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Fatal Facts

A Publication of the National Coroners Information System

Edition 12 (April 2007)

This edition of Fatal Facts features 71 coronial cases where recommendations have been made. These cases were closed by a Coroner between 1 August 2006 and 31 December 2006.

Several recommendations were made regarding aircraft crashes, therefore we have decided to highlight the related cases in detail.

If you wish to seek further information regarding any of the cases contained in this edition, and you are an authorised NCIS user, it is recommended that you visit the NCIS website (www.ncis.org.au). 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 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 at ncis@vifm.org.

Jessica Pearse
Manager, NCIS.

NCIS at a glance

- Number of cases on the NCIS (notified to a Coroner between 1 July 2000 and 31 December 2006 inclusive): 121,227
- Number of findings on the NCIS for cases closed by a Coroner between 01/08/2006 and 31/12/2006: 3,206
- Number of cases with recommendations (closed by a Coroner between 01/08/2006 and 31/12/2006): 71

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 they are not authorised summaries or exact replications of coronial findings. The original finding should always be accessed if it is intended to refer formally to it.

Case No:

QLD.2002.1570, 1594, 1595, 1596, 1597 & 1598

Date of Finding: 7 September 2006

Coroner: State Coroner Michael Barnes

Summary

Inquest into the deaths of 6 persons in a single-engine Piper Cherokee Six aircraft crash when the aircraft crashed into a quarry at the end of the runway on Hamilton Island.

The aircraft took off from Hamilton Island on a charter flight to Lindeman Island, about 15 km to the southeast. On board were the pilot and five passengers.

The engine of the aircraft began malfunctioning soon after take off. The plane banked steeply, before the engine cut out and the aircraft fell to the ground, approximately 300 metres to the west of the runway.

Recommendations:

1. Warning to Cherokee 6 operators.

As fuel tank selector misalignment had been identified as the most likely proximate cause of this incident (and a factor in 35% of all reported safety incidents involving this aircraft type), the Coroner recommended that CASA reconsider whether it has adequately responded to this risk and whether a more definitive and targeted reaction is warranted.

2. Regulatory surveillance of chief pilots duties

The Coroner recommended that CASA consider requiring AOC holders to demonstrate that their work practices will not unduly impinge on their chief pilot's ability to discharge the supervisory aspects of the position and that checking of this be made part of CASA's audit or surveillance processes.

3. The securing of evidence

The Coroner recommended that police officers to whom aviation deaths are reported should record the contact details of all potential witnesses and a précis of the evidence they may be expected to be able to provide. They should liaise with the investigating coroner at an early stage to allow a determination to be made as to the extent to which witnesses should be interviewed by coronial investigators.

Case No:

QLD.2003.1856 (also 1855 & 2579)

Date of Finding: 14 October 2005

Coroner: Annette Hennessey

Summary

Inquest into the deaths of three persons during a medical retrieval flight when the helicopter (a Bell 407) crashed into the sea approximately 3.2 nautical miles east of Cape Hillsborough near Mackay in Queensland.

The helicopter (with a pilot, crewman and paramedic on board) was deployed from Mackay Airport to medivac an injured person from Hamilton Island. When the aircraft failed to arrive a search was initiated. Wreckage of the helicopter was located at Sand Bay, approximately 14.5 nautical Miles NNW of Mackay.

Recommendations:

1. The Department of Emergency Services should give serious consideration to upgrading the requirement for community helicopter providers that the primary aircraft used in the service be a twin-engine IFR rated helicopter where at all possible, and that there be restrictions on the use of single-engine VFR rated helicopters in line with the inherent limitations of those aircraft.
2. That there be a requirement in service agreements with community helicopter providers that pilots in command be IFR qualified and that their competency and recency be maintained in accordance with Queensland Rescue current practices.
3. That where VFR aircraft are utilised by community helicopter providers that primary aircraft should be twin-engine, and that there be a requirement for a standby artificial horizon with separate power and autopilot or stability augmentation system fitted to the aircraft as a minimum requirement for community helicopter providers.
4. That there be a requirement in the service agreements with community helicopter providers that there be competency-based review of pilots' night VFR skills on a regular basis.
5. That the Queensland Government increase funding to community helicopter providers commensurate with the increased requirements already imposed on the community helicopter providers, and those recommended herein, with a view to community helicopter providers being in a position to provide a similar quality service to the State run EMS service across the State.

Case No:

QLD.2003.1856 (also 1855 & 2579)

Recommendations - continued:

6. That the Department of Emergency Services foster and encourage in the community helicopter providers a more proactive approach to aviation standards, and build an organisational culture of operating beyond bare compliance with regulations, particularly performance-based regulations, with a view to improve safety.

7. That the service agreements between the Department of Emergency Services and community helicopter providers provide for the department to facilitate formal and regular liaison, training, policy development, and other contact between the Department, Queensland Rescue, and community helicopter providers on operational and other relevant matters. There should be similar operating procedures, as far as possible, to allow for a consistency in approach to reflect that in the present clinical co-ordination system, and an equitable service and working environment across the State.

