



Deaths involving Animals

This publication outlines some trends and patterns extracted from the NCIS database where an animal has been coded as an object contributing to a death. Basic demographic details and the types of deaths associated with fatal animal related incidents are examined. The publication also highlights coronial recommendations made and provides links to sources of additional information.

WHY FOCUS ON ANIMAL RELATED DEATHS?

Most people are aware of the all too real danger to humans of sharks and crocodiles in our coastal and inland waters.

However, many other animals can cause fatalities for humans if they meet with them at the wrong place and wrong time:

"Buffalo gores man to death in northern Australian town, police say".

"Tragedy as bike hits bull..."

"Jockey dies after fall".

"Deadly snake bite".

"Wasp sting may have killed QLD tourist - police".

"Fatal spider bite".

"Jellyfish death 'preventable".

NCIS QUIZ COMPETITION

Be the first NCIS user to tell us how many men and how many women died from an animal-related cause in your state (searching all NCIS cases) and win a bottle of wine from the Director's cellar

Contact **Megan at (03) 9684 4485** for competition details

Table 1: Types of animals identified on the NCIS as being involved in a death

Bee

Bird

Cat

Cow bull bovine

Crocodile/alligator

Dingo

Dog

Elephant

Feral pig

Hippopotamus

Fish

Horse

Jellyfish

Kangaroo

Shark

Sheep

Snake

Spider

Tick

Unspecified arthropod

Case Statistics for Animal Related Deaths



All jurisdictions except QLD have data available on the NCIS from 1/7/2000 (QLD data is available from 1/1/2001). Data contained in this publication was extracted during April 2006.

Number of Animal Related deaths; by Gender	
Female	41
Male	87

Activity at Time of Incident	Total
Informal sports and active recreation	26
Working, including travelling for work	24
General travel	24
Other Specified activity excluding travel	11
Organised sports and active recreation	6
Gardening	4
Other specified leisure activity	4
Travelling to or from such work (commuting)	3
Hobby activities	3
Washing oneself, such as showering, etc	2
Other specified domestic duties	2
Working or commuting, unspecified	1
Eating, Drinking	1
Leisure time activities with an entertainment element, such as going to the cinema, to a dance/party	1
Resting, Sleeping	1
Other	10
Unlikely to be known	6
Grand Total	128

Age group	Total
1-10	13
11-20	12
21-30	24
31-40	14
41-50	16
51-60	16
61-70	11
71-80	12
81-90	8
91-100	2
Grand Total	128

Research Reports

- * **Dog bite and injury prevention—analysis, critical review, and research agenda**
J Ozanne-Smith, K Ashby and V Z Stathakis
<http://www.achp.health.usyd.edu.au/pets/dogbites.html>
- * **Hospital-treated dog bite injury in Victoria July 1998 to June 2004**
M Congiu, E Cassell, K Ashby
<http://www.monash.edu.au/muarc/VISU/reports/dog.html>
- * **National Injury Surveillance Unit (NISU) - Dog Related Injuries**
R Kreisfeld and J Harrison
<http://www.nisu.flinders.edu.au/pubs/reports/2005/injcat75.pdf>

Case Statistics for Animal Related Deaths



* Number of deaths by jurisdiction and year

Case jurisdiction	2000	2001	2002	2003	2004	2005	2006	Total
VIC	4	4	3	10	4	4	0	29
NSW	1	11	5	5	5	1	0	28
QLD	0	11	6	3	5	2	0	27
SA	2	3	3	1	1	3	1	14
NT	0	3	5	3	0	2	0	13
WA	2	1	1	3	6	0	0	13
TAS	1	0	1	0	1	1	0	4
Grand Total	10	33	24	25	22	13	1	128

* Number of deaths by the Incident Location

Incident Location	Total
Street or highway (public road)	34
Home	28
Other specified place	24
Farm	22
Sports or athletics area (place mainly for formal sports, etc)	10
Recreation area (place mainly for informal recreational activity)	3
Mine or quarry	2
School, other institution, or public administrative area	1
Other	2
Unspecified place	2
Grand Total	128

NCIS Data

Pending cases may impact the accuracy of our findings. The average for NCIS case closure rates are shown below.

