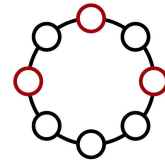


# Fatal Facts



**NCIS**

A publication of the  
National Coroners Information System (NCIS).

This edition of Fatal Facts features 40 coronial cases where recommendations have been made. The cases covered in this edition are those closed on the NCIS between 1 November 2003 and 28 February 2004.

Four common topic areas upon which several recommendations were made are highlighted in detail. The recommendations presented in this edition involve police pursuits, deaths in custody, child run overs and interpersonal (domestic) violence.

If you seek further information regarding any of the cases contained in this edition, it is recommended that you visit the NCIS website ([www.ncis.org.au](http://www.ncis.org.au)). Please log on using your authorised user name and password, and find the particular case by clicking on the "NCIS Search" tab and selecting "Find Case".

If you have forgotten your user name and password or require advice regarding access to the NCIS database, please do not hesitate to contact our Access Liaison Officer, Marde Hoy, at [mardeh@vifm.org](mailto:mardeh@vifm.org) or on (03) 9684 4323.

Should you not currently have access to the NCIS, or wish to enquire about an information search, please contact the NCIS team on [ncis@vifm.org](mailto:ncis@vifm.org)

**March 2006**

**Edition 8**

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### NCIS at a glance

- Number of deaths on the NCIS (as at 1 March 2006): 108,500.
- Number of findings contained on the NCIS for cases closed between 01/11/2003 and 28/02/2004: 2,622.
- Number of recommendations made for cases closed between 01/11/2003 and 28/02/2004\*: 40.

\* For a list of case reference numbers for these recommendations, please refer to pages 9-19.

*Disclaimer: The précis of coronial findings detailed within this publication have been produced by NCIS staff, with the best efforts made to accurately summarise the circumstances, findings and recommendations made by the coroner in each case.*

*Despite this, it should be noted that the material produced in this publication is not an authorised summary or exact replication of coronial findings, and as such, the original finding in its entirety should always be accessed should any reference to the content of a coronial finding be made.*

## Case Study 1 - Police Pursuits:

**Joint Inquest into 3 Incidents Involving Police Pursuits (involving the deaths of 7 individuals)**

### *Incident 1*

**NCIS Case Number:** VIC.2001.3507, VIC.2001.3783 and VIC.2001.3784

**(Local Case Number:** 20013510)

**Finding Delivered:** 29 January 2004.

**Coroner:** State Coroner Graeme Johnstone.

### *Summary:*

Deceased was driving a stolen motor car through Albury NSW. Police attempted to intercept him and a pursuit ensued. The pursuit passed into Victoria where the deceased left the freeway onto dirt roads, lost control at a bend and collided head on into a tree. At the time the collision occurred it appears that he was not being pursued by the police officer as the officer had lost sight of the vehicle.

### *Incident 2*

**NCIS Case Numbers:** VIC.2001.3783 and 3784

**(Local Case Numbers:** 20013763 & 20013764)

### *Summary:*

The deceased was driving a vehicle reported by his mother to NSW Police as being stolen. During the conduct of a police pursuit which entered Victoria, the deceased lost control at a speed of approximately 150 km/h and the vehicle rolled. Also killed in the crash was the front seat passenger.

All of the individuals in the vehicle being pursued were under 17 years. Before the collision their identities and age were known by operators in Victoria Police Communications Centre, D24 Wangarrata (but not those directly involved in managing the pursuit).

After the vehicle had been reported as stolen, the mother of the driver telephoned police to advise them that her son may have been driving. There was relevant information concerning the identity, age and experience of all the young persons in the pursued vehicle that was either not broadcast or if it was because of communications difficulties did not get to operational police who were managing the incident. Had that information been delivered in a timely way the pursuit would have probably been abandoned and the outcome may possibly have been different.

### *Incident 3*

**NCIS Case Numbers:** VIC.2002.1810, 1811, 1812.

**(Local Case Numbers:** 20021821, 1822, 1823)

### *Summary*

This matters involves the driver and two passengers in a stolen motor vehicle which was involved in a brief pursuit with police. The pursuit was abandoned and a short time later the driver of the stolen motor vehicle lost control, with the vehicle striking a pole and fence.

### *Recommendations Arising out of the joint Inquest included the following:*

1. That there should be a significantly increased focus on training, regular re-training and attendant accreditation for officers to be involved in pursuits. Such training also should include dealing with specialist areas such as Pursuit Controllers, Communications Officers (in regional areas) and those responsible for accreditation. After the training regime has been implemented only accredited officers should be involved in pursuits. The training regimes and accreditation controls relating to police officers from other jurisdictions need to be considered for the safe operation of cross-boarder urgent duty driving and incident management.

2. That Victoria Police and the Department of Justice investigate the installation of linked video and dynamic monitoring system in all operational police vehicles (that may potentially be used for pursuit related duties). The consideration of this recommendation is essential to ensure accurate monitoring of the offender's vehicle and the response of the police pursuit vehicle. It is an essential tool for the audit of public and occupational safety responses and will help to accurately identify areas for improvement in practices and procedures.

3. That the Chief Commissioner re-consider an earlier Coronial recommendation in the matter of Balzan that, on a reasonably regular basis independent specialists in risk management be involved in reviewing police work practices and procedures in the area of police pursuits.

This recommendation is aimed partially at an audit checking process and partially ensuring that new ideas in risk management be regularly fed into the system. More particularly it is aimed at constantly improving practice and ensuring that occupational health and safety issues are regularly reviewed. Accordingly, it is essential, in view of the range of potential occupational health and safety issues evident in pursuits, that any such specialists have widespread experience in occupational health and safety issues as well as risk management.

4. As efficient, accurate and timely communication is a vital tool for the safe management of any pursuit (and other critical incidents) it is essential that those working in police boarder communications centres such as Wangarrata are able to have timely and efficient communications with their counterparts across the boarder in towns such as Wagga Wagga.

It is recommended that the Chief Commissioners of both jurisdictions work on improving the efficiency and timeliness of available communications in the cross boarder centres. In this regard, systems available at Wangarrata should be an important focus.

5. The Victorian Chief Commissioner consider reviewing the safety issues surrounding the use of hand held radio microphones by solo drivers in police vehicles operating in the urgent duty driving situation.

