Coroners Court of Victoria Recommendations Report

1 July 2022 – 30 June 2023

13 December 2023

Coroners Court of Victoria

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, where appropriate, make recommendations to stop similar incidents happening in the future.

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

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

The *Coroners Court of Victoria Recommendations Report* is a publication collating all recommendations made over a 12month period and the status of responses received.

This sixth edition covers the period from 1 July 2022 to 30 June 2023. During this period, coroners made 223 recommendations across 96 findings.

Following these recommendations, the Court received:

- 143 responses stating the recommendation was accepted in full.
- 38 responses stating the recommendation was accepted in part or an alternative was proposed.
- 40 responses stating the recommendation remains under consideration.
- 14 responses where the recommendation was not accepted.

In addition to these:

- 4 responses are still being prepared, have been granted an extension or were directed to entities that are not required to respond (awaiting response).
- 2 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 four responses overdue across three matters 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 29 November 2023.

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Suicide

Finding into death of Mr EBG

Keywords: Helium, helium toxicity, plastic bag asphyxia, suicide

Recommendation	Response	Response outcome
That the ACCC make 20 per cent oxygen dilution of helium in balloon kits mandatory, as well as the possibility of the addition of an aversive agent similar to aerosol cans of compressed air used for dusting electronic equipment	Response from the Australian Competition and Consumer Commission	Accepted in Full
That the ACCC reconsider the feasibility of introducing mandatory modifications to helium cylinders in order to limit the ability of individuals to produce a steady flow to enact suicide plans;	Response from the Australian Competition and Consumer Commission	Accepted in Full
That the ACCC continue to work with industry and commercial operators to inform any potential regulatory or other interventions that they may consider in the future to reduce the risk of inert gas inhalation involving balloon helium.	Response from the Australian Competition and Consumer Commission	Accepted in Full
That Consumer Affairs Victoria consider what regulatory approaches to reducing the accessibility of helium as a means of suicide might be feasible in the regulatory environment of the State of Victoria, including requiring helium to be mixed with other gases for sale as balloon gas as well as approaches already considered by the ACCC at the Commonwealth level	Response from Consumer Affairs Victoria	Under Consideration

Finding into death of LKV

Keywords: suicide, private psychiatric facility, financial stress, mental health, inpatient care, ligature points, risk assessment

Recommendation	Response	Response outcome
The Victoria Clinic and the Healthscope National Mental Health Committee review the Risk Assessment and Observation Levels – Patient (Policy 9.07) in relation to the visual observation requirements to ensure it reflects contemporary practice, including expected engagement with a patient	Response received from Healthscope Operations	Accepted in full

Finding into death of Taylor Zachary Oliver

Keywords: suicide, mental health, support services, post-discharge follow-up, sharp object

Recommendation	Response	Response outcome
To improve patient safety and responsiveness of BMHS to clients in crisis, Ballarat Health Services embed in relevant policies/ procedures /protocols/ guidelines a requirement for ED staff to notify BMHS when a current client of BMHS presents to ED with mental health concerns, including when they leave without being seen, unless the patient has a current clinical risk management plan indicating that routine notification of such presentations is contraindicated.	Response received from Grampians Health	Under consideration

Finding into passing of Boe Luke Memery

Keywords: Aboriginal passing, suicide, access to mental health services

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that the Secretary of the Department of Health consider the feasibility of establishing drug and alcohol rehabilitation and detoxification facilities in the Mildura local government area that are appropriately resourced and meet demand for such services in the Mildura community.	Response from Department of Health	Accepted in full
To ensure continuous, quality, and culturally safe mental health care is available to the Aboriginal community in Mildura, I recommend the Department of Health work with the Victorian Aboriginal Community Controlled Health Organisation and Mallee District Aboriginal Services in Mildura to identify mechanisms to: a. Attract and retain qualified clinicians; b. Upskill current staff to become qualified clinicians through scholarships; and c. Provide access to a psychiatrist at MDAS wellness centre.	Response from Department of Health	Accepted in full
To improve the quality of care provided and promote consumer safety, I recommend Mallee District Aboriginal Services focus on documentation and record keeping by: a. Reviewing current file and electronic health record systems to ensure they encourage and facilitate contemporaneous documentation of important clinical information such	Response from Mallee District Aboriginal Services was expected by 1 December 2022	Overdue

as suicide risk assessment and management; and b. Ensuring current staff are aware of and understand their responsibilities in keeping accurate and complete healthcare records in line with the National Safety and Quality Primary and Community Healthcare Standards.		
I recommend Mallee District Aboriginal Services in Mildura ensure all staff working in mental health programs have training in evidence-based and culturally appropriate suicide risk assessment and management practices.	Response from Mallee District Aboriginal Services was expected by 1 December 2022	Overdue

Finding into death of JL

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

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

Finding into death of Dane Warren Simpson

Keywords: suicide, mental health, mental health triage

Recommendation	Response	Response outcome
The Royal Australian College of General Practitioners consider reviewing advice to their members in relation to treating those with Obsessive Compulsive Disorder and to reiterating the utility of gathering collateral information from families and involving family members in treatment, in particular where obsessive thinking and compulsive behaviour may carry the risk of self-harm.	Response from the Royal Australian College of General Practitioners	Accepted in part
The Australian Psychology Society consider reviewing advice to their members in relation to treating those with Obsessive Compulsive Disorder and to reiterating the utility of gathering collateral information from families and involving family members in treatment, in particular where obsessive thinking and compulsive behaviour may carry the risk of self-harm.	Response from the Australian Psychology Society	Accepted in full
That the Royal Australian and New Zealand College of Psychiatrists consider reviewing advice to their members in relation to treating those with Obsessive Compulsive Disorder and to reiterating the utility of gathering collateral information from families and involving family members in treatment, in particular where obsessive thinking and compulsive behaviour may carry the risk of self-harm.	Response from the Royal Australian and New Zealand College of Psychiatrists	Under consideration

Finding into death of Melissa Gaultier

Keywords: suicide, mental health, pregnancy, motor vehicle collision, pedestrian

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that Latrobe Regional Health implement a patient continuity of care transfer admission policy for its inpatient mental health ward, which aims to rectify the circumstances associated with Melissa Gaultier's transfer admission from Monash Health, by ensuring that appropriately qualified clinician(s)/inpatient consulting psychiatrist receiving handover details from another hospital are rostered and available to continue with that patient's care on admission.	Response from Latrobe Regional Hospital	Accepted in full

Finding into death of BL

Keywords: suicide, public mental health services, post discharge follow up

Recommendation	Response	Response outcome
For clients that are being discharged from inpatient/acute settings, MBH [Mildura Base Hospital] implement a formal process to ensure communication with general practitioners regarding admission details, medication and follow up arrangements.	Response from Mildura Base Hospital	Accepted in full
MBH implement a formalised process to ensure that discharge summaries are completed and provided to relevant stakeholders within a timely fashion.	Response from Mildura Base Hospital	Accepted in full
MBH ensure staff are aware of the requirements to document all clinical contacts relating to clients, with documentation to include adequate mental state examinations and descriptions of risk.	Response from Mildura Base Hospital	Accepted in full

Finding into death of YGE

Keywords: suicide, mental health, mental health support, ligature, family violence supports

Recommendation	Response	Response outcome
Family Safety Victoria review the data regarding the suicide of people who inject drugs and who are perpetrators of family violence and use this data to inform the development and review of perpetrator interventions going forward.	Response from Family Safety Victoria	Accepted in full

Finding into death of Mr P

Keywords: suicide, mental health, poor physical health

Recommendation	Response	Response outcome
The Royal Australian College of General Practitioners highlight to its Fellows and members the higher prevalence of suicide by males than females in the community and in particular the increase in prevalence as men age. That the College recommend to its Fellows and members the desirability of proactive timely follow-up of males who present with suicide ideation, a history of such ideation, indicators of depression or a history of suicide attempts and that if a timely follow-up is unavailable refer such patients to an appropriate service which can facilitate such a timely follow-up.	Response from Royal Australian College of General Practitioners	Accepted in full

Finding into death of Mr CLX

Keywords: Myelodysplasia, euthanasia, Cohuna District Hospital, Bendigo Hospital, Cohuna District Nursing Home, Echuca Regional Health.

