

Fact Sheet: Deaths in the Home (Australia 2003-2007)

Introduction

The home has been noted as one of the most common places for injury to occur for both young children and adults¹.

Four causes accounted for two thirds (66%) of all unintentional injury deaths in and around the home reported to a coroner in Australia during 2003-2007. These causes were falls, fire, drowning, and being hit/crushed by a vehicle². These four mechanisms of death will be the focus of this publication.



Major Findings

- Of the 1,992 unintentional deaths in the home included in this data set, 1,313 (66%) involved falls (n=738, 37%), fire (n=278, 14%), drowning (n=211, 11%) or being hit/crushed by a vehicle (n=86, 4%).
- Fatal falls in the home were most frequent in deceased aged 60 or over, while drowning deaths at home occurred most commonly in children aged under 10 (Table 1).
- House fire deaths occurred most frequently in young children and the elderly, with a similar age pattern seen in deceased hit or crushed by a vehicle in the home environment (Table 1).
- Among unintentional deaths in the home resulting from fire, hit/crushed by vehicle or falls, males comprised over 60%. Home drowning deaths occurred in about equal proportions in males and females (Table 2).
- The majority of home drownings involved in-ground swimming pools (49%) or bathtubs (32%) (Table 3). In half the drowning deaths, the deceased was at play or leisure, while over 30% of drownings occurred during bathing activities.
- At least 38 unintentional fire deaths in the home were the result of a lit cigarette
- 19 deaths occurred when males were crushed while working under a vehicle.
- 28% of unintentional fatal falls in the home (where the activity was known) involved home maintenance activities (n=128). 77 deaths involved the deceased falling from a height of more than 1 metre from a roof, balcony or ladder.
- 47% of unintentional fatal falls in the home from a height of more than 1 metre involved persons aged over 70 years (n=89) (Table 4).
- Alcohol intoxication was mentioned in the cause of death for 80 of the 1,135 deaths where the deceased was aged over 14 years of age (7%). Further research should be conducted by examining toxicology reports in detail to more comprehensively assess the proportion of deaths in the home in which alcohol intoxication may be a factor.

¹ Kidsafe Victoria indicates that over 60% of all child injuries in Victoria every year occur in the home (Media release, "Give your Children Safety this Christmas, December 11 2009, Kidsafe Victoria website. <http://www.kidsafevic.com.au> Accessed 23 December 2009). A report which examined all fatal injuries reported to a coroner during 2006 found 44% of all fatal injuries occurred at home (NCIS, unpublished, 2006 "Injury Mortality Data Report").

² Deaths which resulted from anti-social or violent behaviours undertaken in the home, such as drug taking or self harm were removed from this analysis. See Appendix 1 for more detailed information about case inclusion and exclusion criteria.

Methods and Limitations

The methods and limitations of this review are provided in Appendix 1 and the results are described in detail below. The results are followed by a brief introduction to the prevention of home injuries. Case examples of some of the most common and preventable examples of unintentional injury deaths in the home are provided in Appendix 2, together with coroners' comments and recommendations which have broad application. Links are also provided to additional home safety resources.

Detailed Results

Table 1. Four Mechanisms of Unintentional Deaths in the Home (2003-2007) by Age Group

Age Group (years)	Falls		Fire		Drowning		Hit/Crushed by Vehicle		TOTAL
	N	(%)	N	(%)	N	(%)	N	(%)	
0-9	6	(0.8)	40	(14.4)	98	(46.4)	25	(29.1)	169
10-19	5	(0.7)	13	(4.7)	7	(3.3)	2	(2.3)	27
20-29	12	(1.6)	17	(6.1)	15	(7.1)	3	(3.5)	47
30-39	31	(4.2)	25	(9.0)	18	(8.5)	8	(9.3)	82
40-49	63	(8.5)	38	(13.7)	17	(8.1)	10	(11.6)	128
50-59	78	(10.6)	31	(11.2)	11	(5.2)	11	(12.8)	131
60-69	112	(15.2)	33	(11.9)	14	(6.6)	7	(8.1)	166
70-79	172	(23.3)	34	(12.2)	15	(7.1)	7	(8.1)	228
80+	259	(35.1)	47	(16.9)	16	(7.6)	13	(15.1)	335
Total	738	(100)	278	(100)	211	(100)	86	(100)	1,313

Mechanisms of fatal unintentional injuries in the home varied with age group. Around 58% of all fatal falls in the home involve deceased aged 70 years or greater, while 46% of home drownings involved children aged under 10. Children under 10 years were also the most frequent age group for deaths after being hit or crushed by a vehicle, with those aged 80 or older the second most prevalent age group for such vehicle related deaths. House fire fatalities were spread more evenly across the very young, middle aged and older groups (Table 1).