8. That to reflect the increase in funding to community helicopter providers, and in order to further improve safety, the service agreements between Department of Emergency Services and community helicopter providers include a clause to permit the department to require audits by appropriately qualified independent auditors, and that auditing periods be of a frequency consistent with industry standards.

9. That Hamilton Island Management and Lewin Group Holdings give serious consideration to the provision of a capability on Hamilton Island for overnight care of patients who may be required to be provided care until appropriate EMS transport can be safely provided.

10. That the Queensland Ambulance Service, Queensland Health, and island management companies and communities investigate the appropriateness of undertaking an analysis of facilities for first-aid, emergency assistance and medical facilities on residential and resort islands referable to workload and patient needs, and taking into account use of EMS transport for them.

11. That Department of Emergency Services conduct a review of helicopter services and their aero-medical capabilities available on Hamilton Island, water-based transport available in the Whitsunday Group suitable for EMS use; and conduct an assessment of any need for the extension or addition to the existing community helicopter provider, EMS Service.

12. That CASA consider regulating for the initial training of a helicopter pilot to include night VFR training.

13. That CASA and the industry move towards a national system of accreditation and uniform standards for provision of EMS services in Australia.

14. That CASA investigate reclassification of EMS helicopter operations into charter category, or create a separate EMS category of aviation in order to provide the benefits of increased level of regulation and CASA oversight, than that presently available under the aerial work category.

15. That CASA ensure that appropriate information be provided to pilots on an ongoing basis regarding the issue of spatial disorientation.

16. The Coroner supports CASR draft regulations point 61 and 133 becoming final.

17. That beacons, both visual and radio, be placed on prominent and appropriate high points along routes commonly utilised by aero-medical retrieval teams, including Cape Hillsborough.

18. The Coroner supports the ATSB recommendations 20030213, review night VFR requirements and promulgation of information to pilots; 20040052, assessment of safety benefits of requiring a standby altitude indicator with independent power source in single pilot night VFR; 20040053, assessment of safety benefits of requiring an autopilot or stabilisation augmentation system in single pilot VFR; and R20050002, review operator classification and minimum safety standards for helicopter EMS operations.

19. That Hamilton Island management give consideration to financial support of CQ Rescue further to that already detailed, in much the same way as other communities and major corporations in the region provide financial support.

Case No:

WA.2003.1220, 1221, 1222 & 1223

Date of Finding: 18 August 2006

Coroner: State Coroner Alastair Hope



Summary

A R44 helicopter on a charter flight crashed in inhospitable terrain approximately 42.6 kilometres north west of Kununurra on return from a fishing expedition. As a result of the crash the pilot and three passengers died.

Recommendations:

1. That in respect of private providers of aerial services to Western Australia Police, regular audits be conducted to ensure that effective response can be achieved by those providers.
2. That arrangements be put in place which would enable the emergency co-ordinator to liaise directly with the private providers of aircraft to police to avoid possible delays involved in making arrangements through the Police Airwing.
3. That arrangements be put in place to ensure that all police officers transferred to country regions receive adequate training in respect of emergency plans and that in the case of officers stationed in country locations for extended periods, that adequate refresher courses be undertaken.
4. That WA Police acquire suitable searchlight facilities or ensure that private contractors can provide such facilities so that night searches can be conducted in the event that an aircraft crash or similar incident occurs at night and there are survivors.
5. That CASA take steps to ensure that pilots working for commercial operators complete reliable flight note details which provide sufficient information to ensure that maximum take off weights are not exceeded.
6. That for aircraft where there is a relatively small safety margin in respect of weight and balance issues, that commercial operators should ensure that issues relating to the weight of passengers are addressed prior to accepting bookings.
7. That CASA require commercial operators of aircraft to retain all relevant manufacturer safety notices in their Operations Manuals and in the event that any safety notice is not to be complied with by the operator, that the manual also contain a document indicating that the notice is not to be complied with, the extent to which the notice is not to be complied with and the reason for that non-compliance.
8. That CASA consider whether there should be additional requirements for pilots carrying passengers for reward in remote and potentially hazardous environments in addition to the requirement to hold a commercial pilot licence so as to ensure that those pilots are well trained and experienced.

Other aviation related recommendations contained on the NCIS (excludes hang-gliding, paragliding and parachuting):

NSW.2001.2175 - ultra light (unspecified)
NT.2000.295 - single engine Piper Warrior
TAS.2003.113, 114, 116, 117 - Cessna 172
TAS.2004.95 - Aero Commander 500-S (Shrike)
VIC.2001.2957 - Cessna 172
WA.2001.1604, 1605, 1606 - Cessna C310R