Recommendation	Response	Response outcome
Cohuna District Hospital provides psychosocial supports for residents in the aged care and palliative care programs.	Response from Cohuna District Hospital	Accepted in full
Strengthen staff training in the assessment of suicide risk for aged care and palliative patients.	Response from Cohuna District Hospital	Accepted in full
Develop a flowchart outlining access to mental health services for residents in the aged care and palliative programs.	Response from Cohuna District Hospital	Accepted in full
Update the suicide risk procedure for aged care and palliative programs.	Response from Cohuna District Hospital	Accepted in full

Finding into death of Cody Morrella Watson

Keywords: Mental health, child sexual abuse and assault, best practice, trauma informed care, suicide, complex mental health issues, specialist training

Recommendation	Response	Response outcome
That the consortium of service providers designing and delivering the Mental Health Statewide Trauma Service consider the specific needs of child sexual abuse victim survivors who are receiving care from public mental health services.	Response from Department of Health	Accepted in full
As part of its planned initiatives responding to recommendations of Royal Commission into Victoria's Mental Health Services, that the Department provides the following development and capabilities to mental health and wellbeing professionals: (a) trauma-informed skills and competency; (b) education that is specific to the needs of clinicians working with children and adolescents and young adults who have experienced or been exposed to child sexual abuse; and (c) education that is specific to the workforce providing the first response (including emergency departments, psychiatric triaged and access teams) to victim/survivors who are in crisis following disclosure or in the context of already disclosed child sexual abuse/trauma.	Response from Department of Health	Accepted in full

Finding into death of Mr W

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

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

Finding into death of Anna Lawrence

Keywords: Alcohol and Baclofen toxicity, prescription drugs, suicide, complex medical history, mental health, alcohol dependency, alcohol rehabilitation, familial relationship breakdown

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Therapeutic Goods Administration consider whether, by revising the Australian Register of Therapeutic Goods entry for Baclofen to include alcohol use disorder as an approved indication, safer Baclofen prescribing practices could be achieved in order to improve the outcome for patients with alcohol use disorder and reduce the risk of death by Baclofen overdose in future.	Response from Health Products Regulation Group	Rejected in full

Finding into death of David Bramwell Van Vledder

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

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

Finding into death of Justin Patrick Crome

Keywords: suicide, fall from height, mental health, complex mental health issues, psychotic illness, inpatient assessment order, stalking

Recommendation	Response	Response outcome
Pursuant to section 72(2) of the Act, I make the following recommendation: that St Vincent's Mental Health embed into its relevant policies and procedures a requirement for case managers to escalate to a psychiatrist when a patient in community care: misses multiple consecutive appointments; and has not been recently reviewed by their case manager, psychiatric registrar, or psychiatrist.	Response from St Vincent's Hospital	Accepted in full

Finding into passing of Mathew James Luttrell

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

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

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

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

To the Secretary to the Department of Health, via the Chief Psychiatrist or as otherwise appropriate: I recommend that consideration be given to clarifying the definition of 'seclusion' in the context of the new Mental Health and Wellbeing Act (including by way of issuing an updated OCA guideline) in order to crystallise whether seclusion relates to: (i) the confinement of a patient alone to an area in which they cannot leave; (ii) the confinement of one or more patients to an area in which they cannot leave; and (iii) whether the definition of seclusion is met if a staff member is present.	Response from Department of Health	Accepted in full

Finding into death of PA

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

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

Finding into death of Silin Wang

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

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

Finding into death of Amanda Jane Stapledon

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

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

Finding into death of Michael Stephen Delaney

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

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

Overdose and poisoning

Finding into death of Jessica Higgins

Keywords: unintentional overdose, ketamine infusion, opioid, oxycodone, methadone, naloxone, SafeScript, mixed drug toxicity, chronic pain, hypoxic brain injury

Recommendation	Response	Response outcome
I recommend that the Royal Australian College of General Practitioners and the Faculty of Pain Medicine reiterate to their members the importance of considering buprenorphine in chronic pain management in appropriate cases.	Response from Royal Australian College of General Practitioners Response from Australian and New Zealand College of Anaesthetists	Accepted in full Accepted in full
I recommend that the Royal Australian College of General Practitioners and the Faculty of Pain Medicine reiterate the risks associated with patients who are prescribed multiple and concurrent medications with sedative properties, and that frequent reviews of patients ought be undertaken in a face-to-face setting to assess for adverse signs and symptoms.	Response from Royal Australian College of General Practitioners Response from Australian and New Zealand College of Anaesthetists	Accepted in full Accepted in full
I recommend that the Royal Australian College of General Practitioners and the Faculty of Pain Medicine reiterate to their members the importance of practitioners ensuring that all interactions with their patients, especially those with multiple providers, are documented in clear, written form in the patient's medical record, and that all patients are instructed in clear, written terms regarding their medication usage and doses to avoid potential adverse outcomes.	Response from Royal Australian College of General Practitioners Response from Australian and New Zealand College of Anaesthetists	Accepted in full Accepted in full

Finding into death of Jodie Marie Overstead

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

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

Finding into death of Bradley Scott Liefvoort

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

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

Finding into passing of Jayden Kain Wright

Keywords: Aboriginal passing, combined drug toxicity, mental health, prescription drugs, pain, drug dependence, pregabalin, unintentional, SafeScript

Recommendation	Response	Response outcome
I recommend that the Therapeutic Goods Administration include pregabalin in the scope of medications currently monitored by the SafeScript real-time prescription monitoring scheme.	Response from Therapeutic Goods Association Response from Department of Health	Under consideration

Medical

Finding into death of Sotirios Temopoulos

Keywords: surgical complications, sepsis, ischaemic heart disease, hospital, post discharge care, medication error

Recommendation	Response	Response outcome
I recommend that the Federal Health Minister conducts a feasibility study for the introduction of a national incident and near miss reporting mechanism for medication errors.	Response from Minister for Health and Aged Care	Accepted in full

Finding into death of Heather Jean Lucas

Keywords: Anaphylaxis, chemotherapy, ischaemic heart disease, cancer, carboplatin

Recommendation	Response	Response outcome
Cabrini Health review the grading scale utilised in the Platinum Hypersensitivity Reaction Guidline and consider implementing a recognised scale includes reference to more detailed signs and symptoms for each grade so as to facilitate a more accurate assessment of any reaction and grading with a view to reducing the possibility of underestimation of severity of assessment.	Response from Cabrini Health	Accepted in full
Cabrini Health review their procedures to ensure that when a patient undergoes 'rechallenge' that an appropriately qualified, trained and equipped medical practitioner is at the bedside at least for administration of the drug and for a period within which any adverse reaction would be expected to manifest taking into account that any patient who has previously experienced grade 2 or greater reactions will not be re-challenged.	Response from Cabrini Health	Accepted in full
Cabrini Health review its record keeping processes and procedures including the Adverse Drug Reaction System and ensure that all adverse drug reactions are recorded in a timely fashion on all databases, written and electronically held including in the patient's medical record that are accessible by clinical staff and explicitly considered before any re challenge	Response from Cabrini Health	Alternative adopted
The Patient Assessment Tool – Day Oncology tool be amended to allow explicit recording of allergic reactions so that staff are not required to only rely on a patient	Response from Cabrini Health	Accepted in full

informing them of a previous allergic reaction		
Cabrini Health implement these processes and procedures across all its campuses.	Response from Cabrini Health	Alternative adopted

Finding into death of Warren Douglas Frazer

Keywords: Video assisted thoracoscopic surgery, cancer, adenocarcinoma, post-surgical complications, neurological complication

Recommendation	Response	Response outcome
The Northern Hospital draw and implement a formal policy describing how family members and next of kin of those undergoing surgery are to be kept informed about the progress of the surgery particularly when the surgery takes longer than prior estimates provided to family and next of kin.	Response from The Northern Hospital	Accepted in full
The Northern Hospital seek to formalise arrangements for transferring patients to St.Vincent's Hospital or The Austin Hospital and engross those arrangements in a protocol the terms of which are agreed upon by the hospitals. See paragraph 30 of Dr Ferguson's statement	Response from The Northern Hospital	Accepted in full
The Northern Hospital audit compliance with the Cancer Optimal Care Pathway in relation to patients' peri-operative investigations and planning. See paragraph 37 of Dr Ferguson's statement	Response from The Northern Hospital	Accepted in full
The Northern Hospital audit the effectiveness of the Head of Thoracic Surgery and the then newly appointed full time Thoracis Surgeon providing timely assistance and support to thoracic and other surgeons operating at the Northern Hospital.	Response from The Northern Hospital	Accepted in full

Finding into death of Helen Welsh

Keywords: sepsis, e-coli, comorbidities, complex medical history, hospital

Recommendation	Response	Response outcome
That Austin Health consider implementing the SCV clinical sepsis pathway.	Response from Austin Health	Accepted in full

Finding into passing of Cindy Jane Martin

Keywords: Aboriginal passing, obstructive sleep apnoea, obesity, mental health, complex medical history, cardiac arrest, hospital

Recommendation	Response	Response outcome
To improve the safety of patients who have obstructive sleep apnoea and who for reasons of distress, or lack of consent or willingness, will not use their own or a provided CPAP machine, NWMH build on its work with the Royal Melbourne Hospital Department of Respiratory Medicine to: a. Explore the options for improving the safety of patients in such circumstances; and b. Develop a guideline/advice for the monitoring of patients including any identified indicators of concern.	Response from Northern Health	Accepted in full

Finding into death of Ruth Ann McKenna

Keywords: surgical complications, complex medical history, gynaecological surgery

Recommendation	Response	Response outcome
I recommend that Goulburn Valley Health: a. Considers a review of its policies and procedures to ensure that patients are not placed on the waiting list for surgery until final sign off of all investigations requested during the pre-anaesthetic consultation; b. work with echocardiography services to streamline assessments for patients with reduced exercise tolerance and possible underlying cardiac problems; and c. review the system of communication between the pre-anaesthetic clinic and surgical teams to ensure surgeons are apprised of the outcome of PAC review, management plans and (where necessary) requests for further investigations and the outcome of same, in advance of the surgery date.	Response from Goulburn Valley Health	Accepted in full
I recommend that the Royal Australian and New Zealand College of Obstetricians and Gynaecologists liaise with the Department of Health to explore the possibility and feasibility of developing a laparoscopic surgery database within Victoria to enhance quality and accountability in laparoscopic gynaecological surgery. Such a database could enable health authorities to access live outcome data, provide feedback to clinicians, target training, and make recommendations to clinicians and services regarding service capability.	Response from Royal Australian and New Zealand College of Obstetricians and Gynaecologists Response from Department of Health	Under consideration Rejected in full