Table 2. Unintentional Deaths in the Home (2003-2007) by Gender of Deceased

Gender	Falls %	Fire %	Drowning %	Hit/Crushed by Vehicle %
Male	64.0	63.7	50.2	70.9
Female	36.0	36.3	49.8	29.1
Total	100	100	100	100

Males featured more prominently in deaths from unintentional injuries at home in three of the four common causes of death, while drowning showed a more even gender distribution (Table 2).

Drowning



Of drowning deaths where the activity at the time of the incident was known (n=176), half of the deaths occurred while the deceased was engaging in leisure or play (n=90, 51%), while 58 drownings (33%) occurred during bathing or washing activities. Fourteen people died from drowning while undertaking household maintenance or chores, such as cleaning a swimming pool or gardening (during which they overbalanced or fell into a body of water).

More than half of all unintentional drowning deaths in the home involved a swimming pool, spa or hot tub (n =120, 57%), while more than 30% involved a bathtub.

Table 3. Unintentional Drowning Deaths in the Home (2003-2007) by Object

Object Type	Frequency	%
In-ground Swimming Pool	103	48.8
Bathtub	68	32.2
Above-ground Swimming Pool External Spa or Hot Tub	17	8.1
Fishpond/Ornamental Lake	9	4.3
Dam Lake Waterhole	3	1.4
Water Tank	3	1.4
River, Stream or Creek	2	0.9
Gutter, Drain or Kerb	2	0.9
Other	4	1.9
Total	211	100%

*Other objects include: shower, bucket, laundry tub, open drain or channel.

Fire

Of fire related deaths in the home where the activity was known (n= 191) 64% occurred while individuals were noted to be sleeping or resting (n=123), while 10% occurred while cooking (n=20). Children playing with flammable materials accounted for at least 7 deaths, and 2 deaths from fire occurred due to ignition of petrol while the deceased was undertaking vehicle maintenance. At least 38 deaths at home from fire during 2003-2007 (or 14% of all home fire deaths) were the result of a lit cigarette.



Hit/Crushed by Vehicle

Of those persons killed after coming into contact with a vehicle around the home where the individual's activity was known (n=69) 28% were males crushed when conducting maintenance work under a vehicle (n=19). Six deaths involving vehicle crushing/impact occurred while an individual was engaged in paid work at a home premises, and 25

infants or children were struck by a car in the driveway/yard of a home while playing or moving around in the vicinity of a vehicle. Forty adults (those aged over 18 years) were killed by a collision or impact with a vehicle in a domestic driveway (excluding those crushed while working under a vehicle), with 18 of these individuals aged over 65 years. In 7 of those cases the deceased was hit when the driver of the vehicle did not see the deceased or pressed the incorrect pedal, while on 9 occasions the deceased was hit by a vehicle which rolled when left in gear with no driver.



Falls

Of falls where the activity of the deceased was known (n=465), 28% occurred when the deceased was engaged in home maintenance or chores (n=128). This included gardening and working on the roof. Sixteen deaths from falls occurred while the deceased was performing paid work in the home, and at least 88 deaths involved falls while climbing or descending from stairs or steps. Sixteen people fell while washing/bathing.

Table 4. Unintentional Fall Deaths in the Home (2003-2007) by Type of Fall

Type of Fall	Age Group (yrs)	Frequency	%
On the same level	0-19	1	0.2
	20-59	36	6.9
	60-69	24	4.6
	70-79	41	7.9
	80 or older	86	16.5
	Sub-total		188
Involving Stairs/Steps	0-19	1	0.2
	20-59	31	6.0
	60-69	10	1.9
	70-79	27	5.2
	80 or older	19	3.6
	Sub-total		88
Less than 1 metre (excluding stairs)	0-19	4	0.8
	20-59	10	1.9
	60-69	7	1.3
	70-79	12	2.3
	80 or older	23	4.4
	Sub-total		56
Greater than 1 metre (excluding stairs)	0-19	5	1.0
	20-59	64	12.3
	60-69	31	6.0
	70-79	47	9.0
	80 or older	42	8.1
	Sub-total		189
TOTAL	All ages	521	100

Note: There were 217 instances of falls where the type of fall was unspecified or unknown. These are therefore not included in Table 4.