Child Deaths

<p>NSW.2003.3573</p>	<p>Autistic child asphyxiated by mother.</p> <p>Recommendations:</p> <p>To the Minister responsible for the Department of Ageing, Disability & Home Care</p> <ul style="list-style-type: none"> •That consideration be given to the allocation of funding to be ear marked specifically to provide services to severely disabled children and their parents (particularly children with an early diagnosis of autism) at the earliest possible time by means of early intervention. Such funding should identify the need for early intervention in regard to such services as speech therapy, motor and communication skills in order to provide the best window of opportunity for such children to reach their maximum potential. Such services should also identify the needs of the parents in regard to respite, counselling and continuing support. •Consideration be given to implementing a system through which children with severe disabilities (such as autism) who are being cared for by their parents have their specific needs assessed and where appropriate allocating a case worker to assist and support the child and family in regard to accessing available and necessary services. <p>To the Minister's responsible for Department of Community Services, Department of Ageing, Disability & Home Care, Department of Education & Training</p> <ul style="list-style-type: none"> •That consideration be given to setting up a working party at a high departmental level, to consider how relevant inter agency information may be shared in a timely manner. Any such working party should consider the Ombudsman's report of May, 2006, to Parliament titled "Services for Children with a Disability and their Families". Any such working party might also consider the report prepared for the Deputy Ombudsman by the Department of Community Services, Child Deaths and Critical Reports Unit in regard to the Inquest into the death of (1276/2003). •That the Registrar of my Court order a transcript of the evidence and forward it to the appropriate Ministers with my findings and recommendations.
<p>SA.2004.382</p>	<p>The deceased (aged 13 years) became unwell approximately 2 weeks before her death, suffering from a headache, elevated temperature and vomiting. Her GP suspected a urinary tract infection, with hospital tests supporting this diagnosis. Despite an offer of admission to the hospital, the deceased preferred to go home. She was given an injection in her left leg of Stemetil, and a prescription for trimethoprim tablets.</p> <p>Four days later the deceased remained unwell, and awoke unable to move her left leg and had spasms in her left arm. She returned to the [-] Health Service that night, and was transferred by ambulance to the [-] Medical Centre for further assessment.</p> <p>After an extensive assessment, it was decided that the deceased needed to be transferred urgently to the [-] Hospital. This was done via ambulance. On arrival at the [-] Hospital, the deceased was found to have suffered a major deterioration in her neurological status. Despite extensive treatment as the [-] Hospital, she died approximately 9 days later.</p> <p>Cause of death: cerebral oedema and infarction secondary to extensive subdural empyema.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the Department of Health give consideration to the development of a policy under which practitioners at hospitals such as the [-] Health Service should if they have any doubt as to whether a paediatric patient may require neurosurgery, give serious consideration to sending the patient direct to the [-] Hospital in the first instance rather than to the [-] Medical Centre.
<p>SA.2004.1099</p>	<p>The deceased (aged 16 years) had a family history of asthma. In the years prior to her death the deceased complained of a dry cough, coughing fits associated with vomiting, and 'nocturnal wheezing'. One doctor diagnosed viral pharyngitis, and others provided her with a prescription for a Ventolin inhaler. When her coughing failed to improve after using the Ventolin puffer, the deceased tried 'over the counter' cough medicines. Her condition worsened in the month prior to her death, with presentations made to her local GP and [-] Hospital. She experienced difficulty breathing, and passed out in the car on the way to hospital. She arrived at hospital and remained in Intensive Care, unconscious and unresponsive until her death.</p> <p>Cause of death: Acute asthma (hypoxic encephalopathy).</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That all medical practitioners who manage patients with asthma have available to them spirometry testing equipment either in their clinic or in some convenient location which enables lung function testing to be conducted when necessary and without delay. • That where spirometers are not yet available in Accident and Emergency Departments of metropolitan and regional hospitals, that they be acquired as a matter of urgency and that medical and nursing staff be provided with appropriate training to conduct spirometry where necessary. • That the Minister for Health explore ways to facilitate the development of systems in regional areas for 'continuity of care' for patients who are seen by 'on-call' practitioners in Accident and Emergency Departments of local hospitals and are referred back to their general practitioners for follow-up.