Finding into death of Susan Mary Royals

Keywords: cancer, hospital, complex medical history, Whipple procedure, surgical complications, central venous catheter

Recommendation	Response	Response outcome
Safer Care Victoria develops a standardised approach for CVC insertion which encourages the use of ultrasound guided insertion (and other methods of confirming venous placement) to reduce the likelihood of instances of arterial puncture.	Response from Safer Care Victoria	Accepted in full

Finding into death of Robert Albert Burns

Keywords: multiorgan dysfunction syndrome, surgical complications, sepsis, transfer delay, complex medical history, comorbidities, anastomotic leak, surgeon to surgeon communication

Recommendation	Response	Response outcome
I recommend that South West Health Care (SWHC) conduct a review of their approach to both the deteriorating and 'not progressing' post-operative colorectal surgical patient with a view to reliably and consistently applying the recommendations of the Victorian Surgical Consultative Council.	Response from South West Healthcare	Accepted in full
I recommend that South West Health Care implement multi-disciplinary consultant ward rounds or management meetings in ICU, particularly with regards to unstable or deteriorating patients with multiple potential problems who are failing to respond to treatment as expected.	Response from South West Healthcare	Accepted in full
I recommend that South West Health Care implement a policy of surgical 'peer review' of deteriorating or non-progressing patients.	Response from South West Healthcare	Accepted in full
I recommend that South West Health Care implement a policy whereby failed attempts by junior medical staff to transfer a patient to a higher level of care are escalated to a consultant to ensure timely transfer by discussion between peers at the sending and receiving hospital.	Response from South West Healthcare	Accepted in full
I recommend that South West Health Care implement a policy of direct surgeon to surgeon communication when a complicated and/or deteriorating patient is in	Response from South West Healthcare	Accepted in full

need of transfer for care by another surgeon at another hospital.		

Finding into death of Christine Stephen

Keywords: Colorectal surgery, intensive care and management, post-operative care, hospital, elective surgery, complex medical history

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that Healthscope consider developing a suitable rigorous and reliable technology-based alternative to an electronic patient monitoring system in a manner that is consistent with the Medical Board of Australia's guidelines on telehealth consultations.	Response from Healthscope.	Rejected in full

Finding into death of Armin Schaefer

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

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

Finding into death of Antoinette O'Brien

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

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

which captures relevant information in a meaningful and effective way.	Health and Safer Care Victoria	

Finding into death of Reginald William Griggs

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

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

Finding into death of Gary Ronald Burgess

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

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

Finding into death of Mr V

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

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

Finding into death of Thelma Annie Ogilvy

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

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

Transport and Road Safety

Finding into deaths of Maxwell Quartermain, Greg De Haven, Glenn Garland, John Washburn and Russell Munsch

Keywords: Air-crash, aviation, Essendon Airport, aircraft, pre-flight checks

Recommendation	Response	Response outcome
CASA [Civil Aviation Safety Authority] consider redoubling emphasis of the essential nature of check-list discipline especially to older pilots perhaps as a part of the increased obligations for more frequent IPCs borne by pilots older than 65.	Response from Civil Aviation Safety Authority	Under consideration
CASA consider promulgating explicit directions to the effect that if a rudder trim tab function test is undertaken as a part of pre-flight check that subsequently and prior to take-off the position of the rudder trim tab be checked on more than one occasion.	Response from Civil Aviation Safety Authority	Accepted in part
CASA consider instigating a formal 'audit trail' for NCNs and their acquittal.	Response from Civil Aviation Safety Authority	Accepted in part
CASA consider requiring pilots to have IPCs conducted by a variety of testers. The extent of variety of testers and time periods within which such variety is required may be best determined by CASA itself.	Response from Civil Aviation Safety Authority	Accepted in part

Finding into passing of Shawn James Marion

Keywords: motor vehicle collision, pedestrian, Aboriginal passing

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that Maribyrnong City Council consider installing additional street lighting at the location at which the collision occurred.	Response from Maribyrnong City Council	Under consideration

Finding into death of John Jacob Beirouti

Keywords: police pursuit, substance use, family violence, motor vehicle collision

Recommendation	Response	Response outcome
Considering the ambiguity still present within the policy framework traversed above, I recommend that the Chief Commissioner reconsider and amend the new VPM *Road Policing – Operations* policy to provide clear guidance on operational policing decisions, specifically but not limited to the direction that 'police members are required to discontinue the attempted intercept and not follow the vehicle'.	Response from Victoria Police	Accepted in full

Finding into death of Ludmila Sezonenko

Keywords: Motor vehicle collision, pedestrian, lighting, freeway

Recommendation	Response	Response outcome
I recommend that VicRoads install lighting under the Heatherton Road overpass to improve visibility on this section of the Monash Freeway.	Response from Department of Transport	Under consideration

Finding into death of Trevor Henry McKie

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

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

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

Finding into death of Mr J

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

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

Deaths in custody

Finding into death of Bazouni Bazouni

Keywords: death in custody, substance use, medical treatment, communication failure, hypoxic brain injury

Recommendation	Response	Response outcome
That Corrections Victoria considers developing and implementing a training program, to be undertaken by correctional staff and medical staff together (i) to enhance their mutual understanding of each other's respective roles in Victoria's prison system; and (ii) to encourage a co-ordinated, timely and effective sharing of information between them, including in relation to circumstances requiring medical assessments and observations of prisoners and assessments of security risks posed to staff by prisoners requiring medical attention.	Response from Department of Justice and Community Safety	Accepted in full

Finding into deaths of Wiki Raymond Lowe and Noel Thomas

Keywords: death in custody, suicide, ligature, risk assessment

Recommendation	Response	Response outcome
That the Secretary to the Department of Justice and Community Safety investigate the viability and utility of prisons in Victoria each centrally and remotely monitoring the vital signs of prisoners who have undergone risk assessment for suicide or self-harm including the extent to which any such monitoring may reduce the need for prisoners allocated S1 ratings being held in 'Muirhead type' cells.	Response from Department of Justice and Community Safety	Accepted in full
That when prison authorities consider transferring a prisoner from one prison to another, that such authorities explicitly consider whether there is any reasonable alternative for dealing with the perceived need for such transfer.	Response from Department of Justice and Community Safety	Accepted in full
The Secretary to the Department of Justice and Community Safety ensure that Victorian prisons have timely access to 'interstate' medical records of prisoners in custody in Victoria.	Response from Department of Justice and Community Safety	Accepted in full
The Secretary to the Department of Justice and Community Safety facilitate the 'step down' management plan for prisoners whose S rating is reduced from S3 to S4 as foreshadowed in the JARO Report into Mr Thomas's death including the use of annexure six to that Report.	Response from Department of Justice and Community Safety	Accepted in full
The Secretary instigate auditing of the utility and effectiveness of the referral process set out in the JARO Report into Mr Thomas's death for prisoners thought to be struggling	Response from Department of Justice and Community Safety	Alternative adopted

with issues to ‘Offending Behaviour Programs’.		
The Secretary ensure that a clear line of responsibility is in place for rescheduling cancelled medical appointments in Victorian Prisons taking into account respective prison authorities and all relevant medical services providers. Further that the operation of that ‘line of responsibility’ is audited for efficient, effective operation.	Response from Department of Justice and Community Safety	Accepted in full

Finding into death of Mladen Jovanoski

Keywords: suicide, corrections, Fulham Correctional Centre, medical concerns, medical care, prisoner transfer

Recommendation	Response	Response outcome
That Corrections Victoria consider further updating its procedures to require that any decision to cancel a medical transfer must, where relevant, first involve referral to the Health Services Manager at the prisoner's home prison or a clinician who is best placed to advise on the priority to be given to the case.	Response from Department of Justice and Community Safety	Accepted in full
That Corrections Victoria implement a policy to require all persons involved in a decision to cancel a medical transfer to record: the circumstances; the reasons; and the persons involved, and implement a system for doing so.	Response from Department of Justice and Community Safety	Accepted in full
That Corrections Victoria and Justice Health develop a tool to guide persons in an operational setting so that an anticipated cancellation of a transfer may be properly escalated in advance of the potential loss of the scheduled medical appointment.	Response from Department of Justice and Community Safety	Accepted in full
That Corrections Victoria investigate the feasibility of adding a warning flag (not containing any medical information itself) in the Prisoner Information Management System (PIMS) or other system to highlight the need for priority of a medical transfer where clinically indicated.	Response from Department of Justice and Community Safety	Accepted in part
That Corrections Victoria investigate the feasibility of adding an alternate intermediate location in the PIMS where the circumstances relating to the individual prisoner allow.	Response from Department of Justice and Community Safety	Accepted in part
That Corrections Victoria re-establish its quarterly governance	Response from Department of	Accepted in full

forum or comparable process capable of monitoring its response to issues identified, and recommendations made, by JARO, Justice Health or similar entities.	Justice and Community Safety	

Finding into passing of Veronica Nelson

Keywords: Aboriginal passing, Dame Phyllis Frost Centre, bail refusal, inadequate medical care, Wilkie Syndrome, bail reform

