrospectively attached which determine the number of people, the conditions for which the vessel is suited and the maximum engine capacity of the vessel.	Response from Transport Safety Victoria	Under consideration

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 of Jordan White

Keywords: hypoxic ischaemic encephalopathy, neck compression, infant, equipment fault

Recommendation	Response	Response outcome
The Victorian Department of Health and Human Services and Kidsafe Victoria, together develop and implement a strategy to increase public awareness of the potentially fatal dangers of parents using faulty or damaged 'baby care equipment' such as portacots with a view to reducing, if not eradicating accidental deaths such as that of Baby Jordan caused by such use.	Response from Kidsafe Victoria Response from Consultative Council on Obstetric and Paediatric Mortality and Morbidity	Under consideration Accepted in full

Finding into death of Seth James Haddow

Keywords: motor vehicle incident, head injury, child

Recommendation	Response	Response outcome
The Victorian Department of Health and Human Services, Kidsafe Victoria, the Transport Accident Commission and the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (the Organisations) together consider the circumstances of Seth Haddow' s death and undertake research to identify the factors that contributed to it and to like deaths between 2015 and 2019.	Response from Kidsafe Victoria Response from Department of Health Response from Consultative Council on Obstetric and Paediatric Mortality and Morbidity Transport Accident Commission were expected to respond by April 2021	Under consideration Under consideration Under consideration Overdue
That the Organisations together develop a strategy aimed at reducing, if not eradicating such deaths and increase the public awareness of the identified factors, their associated dangers and developed strategies.	Response from Kidsafe Victoria Response from Department of Health Response from Consultative Council on Obstetric and Paediatric Mortality and Morbidity Transport Accident Commission were expected to respond by April 2021	Under consideration Under consideration Under consideration Overdue

Finding into death of Catherin D'Rozario

Keywords: acute asthma, allergic response, anaphylaxis

Recommendation	Response	Response outcome
That, in order to reduce the risk of harm associated with food allergies and anaphylaxis that the Royal Australian College of General Practitioners, the Royal College of Physicians and in consultation with the Australian Society of Clinical Immunology and Allergy work collaboratively towards educating their members and fellows of the dangers and that they consider referring all patients (especially children and young persons) who present with food allergies to a specialist immunologist or immunology clinic such as that at the Royal Children's Hospital for assessment and management of such allergies.	The Royal Australian College of General Practitioners was expected to respond by April 2021 Extension granted for the Royal Australian College of Physicians Australian Society of Clinical Immunology and Allergy	Overdue Awaiting Response Under consideration
That the Australian Society of Clinical Immunology and Allergy, the Victoria Department of Education and the Victorian Department of Health consult widely and work collaboratively towards establishing an educational program directed to parents, teacher and students of school and universities alerting them to the potentially fatal consequences of food allergies and anaphylaxis.	The Royal Australian College of General Practitioners was expected to respond by April 2021 Extension granted for the Royal Australian College of Physicians Australian Society of Clinical Immunology and Allergy	Overdue Awaiting Response Under consideration

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.	Response from Royal Australasian College of Physicians	Rejected in full
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.	Response from Royal Australasian College of Physicians	Rejected in full
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 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

Responses overdue by more than nine months

Each edition of the Court's Recommendations Report covers a 12-month period. This edition includes the period between 1 April 2020 - 31 March 2021.

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 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

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