Deaths in Custody

NSW.2005.870	<p>The deceased (in Corrective Services custody) had a history of chronic renal failure which required dialysis three times a week. On the day of his death the deceased was located in his cell with blood tinged frothing around his mouth. Nursing staff administered oxygen however he was not responsive and was conveyed to Hospital whereby the life was pronounced extinct. Cause of death: Intra-cerebral haemorrhage due to hypertension and chronic renal failure, a natural cause.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the Department of Corrective Services considers relocating all Cell Call Alarms in gaol hospital wards, clinics, detoxification wards and the like, to positions adjacent to beds so that seriously ill prisoners can activate them from such beds.
QLD.2003.1372	<p>The deceased was sentenced to six months imprisonment for breaches of domestic violence orders. He was taken into custody and held at a watch house. At that time he appeared to be in good health, did not appear to be affected by liquor and did not complain to police of any illness or injury. The next morning he was lying on a bench in a communal cell when he was seen to convulse, fall to the ground, continue to fit, and lapse into unconsciousness. Despite attempts by an ambulance officer who soon arrived, he was unable to be resuscitated.</p> <p>Cause of death: Sudden unexpected death in epilepsy.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the QPS, liaise with the Director of Queensland Health's Clinical Forensic Medicine Unit to review the most effective way to identify and respond to alcohol withdrawal risk among watch house detainees with particular attention to the special needs of remote watch houses.
SA.2003.3167	<p>At the time of his death the deceased was detained pursuant to the Mental Health Act (after voices told him to crash his car into a parked vehicle). The deceased was assessed, with a diagnosis made of 'psychosis - acute'. He was detained for a period in a psychiatric ward, was referred for a CAT scan, an EEG, and urine tests, and was prescribed risperidone. The results of the EEG were abnormal, however the EEG Telemetry Unit received no further contact from the psychiatric team in relation to this. Instead, amongst other things, sodium valproate was prescribed, and the deceased was discharged to the 'Hospital at Home' program for ongoing treatment. One week later he was readmitted with a worsening condition. A brain perfusion study was conducted with a diagnosis of brain death.</p> <p>Cause of death: Acute Dopamine Imbalance Syndrome</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the [-] Hospital re-emphasise the need for full and appropriate interaction between those two disciplines (the treating psychiatrists and the neurology departments) in appropriate cases. • That the Forensic Science Centre should identify, in all toxicology reports, the date and time at which the sample being tested was taken, and that, where in any case that has been the subject of a coronial post-mortem examination, toxicology tests are carried out, a report of those tests be provided to the State Coroner.
SA.2002.2629 & SA.2003.964	<p>The deceased was detained after strangling his girlfriend. Over the next 5 months the deceased was detained firstly at the [-] Hospital, and then at the [-] Remand Centre. He was located by correctional services officers in his cell when it was unlocked that morning.</p> <p>Cause of death: suffocation by plastic bag.</p> <p>Recommendations:</p> <p>The Coroner noted that the Prison Health Service is not the subject of specific statutory recognition, and considered that some advantage might be obtained by a statutory codification of the existence and role of the Prison Health Service. Further, some relaxation of the ordinary obligations of confidentiality imposed upon a medical practitioner might be provided for in such a code if the provision of information were in the best interests of the prisoner. A statutory codification of the Prison Health Service might also afford an opportunity to modify the relationship of the health service to the prisoner in a way better designed to recognise the realities of the prison system than the current approach which is largely based upon the same system which applies to persons who are not imprisoned.</p> <p>The Coroner therefore recommended:</p> <ul style="list-style-type: none"> • That the Department for Correctional Services gives consideration to the introduction of measures of the kind referred to above. • That the Department of Health gives consideration to the introduction of measures of the kind referred to above.
SA.2004.397 & SA.2004.2938	<p>Joint inquest into the deaths of two men (in separate incidents) from hanging at a Remand Centre. Common features surrounding the deaths included the following: both men died 5-6 weeks after being brought into custody at the Centre, had expressed thoughts of self-harm to staff, were housed in mainstream units in doubled up—shared cells, and the hangings took place when the respective cellmates had been removed to attend Court. On both occasions officers first in attendance did not have at their immediate disposal a Hoffman knife, which would have assisted in removing the ligature in a timely fashion.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That on the assumption that the Government has no intention in the foreseeable future of providing funding for the upgrade of prison cells to comply with "safe cell" principles, the Minister for Correctional Services seek funding to convert a portion of the existing facilities in such a way as to provide safe and humane "special needs" units in each custodial institution for the accommodation of those prisoners requiring this type of management. • That all Correctional Service officers who have contact with prisoners in South Australian prisons and the Remand Centre be provided with a Hoffman knife and have it in their possession ready for immediate use whenever they are working with prisoners.