Table 4 indicates that of the cases where the type of fall was known (n=521), 36% percent involved falls on the same level, with the same percentage involving falls greater than 1 metre.

A quarter of falls from greater than 1 metre involved deceased aged between 70-79 years (n=47, 25% of falls greater than 1 metre) and the majority of falls from more than 1 metre in that age group involved males (83%).

Almost half of all fatal falls from the same level occurred in individuals aged over 80 years (n=86, 46% of same level falls).

Of falls greater than 1 metre, 24 deaths (or 13% of all falls from a height of more than 1 metre) involved the deceased falling from a roof or balcony. Fifty-three deaths involved a fall of more than 1 metre off a ladder (28% of such falls). The 70-79 age group had the highest number of falls from a ladder (n=18, 34% of ladder falls), while falls from a roof or balcony was most common in deceased aged between 20-59 years (n=11, 46%). A number of falls from balconies in the 20-59 year old group involved an alcohol level in the deceased detected above 0.1g/100ml (n=6).

Alcohol involvement

Of the 1,313 deaths in the home which are the focus of this report, reference to alcohol intoxication or abuse within the medical cause of death was made in 80 cases³. This is likely an under-representation of the actual number of cases where alcohol was a factor, as toxicology results were not manually reviewed for all 1,313 deaths due to time constraints, intoxication may have been incidental to the death and pathologists may not always reference alcohol as a factor, and some individuals may have died a number of days after the incident, meaning alcohol levels at the time of the incident are likely to be unknown.



Of the 80 cases where reference to alcohol intoxication or abuse (confirmed by BAC) were made in the cause of death, 18 cases involved drowning, 51 cases involved falls⁴, 10 cases involved home fire deaths and 1 related to a case where the deceased was hit/crushed by a vehicle.

There were an additional 14 cases where the involvement of alcohol was mentioned in the cause of death (intoxication, alcoholism etc.) however there was either no alcohol over 0.05g/100ml detected or no toxicology report available to assess the involvement of alcohol.

Prevention

A systematic approach to the prevention of both fatal and non-fatal home injury begins with data collection and analysis to identify patterns and trends and likely contributing

³ Where alcohol abuse was referenced in the cause of death, toxicology results were accessed to confirm a BAC of over 0.05g/100ml

⁴ Of the 51 falls where alcohol was mentioned in the medical cause of death, 11 involved falls down stairs, 13 involved falls on the same level, and 9 were falls from greater than 1 metre. In 18 of the instances, the type of fall was unknown.

factors. A chain of events leading to injuries can generally be identified, which includes factors related to the person, the product or structure that actually caused the injury and the physical and social environment. Breaking the chain of events at any point has the potential to prevent injuries.

Analysis of aggregated detailed data, such as that presented here, leads to specific problem identification and also identifies points for intervention. This public health approach complements the coroners' case-based approach.

Particular targets for prevention identified by the current review include: the establishment and maintenance of effective barriers to young children reaching hazards such as home swimming pools and areas of motor vehicle movement; supervision of young children around hazards at all times (e.g. bathtubs); safe practices for DIY activities or, alternatively, employment of a skilled tradesperson; effective safety devices present and maintained, including smoke alarms, electrical circuit breakers and keys in deadlocked doors when at home. For some hazards identified, such as stairs, further research is required to identify the specific problems that could be solved by design, barriers or other means. It is suggested that additional detailed research as to the influence of alcohol in deaths in the home be undertaken.

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Appendix 1

Method

About the NCIS

The National Coroners Information System (NCIS) is a national data storage and retrieval system for Australian coronial cases. Information about every death reported to an Australian coroner since July 2000 (January 2001 for Queensland) is stored within the system. The data is coded onto the system by coronial clerks within each jurisdiction and is checked for quality and accuracy by the NCIS Unit. The data stored on the system includes demographics about the deceased, details about the incident that led to the death, the medical cause of death and (if the death is due to a non-natural cause) the intent of the deceased and the object and mechanisms involved in the death.