6. That the Victorian Chief Commissioner consider (as part of the new focus of Victoria Police on "safety first" in urgent duty driving) engaging independent expert consultants to review the safety of the upper end of operational speeds undertaken in some pursuits on free-ways. Such consultants should be independent of the force and have expertise in road and occupational health and safety issues.

7. As efficient, accurate and timely communication is a vital tool for the safe management of any pursuit (and other critical incidents) it is essential the following criteria are met:

- Fully trained and accredited operators (already the subject of general recommendation on

training);

- Police use the best available equipment with appropriately designed work stations and environment;

- Procedures are designed to ensure that information is accurately collected and delivered (in a timely way) to those supervising and managing an incident;

- Supervision by experienced officers (who are trained supervisors) of the D24 operators; and

- Regular monitoring of training, equipment, practices and procedures to ensure that appropriate improvements are fed back into the system in a timely way (*specific to incident 2 only*).

8. The Chief Commissioner ensure that, as far as is practicable, the technical quality of equipment used in police motor vehicles and motorcycles likely to be involved in pursuits is the best available in accordance with modern communications practice.

9. That Police Command should undertake a critical incident review in all cases where a pursuit (or potential pursuit) has resulted in death or serious injury. Consideration should be given to any such review being undertaken to a defined standard. By way of example - the internal reviews in deaths in prison undertaken under the supervision of the Correctional Services Commissioner should be considered as a potential model (*specific to incident 3 only*).

10. That the Attorney General considers a reference to the Victorian Law Reform Commission on the use by witnesses of the right to refuse to give evidence on the grounds of self-incrimination and how that right effectively operates in the context of a Coronial Inquiry. This reference should be seen in the context of the potential for reform of this area of the law to improve the accuracy of factual information coming before a coroner (*specific to incident 3 only*).

11. That, in light of the experience in Western Australia (and the joint research work of the Crime Prevention Committee and Victoria Police), consideration be given by the Victorian Government to the introduction of a compulsory immobiliser scheme to operate on the transfer of ownership of passenger and light commercial motor vehicles (*specific to incident 3 only*).

12. That the Victorian Government consider providing and supporting a pilot program specialising in "Youth Diversion Programs" as suggested by the research work and submission to the Coroner by Crime Prevention Committee and Victoria Police. It is noted that the general thrust of this submission (Joint Crime Prevention Victoria) is supported in the Recommendations of the "Police Pursuit Review 2002" (*specific to incident 3 only*).

\* \* \* \* \*

*Interested in other recommendations contained on the NCIS concerning police pursuits?*

VIC.2000.2926  
VIC.2001.3835  
VIC.2002.244  
VIC.2002.2895 and VIC.2002.2896  
VIC.2004.433

### Police Pursuits continued.

NCIS Case Number: SA.2001.1056.

(Local Case Number: 1052/2001)

Finding Delivered: 7 November 2003.

Coroner: (Then) State Coroner,  
Wayne Chivell.

#### Summary:

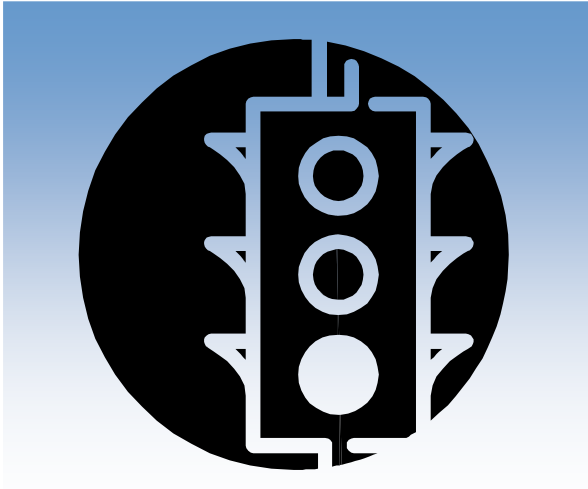
Death resulted from injuries sustained in motorcycle collision with kerb, leading to the deceased being thrown onto the footpath and sustaining severe head injuries. At the time of his death, the deceased was being pursued by police vehicles because he had committed several offences.

#### Recommendation(s)

1. The Commissioner of Police should review the General Orders applicable to urgent duty driving with a view to removing any perceived ambiguity in the obligations upon police officers who have been instructed to terminate an urgent duty driving situation.
2. The Commissioner of Police should review operational arrangements within SAPOL so that during a critical incident such as urgent duty driving, there is no uncertainty about who is in control of the incident from a supervisory standpoint. In this instance, there appears little doubt that the control of the incident should have come from the officers in ComCen.

\* \* \* \* \*





\* \* \* \* \*

## Case Study 2: Child Run overs

NCIS Case Number: VIC.2003.680.

(Local Case Number: 20030683)

Finding Delivered: 11 February 2004.

Coroner: Heather Spooner.

### *Summary:*

The deceased (aged three years) sustained fatal injuries when she was run over by a horse float being towed by her father. The children were sitting on the metal plate between the vehicle and the float whilst the vehicle rode back to the clubhouse with parental consent. She was then seen to try and grab onto the float before falling onto the ground where she was run over by the trailer wheels.

### *Conclusion*

This tragic death was entirely preventable and highlights the need for parents to resist the demands of their children to participate in hazardous activities that will inevitably lead to injury or death.

### *Recommendation(s):*

1. Consideration should be given to ensuring the continued promotion of best practice and the conduct of further research and surveillance to identify hazards that cause fall-related deaths in children so that they may be prevented.

NCIS Case Number: TAS.2003.37

(Local Case Number: H0023/2003)

Finding Delivered: 14 January 2004.

Coroner: Michael Rodney Hill.

### *Summary:*

The deceased was riding her bicycle on her grandparent's farm, and had been warned by her grandfather to stay where she was while he was travelling in his utility vehicle. The deceased was last seen riding in the opposite direction.

It appears however that (unbeknownst to her grandfather) the deceased then began chasing the ute on her bicycle, and that during the process of reversing, the ute has struck her, resulting in crushing injuries to abdomen and head.