Deaths in Custody—cont

SA.2004.983	<p>The deceased was found collapsed with a shoelace tied around her neck, attached to wire mesh in the female exercise yard of the [-] Cells.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the Government continue to do what is necessary to facilitate access by operational police officers to the National database Person Profile system to enable checks to be conducted concerning a prisoner's potential risk of self-harm. • That the holding cell facilities at the [-] Cell Complex be upgraded to provide toilet and water facilities, together with more appropriate seating and emergency intercom devices. The facilities should incorporate a measure of privacy which is consistent with the requirement to maintain adequate supervision.
SA.2004.3039	<p>The deceased threw himself in front of a truck after absconding from the [-] Hospital. He was transferred to hospital where he underwent surgery and was placed on life support. A decision was then made to switch off life support. Multi organ failure due to consequences of multiple injuries.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That provision be made to increase the number of closed ward extended care beds available at [-] Hospital (or a suitable alternative facility), for persons with chronic mental illness who have not responded sufficiently to treatment in an acute facility and who are deemed unsuited to management in the community. • That administrators and senior nurses in acute psychiatric facilities examine their observation policies and practices to ensure that patients who have been detained in these facilities and have not been granted leave in the community, are adequately supervised.
Drowning	
NSW.2005.5219	<p>The deceased drowned in the [-] River. At the time of his death he was running away from Police (after breaking into a hotel).</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • (To the [-] Shire Council) that consideration be give to the erection of an appropriate sign or signs on those parts of the [-] River where it is likely those members of the public may picnic or enter the river to bathe. Such signs could either in words or signs draw to the attention of the public the possible dangers of swimming in an area of weed infestation.
TAS.2005.447	<p>The deceased fell into the water while attempting to climb aboard his yacht. The deceased was significantly intoxicated at the time.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the management of the [-] Hotel and in fact all licensed premises examine the criteria they use in determining whether a patron is or is not “drunk” within the meaning of the legislation. In the interests of the individual and of society generally, the requirements of responsible service of alcohol must be honestly and properly applied.
Drugs or Alcohol	
TAS.2005.447	<p>The deceased fell into the water while attempting to climb aboard his yacht. See above.</p>
TAS.2006.292	<p>One to two days prior her death, the deceased took a quantity of alcohol and drugs with the intention of taking her own life. That act precipitated her aspiration pneumonia and subsequent hypoxic brain damage which resulted in her death.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • The Coroner noted the suggestion of the State Forensic Pathologist that the [-] Hospital undertake a review of its toxicology procedures for patients admitted for treatment of drug overdose. ‘In this instance, had comprehensive toxicology been obtained or at least blood samples retained, the Pathologist would have had access to information which could have better enabled him to opine upon the role played by the drugs in (the deceased’s) death. • The Coroner accepted the Pathologist’s suggestion and recommended that the [-] Hospital undertake a review of its toxicology procedures for cases of this nature and that such revision include consultation with the State Forensic Pathologist.

Drugs or Alcohol—cont

VIC.2003.9	<p>Cause of death: Combined drug toxicity (Benzhexol, together with significant levels of analgesics, benzodiazepine and antipsychotic medications).</p> <p>The deceased had a history of mental illness, with four psychiatric admissions, and later treatment from local GP's. During the inquest the Coroner found that the death was contributed to by patient management difficulties, including the following: the GP's had not obtained or sought to obtain a Discharge Management Plan following the last inpatient admission of the deceased; the deceased prohibited his doctors from discussing or liaising with his family about his condition; the deceased refused to co-operate in referral to specialist psychiatric services; and the deceased persisted in regulating his own intake of medications.</p> <p>Recommendations: That bodies associated with pharmacists, G.P's and psychiatrists disseminate information, pertaining to:</p> <ol style="list-style-type: none"> 1) The existence, risks and dangers of abuse of anticholinergics, particularly Benzhexol. 2) The forming of strategies to deal with potential abuse of medication, including but not confined to <ol style="list-style-type: none"> a) Weekly or even daily dosage dispensing, subject to preservation of a workable practitioner-patient relationship. b) Use of blister packaging and dosettes as aids for regular and orderly consumption by patients, where possible. c) The benefit, and promotion of regular consultation between pharmacists and prescribing practitioners where any abuse or overdosing risks are perceived. d) Whether the PBS authorisation or practice of prescribing dosage of 200 Benzhexol with repeats should be reviewed and reduced. <p>The Coroner also directed that such bodies report their response and action taken to him as a result of this finding, within a period of 3 months, and that the finding be distributed together with a copy of relevant published articles (see below).</p> <ol style="list-style-type: none"> a) The 1984 British Medical Journal article b) The Sydney "Psychiatric services" article from 2000 c) The Forensic Science International article
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Fires, scalds or burns

TAS.206.98	<p>Combined effects of smoke inhalation due to a house fire and acute alcohol intoxication.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • The Coroner echoed the 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.
VIC.2005.1793	<p>The deceased, aged 92, suffered a fall in the shower of his home. He suffered scalding injuries from the hot water of the shower to an estimated twenty five percent of the body surface area.</p> <p>Recommendations: The Coroner indicated that the death from scald burns could have been prevented by the use of an approved anti-scald device such as a Thermostatic Mixing Valve, and that the case underscored the necessity for government and community safety agencies to undertake further work in this area.</p> <p>The Coroner also supported the following recommendation on scald prevention contained in "Fire, Contact Burn and Scald Injury Fatalities among Children (0-9 years) and Seniors (70+ years) in Victoria, 2000-2003" [a research report compiled by Ms. Lyndal Bugeja for the State Coroner's Office and the Department of Human Services]:</p> <ul style="list-style-type: none"> • "Renewed effort should be made to convince all householders to lower the maximum temperature of hot water delivered to bathroom outlets to 50 degrees Celsius."

Intentional self-harm

SA.2002.2629 & SA.2003.964	Suffocation by plastic bag. See page 6.
SA.2004.397 & SA.2004.2938	Joint inquest into the deaths of two men (in separate incidents) from hanging at a Remand Centre. See page 6.
SA.2004.3039	The deceased threw himself in front of a truck after absconding from Hospital. See page 7.
TAS.2006.292	One to two days prior her death, the deceased took a quantity of alcohol and drugs with the intention of taking her own life. See page 7.