Case Identification

The following criteria were used to identify deaths on the NCIS of relevance for this report:
All deaths reported to a coroner within Australia

- Where the date of notification was between 1 January 2003 and 31 December 2007,
- where the case was closed
- where the "Location Type 1" field was coded as "Home"
- where the definition met the external causes definitions used by the International Classification of Diseases

Exclusion of particular cases

- Cases were removed from the dataset if:
 - the intent on completion was Intentional Self Harm or Assault
 - the activity was self inflicted harm, drug taking activities, violent or aggressive activities or chroming/petrol sniffing.
 - the medical cause of death indicated drug toxicity, SIDS or exposure to asbestos.

Limitations

This data does not purport to be representative of every relevant death within the time period specified. Due to occasional processing and coding errors, missing data, and cases not being closed, it is possible that this data set may be an under-representation of the total of number of deaths. Only cases reported to a coroner in 2003 – 2007 inclusive which were closed on the NCIS at the time of data extraction were included in the scope of this report. There may therefore be some relevant deaths reported during 2003 – 2007, which are not included in this data set.

Appendix 2: Selection of Coronial Recommendations and Other Resources to Improve Safety In the Home

Drowning

Pool fencing

Circumstances:

- 1) Toddler dragged chair up to pool gate and standing on chair, opened gate, and accessed above-ground pool.
- 2) Toddler entered the swimming pool enclosure through one of the gates which was closed but not locked by the automatic safety devices. The automatic safety devices failed to operate correctly due to damage or wear of the devices or the gates.
- 3) Toddler gained access to an above ground pool surrounded by a wooden fence.

Comments/Recommendations:

- 1)
 - (a) That the Australian Standard pertaining to swimming pools and especially swimming pool gates and fences be reviewed, upgraded and inspected, to include a child resistant lock incorporating a vertical and horizontal locking mechanism.
 - (b) That all local authorities adopt a system to identify all properties in their local authority areas which have both in-ground and above ground swimming pools installed.
 - (c) That all local authorities be required by legislation to institute a regular system of inspection of swimming pools and surrounding structures to ensure compliance by pool owners.
 - (d) That the Real Estate Institute of Queensland and the Queensland Law Society review the standard contract of sale to provide a mandatory condition that a certificate of compliance and clearance be received from the local authority before settlement of a property at which a swimming pool has been constructed.
- 2) "I would recommend to all Local Government Authorities that consideration be given to implementing a system that swimming pool safety enclosures and gates be inspected as soon as practicable after the settlement of the sale of a property on which there is located a swimming pool in addition to their inspections conducted in accordance with law."
- 3) "That all properties offered for rent have a Local Council certificate stating that the swimming pool complies to the Australian Safety Standard and meets all other legislative requirements."

Drowning in the bath

Circumstances: Toddler (19mths) was briefly left in the bath with sibling (2.5 years).

[Authors note: Reference within the finding was made to a Royal Life Saving Society Fact Sheet titled "Bath Time Safety - KeepWatch and Keep them Alive." The Fact Sheet highlights important messages such as always supervising your child when bathing, never leaving them alone or leaving an older sibling with responsibility for supervision.]

Recommendation:

I commend the [above] program and urge government to support the various strategies which will need to be adequately funded if the message is to be heard and heeded.

Fire

General safety principles relating to house fires

Circumstances: Three children died when a home was accidentally set alight with a cigarette lighter.

Recommendations:

"In the interest of public safety I recommend that the peak Government Departments as well as private organisations involved with children and families promote the following issues in public awareness campaigns:

1. Adults must ensure that cigarette lighters are not accessible to children.
2. Parents should emphasise to children the potentially lethal human consequences of playing with cigarette lighters.
3. In the event of fire, all persons, particularly those in dependent situations such as children should be evacuated from the premises before attempting to combat the fire.
4. Occupants of the premises must ensure that all doors and windows can be opened in the event of an emergency.
5. Householders should be informed that lounges are made from highly flammable materials and, if set alight, the fire can be expected to develop most rapidly.