State	Average % Closed cases
ACT	89.25%
NSW	73.60%
NT	98.29%
QLD	86.17%
SA	96.50%
TAS	95.24%
VIC	96.04%
WA	77.33%

Further Reading

- * Animal Related Injuries
Safe Communities QLD.
<http://www.safecommunitiesqld.org/modcore/AnimalrelatedInjury/frontend/index.asp>
- * An update of injuries associated with marine animals
K Ashby - Monash University Accident Research Centre (MUARC), 1 March 2004
<http://www.monash.edu.au/muarc/VISU/reports/marine.html>
- * Bites and Stings
R Hockey and E Miles - Queensland Injury Surveillance Unit (QISU), Injury Bulletin No 64 February 2001
http://www.qisu.org.au/modcore/PreviousBulliten/backend/upload_file/issue064.pdf
- * Dog Bites
Queensland Injury Surveillance Unit (QISU), Injury Bulletin No 6 June 1991
http://www.qisu.org.au/modcore/PreviousBulliten/backend/upload_file/issue006.pdf
- * Horse-related Injuries
R Hockey and E Miles - Queensland Injury Surveillance Unit (QISU), Injury Bulletin No 67 August 2001
http://www.qisu.org.au/modcore/PreviousBulliten/backend/upload_file/issue067.pdf

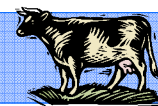


Animal Related Deaths by Mechanism

Table—Animal Related Deaths by Mechanism:

Mechanism of Injury	Animal	Total
Bitten by animal	Shark	8
	Dog	7
	Crocodile or alligator	3
	Snake	3
	Other specified land mammal	1
	Unspecified arthropod	1
Contact with blunt object	Cow, bull, bovine	16
	Other specified land mammal	12
	Horse	8
	Dog	2
	Bird	2
	Crocodile or alligator	1
	Sheep	1
	Crushing	Horse
Cow, bull, bovine		2
Drowning and immersion	Shark	1
Falling, stumbling, jumping	Horse	24
	Dog	2
	Cat	1
Invenomation	Bee	5
	Snake	4
	Spider	3
	Jellyfish	1
	Tick	1
Mechanical threats to breathing	Snake	1
Other specified contact	Horse	3
	Other specified land mammal	1
Other specified effect of chemical substance	Fish	2
Other specified mechanism of injury	Shark	1
Other specified piercing/penetrating force	Cow, bull, bovine	2
Other specified threat to breathing	Horse	1
	Tick	1
Unspecified mechanism of injury	Dog	1
	Shark	1
Grand Total		128





* Based on where the 'Recommendation/Warning' field is recorded by coronial staff as 'Recommendations Made/warnings Made'.

Horses

NT 2002.130

ELIZABETH MORRIS, D0083/2002

The deceased and her daughter were participating in an organised cattle muster provided by a Cattle Station for its guests. There were two helmets available for use at the property on the day, however the deceased was not wearing one, nor had she been offered one. Both the deceased and her daughter were experienced riders.

A short time after mounting the horse, and for no apparent reason, the deceased's horse shied and started stepping backwards. As the horse stepped backwards, its left rear leg slipped. This caused the animal to fall to the left and backwards with the deceased still seated in the saddle hanging onto the reins.

As the deceased fell, her head made contact with an unknown object. It is not certain as to what happened during the deceased's fall.

Recommendation

Whilst it is the experience of these station owners that experienced riders normally decline the offer of a helmet, I would recommend that the practice of the public wearing appropriate hard helmets in commercial horse riding situations such as this be encouraged, if not made mandatory by tourist operators.

VIC 2002.625

ROWAN MCINDOE, 2002/637

The deceased was a 51 year old horse strapper, of over 30 year's experience riding horses. At about 8:00 am he mounted a 3 year old un-raced gelding - a quiet horse with no history of being flighty. With two other riders, the deceased trotted/walked the horse to the track - about 1600 metres from the stables. Once on the track the deceased completed half a lap of training, when the horse stumbled, throwing the deceased to the ground. Witnesses reported that the deceased may have broken his neck.

Recommendations

A recommendation from the Victorian Workcover Authority has been communicated to the racing industry in the following terms.

A more rigorous checking system across the Racing Industry

should be installed. Perhaps protective vests should be worn on the outside of clothing to eliminate the assumption that a rider has one on. The employers (horse trainers) abide by the Australian Racing Rules and thus do not have systems in place to ensure riders protective equipment is appropriate. If this is industry practice, the Victorian Racing Industry (VRI), the governing body needs to inform employers of their duties under the Occupational Health and Safety Act 1985 and how the Act overrides the Australian Racing Rules.

I endorse this recommendation.