Intentional self-harm—cont

NSW.2003.6374 & 6375	<p>Husband shot his wife, and then himself.</p> <p>Recommendations:</p> <p>To the Commissioner of Police</p> <ul style="list-style-type: none"> • An education/communication plan should be implemented to inform all police involved in the preparation of bail reports of the necessity of ensuring that all outstanding court matters are updated prior to the presentation of the criminal history in court. <p>To the Attorney General and Commissioner of Police</p> <ul style="list-style-type: none"> • Consideration should be given to the introduction of a system whereby a Statement of the Victim of a "serious personal violence offence", outlining that person's concerns for her/his personal safety if the accused is released on bail, must be taken into account by a court on a bail application in respect of that offence. • Consideration should be given to devising and implementing a process whereby the Officer in Charge of the investigation into a "serious personal violence offence", or the senior police officer at his station, is notified immediately when the person accused of that offence is released on bail so that the victim can be alerted. <p>To the Premier</p> <ul style="list-style-type: none"> • In recognition of their attempts at intervening to assist (the victim) while she was being attacked and shot and, thereby, placing their own lives at risk when confronting an assailant armed with a gun, the Coroner nominated 3 persons who should be commended and considered for bravery awards.
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Interpersonal violence

NSW.2003.3573	Autistic child asphyxiated by mother. See page 5.
NSW.2003.6374 & 6375	Husband shot his wife, and then himself. See above.
NT.2004.263	<p>The deceased died from complications of a stab wound to the chest (inflicted by her husband).</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the Chief Executive Officer of the Department of Health & Community Services, and the responsible Chief Medical Officer(s) review the performance of Dr (-) in relation to this matter and provide appropriate professional mentoring, counselling and direction to him.
NT.2005.125	<p>The deceased was beaten to death by her husband. The husband was on parole at the time, having been released from prison approximately a year and a half earlier (after serving time for earlier assaults on the deceased).</p> <p>Recommendations:</p> <p>The coroner considered whether a system of mandatory reporting should be introduced requiring health professionals to notify police of incidents of domestic violence that come to their attention in the course of their professional responsibilities. There was insufficient material before the Coroner though for him to embark upon making recommendations to that effect.</p> <ul style="list-style-type: none"> • The Coroner did however commend to government the system that now exists for the mandatory reporting of sexual offences by health professionals and recommended that a similar such system relating to circumstances of domestic violence be made the subject of discussion and review by government. • That the measures outlined by (Acting General Manager of Community Corrections Northern Territory Correctional Services) are carried out. • That a review take place concerning the training needs of officers and appropriate levels of qualifications.
SA.2002.2629 & SA.2003.964	Suffocation by plastic bag. See page 6.

Interpersonal violence—cont

SA.2001.2423 & SA.2003.986	<p>Joint inquest into the deaths of two men killed by persons who had been diagnosed with a mental illness and had previously been managed by the State's Mental Health Service.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the Government give serious consideration to the re-establishment of a Centre of Excellence in Psychiatry. • That provision be made to increase the number of hospital beds available for patients with mental illness, to facilitate acute management as well as medium and long-term management. • That the Minister for Mental Health consider abandoning the system which requires patients to be transferred during one episode of illness from one hospital to another for the purpose of being housed in an open ward prior to discharge. • That the Minister for Mental Health do what is possible to secure dedicated residential accommodation in areas supported by community health workers, for patients with chronic mental illness who are deemed capable of living in the community, but who pose a potential risk of violence to members of the community when they become unwell. • That the Government consider amending the Mental Health Act (1993) to broaden the scope of Community Treatment Orders to require that a person resides in an area serviced by Community Mental Health Teams. • That where non-compliance is considered a potential problem, random testing be conducted both in hospital and post-discharge, to monitor levels of prescribed oral medication for patients suffering mental illness. • That the Government allocate more resources to the Community Health Teams which are required to monitor patients subject to Community Treatment Orders. • That the Government consider negotiating with interstate Ministers for Mental Health with a view to addressing the jurisdictional limitations to Community Treatment Orders. • That the Government consider amending the Mental Health Act (1993) with a view to enabling psychiatrists to order a further period of detention for patients who may not appear acutely psychotic, but require a longer period in hospital to clarify their mental health status before they can be discharged safely into the community. • That a panel of senior psychiatrists be established to undertake a periodic review of the medical files of patients with chronic mental illness whose longitudinal history is deemed to be essential knowledge for those who are required to manage the patients in the future. The periodic reviews should result in the production of a comprehensive summary, made available either electronically or in hard copy, to psychiatric units in public hospitals as well as Community and Crisis Assessment Teams . • That consideration be given to making available all or part of the contents of Court ordered reports concerning forensic psychiatric patients, for the benefit of treating practitioners to ensure that all relevant background information, including details of previous violent conduct, is taken into account when managing their in-patient treatment and discharge. • That senior psychiatrists consider imposing a requirement that before a 21 day detention order is revoked, a comprehensive assessment takes place by a sufficiently senior practitioner who has familiarised himself or herself with the patient's longitudinal history where relevant. The assessment should be documented in the medical notes under an appropriate heading. • That consideration be given to revising the procedures for the administration of intramuscular antipsychotic medication to patients who are obese.
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Medical treatment (health care / adverse effects)