Recommendation	Response	Response outcome
1. I recommend that the Victorian government consider funding allocations sufficient to facilitate achievement of the recommendations that follow.	Response from Attorney-General of Victoria	Under consideration
2. I recommend that the Victorian Government in consultation with Victoria Police, the Department of Justice and Community Safety, the Department of Health and peak Aboriginal and/or Torres Strait Islander organisations urgently develop a review and implementation strategy for the State's implementation of the 339 recommendations of the 1991 Final Report of the Royal Commission into Aboriginal Deaths in Custody.	Response from Attorney-General of Victoria	Alternative adopted
3. I recommend the urgent review of the Bail Act with a view to repeal of any provision having a disproportionate adverse effect on Aboriginal and/or Torres Strait Islander people. (Legislative change)	Response from Attorney-General of Victoria	Alternative adopted
4. I recommend urgent legislative amendment of the Bail Act including that: 4.1. section 4AA(2)(c) is repealed ('double uplift'); 4.2. clause 1 of Schedule 2 is repealed (including any indictable offence in certain circumstances within reverse onus regime); 4.3. clause 30 of Schedule 2 is repealed (including bail offences within reverse onus regime); 4.4. section 18(4) is repealed;	Response from Attorney-General of Victoria	Alternative adopted

4.5. section 30 is repealed (failure to answer bail); 4.6. section 30A is repealed (contravention of conduct condition of bail); 4.7. section 30B is repealed (commit indictable offence on bail); 4.8. section 18AA is amended so that – 4.8.1. an applicant for bail need not establish ‘new facts and circumstances’ before making a second application for bail; and 4.8.2. an applicant for bail who is vulnerable (for instance, by virtue of being an Aboriginal or Torres Strait Islander person, a child, or a vulnerable adult as these terms are defined in sections 3 and 3AAAA, respectively, of the Bail Act) need not establish ‘new facts and circumstances’ before making any subsequent application for bail; 4.9. section 3A is amended to include more guidance to BDMs about the procedural and substantive matters to be considered to ensure application of the section gives effect to the purposes for which it was inserted, including to address the persistent over-representation of Aboriginal people in the criminal justice system; 4.10. revision of section 3A should occur in a manner that is consistent with principles of self-determination of First Nations peoples; 4.11. section 4E(1)(a)(ii) is amended to narrow the scope of commit ‘offence’ while on bail; 4.12. before a BDM refuses bail to an Aboriginal person, they are required by law to articulate (and record) what enquiries were made into the surrounding circumstances and what factors relevant to		

sections s3A and s3AAA of the Bail Act were considered to reach the decision; 4.13. BDMs intending to refuse an application for bail are required by law to make all necessary enquiries about, and where necessary note on any remand warrant, any potential custody management issues.		
5. I recommend legislative amendment to section 464FA of the Crimes Act 1958 (Vic) (Crimes Act) to require an investigating official to inform an Aboriginal and/or Torres Strait Islander person in custody not only that the Victorian Aboriginal Legal Service (VALS) has been notified that the person is in custody but also that: 5.1. the purpose of the notification is for VALS to perform a welfare and wellbeing assessment on the person including – 5.1.1. identification of any medical, physical and mental health concerns, disability or impairment (including due to substance use); and 5.1.2. communication of any identified risks to the person's safety while in custody to Police so that appropriate management and care is provided; 5.2. the person may communicate with a VALS Client Notification Officer (CNO); 5.3. with the person's consent, CNOs may advise their family members, partner or other people of their wellbeing and whereabouts; and 5.4. with the person's consent, CNOs will contact a VALS on-call solicitor to provide pre-interview legal advice.	Response from Attorney-General of Victoria	Alternative adopted

6. I recommend legislative amendment to sections 464A(3) and 464C of the Crimes Act, respectively, to require, in accordance with the principles known as the Anunga Principles, 1388 an investigating official to explain to an Aboriginal and/or Torres Strait Islander person in custody in simple terms: 6.1. the meaning of the caution and ask the person to tell the investigating official in their own words, phrase by phrase, what is meant by the caution to ensure that both the right to remain silent and that anything they do or say may be used in evidence is understood; and 6.2. the meaning of each communication right and ask the person to tell the investigating official in their own words, phrase by phrase, what is meant by the rights to ensure they are understood.	Response from Attorney-General of Victoria	Alternative adopted
7. I recommend that the Chief Commissioner of Victoria Police amend any Victoria Police Manual (VPM) policies and guidelines to: 7.1. ensure an Aboriginal or Torres Strait Islander person under arrest has a meaningful opportunity to make an informed decision about whether to accept an offer to communicate with a VALS CNO, including providing the person with information about the purpose of that contact and what assistance the CNO may be able to provide; 7.2. ensure an Aboriginal or Torres Strait Islander person under caution has a meaningful opportunity to both: 7.2.1. consider whether to exercise their rights to communicate with a friend or relative and a legal practitioner; and	Response from Victoria Police	Accepted in full

7.2.2. to exercise those rights; 7.3. ensure they prominently identify the circumstances in which Police BDMs are permitted under the Bail Act to grant bail to an Aboriginal or Torres Strait Islander person who is required to demonstrate the existence of exceptional circumstances; 7.4. require a record of all bail decisions made by Police BDMs, including where bail is neither granted nor refused but a person is taken before a court for decision, that reflects who made the decision, the relevant charge(s) and, if bail is not granted, the reasons for the decision and the information that informed the decision; 7.5. require that when preparing a remand brief, members include reference to a person's Aboriginality in the remand summary so that BDMs are alerted to the relevance of s3A of the Bail Act in any remand/bail application.		
8. I further recommend that the Chief Commissioner of Police review and if necessary update its training to: 8.1. all members to highlight the requirement that police members, as a Public Authority under the Charter, are required to act in accordance with the Charter when making decisions in the course of their duties. The training should provide members with knowledge and skills enabling members to us the Charter in the real-life decisions they make in the performance of their duties. Its aim should be to embed the Charter in police practice not merely raise members' awareness that the Charter is 'relevant' to Victoria Police as a public authority; and	Response from Victoria Police	Accepted in full

8.2. all police prosecutors to highlight their obligations as officers of the court including their duty to inform the court of all relevant matters within their knowledge, including those favourable to an accused.		
9. I recommend that the Victoria Police partners with appropriate Aboriginal Community Controlled Organisations to develop and implement a strategy for ongoing cultural awareness training, monitoring and performance review for all members.	Response from Victoria Police	Accepted in full
10. I further recommend that the Chief Commissioner of Police urgently correct any misunderstanding suggestive of an 'informal policy' that: 10.1. requires or encourages members to oppose all bail applications involving the exceptional circumstances test ; or 10.2. discourages police BDMs from the proper consideration of their discretion pursuant to section 13(4) of the Bail Act when it is available.	Response from Victoria Police	Accepted in full
11. I also recommend that the Chief Commissioner of Victoria Police require police BDMs undertake periodic training to address the interpretation and application of section 3A of the Bail Act.	Response from Victoria Police	Accepted in full
12. I recommend that the Chief Commissioner of Police collect and retain statistics that identify: 12.1. the number of people charged with an offence to which the 'exceptional circumstances test' applies and data relating to: 12.2. whether those people are bailed by Police or remanded in custody 12.3. the racial and/or	Response from Victoria Police	Under consideration

cultural identity of the person, including whether they identify as Aboriginal or Torres Strait Islander; and 12.4. the sex of the person; and 12.5. the number of people charged with an offence to which the 'compelling reasons test' applies and data relating to: 12.5.1. whether those people are bailed by Police or remanded in custody; 12.5.2. the racial and/or cultural identity of the person, including whether they identify as Aboriginal or Torres Strait Islander; and 12.5.3. the sex of the person. The data relating to these matters should be published and available for use by independent organisations and/or researchers.		
13. I recommend that the Magistrates Court of Victoria ensure that the Court Integrated Services Program (CISP) is staffed whenever the court is open, including throughout Bail and Remand Court sessions.	Response from Magistrates Court of Victoria	Accepted in full
14. I recommend that the Magistrates' Court of Victoria employ sufficient Aboriginal or Torres Strait Islander staff in roles (however described) within the court to provide assistance to and, where necessary, advocacy for, Aboriginal and Torres Strait Islander court users including people remanded in custody, and develop and implement: 14.1. a process by which the Position Description for these roles is led by Aboriginal and Torres Strait Islander people with relevant expertise, in consultation with stakeholders including the end users of the service provided; and	Response from Magistrates Court of Victoria	Under consideration

14.2. robust processes to ensure timely notification of Aboriginal and Torres Strait Islander staff about the presence at court of any Aboriginal and Torres Strait Islander people, including people in custody, who may benefit from their assistance.		
15. I further recommend that the Magistrates' Court of Victoria collect and retain statistics that identify: 15.1. the number of people charged with an offence to which the 'exceptional circumstances test' applies and data relating to: 15.1.1. whether those people are bailed or remanded in custody; 9 15.1.2. the racial and/or cultural identity of the person, including whether they identify as Aboriginal or Torres Strait Islander; and 15.1.3. the sex of the person; and 15.2. the number of people charged with an offence to which the 'compelling reasons test' applies and data relating to: 15.2.1. whether those people are bailed or remanded in custody; 15.2.2. the racial and/or cultural identity of the person, including whether they identify as Aboriginal or Torres Strait Islander; and 15.2.3. the sex of the person. The data relating to these matters should be published and available for use by independent organisations and/or researchers.	Response from Magistrates Court of Victoria	Under consideration
16. Legal education - I recommend that the Victorian Legal Admissions Board consider requiring that Practical Legal Training course providers deliver compulsory Aboriginal and Torres Strait Islander cultural awareness training as part of the curriculum.	Response from Victorian Legal Admissions Board Response from The Victorian Bar	Accepted in full