### *Comments:*

The evidence...also indicates that (the grandfather) may have had limited rearward vision as a result of tool boxes fitted to the rear tray of the utility. These fixtures are not unlawful and are common on most farming vehicles. Whilst the dangers of reversing large vehicles are well documented we have to take into account the part that the human element plays in such incidents.

(The deceased) was not wearing a helmet whilst riding her bike. Whilst on this occasion (the Coroner was) unable to say if a helmet could have prevented the death, it is important to mention that helmets should be worn by cyclists, and particularly children, where ever they are riding their bikes.

Every year (we) experience several fatalities of a similar nature. (I) urge all drivers and parents to remember the risks often mentioned in relation to small children and the reversing of vehicles and also the wearing of appropriate head protection.

### Case Study 3: Domestic Violence.

NCIS Case Numbers: TAS.2002.561 and 560.

(Local Case Number: L0251/2002 & L250/2002)

Finding Delivered: 12 February 2004.

Coroner: Peter Henric Wilson.

#### Summary:

Murder/suicide. The victim had obtained a Domestic Restraint Order against her de-facto approximately 2 weeks before her death.

#### Recommendation(s):

(As handed down for TAS.2001.256 & TAS.2001.257).

- That applications for Domestic Restraint Orders be separated into two distinct types:

The first to deal exclusively with intimate male/female relationships, and that these be dealt with in the Criminal Division of the Magistrates Court.

The second to deal with all other applications, for instance as between neighbours, and those who cause problems for others, which will be dealt with in the Civil Division of the Magistrates Court.

- Police will only be concerned with applications before the Criminal Division and in the Civil Division only where confiscation of firearms is ordered.
- This should allow for a more focused approach by Police, and would have the advantages of freeing Police resources to deal with these more serious matters, and at the same time be seen to be compatible with the Police role of protecting the public and with the jurisdiction exercised in the Criminal Division of the Magistrates Court.
- The relegation of all other matters to the Civil Division would also seem to be more compatible with that jurisdiction and should provide advantages in better utilisation of court time in the Criminal Division and quite possibly in the Civil Division also where pre-trial procedures and costs disincentives apply to weed out unmeritorious or mere nuisance applications.
- In such a case an offender or respondent should be immediately disarmed of any firearms in his possession or to which he has access, and Police should have power to enter any premises or vehicles for that purpose whether the offenders premises or vehicles or not, provided he is thought to be able to access firearms from such source.
- Any such offender/respondent should be arrested and detained in custody until brought before a court for an offence or to facilitate the making of a Domestic Restraint Order. Police should not have the power to grant bail in such cases.
- On any application in court for bail the court should have regard to the safety of the applicant/complainant as the paramount consideration, and should not grant bail unless it is affirmatively satisfied that the safety of the applicant/complainant is not at risk, or grant bail at all where it appears that the offender may have access to firearms and the Police have not been able to recover them.
- In the case of intimate relationships, applications for Restraint Orders presently come before the court from a variety of sources, the applicant herself (I say "herself" as that is usually the case) domestic crisis workers or the Police.
- In all such cases, the Court Registry should notify Police of any such application in order that Police can respond by checking for and confiscating any firearms in his possession.
- The Registry is also to advise Police of Civil Orders confiscating firearms.
- A mechanism should be adopted which will ensure the speedy confiscation of firearms in such cases.

## Domestic Violence continued.

- The more vexed question of the withdrawal of a complaint or application by a complainant/applicant, which arises most frequently where reconciliation is underway but where Police still hold fears for her safety, and usually early on in the parties difficulties, should address and allow for a “cooling off” period whereby the Court would simply adjourn the proceedings for a period of not less than 3 months with appropriate bail conditions, but which would not permit the return of firearms to the offender in any event for a further period of 6 months thereafter.
- Tasmania Police have developed policy initiatives and continue to do so in efforts to address family violence, and the Attorney-General has initiated a review which is currently well-advanced and which canvasses various issues as well as the greater detail needed to be considered before implementation, and these actions are to be commended.
- These are recommendations in the broad only directed towards securing the safety of the applicant through arrest and detention for court of the offender/respondent and his disarming at an early stage in their dispute. While it may not be possible to protect a victim in every situation or for all time, these recommendations are designed to address violence or the threat of it, at that early stage when emotions can be heightened and before the passage of time has had a chance to lead to a cooling-down.

\* \* \* \* \*

### NCIS Case Numbers:

NSW.2000.5246 and NSW.2000.6480.

### (Local Case Numbers:

0102093/00 & 0102092/00).

**Finding Delivered:** 11 December 2002.

**Coroner:** (Then) State Coroner J M Milledge.

### *Summary:*

A man and woman were found dead by police. It was found that the man had shot the woman, with whom he was in a romantic relationship, after she confronted him about his relationship with another woman. He then shot himself.

### *Recommendation(s):*

To the Minister for police and to the Attorney General of New South Wales

1. That there be imposed an obligation pursuant to the provisions of the Firearms Act and Regulations upon any person issued with a rifle.

### *Other interpersonal (domestic) violence recommendations:*

NSW.2000.6480  
NT.2001.215  
TAS.2001.256 and TAS.2001.257  
VIC.2002.3842 and VIC.2002.3843

\* \* \* \* \*

## Case Study 4: Deaths in Custody

**NCIS Case Number:** NSW.2002.6574

**(Local Case Number:** 0111343/02)

**Finding Delivered:** 12 January 2004.

**Deputy State Coroner C Milovanovich**

### *Summary:*

The deceased was arrested, charged and detained under a first instance warrant issued by the NSW Drug Court, and placed into the custody of Corrective Services. Death resulted from hanging (with bedsheets from a blackboard near the entry door of the cell).

### *Recommendation(s):*

1. ...that immediate action be taken to remove noticeboards that can provide an obvious hanging point from all New South Wales regional centres.

....cont'd

## Deaths in Custody – cont'd

**NCIS Case Number:** WA.2002.490

**(Local Case Number:** 0519/2002)

**Finding Delivered:** 10 February 2004.

**Coroner:** State Coroner Alastair Hope

### *Summary:*

The deceased (a remand prisoner) was discovered hanging from a torn sheet tied to bars of the window in his cell by prison officers during the nightly "body check". The construction of the cell had been completed in 2000.