ACT.2002.185	<p>The deceased (aged 76 years) died in the Intensive Care Unit (ICU) of [] Hospital 16 days after she was first admitted.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the [] hospital review the appropriateness of sending very ill patients to areas such as Medical Imaging for procedures that can be just as easily, and more safely, performed in ICU. • That the [] Hospital Management give consideration to implementing an accreditation or certification system for Residents who are required to carry out minor procedures including the insertion of nasogastric tubes and intercostal catheters. <p>The Coroner also attached to his Decision in a separate Annexure "A" a list of recommendations made by the family of the deceased as a result of their experiences in this matter, and asked that the hospital management review these recommendations with a view to implementing any that are practical and meet the needs of the hospital.</p>
ACT.2003.226	<p>The deceased was admitted to [] Hospital for the purposes of undergoing a medical examination relating to an existing medical condition of ulcerative colitis. After a chest x-ray revealed lesions to the upper right chest and a CT scan revealed an unknown mass on the right side of his bowel, the deceased agreed to surgery to remove the mass for the purposes of analysis. The deceased underwent surgery and the mass was removed and sent for analysis. The next day he was found to have suffered what medical staff believed was a cardiac arrest, and he passed away that night.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the Hospital's management should ensure, where possible, that nursing staff allocated to surgical wards have appropriate experience. • That all patients given large doses of analgesia after undergoing major surgery and then commenced on patient controlled analgesic devices should be closely monitored, preferably in a high dependency ward. • That consideration be given to implementing a program of improved note taking by both nursing and medical staff, in line with the recommendation made by (the Counsel assisting the Coroner) and included earlier in this Decision.

Medical treatment (health care / adverse effects)—cont

NSW.2002.5765	<p>Hypoxic brain damage sustained during a dental procedure (no further information regarding the circumstances are contained on the NCIS).</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That consideration be given to amending the current guidelines on Sedation for Dental Procedures issued by the ANZCA and the RACDS to require that pre-operative anaesthetic checks be performed on another day shortly before the scheduled date of the procedure. • That a code of professional conduct be established pursuant to the Dental Practice Act 2001 section 35 by the New South Wales Dental Board with respect to the use of intravenous or IV sedation in dental procedures. Such a code should be reflective of the current guidelines on Sedation for Dental Procedures. • The New South Wales Dental Board considers requiring those practitioners who perform intravenous sedation in their surgeries to complete a refresher course in IV sedation at intervals considered appropriate by the board and that they in turn be required to regularly conduct refresher courses with surgery staff. • That the New South Wales Dental Board considers requiring those practitioners who perform intravenous sedation in their surgeries to obtain from the patient's general practitioner salient advice as to the patient's fitness to undergo the procedure - current conditions, medications and the like.
NSW.2003.2764	<p>The deceased (aged 40 years) sustained a subdural haematoma and fracture of the right frontal bone of his head as a result of an accidental fall from his bed. The deceased had a lengthy medical background of congenital hydrocephalus, with intellectual delay and mental retardation, spina bifida, paraplegia and epilepsy.</p> <p>Recommendations:</p> <p>To the Director of the Department of Ageing and Disability Services.</p> <ul style="list-style-type: none"> • In relation to the [-] Centre, a specific safety policy be developed setting out the 'steps' for transporting clients from beds to ARJO shower trolleys using the ARJO maxilift. This policy should emphasise that once the bed rails have been lowered, a staff member must be positioned to prevent the client falling from the bed until the client is secured by the ARJO maxilift.
QLD.2004.2896	<p>The deceased was been admitted to the [-] Hospital Mental Health Facility as an involuntary patient under section 108 and 112 of the Mental Health Act 2000. The deceased received numerous medications whilst at the [-] Hospital. Over the course of the next week the deceased gradually become less alert and more drowsy, spending more and more time in bed and becoming less responsive. He become unresponsive to stimuli and could not interact in a conscious manner.</p> <p>The deceased had a lumbar puncture for altered states of consciousness. He was found the next day seizing for a few minutes and was transported to the [-] Hospital for treatment. The deceased was then transferred to the ICU of the [-] Hospital. The deceased has then gone into a coma. The deceased has had numerous seizures throughout the day, and later passed away after life support was removed.</p> <p>Cause of death: Global cerebral hypoxic injury; Status epilepticus.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That if they have not already done so, the [-] Hospital give consideration to developing a rapid tranquilisation policy. • That the [-] Hospital review its policy of not having a psychiatrist review patients in the SCU daily.
SA.2003.875	<p>Asphyxiation, due to aspiration of food while in hospital.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the [-] Hospital ensure that nursing staff are made aware of the importance of having regard to the original source of information about a patient's dietary requirements and that, accordingly, they be required to read a patient's progress notes or clinical record at the commencement of a shift for this purpose. • That all documentation created in order to facilitate the transfer of information from the members of one nursing shift to the next be checked by a person in authority so as to ensure that the information contained in handover documentation accurately reflects instructions recorded in the clinical record or progress notes pertaining to a particular patient. • That the [-] Hospital, through whatever means are considered to be appropriate, reinforce the necessity for nursing staff to be vigilant to ensure that dysphagic patients receive meals of the correct consistency. • That the [-] Hospital, by whatever means are considered appropriate, clarify the duties and responsibilities of nursing staff in relation to the actual feeding of dysphagic patients. • That the [-] Hospital ensure that nursing staff, who are caring for patients with swallowing disorders, fully understand the risk factors associated with the individual patients in their care so as to enable them to more readily identify situations in which a patient has been provided with a meal of inappropriate consistency. • That the [-] Hospital give further consideration to the introduction of computerised communication between wards and the kitchen, especially involving wards caring for dysphagic patients.