Additionally, I recommend that, in the interest of public safety, the Attorney-General consider, within a specified time period, by the operators of "back to base" alarm systems to owners of premises in the event that the alarm system becomes non-operational."

Smoke detectors & security devices

Circumstances:

- 1) An elderly man died in an accidental house fire most probably caused by an electrical kitchen appliance.
- 2) Housefire in which 2 people died. No smoke detectors were in the house and efforts to save the occupants of the house were impeded because of security screens at the front door and covering all the windows.
- 3) Middle aged male died in housefire, and was found in the laundry at the base of the rear door of premises, which was dead locked with no key evident in the lock.
- 4) An elderly female died in a house fire from which the origin was unable to be determined. The remnants of a hard-wired smoke alarm were found, however there was no battery located within the smoke alarm casing or nearby.

Comments/Recommendations:

1) "I feel it would be remiss of me not to make a recommendation that the public be reminded of the benefit of having a properly installed, maintained and working smoke detector in their premises".

2) "I recommend that the Australian Building Codes Board give consideration to including in the Building Code of Australia requirements in respect of security screens, deadlocks and other security devices which would ensure acceptable standards of safety in the event of fires and other emergency situations."

"I recommend that the Department of Housing and Works continue to work with FESA [Fire and Emergency Services Authority] with a view to determining whether it is practicable to amend Building Regulations 1989 so as to mandate the installations of smoke detectors within existing buildings in certain circumstances such as the time of property sale or the entering into of new leasing arrangements."

3) "I feel it necessary to comment on the dangers of dead locks and echo the strong recommendations of the Tasmania Fire Service that people who have dead locks fitted to doors have the keys in the locks at all times while at home to ensure a safe exit of the house in the case of an emergency."

4) "I note that whilst there was a smoke detector fitted in [the] home, it was probably not in a working condition. There is the possibility that had the smoke detector been in a working condition either [the deceased] or another person may have been alerted to the fire at an early stage. The sooner owners are required to install wired-in alarms the sooner the exposure to risk by the inadvertent failure to replace batteries in smoke detectors may be averted. It is to be noted for example, that in South Australia the new owner of any house purchased must replace battery-operated alarms with wired-in alarms. In the meantime, I **recommend** that the use of 10-year single purpose lithium battery in smoke alarms should be promoted [and] I **recommend** consideration be given to the introduction of and promotion of an even broader outreach give-away and installation program for low income households with young children and house-bound older people who may lack the physical capacity to properly maintain battery operated smoke alarms."

Fuse wiring

Circumstances: House fire in which a family of four died, thought to have been probably caused by some failure in a lighting circuit that was inadequately protected by the correct amperage fuse.

Comment/Recommendation:

"Electricians apparently find it fairly common that fuses are not repaired with correct amperage fuse wire. If a lower amperage fuse wire is used no safety problem is created but the situation is very different if one is used that exceeds the design amperage.

While the problem is largely overcome in new and substantially new electrical installations, there will be a very large number of houses that still rely for protection of both the power and lighting circuits on ceramic fuses. It is probable...lives were lost on this occasion because of incorrect amperage wire being placed in the fuse.

An excessive amperage fuse potentially has a two-fold effect. It not only masks the existence of a problem that probably created the initial need to replace the fuse, but it also allows for the circuit itself to bear a load in excess of that for which it was designed giving rise to possible deterioration or failure.

I **recommend** that electrical safety advertising be used to remind consumers of this important risk, and to reinforce warnings against such "handyman" repairs."

Flammable clothing and objects

Circumstances:

- 1) It is believed an elderly female was cooking on her gas stove when the sleeve of her dressing gown caught fire.
- 2) Four children died in a housefire after a polyurethane cushion was accidentally kicked into a radiant heater.

Recommendations:

- 1) "That the Fire Service agencies, Office of Gas Safety and Consumer Affairs Victoria review the standards for flammability warning labels on adult clothing".

"That the Fire Service agencies, Office of Gas Safety and Consumer Affairs Victoria review the issue of public warnings via a variety of agencies such as Senior Citizen organisations, gas distribution companies, insurance companies, etc."

- 2) **"To the Minister for Emergency Services**

The Minister should consider, and implement, the best means of publicising within the community the fact that polyurethane furnishings are highly flammable and that, in the event of fire, the first priority of householders should be to evacuate their homes. Additionally, every home should have an evacuation plan.