### *Recommendations:*

1...that the Department of Justice take immediate action to assess cells in the various prisons throughout the state with a view to identifying possible hazards such as obvious hanging points. Many of these hazards are obvious to untrained observers and their identification does not require expert review – what is required is action.

2...that the Department of Justice includes minimization of obvious hanging points as an instruction in the design of all cells to be constructed in the future.

3...that the Department of Justice review procedures with a view to promoting direct interaction between psychiatrists and psychologists, social workers and others involved with the monitoring of prisoners.

4...that the Department of Justice review ARMS (the At Risk Management System) procedures so that ARMS documentation is available at a prison where a prisoner is housed until the completion of his or her sentence.

5...that the Department of Justice review procedures to ensure that when a prisoner fails to take medication which is important to the well being of the prisoner, that failure is identified and reported to the relevant personnel.

6...that the Health Department consider having a review of the practical application of the Mental Health Act 1996 as it relates to community treatment orders with a view to determining whether community treatment orders are serving the purpose for which they are intended and, if not, with a view to determining whether the Mental Health Act 1996 requires amendment to avoid any perceived practical difficulties relating to the making or of enforcing of such

**NCIS Case Number:** SA.2000.2876

**(Local Case Number:** 2868/2000)

**Finding Delivered:** 13 February 2004.

**Coroner:** (Then) State Coroner Wayne Chivell

### *Summary:*

The deceased was located hanging in his cell during a medication round. The hanging point was strip of bed sheet fed through a gap between a shelf in the cell and a metal tubular bracket installed to support the shelf.

### *Recommendation(s):*

1. That the Chief Executive Officer, Department for Correctional Services, reconsider the system whereby access to a prisoner's cell may only be gained with a master key kept in the Main Control Room. In particular, the feasibility of a system whereby the cell could be opened electronically from the Main Control Room should be investigated.

2. The 'safe-cell' principles should be adopted and implemented in prisons throughout South Australia as a matter of urgency.

\* \* \* \* \*

**NCIS Case Number:** NSW.2003.506

**(Local Case Number:** 0110126/03)

**Finding Delivered:** 14 January 2004.

**Deputy State Coroner C Milovanovich**

### *Summary:*

The deceased was serving a sentence for Assault, Breach AVO and Driving Matters, with two additional matters before the court (Assault Officer and attempt escape). During morning head checks, the deceased was discovered suspended from a cord around his neck attached to the ventilation grille above the door to his cell.

### *Recommendation(s):*

1. That any recommendations that are recorded regarding cell placement where a mandatory risk intervention has not been called, should be placed on the offender management information system for future reference in the screening process.

# Recommendations Summary

\* Case is featured in more detail in this edition

NCIS Case Number	Summary of incident
<b>Deaths in Custody</b>	
NSW.2002.6574 *	Death in custody. See page 7.
NSW.2003.506 *	Death in custody. See page 8.
SA.2000.2876 *	Death in custody. See page 8.
VIC.2000.4141	<p>The deceased was in custody at an Immigration Detention Centre, and despite appeals to several courts for permission to remain in Australia, he was to be deported. On that day of the deportation, the deceased climbed a basketball ring in the exercise yard, where he remained for approximately 8 hours. Despite attempts by staff to coax the deceased down during the day, the deceased jumped, and in doing so struck either the ground or a brick retaining wall on his descent.</p> <p>Recommendation(s):</p> <ol style="list-style-type: none"> <li>1. Any incident involving a detainee who may be at risk of self harm or suicide be the subject of video and audio tape recording;</li> <li>2. Current procedures and communications (in particular all psychological assessment and at risk testing) as between DIMIA and ACM should be evaluated and the subject of a revised protocol with respect to all detainees who are known to be at risk of self harm, in particular all persons who have been served with a Notice of Removal, for whom all legal avenues for immigration have been exhausted and for whom removal is imminent;</li> <li>3. In accordance with the observations made by Prof (-) the formal intake psychological assessment be reviewed;</li> <li>4. The available interpreting facilities available to the detention centre in crisis situations must be reviewed to ensure that each language group is adequately accommodated;</li> <li>5. Consideration should be given to the development of a protocol concerning the utilization of external facilitators in crisis situations;</li> <li>6. Whilst it may involve some overlap, I adopt the following recommendation contained within the Lingard Report "local DIMA and Centre Management, in conjunction with each other, develop a procedure which ensures both authorities are aware of the pending deportation hand down notices being served on detainees or other notices likely to impact on the stability or security of a detainee. Centre Management should also ensure each detainee is formally assessed immediately after notification and a Case Management plan developed that would continually monitor the detainee's well being, security and stability up until deportation or until the crisis has passed or he or she no longer poses a threat to themselves" .</li> </ol>
WA.2002.490 *	Death in custody of remand prisoner. See page 8.
<b>Drowning</b>	
NSW.2002.203	<p>The deceased (aged 11 months) died as a result of drowning in her parents unfenced backyard swimming pool.</p> <p>Recommendation(s):</p> <p>To the Department of Fair Trading and Local Government, that the rules, regulations and requirements relating to the fencing of backyard swimming pools be reviewed, particularly the requirements at point of sale to notify potential purchasers as to the necessity of compliance with Local Government requirements.</p>

<b>Electrocution</b>	
NSW.2000.8053	<p>The deceased (a licensed plumber) was working in the roof cavity of a renovated house, attempting to install a water pipe line for a solar hot water system. In order to do so, the deceased was using oxy equipment to cut and join the copper pipes. It appears that the deceased has cut the main water pipe line which is connected to the existing hot water system. The deceased has taken hold of the pipe and received a severe electric shock.</p> <p>Recommendation(s): The Coroner adopted the recommendation that the Electrical Safety Branch of the NSW Office of Energy should liaise with the Master Plumbers and Mechanical Contractors Association of NSW, the Master Builders Association of NSW and the Housing Industry Association of NSW with a view to notifying their members of the potentially fatal risk of electrocution while working on or about sites that could involve live electrical power in water pipes and hot water systems &amp; particularly to recommend the universal use of bonding strip (insulated jumper leads) when working on any metal piping.</p>
<b>Falls</b>	
NSW.2001.8878	<p>The deceased was a long term resident of an aged care facility. The deceased has had a fall which has caused a fracture to her pelvis. As a result of her injury she was treated at a Hospital and then transferred back to the facility for treatment and recuperation. Following the fall and subsequent treatment the health of the deceased deteriorated, leading to her death.</p> <p>Recommendation(s): ...(that) aged care hospitals be provided with slip proof surfaces.</p>
<b>Homicide</b>	
NSW.2000.5246 & NSW.2000.6480 *	Murder/suicide. See page 7.
TAS.2002.561 (also 560). *	Murder/suicide. See page 6.
<b>Legal Intervention</b>	
SA.2001.1056 *	Police pursuit. See page 4.
VIC.2001.3507 *	Police pursuit. See page 2.
VIC.2001.3783 and 3784 *	Police pursuit. See page 2.
VIC.2002.1810 / 1811 / 1812. *	Police pursuit. See page 2.