17. Legal education - I recommend that the Legal Services Board and Commissioner and the Victorian Bar consider including Aboriginal and/or Torres Strait Islander cultural awareness training as a mandatory requirement of continuing professional development for practising legal practitioners.	Response from Legal Services Board and Commissioner Response from The Victorian Bar	Alternative adopted Alternative adopted
18. Custodial health – Governance and scrutiny: I recommend that the Victorian Government revise the system for auditing and scrutiny of custodial health care services to ensure that it is: 18.1. independent; 18.2. comprehensive; 18.3. transparent; 18.4. regular; 18.5. designed to enhance the health, wellbeing and safety outcomes for Victorian prisoners; 18.6. designed to ensure custodial health care services are delivered in a manner consistent with Charter obligations; and 18.7. that the implementation of any recommendations for improved practice identified by the system for auditing and scrutiny is monitored.	Response from Attorney-General of Victoria	Accepted in full
19. Custodial health – Governance and scrutiny: I recommend that the Department of Health and the Department of Justice and Community Safety: 19.1. consult to determine, from a clinical patient outcome perspective, which department should have oversight of custodial health services; and 19.2. consult with stakeholders (including peak clinical bodies,	Response from Attorney-General of Victoria on behalf of The Department of Health and Department of Justice and Community Safety	Accepted in full

organisations representing the lived experience of prison, public health services, private health 11 providers, Aboriginal and Torres Strait Islander community representatives) to determine what model of healthcare delivery in will achieve the best health outcomes for people in Victorian prisons.		
20. Custodial health policy - I recommend that Justice Health: 20.1. immediately amend the Justice Health Opioid Substitution Therapy Guidelines (OST Guidelines) to enable medical practitioners to prescribe opioid substitution therapy to women hose health may be at significant risk by being required to undergo opiate withdrawal; and 20.2. urgently review of the OST Guidelines to ensure that all women with opioid dependencies are given access to opioid substitution pharmacotherapy upon reception to prison, including the option of methadone or suboxone and their long-acting injectable buprenorphine formulations, irrespective of the length of incarceration.	Response from Attorney-General of Victoria on behalf of Justice Health	Accepted in full
21. Custodial health policy – I further recommend that Justice Health review and, if necessary, revise the Justice Health Quality Framework.	Response from Attorney-General of Victoria on behalf of Justice Health Attorney-General and The Victorian Government - ANNEXURE B Attorney-General and The Victorian Government - ANNEXURE C	Accepted in full
22. Custodial health services - I recommend that the Victorian Government establish a subacute unit at the Medical/Health Centre at	Response from Attorney-General of Victoria	Under consideration

Dame Phyllis Frost Centre available to all prisoners who require it, and that 12 includes oversight by a specialist who has completed Advanced Training in Addiction Medicine.		
23. Custodial health services - As an interim measure, until a subacute unit on site at Dame Phyllis Frost Centre is operational, I recommend that an agreement or Memorandum of Understanding be agreed as a matter of urgency between Corrections Victoria, Justice Health and Correct Care Australasia and/or the Health Service Provider at the Dame Phyllis Frost Centre and the most appropriate proximate public hospital for the provision of equivalent community health services not presently provided at the Medical/Health Centre.	Response from Attorney-General of Victoria on behalf of Corrections Victoria and Justice Health Response from Correct Care Australasia	Under consideration Under consideration
24. Custodial health services - I recommend that The Victorian Government establish at the Medical/Health Centre at the Dame Phyllis Frost Centre Point-of-Care testing in accordance with requirements that are equivalent to the Royal Australian College of General Practitioners Standards for Point-of-Care testing.	Response from Attorney-General of Victoria	Under consideration
25. Custodial health services - I recommend that the Department of Justice and Community Safety and/or Justice Health, in partnership with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), take concrete steps to build the capacity of VACCHO to provide in-reach health services in prisons.	Response from Attorney-General of Victoria on behalf of The Department of Justice and Community Safety and Justice Health	Accepted in part
26. Custodial health services - I recommend that Justice Health and Correct Care Australasia and/or the Health Service Provider at Dame Phyllis Frost Centre ensure that all Aboriginal and/or Torres Strait	Response from Attorney-General of Victoria on behalf of Justice Health	Alternative adopted Rejected in Full

Islander prisoners have the option during the reception medical assessment of consulting with an Aboriginal Health Practitioner or Aboriginal Health Worker, either in person or by telehealth, within 48 hours. The prisoner's response to this offer should be documented.	Response from Correct Care Australasia	
27. Custodial health services - I recommend that Corrections Victoria and Correct Care Australasia and/or the Health Service Provider at the Dame Phyllis Frost Centre develop and implement a robust procedure for 'clearance' of a prisoner (at initial reception or subsequently) from the Medical/Health Centre to a cell elsewhere at Dame Phyllis Frost Centre that requires certification in writing by a medical practitioner that the prisoner is fit to be confined in an unobserved cell. 27.1. The medical practitioner's certification should include: 27.1.1. confirmation that the prisoner is medically fit to leave the Medical/Health Centre; 27.1.2. whether the medical practitioner recommends any medical or management observations to ensure the prisoner's health or wellbeing; 27.1.3. identification of any specific clinical deterioration risk indicators the medical practitioner recommends custodial and health staff monitor; and 27.1.4. instructions to guide the response, including escalation of the prisoner's care, if clinical deterioration risk indicators are observed. 27.2. If no medical practitioner is available, written certification may be provided by a registered nurse, but any prisoner cleared by a	Response from Attorney-General of Victoria on behalf of Corrections Victoria Response from Correct Care Australasia	Alternative adopted Under consideration

registered nurse should be placed on 60/60 management observations pending medical practitioner review of the prisoner as soon as practicable thereafter.		
28. Custodial health services - I recommend that Correct Care Australasia and/or the Health Service Provider at the Dame Phyllis Frost Centre, in collaboration with Corrections Victoria and Justice Health, develop 14 and implement clear guidelines to assist custodial and clinical staff to identify a prisoner's clinical deterioration, including the indicators that must result in an escalation of a prisoner's care to clinical staff, a medical practitioner or transfer to hospital.	Response from Correct Care Australasia Response from Attorney-General of Victoria	Accepted in full Accepted in full
29. Custodial health services - I recommend that Justice Health require custodial Health Service Providers to: 29.1. engage with Victoria's Aboriginal and Torres Strait Islander communities to learn how culturally safe and culturally appropriate principles can be embedded into their delivery of health services to Victorian prisoners. This process should be ongoing, guided by Victoria's Aboriginal and/or Torres Strait Islander communities and be conducted in the manner determined by these communities; 29.2. encourage and facilitate the doctors employed by the Health Service Provider to become members of the RACCGP to enable them to access RACGP training programs; 29.3. identify alternative alcohol and other drugs training programs for medical practitioners; 29.4. ensure medical practitioners employed or contracted by the	Response from Attorney-General of Victoria on behalf of Justice Health	Accepted in full

Health Service Provider for a period of more than six months complete training equivalent to the Royal Australian College of General Practitioners' Alcohol and Other Drugs GP Education program within six months of the practitioners commencing. 29.5. ensure registered nurses employed by the Health Service Provider complete the Australian College of Nursing's Continuing Professional Development modules in: 29.5.1. addressing AOD Use in Diverse Communities; and 29.5.2. opioid Withdrawal Nursing Care and Management. 29.6. employ medical practitioners and nurse practitioner qualified to practise opioid pharmacotherapy; and 29.7. employ a full-time specialist who has completed Advanced Training in Addiction Medicine.		
30. I recommend that Correct Care Australasia engage with Victoria's Aboriginal and Torres Strait Islander communities to learn how it can embed culturally safe and culturally appropriate principles into their delivery of health services to Victorian prisoners. This process should be ongoing, guided by Victoria's Aboriginal and/or Torres Strait Islander communities and be conducted in the manner determined by these communities.	Response from Correct Care Australasia	Accepted in full
31. I further recommend that Correct Care Australasia: 31.1. encourage and facilitate the doctors it employs to become members of the RACCGP to enable them to access RACGP training programs; and	Response from Correct Care Australasia	Accepted in part

31.2. identify alternative alcohol and other drugs training programs for CCA medical practitioners; and 31.3. ensure medical practitioners employed or contracted by CCA for a period of more than six months, have completed training which is equivalent to the Royal 16 Australian College of General Practitioners' Alcohol and Other Drugs GP Education program; 31.4. ensure registered nurses employed by the Health Service Provider complete the Australian College of Nursing's Continuing Professional Development modules in: 31.4.1. addressing AOD Use in Diverse Communities; and 31.4.2. opioid Withdrawal Nursing Care and Management; 31.5. employ medical practitioners and nurse practitioner qualified to practise opioid pharmacotherapy; and 31.6. employ a full-time specialist who has completed Advanced Training in Addiction Medicine.		
32. I recommend that Correct Care Australasia report the deficiencies in care identified in this Finding to its current accreditation providers before it participates in any further tender for the provision of custodial health services in Victoria.	Response from Correct Care Australasia	Accepted in full
33. I recommend that Corrections Victoria review its practice whereby only two Prison Officers have access to cell keys during the Second Watch overnight at Dame Phyllis Frost Centre and address any impediment to the timely entry to cells that might arise so to ensure prisoner health, welfare and safety.	Response from Attorney-General of Victoria on behalf of Corrections Victoria	Accepted in full