To the Minister for Fair Trading

Given the highly flammable nature of polyurethane furnishings, the Minister should consider the feasibility of mandating that a fire retardant be added to the products.

To the Minister for Community Services

It would be appropriate to ensure that caseworkers of the Department of Community Services are trained in the recognition of fire hazards such as radiant heaters and polyurethane lounges to facilitate their recognition of potential physical risks to children.”

Possible sources of ignition

Circumstances:

- 1) An elderly male died in a house fire, which was suspected to have been started by a lit candle.
- 2) Death of four children in a house fire, thought to have been started by a wood heater. The wood heater had a hole in the baffle plate, kiln dried off cuts of wood were used, and the air control was probably left open, which likely contributed to the heater and flue operating at a very high temperature. Clothing was also left hanging close to the flue.
- 3) An elderly male, who had a confirmed practice of leaving his electric blanket on all day on a high setting, died in a house fire. It is thought the practice of leaving the electric blanket on permanently initiated some form of combustion on the deceased’s bed.

Comment/Recommendations

1) “The burning of candles is potentially a high risk activity and has been the source of numerous house fires. This Court is aware of the fact that the Fire Services frequently warn the public about this high risk activity and supports regular public awareness campaigns”.

2) “I can only emphasise the need for anyone with a wood heater to ensure that it is installed correctly, remains in a serviceable condition and is operated in accordance with the manufacturer’s directions. I add my warning to those of many others that appropriate care and attention must be given when using heaters, be they wood fired or otherwise, to dry clothing. I encourage everyone to heed the various community service warnings and publications on this topic produced by Tasmania Fire Service and others”.

3) “This tragic outcome sadly serves to once again to illustrate the dangers of using electric blankets other than whilst they are in a serviceable condition and in accordance with the manufacturer’s recommendations. The community must recognise that fire safety advice provided at regular intervals by the Tasmania Fire Service and other community organisations is based upon a realistic appreciation of identified risks and that if persons choose to disregard such warnings they unnecessarily expose themselves, their family or others to risk of death or injury. This incident and the probable cause of the fire is evidence that these things can and do happen.”

“It was clearly a dangerous practice to leave an electric blanket on continuously. Additionally, I note the following recommendations made by the Tasmania Fire Service”:

“Electric blankets

- *Leave electric blankets on the bed all year round – or roll them up for storage as folding them may cause damage to the wiring.*
- *Make sure your electric blanket is laid flat and tied firmly to the bed.*
- *Always switch the blanket off before going to bed or leaving the house.*

- *Sleeping with your electric blanket on is dangerous. Your body weight may cause the blanket to over-heat, damaging the wiring and starting a fire.*
- *Placing heavy objects on your electric blanket can cause spot heating or damage the wiring and start a fire.*
- *Run your hand over the blanket regularly. If you suspect spot overheating, turn it off and have the blanket checked by an authorised repairer or replace it.”*

Falls

Fall from a height while undertaking home maintenance

Circumstances:

- 1) The deceased was fixing the roof of his pergola at home, when it appears he fell through the “laserlite” (fibreglass type corrugated roof sheeting) skylight section of the pergola, 3.3 metres to the ground below.
- 2) An elderly male had constructed a home made scaffold on which he was working to prepare a window for painting. He had been working without a break for 2 hours when he stepped on one end of the plank he was using, which tipped up and caused the deceased to fall approximately 3 metres to the ground below. The deceased was wearing a helmet, however it came off in the fall.
- 3) The deceased was a male in his 50's, who as a self employed handyman was hired to perform general cleaning work at a premises. While attaching a wooden board to a pergola while standing on a ladder, the deceased fell from the ladder and was found on the ground.

Comments/Recommendations:

- 1) Worksafe in consultation with the State Coroner’s Office undertake research to identify the prevalence of individuals (whether at home or work) falling through roofs or fibreglass type skylights with a view to identifying countermeasures.
- 2) “Although Australian Standards have been primarily developed for the workplace, they represent best practice in safety generally. People involved in working on home maintenance should aim to follow these standards as closely as possible in order to minimise the risk of injury.