## Medical Treatment

SA.2000.2058	<p>The deceased was a female in her thirties who was admitted to hospital suffering headaches, numbness and weakness in the right hand, slurred speech, nausea and neck stiffness during the previous 24 hours. She suffered a generalised tonic/clonic seizure in the Emergency Department, and another such seizure while undergoing a Computerised Tomography (CT) scan. The scan was repeated after the deceased was sedated, intubated and ventilated. The deceased was then admitted to the Critical Care Management Unit (CCMU) where she remained over the weekend. Further investigation of her condition in the form of Magnetic-Resonance Imaging (MRI) took place after the weekend, with a decompressive craniotomy performed the next day (along with anti-coagulation therapy). Despite this treatment, the deceased passed away the following day from a massive intra-cerebral bleed. The inquest focussed on the communication and follow-up of the second CT results over the weekend period.</p> <p>Recommendation(s): That the Flinders Medical Centre reviews its clinical practices and procedures to ascertain whether more could be done to ensure that communication between clinicians, and between clinicians and radiologists could be improved, that the appropriate specialties are involved in treatment, and that Consultants are adequately briefed before making decisions in relation to treatment;</p> <p>That the Flinders Medical Centre Radiology Department ensure that written reports are maintained in their original state on the record, and that any changes should only be by way of addendum rather than rewriting the original report.</p> <p>That whenever medical practitioners prescribe the OCP, they should take a careful personal and family history to ascertain if there is any relevant history of thrombo-embolism. If so, the patient should be screened for Factor V Leiden, and, if positive, should be advised of the substantially increased risk of thrombo-embolism.</p>
SA.2001.720	<p>The deceased was totally incapacitated and in a persistent vegetative state, as the result of a severe organic brain injury she suffered from an anaphylactic reaction to an anaesthetic during an emergency procedure for a suspected ruptured ectopic pregnancy. This led to severe anoxic encephalopathy from which she did not recover.</p> <p>Due to the extent of paralysis resulting from the brain injury, it was necessary for the doctors to create a tracheostomy in order to maintain artificial ventilation. Enteral nutrition was also commenced (via a Percutaneous Endoscopic Gastrostomy ('PEG')) to protect her airway. Some time after this procedure (exact period unknown), the PEG tube fell out causing spillage of liquid food. A registered nurse attempted to reinsert a smaller PEG tube but was unsuccessful. A medical practitioner was then called for, who inserted 'with difficulty' the same size PEG tube as had been previously inserted.</p> <p>After developing respiratory difficulty, the deceased was examined by a medical practitioner, and X-rays were taken, however no evidence of pneumonia (for which she had been taken to the Emergency Department for investigation) was found. The deceased was discharged to the care facility she resided at, but with her condition continuing to deteriorate over the next 11 hours, she was transferred back to hospital.</p> <p>An abdominal X-ray found free gas in the abdominal cavity, suggesting that the PEG tube had been misplaced, or a hollow viscus had been perforated and stomach contents had discharged into the abdominal cavity. Given the deterioration of her condition, palliative care was provided up until her death four days after the re-insertion of the PEG tube.</p> <p>At inquest, the treatment of the deceased at the hospital (and discharge home) was considered, as well as failure of the doctor to contemporaneously record the replacement of the PEG tube in the clinical record.</p> <p>Recommendation(s): ...that the Chief Executive Officer of the Royal Adelaide Hospital consider whether the procedures in the Emergency Department of the hospital can be amended to ensure that better discharge planning occurs to prevent such a recurrence. ...that Dr &lt;-&gt; should review her clinical practice to ensure that she always makes appropriate contemporaneous entries in the case notes. I also recommend that ( care services) should review their systems to ascertain whether the difficulties Dr &lt;-&gt; encountered in accessing the clinical record can be avoided or minimised.</p>

**Medical Treatment continued...**

VIC.2000.3647	<p>The deceased was involved in a motor vehicle accident and as a result, suffered a fractured right pubic ramus, and right clavicle, fractured right ribs and large right sided pneumothorax. He was admitted to Hospital and following treatment, but while still in some pain, he was transferred to a rehabilitation facility. While at the centre there were significant problems with pain control and the deceased's condition deteriorated, despite antibiotic treatment for what was believed to be a probable chest infection, he having developed shortness of breath and a productive cough.</p> <p>Cause of death:</p> <p>1a) inadequate management of septic shock and resuscitation with blood 1b) right lateral thoracotomy with drainage of empyema</p> <p>Independent opinion from the Victorian State Committee of the Royal Australasian College of Physicians (through the Director of Intensive Care Research at the Austin and Repatriation Medical Centre).</p> <p><i>"... the patient fulfilled the international consensus criteria for the diagnosis of septic shock for at least 6 hours and that the patient received inadequate treatment for this condition...(further).. resuscitation was undertaken with minimal monitoring thus markedly decreasing patient safety...(and) .. the patient fulfilled the criteria for activation of the hospital Medical Emergency Team (MET) for at least 14 hours. "</i></p> <p>The Director also detailed numerous omissions and examples of inadequate treatment. It concluded, that the deceased died of cardiac arrest precipitated by a combination of factors, which included prolonged inadequately treated septic shock, fluid overload with pulmonary oedema and associated untreated anemia. These conditions were active for hours before the final event, thus offering a chance for timely intervention and correction.</p> <p>Comments/recommendations:</p> <p>Following the tragic death of (deceased), Southern Health has implemented measures aimed at minimising a repetition of further death occurring in similar circumstances:-</p> <p>a) The MET system has been reviewed to simplify its operation and the induction information provided to junior medical staff regarding operation of the MET system, has been strengthened.</p> <p>b) A patient cannot be transferred from recovery to a general ward if that patient does not meet MET criteria, and appropriate consultation is required to determine the continuing management of such patient.</p> <p>Further changes undertaken by Southern Health are:-</p> <p>1) Quality of care review mechanisms and the investigation of serious incidents and adverse events have been reassessed and improved.</p> <p>2) Measures that include, comprehensive disclosure of the circumstances of adverse events, have been implemented aimed at improving communication of information between health care professionals and patients and their families.</p> <p>The deceased's family, despite the gravity of their loss, are grateful to Southern Health for the admissions made and particularly to the hospital's Intensive Care Unit Director, for his openness and honesty in explaining to them the circumstances surrounding the death. It is recommended that this enlightened and commendable approach be adopted by all institutions and health professionals in the course of managing avoidable adverse events.</p>
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## Medical Treatment continued...