34. I recommend that the Department of Justice and Community Safety partners with appropriate Aboriginal Community Controlled Organisations to develop and implement a strategy for ongoing cultural awareness training, monitoring and performance review, which is applicable to: 34.1. CV; and 34.2. Correct Care Australasia and/or the Health Service Provider at Dame Phyllis Frost Centre.	Response from Attorney-General of Victoria on behalf of The Department of Justice and Community Safety	Under consideration
35. I recommend that the Department of Justice and Community Safety develop and implement a policy and deliver training to Corrections Victoria staff about the operation of that policy, to ensure that cultural considerations are incorporated into management of a deceased Aboriginal or Torres Strait Islander person in custody and, to the extent possible, the scene of that person's passing.	Response from Attorney-General of Victoria on behalf of The Department of Justice and Community Safety	Accepted in part
36. I recommend that the Department of Justice and Community Safety urgently redesign the Justice Assurance and Review Office and Justice Health Death In Custody reviews to ensure reviews: 36.1. are independent; 36.2. receive input from relevant staff who interacted with or were responsible for decisions affecting the prisoner proximate to their death; 36.3. are comprehensive; 36.4. identify opportunities for improved practice and to enhance the wellbeing and safety of prisoners, rather than merely assess compliance with relevant policies; 36.5. if the deceased is an Aboriginal and/or Torres Strait	Response from Attorney-General of Victoria on behalf of The Department of Justice and Community Safety	Alternate adopted

Islander person, that adequacy of their cultural care (including post-death treatment) is assessed by a suitable member of the Aboriginal community; and 36.6. are timely.		
37. I recommend that Justice Health, Corrections Victoria and Correct Care Australasia and/or the Health Service Provider at Dame Phyllis Frost Centre each review, and if necessary, amend any policy or practice relating to staff 'debriefs' following a death in custody or other sentinel events. The review should consider and clarify: 37.1. the purpose of debriefs, including whether they are intended to serve a staff welfare function, evaluate practice and/or policy to identify systems or other deficits, or a combination of these matters; and 37.2. a process to optimise the participation of relevant staff in any debrief.	Response from Attorney-General of Victoria on behalf of Justice Health and Corrections Victoria Response from Correct Care Australasia	Accepted in full Accepted in part
38. I recommend that the Victorian Department of Health, in collaboration with relevant Aboriginal Community Controlled Health Organisations and other stakeholders, prioritise the design, establishment and adequately resource a culturally safe, gender-specific residential rehabilitation facility for Aboriginal and/or Torres Strait Islander women with drug and/or alcohol dependence.	Response from Attorney-General of Victoria on behalf of The Department of Health	Under consideration
39. I recommend that no later than 12 months from the date of this Finding, Corrections Victoria, Justice Health and Correct Care Australasia, as public authorities under the Charter request that the Victorian Equal Opportunity and Human Rights Commission conduct a review under Section 41(c) of the Charter of any improvements to	Response from Attorney-General of Victoria on behalf of Corrections Victoria and Justice Health Response from Victorian Equal Opportunity and	Under consideration Under consideration

programmes, practises, and facilities made in response to the recommendations above, and provide an overview of the results of that review for publication on the Coroners Court of Victoria website along with the responses to the Recommendations made in this Finding.	Human Rights Commission Response from Correct Care Australasia	Rejected in full

Deaths in care

Finding into death of Kira Shae James

Keywords: death in custody, suicide, ligature, mental health, involuntary patient

Recommendation	Response	Response outcome
That Forensicare amend its policy on Patient Counts to include an escalation process that is applicable in circumstances where the clinician allocated to conduct the count is unable to complete it within the required timeframe. This escalation process should enable the task to be reallocated to an available clinician.	Response from Forensicare	Accepted in full

Finding into death of Christopher Traill

Keywords: suicide, hospital, psychiatric unit, ligature, addiction, mental health, compulsory inpatient care

Recommendation	Response	Response outcome
With the aim of preventing like deaths and promoting public health and safety within a mental health in-patient unit, I recommend that on admission to the in-patient Unit, Bendigo Health mandate the removal of all personal items that could be used for self harm as described as "Dangerous Items" in the Chief Psychiatrist's Guideline.	Response from Bendigo Health	Accepted in full
With the aim of preventing like deaths and promoting public health and safety within a mental health in-patient unit, I recommend that Bendigo Health review their processes related to identifying personal items that have the potential to be used for harm and without identifying all the specifics that should be considered within that review, I recommend it should include reference to whose responsibility it is to make the assessment, to document the assessment and whose responsibility it is to implement the removal of said identified items	Response from Bendigo Health	Accepted in full
With the aim of preventing like deaths and promoting public health and safety within a mental health in-patient unit, I recommend that Bendigo Health implement a practice of providing patients alternative items to replace any personal items removed for risk minimising purposes.	Response from Bendigo Health	Accepted in full

Finding into death of Catherine Anne Williamson

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

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

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

Finding into death of Paige Dent

Keywords: Motor vehicle collision, mental health, drug use, in care, hospital, Mental Health Act, inpatient treatment order

Recommendation	Response	Response outcome
That Monash Health formulate a policy for formally documenting enquiries in relation to accessing high and low dependency beds for patients subject to an Inpatient Treatment Order who present to the hospital's emergency department, in accordance with the following stepped process of elimination some of which is outlined in the Chief Psychiatrist's Access to Beds Guide: i. At first instance, clinicians should provide active treatment of the patient in the emergency department to reduce the patient's frustration and agitation that may ultimately cause them to abscond. ii. Source an in-area (within the Monash Health Mental Health network) high dependency unit bed. iii. If unavailable, source an out-of-area (outside of the Monash Health Mental Health network, but within the Victorian Public Mental Health network) high dependency unit bed. iv. If unavailable, source an in-area low dependency unit bed. v. If unavailable, source an out-of-area low dependency unit bed. vi. If unavailable, and as a last resort in the absence of suitable high and low dependency unit beds, situate the patient in the ED with a continuous patient observer, positioned the furthest away from exits.	Response from Monash Heath	Accepted in part

Aged care

Finding into death of Phillip Charles Hodges

Keywords: Choking, food bolus, aged care, inadequate training, complex medical history

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Federal and State Government Health Departments create a legislative mandate requiring annual drills for residential aged care staff to enable the staff to develop the necessary skills to abate the medical emergency risks presented by choking incidents.	Response from Minister for Ambulance Services Response from Minister for Health and Aged Care	Rejected in full Under consideration
In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Federal and State Government Health Departments include a training module to cover emergency procedures in choking incidents as part of any standing First Aid Response training in residential aged care.	Response from Minister for Ambulance Services Response from Minister for Health and Aged Care	Rejected in full Accepted in full
In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Federal and State Government Health Departments devise or develop a training module for staff employed in residential aged care to be trained to safely provide feeding assistance at all times to residents with modified texture diets.	Response from Minister for Ambulance Services Response from Minister for Health and Aged Care	Alternative adopted Accepted in full

Finding into death of Ms F

Keywords: bed poles, neck compression, haemothorax, complex medical history, home care

Recommendation	Response	Response outcome
The Victorian Department of Health, as part of their responsibility to support independent living for the State's older people, provide clear public advice to Victorians about the potential risk to life of the KA524 bed pole or similar style, and of the risks posed by improperly used bed poles in particular	Response from Department of Health	Accepted in full

Finding into death of Heather Amy Robertson

Keywords: Aged care, falls prevention, supervision

Recommendation	Response	Response outcome
That Trinity Manor review its staffing arrangements in its dining rooms to ensure that there is adequate supervision of residents during mealtimes.	Response from Trinity Manor	Accepted in full

Finding into death of Margaret Alice Cook

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

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Royal Australian College of General Practitioners consider using Margaret Alice Cook's matter as a case study to highlight the utility of the making of an advance health directive as part of general practice education and general practitioners' obligations under the Medical Treatment Planning and Decisions Act 2016.	Response from Royal Australian College of General Practitioners	Accepted in full

Finding into death of Nickolaos Vlahos

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

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

Family Violence

Finding into death of Alicia Maree Little

Keywords: Family violence, intimate partner homicide, separation, dangerous driving

Recommendation	Response	Response outcome
With the aim of promoting public health, preventing deaths, and supporting mental health practitioners to address family violence, I recommend that the National Federation Reform Council (NFRC) review the current registration standards required of registered psychologists. Measures should be considered to introduce family violence mandatory CPD for registered private psychologists and private psychiatrists to provide for an occupation-specific level of family violence understanding and referrals for further support where a patient/client is identified as experiencing or suspected to be experiencing family violence.	Response from the office of the Prime Minister of Australia	Under consideration

Finding into deaths of Claire, Anna, Matthew and Katica Perinovic

Keywords: Filicide, family violence, suicide, mental health

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that the Royal Australian and New Zealand College of Psychiatrists review and update the Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders to improve best practice in clinical care provided to patients diagnosed with First Episode Psychosis in community mental health practices and in light of the circumstances of Katica and her children's deaths.	Response from Royal Australian and New Zealand College of Psychiatrists Updated response from Royal Australian and New Zealand College of Psychiatrists	Under consideration

Finding into death of Fatima Batool

Keywords: Intimate partner homicide; CALD; family violence, family violence intervention order, FVIO, mental health

Recommendation	Response	Response outcome
With the aim of promoting public health, preventing deaths and supporting medical practitioners to address family violence, I recommend that the National Federation Reform Council (NFRC) review the current registration standards required of medical practitioners with a view to updating CPD requirements for General Practitioners. A specific portion of CPD training undertaken by General Practitioners should be dedicated to family violence to reach an occupation-specific level of family violence understanding and referrals for further support where a patient is identified as experiencing or suspected to be experiencing family violence.	Response from the office of the Prime Minister of Australia	Under consideration
I recommend that similar measures be taken to introduce family violence mandatory CPD for registered psychologists and psychiatrists to provide for an occupation-specific level of family violence understanding and referrals for further support where a patient/client is identified as experiencing or suspected to be experiencing family violence.	Response from the office of the Prime Minister of Australia	Under consideration