TAS 2002 118

IAN ROGER MATTERSON, H0107/2002

The deceased was seen riding on the cross country course towards a jump known as the North Forest jump. He disappeared behind scrub, which obscured further view of his passage and the deceased's horse returned along the track towards the car park without its rider. The deceased was found lying on the wayside of the jump, his riding helmet firmly in place. He was unconscious with laboured breaths. The Coroner found that the deceased died as a result of a ruptured heart due to chest injuries received following a horse riding fall.

Recommendations

The deceased was wearing a riding helmet at the time of the incident. There have been several comments made regarding the wearing of a back protector. From the degree of injury sustained by the deceased, I am satisfied that had such safety equipment been worn by him it would not have produced a different outcome.

Regardless of an individual's experience, I strongly recommend that an activity such as horse riding be carried out under supervision and in the company of others. I commend the actions of medical personnel at the grounds and the foresight of the Club to ensure such persons are present at events.

I find that death occurred as a result of misadventure while the deceased was riding alone and without permission on the cross country course.

Relevant Links

Horse-related injury in Australia

Raymond A. Cripps

<http://www.nisu.flinders.edu.au/pubs/bulletin24/bulletin24.html>

Fast Facts—Equestrian Safety (USA)

<http://www.thinkfirst.org/Documents/FastFacts/TFequestrian137.pdf>

Preventing Equestrian Injuries

Monash University Accident Research Centre

<http://www.monash.edu.au/muarc/projects/horse.pdf>

Horse-Related Injuries to Children in Alberta, Canada

http://www.calgaryhealthregion.ca/hecomm/IPC/Resources/colourjuly05/fact_riding_05.pdf



Crocodile

NT 2002.283

GREG CAVANAGH, D0197/2002

The deceased and her sister departed for Kakadu National Park as part of an adventure tour conducted through Gondwana Adventure Tours and Expeditions.

The group swam at various locations over the following two days. During one of these outings, a large saltwater crocodile swam amongst the group and dragged the deceased below the water.

Recommendations:

As discussed herein, the reasons for the implementation of an accreditation scheme in the tourism industry are compelling, notwithstanding the various practical and legislative difficulties that arise. The benefits that would accrue from such a scheme in terms of public safety are substantial. For those reasons, I make formal recommendation to the Attorney-General for the Northern Territory that government expedite the implementation of a statutory licensing system for tour guides which would require, at the very minimum, that all tour guides have training in first aid and that all tour operators carry public liability insurance. I make this recommendation without seeking to suggest that the death in question would have been avoided had such a system been in place.

Upon reflection, I agree that a blanket ban on swimming in Kakadu National Park would be a disproportionate response to these and similar deaths. I concur with the submissions made by counsel for the Director of National Parks and Parks Australia (as set out in Paragraph 41 hereof) in this respect and recommend amendments to the regulatory regime in the broad terms discussed therein.

Shark

SA 2002.594

WAYNE CHIVELL, 1099/2002

The deceased, then aged 23 years, was a professional scallop fisherman. He operated a 6½ metre aluminium boat and leased a scallop fishing licence from his brother. The deceased had been diving for between five and ten minutes when a shark attacked tearing through the deceased's right leg and hip joint.

The Coroner found that the deceased was wearing his 'Shark Pod' device incorrectly at the time of the attack in that the fin electrode, instead of being attached to his fin, was attached to his airline supported by a float which had the potential, particularly when he reached the surface, to make the shark repellent device less effective;

Recommendations:

I therefore recommend, pursuant to Section 25 (2) of the Coroners Act, that commercial and recreational divers, when operating in waters where there is a risk of the presence of sharks, should wear a shark repellent device of the 'Shark Pod' or 'Shark Shield' type, provided that the equipment should be used in accordance with the manufacturers instructions, and should be turned on for the entire duration of time in the water.

“ We need a way of life in which the animal, guided by reason, may romp but will not bite.”

- Abraham Myerson

Bulletin Feedback Form

We are interested in your thoughts on our third 'trend analysis' bulletin.

Are you interested in receiving future editions?

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- House fires
- Analysis of Natural Cause deaths using ABS ICD-10 codes
- Sports related deaths
- Water craft or Air craft deaths
- Pedestrian Vs Motor Vehicle deaths
- Rural/Regional Deaths using ABS codes

Other:

Other Comments:

Please Return To:

National Coroners Information System (NCIS)
c/o Victorian Institute Forensic Medicine
57-83 Kavanagh Street, Southbank VIC 3006
Fax: 03 9682 7353

OR email comments to Marde Hoy, NCIS Access Liaison Officer at the following address: mardeh@vifm.org