VIC.2002.3812	<p>Deceased was admitted to a private hospital in relation to hip replacement surgery. This surgery took place with apparent unknown complications. The following day the deceased suffered cardiac arrest. Hospital staff commenced cardiac compression. A new model semi-automatic defibrillator was prepared to be used although none of the hospitals staff had been trained in its use. The deceased had to be resuscitated by metropolitan fire brigade with their own defibrillator and was transferred to the ICU of a tertiary public hospital. Several days later, it was found that the deceased did not record brain activity. Hence life support was removed the following week.</p> <p>Investigation into the circumstances surrounding the death revealed that despite the presence of the new model of semi-automatic external defibrillator on the ward, there was no formal requirement for staff to be trained in the use of the new equipment. The hospital is one at which medical practitioners are not present at all times and at which there is no intensive care unit, accordingly advanced life support as defined by the Australian Resuscitation Council was not undertaken by nursing staff. Following the death, the hospital added the use of semi-automatic external defibrillators to their basic life support education and competency assessments for nursing staff. In addition, a review of their Code Blue policy was also undertaken.</p> <p>Recommendation</p> <p>It is recommended that Mayne Group Limited introduce the semi-automatic external defibrillator education and competency testing package established at Mentone Private Hospital, to all their hospitals.</p>
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## Motor Vehicle Accidents

ACT.2003.52	<p>The deceased sustained fatal injuries when the vehicle he was driving (a large tray-back truck) collided with an armco railing, crossed onto the rock landscaped slope between the carriage-ways, and then rolled over. The deceased was not wearing his seat belt and was expelled through the open drivers window.</p> <p>Recommendation(s): that the Minister give consideration to introducing legislation requiring that lap-sash type seat belts be retro-fitted to motor vehicles, especially trucks, not so presently equipped. (Passenger seats on buses are not included within this recommendation).</p>
NSW.2002.5310 (also 5308 and 5312).	<p>Fatal injuries were sustained by three of the five vehicle occupants in a single vehicle collision with an electricity pole whilst trying to round a bend. As a result of impacting with the power pole, the vehicle has rebounded off the pole, colliding with a barbed wire fence.</p> <p>Recommendation(s):</p> <p>...the RTA should, in conjunction with the New South Wales Police Service, investigate that section of the road in order to determine a number of issues. They are whether the speed limits, advisory signs, suitable barriers and the positioning of power poles are appropriate having regard to the number of fatalities in recent time along that section of the road.</p>
NSW.2000.5077	<p>The deceased sustained fatal injuries when struck by an electric train whilst fleeing from police after he had been placed under arrest.</p> <p>Recommendation(s):</p> <p>Need to read and communicate cops system warnings to police in the field.</p> <p>1) that recommendation number 3, inquest 502 of 2000 be again implemented in respect of all NSW police officers, and civilians who may have the need to utilise the cops system at request of officers in the field.</p> <p>2) that those responsible for the initial training of police officers in the use of the cops system review their courses to ensure that adequate instruction is given in relation to communicating cops system warnings to police in the field. Need to separate police when they are involved in an incident involving a death in police custody or during a police operation within the meaning of section 13a, coroner's act 1980.</p> <p>3) that all police who may be tasked to investigate deaths pursuant to sections 13a, coroners act (deaths in police custody or during police operations) be reminded of the need to promptly separate officers involved in such deaths.</p>

Motor Vehicle Accidents continued...	
NSW.2000.5326	<p>The deceased sustained fatal injuries in a motor vehicle collision between a pickup truck/van and another motor vehicle and trailer.</p> <p>Recommendation(s):</p> <p>That the appropriate Minister enacts legislation to ensure the responsibility of the security of loads is shared equally by the owner or consignor of the property.</p> <p>The transport company responsible for transporting the goods and the driver of the motor vehicle. It can not be said that public safety can be ensured if all of those persons do not share that responsibility.</p> <p>The appropriate authorities conduct a review of the roadway, to investigate what changes can be made to make travel of heavy vehicles and other motorists that travel that road, a safer path on that particular roadway.</p>
TAS.2003.37 *	Child run over by utility on farm. See page 5.
VIC.2003.680 *	Child run over by horse float. See page 5.
VIC.2003.1589	<p>The deceased was involved in a motor vehicle collision with another vehicle. The intersection is controlled by "give way" signs applicable to the vehicle being driven by the deceased, however it appears that the deceased did not give way to the other vehicle.</p> <p>There is a gradual rise in the roadway leading up to a railway line which runs parallel with the road the collision occurred on. As vehicles approach the intersection from the east (from where the deceased's vehicle came), the elevated railway line impedes the driver's view of both the intersection and vehicles travelling along the Bendigo Pyramid Road. On crossing the railway line from the east there is a sharp decline and a short distance (10.2 metres) to the intersection.</p> <p>It is clear that the design and layout of this intersection was a contributing factor in the collision and death.</p> <p>Comments:</p> <p>This case is an example of where design and layout of an intersection is potentially dangerous in that it does not provide adequate advanced visibility for drivers approaching from the east. The approach is potentially deceptive.</p> <p>Accordingly the dangerous nature of the approach from Main Street to its intersection with Bendigo Pyramid Road, Sebastian requires urgent attention by the relevant authority in order to reduce the risk to other drivers that may be placed in the deceased's position.</p> <p>It is suggested that VicRoads undertake this work and/or liaise with the City of Greater Bendigo in order to urgently address this identified safety issue (it may be that there are other similar intersection layouts in this, or other areas of Victoria, that possibly require consideration in the light of the investigation in this case).</p>