Finding into death of Emma Gertrude Weidemann

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

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

Child/infant deaths

Finding into death of Jacqueline Isabella Vodden

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

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

Finding into death of YOA

Keywords: drowning, river, child, camping, water safety, supervision, water hazard

Recommendation	Response	Response outcome
I recommend that the DELWP install appropriate signs at the Wood Point campsite to warn visitors of the dangers of swimming in the river, including the dangers OF sudden floods and strong currents.	Response from Department of Environment, Land, Water and Planning (DELWP)	Accepted in full
I recommend that the DELWP liaise with Snowy Hydro to establish a real-time warning system to notify DELWP employees and relevant personnel about water releases from the Jindabyne Dam.	Response from Department of Environment, Land, Water and Planning (DELWP)	Alternative adopted
I recommend that the DELWP liaise with the appropriate authorities to conduct a feasibility study of installing/improving mobile phone reception and coverage in the and around the area of the Wood Point camping ground to allow for prompt emergency notifications if required.	Response from Department of Environment, Land, Water and Planning (DELWP)	Accepted in part

Finding into passing of Master S

Keywords: Keywords: Aboriginal passing, chroming, volatile substances, child protection, poisoning, substance abuse, family violence exposure, contact with justice system

Recommendation	Response	Response outcome
That the Department of Health review and update the content of its booklet titled About Inhalant Abuse: For Health and Community Workers in light of what in now known about volatile substance misuse and related harms, to ensure that youth workers and others who work with young people at risk of volatile substance m issue have access to best and most contemporaneous advice to support this vulnerable group. The booklet should be re-launched when the update is complete.	Response from Department of Health	Accepted in Full
That the Department of Health undertake a review of what is known about volatile substance misuse, how it has evolved as a public health issue in Victoria over the past 15 years and what strategies have worked both here and internationally to reduce associated harms. The review would ideally include engagement with manufacturers of products that are strongly implicated in volatile substance misuse, to gain a better understanding of how product re-design might contribute to harm reduction in this area. Upon completing the review, the Department of Health should consider what resources it might produce for relevant audiences (for example educators, parents, police) who might be in a position to identify and address volatile substance misuse among young people in our community.	Response from Department of Health	Accepted in Full

Finding into death of Oliver Vincent Paul Cronin

Keywords: Gaming disorder, behavioural issues, mental health, video games

Recommendation	Response	Response outcome
To help prevent psychological harms to adolescents and young adults from gaming platforms and online gaming, I recommend the Office of the eSafety Commissioner raises awareness in adolescents and young adults of the risks of gaming on their psychological wellbeing and promote the inclusion of information about gaming and psychological wellbeing in school based digital health programs.	Response from Office of the eSafety Commissioner	Accepted in full
To help develop a reliable evidence-base about gaming and adolescents and young adults in Australia, which will inform strategic and local policies, the standardisation of advice on the risks of psychological harms and online gaming, prevention strategies, and the development of contemporary and evidence-based interventions, I recommend the Office of the eSafety Commissioner promote research that establishes the incidence and prevalence of psychological harms to adolescents and young adults from online gaming.	Response from Office of the eSafety Commissioner	Alternative adopted

Finding into death of Timothy Dale Fehring

Keywords: international school excursion, overseas tour, Hypoxic-ischaemic encephalopathy, acute gastritis, acute bilateral bronchopneumonia, cardiac arrest

Recommendation	Response	Response outcome
The Department of Education and Training increase the staff to student ratios on international trips, so the chaperones have more flexibility in accommodating student or staff illness whilst managing the remaining students.	Response from Department of Education and Training	Accepted in full
The Department of Education and Training revisit the DET Excursions Policy considering these Findings.	Response from Department of Education and Training	Accepted in full

Finding into death of HC

Keywords: infant, CALD, perinatal asphyxia, global cerebral ischaemia, labour complications

Recommendation	Response	Response outcome
I recommend that Werribee Mercy Hospital finalise and submit the business case for an African Liaison position at the hospital.	Response from Mercy Health Mercy Health (Attachment A) Mercy Health (Attachment B) Mercy Health (Attachment C) Mercy Health (Attachment D)	Accepted in part
I recommend that Werribee Mercy Hospital develop an information package for staff on the roles of support people and how to communicate with them effectively, with guidance on how to escalate issues that may impact on safe birthing outcomes.	Response from Mercy Health Mercy Health (Attachment A) Mercy Health (Attachment B) Mercy Health (Attachment C) Mercy Health (Attachment D)	Accepted in full
Werribee Mercy Hospital documentation on partograms should include all findings to allow for accurate assessment and help with recognition of an abnormal labour process.	Response from Mercy Health Mercy Health (Attachment A) Mercy Health (Attachment B) Mercy Health (Attachment C) Mercy Health (Attachment D)	Accepted in full

I recommend that Werribee Mercy Hospital consider the use of stickers for the documentation of an abnormal CTG as stipulated in the Intrapartum Fetal Surveillance Clinical Guideline.	Response from Mercy Health Mercy Health (Attachment A) Mercy Health (Attachment B) Mercy Health (Attachment C) Mercy Health (Attachment D)	Accepted in full
I recommend that Werribee Mercy Hospital encourage staff to attend the Fetal Surveillance Education Program offered by RANZCOG on a regular basis.	Response from Mercy Health Mercy Health (Attachment A) Mercy Health (Attachment B) Mercy Health (Attachment C) Mercy Health (Attachment D)	Accepted in full

Finding into death of Master S

Keywords: Keywords: asthma, SafeScript, Aboriginal passing, child protection, hospital access

Recommendation	Response	Response outcome
Accordingly, pursuant to section 72(2) of the Act, I make the following recommendation: That the Victorian Department of Health expand the scope of drugs monitored by the SafeScript real-time prescription monitoring program, to include all prescription medications that are prescribed and dispensed throughout Victoria without exception.	Response from Department of Health	Rejected in full

Finding into death of DVR

Keywords: fire, child, charcoal, smoke inhalation, sprinklers, fire hose

Recommendation	Response	Response outcome
I recommend that the Department of Families, Fairness, and Housing (DFFH) consult with relevant organisations and conduct a feasibility study into whether fire sprinkler systems could be installed in all current (and future) public housing premises.	Response from Homes Victoria	Under consideration
I recommend that the DFFH ensure that all technicians who perform inspections and testing of fire systems, and any other essential safety measures work, be required to hold appropriate licences so that servicing is performed to the requisite standard.	Response from Homes Victoria	Accepted in part
I recommend that the DFFH considers the potential role of MCHN services or other services in identifying and improving the fire safety practices of parents of young children, particularly those facing social and financial disadvantage.	Response from Homes Victoria	Accepted in full

Missing persons

Finding into death of GFE

Keywords: Missing person, drowning, sailing, lifejacket, personal floatation device (PFD), Emergency Position Indicating Radio Beacon (EPIRB), yacht, hypoxic episode

Recommendation	Response	Response outcome
I recommend that Marine Safety Victoria and the Department of Transport develop legislation mandating that solo operators in enclosed and coastal Victorian waters must wear a PFD Type 1 with an attached registered EPIRB.	Response from Safe Transport Victoria Response from Department of Transport	Alternative adopted Alternative adopted
I further recommend that Marine Safety Victoria and the Department of Transport develop legislation mandating that any recreational vessel that has an LPG system on board in an enclosed area must have an operable gas detecting system.	Response from Safe Transport Victoria Response from Department of Transport	Rejected in full Rejected in full

Drowning

Finding into death of Robert Wayne Edwards

Keywords: drowning, boating, boat accident, collision, fishing

Recommendation	Response	Response outcome
That the Minister for Fishing and Boating consider the introduction of a new indictable offence to cover situations where the operator of a vessel breaches the COLREGs or operates a vessel in a manner that is unsafe and causes serious injury or death. The new offence would apply where more than one vessel operator may have contributed to the death or serious injury and would not require the prosecution to prove that the accused solely or substantially caused the death or serious injury.	Response from The Minister for Outdoor Recreation	Under consideration

Finding into death of Michael John Hanratty

Keywords: drowning, recreational boating, fishing, sandbar, capsize, personal floatation device (PFD)

Recommendation	Response	Response outcome
With the aim of promoting public health and safety and preventing like deaths, I recommend that the Maritime Safety Division of Transport Safety Victoria highlight and disseminate the circumstances in which Mr Hanratty drowned in their upcoming educational materials and safety promotional campaign.	Response from Transport Safety Victoria	Accepted in full

Finding into death of David Andrew Coulter

Keywords: drowning, capsize, boating, fishing, recreation, large waves]

Recommendation	Response	Response outcome
In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the Maritime Safety Division of Transport Safety Victoria highlight and disseminate the circumstances in which Mr Coulter drowned in its upcoming educational materials and safety promotional campaign.	Response from Safe Transport Victoria	Accepted in full
In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the Maritime Safety Division of Transport Safety Victoria produce and disseminate awareness campaign such as the “Life Jacket Label-Read It” campaign as advanced by the National Safe Boating Council of the United States.	Response from Safe Transport Victoria	Alternative adopted

Finding into death of Terry John Chandler

Keywords: drowning, boating, inexperience, intoxication, fishing, large waves, capsize

Recommendation	Response	Response outcome
In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the Maritime Safety Division of Transport Safety Victoria highlight and disseminate the circumstances in which Mr Chandler drowned in its upcoming educational materials and safety promotional campaign.	Response from Safe Transport Victoria	Accepted in full
In the interests of public health and safety and with the aim of preventing like deaths, I recommend that the Maritime Safety Division of Transport Safety Victoria produce and disseminate awareness campaign such as the "Life Jacket Label-Read It" campaign20 as advanced by the National Safe Boating Council of the United States.	Response from Safe Transport Victoria	Alternative adopted

Finding into death of Nina Barake

Keywords: Floodwaters, floodway, road hazard, emergency planning, risk management

Recommendation	Response	Response outcome
That the Corangamite Shire Council review the floodway over Curdies River on Maddens Bridge Road to consider the feasibility, safety and utility of other construction options or enhancements, in light of the traffic use and frequency of flooding.	Response from Corangamite Shire Council	Accepted in full

Finding into death of Peter Boyle

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

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

online test to be completed prior to renewal of registration.		