Based upon advice received from officers of Workplace Standards Tasmania in the course of this investigation, I would recommend that the following safety precautions are taken before embarking on domestic maintenance work:

- *Take care to comply as far as possible with any Australian Standard applicable to the task at hand so as to reduce the risk of injury or death. Members of the public are encouraged to seek advice by telephoning the Workplace Standards Helpline on 1300 366 322. Copies of publications to assist with safety, such as use of ladders and working at heights, are available by request through the helpline or via the Workplace Standards website at www.wst.tas.gov.au.*
- *Take regular breaks from the work. As a general rule a break of approximately 10 minutes every hour is advisable. This could vary depending on many factors such as age and physical make up. Many persons working on or around their homes are prone to work for long periods to achieve their desired objective. Regular breaks reduce the*

- fatigue that may cause a loss of concentration. This precaution becomes more important for persons in the older age group.
- *Realistically assess physical capability to perform the work.* Consider whether any particular physical or mental limitations or disabilities may give rise to safety concerns or risk of injury in any given task. Review carefully whether the work can or should proceed safely in light of any such limitations.
 - *Conduct a risk assessment.* That is, take time before commencing to identify potential safety hazards in the proposed work. It is important to also consider in this assessment the “worst case scenario” in respect of potential for injury. Steps should then be taken to minimise the risks of the occurrence of those events. In the event of uncertainty as to the best response to the risk, members of the public are welcome to contact Workplace Standards for assistance.”

3) “It is recommended that industry bodies research the possible links between mens’ health, prescribed medications and risk factors for falls from heights based on the number of incidents now being identified.

It is further recommended that industry bodies reinforce the need to secure ladders to make them safe from slipping; to use fall restraint systems and communicate the increased risk to workers of working alone.”

Falls from balcony/decking

Circumstances: The deceased fell an estimated 2 metres when the top rail of a balcony decking gave way. The investigation revealed the balcony had been constructed by the owner, in a manner different to that outlined in permits issued, and did not comply with building regulations. The completed works were also not inspected by the Council.

Comments/Recommendation:

“It would appear that had the balcony railings been built with more care this accident is unlikely to have occurred. It should be a reminder to all builders and home renovators of the paramountcy [sic] of safety considerations when building or renovating.”

Additional “Safety in the Home” Resources

- South Australian Government – “*Safety in the Home*” webpage www.sa.gov.au
- MUARC. (2005) “Preventing Home Fall Injuries: structural and design issues and solutions”. *Hazard*, Edition 59. Available online from: <http://www.monash.edu.au/muarc/VISU/hazard/>
- ACCC. (2009) “*Fire Safety at Home: Be Prepared*”. Booklet. Available online from: <http://www.accc.gov.au/content/index.phtml/itemId/762546>
- Royal Children’s Hospital Melbourne, Safety Centre. (2008). *Home Safety Checklist*. Online publication available from: http://www.rch.org.au/safetycentre/checklist/index.cfm?doc_id=1734
- Victorian Government, Better Health Channel (2009). “Falls prevention for older people” website. Accessible from: [http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/\(Pages\)/Falls_prevention_for_older_people?open](http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/(Pages)/Falls_prevention_for_older_people?open)
- The Royal Life Saving Society of Australia have several fact sheets which provide guidance about how to reduce the risk of drowning in the home. These can be accessed from <http://www.royallifesaving.com.au/www/html/156-fact-sheets.asp>

DATA SOURCES

Data on the NCIS has been provided by each State and Territory Coroner's Office around Australia.

Additional codes are also provided by the Australian Bureau of Statistics (ABS)

 	 <p>ACT Magistrates Court and Tribunals</p>
	 <p>Coroner's Court of Western Australia</p>
 	<p>COURTS ADMINISTRATION AUTHORITY SOUTH AUSTRALIA</p>
	 <p>Coroners Court of Victoria</p>

Note: In some States/Territories the Coroners Office is part of the Magistrates Court

FUNDING AGENCIES

Operational funding for the NCIS is provided by the following agencies:

- Each State and Territory Justice/Attorney-General's Department
- Australian Department of Health and Ageing
- Australian Institute of Criminology
- SafeWork Australia
- Australian Competition and Consumer Commission
- Australian Department of Infrastructure, Transport, Regional Development and Local Government