**Motor Vehicle Accidents continued...**

VIC.2003.2626	<p>The deceased (a pedestrian) was walking towards an intersection when he saw the lights turn green. In order to catch these lights he began to run across the road. At that time a school bus had commenced to execute a left hand turn. The driver had checked the intersection before turning left. At the same time the deceased, who had his head down, was struck by the bus as it was executing its turn. The deceased was knocked to the ground and fell under the rear wheels. He died at the scene of the accident.</p> <p>Recommendation(s)</p> <p>Senior Constable Gatti, who investigated the death of the deceased gave evidence that the intersection where the accident occurred is a cross intersection controlled by traffic control signals for vehicular and pedestrian traffic. He checked the traffic control signals and found them to be operating correctly and observed that the pedestrian lights operate automatically at that time of the morning and it is not necessary for a pedestrian to push the button to receive the walk signal. The road is of bitumen construction and was in good repair at the time.</p> <p>He also said that the accident may not have occurred if the lights did not automatically operate and a pedestrian was required to push the button to operate them. I therefore request S/Const Gatti to seek out the relevant authority who is responsible for the programming of the lights and seek an explanation as to why it is done. Unless there is a sound explanation to continue the practice it should cease. In all the circumstances I request he prepare a report and deliver it to me within 2 months. If necessary, I would be prepared to re-open the Inquest.</p>
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**Psychiatric Treatment—Suicide**

NSW.2000.6396	<p>Fatal injuries sustained as a result of jumping from the Anzac bridge.</p> <p>Recommendation(s) made to the Minister for Health regarding the following:</p> <ul style="list-style-type: none"><li>- Consideration given to the creation of a working party to examine and implement uniform guidelines in all hospitals in NSW where persons are detained under the mental health act.</li><li>- Educating clinicians and staff employed in psychiatric hospitals as to the importance and desirability when assessing a patient under the Mental Health Act to access the person's relatives and friends as a means of obtaining additional history and information relative to the person.</li><li>- Conducting an investigation of all suicides occurring at a hospital within the past five years and (if such investigation confirms the trend indicated in the three deaths investigated) making the information available to all hospitals addressing the need for particular care and observation during the first forty-eight hours of admission to hospitals of persons at risk of self-harm or suicide or of harm to others.</li><li>- Consideration of having the working party to examine and (if thought fit) to make recommendations for the establishment of state wide protocols and procedure to be followed in the event of a patient absconding from a psychiatric hospital.</li></ul>
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### Psychiatric Treatment—Suicide continued...

NSW.2001.3695	<p>The deceased sustained fatal self inflicted stab wounds as he was about to be presented with arrest warrants.</p> <p>Recommendation(s) made to the Minister for Police, Minister for Health, NSW Police Commissioner and Director General of Health.</p> <ul style="list-style-type: none"><li>- revision of the Memorandum of Understanding between NSW Health and NSW Police, together with local protocols, to include a specific section on the execution of warrants by Police Officers on known, or likely, mental health consumers.</li><li>- clients of the community health teams who have been assessed as likely to harm themselves or others be approached to obtain their consent to being listed on Police Records as mental health consumers. Such information should then be communicated to the Local Area Command so that the client's case manager can be contacted by Police in the appropriate circumstances.</li><li>- consideration of whether the appointment of a Police Officer as a designated Mental Health Officer within a Local Area Command would facilitate the communication between Police and the local mental health services.</li><li>- Training Courses for Police Officers be reviewed to include a specific segment on the execution of warrants on mental health consumers.</li><li>- Segments on the interactions between police, mental health consumers and mental health service providers be included as a mandatory component not only of initial police training but also of regular refresher courses.</li><li>- Information available to police about a person's status as a mental health consumer be recorded on the COPS system and on any other system used to record outstanding warrants (and for this information, together with information contained in the "warnings" screen on the COPS system, to be accessed by police prior to the execution of a warrant.</li><li>- Officers should formulate a plan based on this information as to the best way to approach the mental health consumer in executing a warrant.</li></ul>
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### Psychiatric Treatment—Miscellaneous

NSW.2000.5783	<p>Cause of death: Chronic Schizophrenia. No further information available on NCIS.</p> <p>Recommendation(s) (to the Commissioner of Police) that consideration be given to include in the Police Service Handbook regarding 'Missing Persons' that, in the event of a possible sighting of a missing person being reported, the next of kin be notified of such sighting in circumstances where it is known that the next of kin would wish to be informed and especially when it is likely that the next of kin would wish to arrange civil assistance in a search of the vicinity of the area of the possible sighting.</p>
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### Trees/Branches (Falling).

NSW.2000.6322	<p>The deceased, along with family and friends, were camping when a large trunk from a Melaleuca tree crashed onto the tent, killing the deceased.</p> <p>The jury made the following recommendations:</p> <ol style="list-style-type: none"><li>1. That the Minister for the Environment in the course of the review of the 'Myall Lakes National Park - Revised Camping Strategy' take into account the evidence adduced at the Coronial Inquest into the death of (-).</li><li>2. That the Minister for the Environment designate adequate financial resources for the National Parks and Wildlife Service to implement the proposals contained in the 'Revised Camping Strategy for Myall Lakes National Park' immediately.</li><li>3. That the National Parks and Wildlife Service implement the proposals contained in the Revised Camping Strategy for Myall Lakes National Park'.</li><li>4. The National Parks and Wildlife Service implement a tree hazard risk assessment for designated camping sites throughout National Parks. The tree hazard risk assessments must be carried out by suitably trained personnel.</li></ol>
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**Trees/Branches (Falling) continued...**

TAS.2002.571

The deceased and his son were felling trees on a property. One load had been cut and the deceased walked down the hill and felled another tree. Once he had cut the head away from the trunk he called to his son to hook it up to the tractor and pull the head away from the trunk. The son was attempting to pull the head away when he looked back over his shoulder and saw his father being dragged down the bank by the trunk of the tree.