Finding into death of Brad Anthony Godressi

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

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

Workplace

Finding into death of Cameron James Ferry

Keywords: crush injury, tip truck, improper alignment, modified truck body

Recommendation	Response	Response outcome
That the National Heavy Vehicle Regulator consider amending the Vehicle Standards Bulletin (VSB6) or issue a Vehicle Standards Guide to provide clearer guidance on best practice when installing and working with body props on trucks fitted with a tipper body.	Response from National Heavy Vehicle Regulator	Under consideration

Finding into death of Matthew Duncan Gordge

Keywords: traumatic asphyxia, workplace incident, scissor lift, crushing hazard, mobile elevated work platform (MEWP)

Recommendation	Response	Response outcome
WorkSafe Victoria consider the viability of including a provision in the Industry Standard – Elevating work platforms that requires all EMPs to be fitted with secondary guarding technology.	Response from WorkSafe	Alternative adopted

Finding into death of Dominic Salvatore Mele

Keywords: Ride-on lawnmower; mechanical asphyxia; gradient gauge; rollover protection structure, slope gradient

Recommendation	Response	Response outcome
I recommend that Product Safety Australia consider updating the mandatory safety standard to ensure that ride-on lawnmowers be fitted with an inbuilt gradient gauge or alarm to allow operators to easily assess the gradient risk.	Response from Australian Competition and Consumer Commission	Alternative adopted
I recommend that WorkSafe Victoria implement a safety communication campaign specific to ride-own lawnmowers and the risk of roll-over to ensure better education and to highlight the risk to operators.	Response from WorkSafe Victoria	Accepted in full

Recreational activities

Finding into death of Rosy Loomba

Keywords: fall, signage, fencing, cliff, lookout, rock ledge

Recommendation	Response	Response outcome
I recommend that Parks Victoria install additional signage at the Boroka Lookout warning people of the dangers of a fall and to stay within the safety fencing. The sign should expressly state that people have been seriously injured and died at this location.	Response from Parks Victoria	Under consideration

Finding into death of MD

Keywords: deer attack, accidental death, pet deer, adult buck, pet registration

Recommendation	Response	Response outcome
I recommend that Agriculture Victoria circulate a safety warning and/or information sheet for pet deer owners to remind them that it is best practice for deer to be de-antlered prior to mating season.	The Minister for Agriculture was invited to respond by 24 November 2022	Awaiting response
I further recommend that, given that deer owners are not required to register their pets, vets in rural and regional communities display information relating to deer handling safety.	The Minister for Agriculture was invited to respond by 24 November 2022	Awaiting response
Given there is currently no requirement to register pet deer, I recommend that local councils in rural and regional communities consider compulsory registration of pet deer to ensure that owners can be made aware of the dangers related to holding pet deer.	The Minister for Agriculture was invited to respond by 24 November 2022	Awaiting response

Finding into death of Geunhee Park

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

Recommendation	Response	Response outcome
I recommend the Minister for Fishing and Boating and Safe Transport Victoria review the term 'recreational vessel' and amended in relevant legislation and publications to 'vessel'. It may be appropriate to use the term 'private vessel' to create a distinction from 'commercial vessels' if need be.	Response from Safe Transport Victoria Response from the Minister for Fishing and Boating	Under consideration Under consideration
That the Minister for Fishing and Boating consider the introduction of a new indictable offence to cover situations where the operator of a vessel breaches the COLREGs or operates a vessel in a manner that is unsafe and causes serious injury or death.	Response from the Minister for Fishing and Boating	Under consideration

Finding into death of Charles Earl Swanson

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

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

Home maintenance

Finding into death of John Disley

Keywords: Fall, ladder, roof, gutters, elderly

Recommendation	Response	Response outcome
In light of the continuing dangers posed by individuals working on ladders in the domestic context, especially amongst the elderly, I recommend that the Australian Competition and Consumer Commission (ACCC) and the Victorian Department of Health continue their Ladder Safety Matters campaign, including the dissemination of updated messages via relevant media, including social media channels.	Response from Australian Competition and Consumer Commission Response from Minister for Health	Accepted in full Accepted in full
With a view to promoting public health and safety and preventing like deaths, I recommend that the ACCC and the Victorian Department of Health review the impact and effectiveness of the Ladder Safety Matters campaign.	Response from Australian Competition and Consumer Commission Response from Minister for Health	Accepted in full Under consideration

Homicide

Finding into death of Gabriel Messo

Keywords: police intervention, mental health, body worn camera, police firearm, mental health care, mental health supports

Recommendation	Response	Response outcome
I recommend that the Chief Commissioner of Police reviews the feasibility of acquiring technology facilitating the automatic activation of members' Body Worn Camera upon a police-issued firearm being withdrawn from its holster (for example the Axon Signal–Sidearm technology).	Response from Victoria Police	Under consideration
The police Quality and Safeguards Commission should conduct a review of the outsourcing arrangements to ensure that outsource providers of NDIS services have appropriate policies guidelines and training for staff to manage clients suffering mental health conditions who make threats of self-harm or harm to others. The policies and guidelines and training should include identifying a client's deteriorating mental health, and concerning behaviours, and guidelines on the management, escalation and/or referral to appropriate services including escalation to police in appropriate cases.	Response from NDIS Quality and Safeguards Commission	Rejected in full

Finding into death of Vlado Tomislav Micetic

Keywords: police pursuit, gunshot wound, police firearm

Recommendation	Response	Response outcome
In the interests of promoting public health and safety and with the aim of preventing similar deaths, I recommend that the Chief Commissioner of Police develop and maintain a system to ensure that Victoria Police remains adequately informed about their members' fitness for duty. In particular, the system so devised or developed must ensure that their members are both physically and psychologically fit for duty without violating individual rights to privacy, amongst others.	Response from Victoria Police	Under consideration

Finding into death of Elizabeth Judith Robyn Wilms

Keywords: Homicide, intimate partner family violence, interstate arrest warrant, missing person investigation

Recommendation	Response	Response outcome
That New South Wales Police Force and Victoria Police independently and collaboratively review and if necessary amend any police, guidelines or processes relating to the management of warrants (including interstate warrants) to ensure that they are executed in a timely manner.	Response from Victoria Police Response from New South Wales Police Force	Accepted in full Accepted in full

Finding into death of Anthony James Georgiou

Keywords: Loss prevention officer, security staff, use of force, physical restraint, methamphetamine, training

Recommendation	Response	Response outcome
Bunnings consider including in their training of Store Managers instruction in relation to the supervision of LPO's, particularly when such Officers are involved in a physical confrontation with a customer. Bunnings consider include in such training instruction about when Store Managers should become directly involved in actively managing LPO's involved in any such confrontation.	Response from Bunnings Group	Accepted in part
Bunnings record the details, including the names of LPO's involved, of all interactions between LPO's working at Bunnings Stores and customers. That Bunnings periodically audit those records, reviewing the performance of LPO's and provide a copy of those audits and reviews to the direct employers of LPO's operating at Bunnings Stores.	Response from Bunnings Group	Accepted in full
That the Bunnings Training for LPO's as referred to in paragraph 92 of this Finding include the kind of 'refresher training' recommended by Dr Zalewski and set out in his reports provided to the Court in this Inquest. (Exhibits 11 and 12 of this Inquest).	Response from Bunnings Group	Rejected in full

Finding into death of Martin William Sheahan

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

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

Responses overdue by more than 12 months

Each edition of the CCOV Recommendations Report covers a 12-month period. This edition includes the period between 1 July 2022 to 30 June 2023.

This chapter outlines responses that fall outside this edition's reporting period, but which have been reported in previous editions and remain overdue.

Finding into death of Samuel Alexander Chilton

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

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

Finding into death of 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 Eileen Smith

Keywords: head injury, fall, hospital, elder care, fall prevention

Recommendation	Response	Response outcome
I recommend that Mildura Base Hospital provide further education to its nursing and allied health staff on the importance of adhering to patients falls management plans. Such education should be incorporated into its online and in-person orientation and education programs for nursing students.	Response from Mildura Base Hospital was expected by 30 February 2022	Overdue
I recommend that Mildura Base Hospital develop and implement a system to monitor, review and report on compliance with fall prevention practices within the hospital. Such a system may involve regular observational audits and provision of feedback to nursing and allied health staff to increase awareness and to identify areas for improvement in falls prevention practices.	Response from Mildura Base Hospital was expected by 30 February 2022	Overdue