Comments:

The logging industry is one that comes with many inherent dangers, dangers that we try to avert by ensuring that all persons in the industry undergo formal training. There are many people who operate fire wood business without the appropriate training or operating certificates. These operators need to be targeted, not with the intention of taking away their livelihood, but potentially saving their lives.

**Work-related**

NT.2003.211

The deceased was operating an AFRON PA 500E Cherry Picker at the time of the accident from the basket, which was elevated within the upper canopy of a mango tree. There were no witnesses to the events preceding the deceased's accident and as the basket safety locking bar was not secured on the left-hand side of the basket, it appears that by the positioning of the deceased's body on the ground, that the deceased has fallen through the unguarded access egress area of the basket from an approximate height of 4.3 metres onto the ground below.

The AFRON PA 500E Cherry Picker basket safety-locking bar was not secured in position at the time of the accident. The deceased was not wearing a safety belt at the time of the accident, nor was he wearing any personal protective footwear at the time of the accident.

The Mango Farm did not provide the appropriate safety belt for the use on AFRON PA 500E Cherry Picker as per the manufacturer's Safety and Operating Instructions.

The Coroner adopted the recommendation(s) of NT Worksafe that the Mango Farm:

- review their safety procedures to ensure the safe use of elevated work platforms employed in the harvesting of produce.

- provide the appropriate work positioning equipment for personnel operating elevated work platforms as per the manufacturer's Safety and Operating Instructions and the relevant Australian Standards.

- implement systems that will identify all the hazards in the workplace, assess the risks and control the risks.

VIC.2003.169

The deceased had been clearing an area adjacent to the factory. He was driving a forklift to replace a motor on a pallet. The tynes were raised to 3 metres above the ground. The forklift had to travel up a slight incline so the motor could be placed on a metal pallet. As the forklift's front right hand wheels touched the double rail track the inner wheel spun on the metal. The forklift then tipped over and crushed the deceased when he attempted to jump clear of the vehicle.

The following recommendations (formulated by Acting Sergeant William Holmes investigated the circumstances of the death on behalf of the Coroner) were adopted by the Coroner:

1. Seatbelts to be fitted to all forklifts to secure the driver.
2. "Wings" to be fitted to both sides of the forklift seat to prevent the driver falling out due to rollover.
3. Continuous safety training and bi-yearly assessments of persons using forklifts.
4. Solid tyres to be used on forklifts instead of inflated tyres.

**Work-related continued...**

VIC.2002.866	<p>The deceased works for a company that re stumps houses. They were working on a house, re-stumping the entire house. The deceased was under the house taking measurements of the depth of some stump holes when the house collapsed, crushing the deceased under it.</p> <p>Comments/Recommendations</p> <p>It is not possible to say which, if any, of the above criticisms of the re-stumpers' workplace caused the house to fall. The house was situated on a slope and the house slipped down that slope. One, or any, combination of the suggested work practices that were criticised could have caused the house to slip and fall, or it may have been some other cause such as leaving the house on jacks over night. In my opinion a fail-safe system or secondary support system of some kind should be used/implemented on all re-stumping works once the house has been lifted on to jacks and before any person is permitted to enter under the house. Further, when a person goes under such a house to jack up the centre of the house a jack-and-pack system should be used to ensure maximum safety of the workers. A senior investigator with the Legal Services and Investigation Division of the Victorian Workcover Authority, stated that "Our organisation is looking at the whole re-stumping industry". I would recommend that this oversight continue with a view to establishing a standard which could be introduced to the re-stumping industry, which is an unregulated industry at the moment, such standard to set out the appropriate guidelines to be followed when re-stumping houses.</p>
VIC.2002.3012	<p>The deceased was struck by a garbage truck, before falling underneath it. The driver of the truck was unaware of the accident until he discovered the body of the deceased when emptying the bins on the other side of the road.</p> <p>Conclusion</p> <p>It is apparent from the circumstances surrounding this tragic pedestrian death that there is an inevitable risk of death or injury occurring where a system of work requires a garbage truck driver to try to keep a proper lookout whilst both driving forward and lifting bins to the side.</p> <p>Comment</p> <p>I do not consider that the performance of two complex tasks simultaneously could be considered a safe system of work. If the time taken to empty bins would double were trucks required to stop, and if the cost of extra trucks would be prohibitive to the industry, then perhaps consideration could be given to placing another worker in the cabin to operate the side lifter so that the driver is left to concentrate on the single complex task of driving.</p> <p>A comprehensive finding on the Inquest into the Death of (-) (3086/98) was delivered by the State Coroner on the 21st November 2003. Although it dealt with the death of a recycling collector or "runner" at the back of a reversing recycling truck, it does highlight several safety, design and development issues specific to the Waste Collection Industry.</p> <p>Recommendation(s):</p> <p>That Worksafe and the Waste Collection Industry consider the implementation of Guidelines that require garbage trucks to stop whilst operating the side bin lifter or alternatively, that additional workers be employed to perform the side lifter operation.</p>

## Miscellaneous

TAS.2002.575

Child blind cord strangulation. The Coroner found that the deceased climbed onto the bedside drawer unit adjacent to the bed and then became entangled in the exposed loop of the blind cord.

Recommendation(s):

1. A comprehensive public educational program be implemented which highlights the risk of infant strangulation by curtain cords and informs the community about methods of addressing the hazard. The safety campaign should be compelling and effective. It should reach industry and the public through a range of organisations, various publications and other medium.

2. That an effective approach be adopted to render safe blinds and curtains which are already installed.

In implementing this recommendation consideration is drawn to the following matters of importance:

- That inexpensive and effective products and method/s of rendering safe blinds and curtains which are already installed should be immediately and readily available to the public.

- The public information strategy (referred to in recommendation 1) should provide information and guidance about these products and promote the use of these products.

- The blind and curtain industry and entities such as Office of Consumer Affairs should promote the use of products and modifications to existing curtains and blinds to eliminate the hazard of infant strangulation.

3. That a mandatory safety standard/s be implemented in Tasmania with regard to the sale/supply of window coverings with cords to effectively address the risk of infant strangulation.