Medical treatment (health care / adverse effects)—cont

SA.2003.3167	Acute Dopamine Imbalance Syndrome. At the time of his death the deceased was detained pursuant to the Mental Health Act 1993. See page 6.
TAS.2005.56	<p>Intra-abdominal Haemorrhage following a Cholecystectomy with Ischaemic Heart Disease and Generalised Arteriosclerosis.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That Doctor (-) join the Melbourne Vascular Surgical Association as a condition of his authority to practice surgery at the [-] Hospital(s). • That the [-] Hospital(s) make available platelets in all their operating theatres.
TAS.2005.458	<p>Combined effects of Ischaemic Heart Disease and general Anaesthesia for repair of a Femoral Artery Dissection following an Angioplasty</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That Doctor (-) join the Melbourne Vascular Surgical Association as a condition of his authority to practice surgery at the [-] Hospital(s).
TAS.2006.292	One to two days prior her death, the deceased took a quantity of alcohol and drugs with the intention of taking her own life. See page 7.
SA.2004.382	Cause of death: cerebral oedema and infarction secondary to extensive subdural empyema. See page 5.
SA.2004.1099	Cause of death: Acute asthma (hypoxic encephalopathy). See page 5.
VIC.2003.2214	<p>The deceased, who had a history of haemolytic uraemic syndrome resulting in irreversible renal damage and cerebrovascular damage to the brain as well as malignant hypertension, presented to the emergency room of a public hospital with severe abdominal pain. After further deterioration and a lapse into unconsciousness the deceased was transferred to the ICU at a private hospital. The finding reviewed initial treatment at the first hospital, ambulance transfer to the second hospital and management of the deceased's terminal condition.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • The Department of Human Services, Metropolitan Ambulance Service and the College of Emergency Medicine cooperate to develop a standardised form for ward clerks and nurses who organise inter-hospital ambulance transfers across all hospitals which includes the information required for appropriate allocation of ambulances including the reasons for the inter-hospital transfer and the time requested, the patients' vital signs and relevant past history, and an indication of their stability. • The Metropolitan Ambulance Service and the Emergency Services Telecommunications Authority arrange for Card 36-Urgent IHTs of the Advanced Medical Priority Despatch System to prompt call-takers to ask ward clerks and other hospital staff who order non-emergency inter-hospital transfers within 25 to 90 minutes the reasons for the time requested and the patients' current observations or vital signs. • The Metropolitan Ambulance Service change the triage options available to the clinical support officer for cases referred to them because they require a response in between 25 and 90 minutes to include the possibility of sending a non-emergency vehicle within the time specified. • The Metropolitan Ambulance Service implement a process that allows clinical support officers to communicate directly with medical officers requesting inter-hospital transfers in less than 90 minutes when they intend to allocate the transfer to non-emergency transport and/or extend the response time.
VIC.2005.1184	<p>After drinking with other residents of his caravan park, the deceased fell backwards, hit his head and lost consciousness for approximately 10 minutes. Over the following two days, the deceased was behaving erratically and concerned residents called an ambulance. After being admitted to hospital, the deceased had another fall. His condition deteriorated and he died.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That [-] Hospital, and all other Emergency Departments, review their policy in respect of the time frame for the application of the Acute Falls Risk Assessment Tool. The Assessment, or a decision on whether a full assessment is warranted, should be performed on admission to the cubicle area of the ED by the nurse. • The initial observations performed, by the allocated nurse, should include an initial assessment on whether a full falls assessment is required. A tick box on the form would document that the nurse has considered the risk of falls on initial contact with the patient in the cubicle. A number of other boxes could be utilised to indicate if "interventions" are already in place...In the event that the nurse considers that a full assessment is required, it should be completed as soon as practical to the admission to the cubicle area. <p>The objective of expanding on the current policies is to minimise the risk of falls in the Emergency Department through the implementation, and documentation, of appropriate interventions.</p>

Medical treatment (health care / adverse effects)—cont

VIC.2005.2542	<p>The deceased suffered a retroperitoneal haemorrhage and acute renal impairment. Due to ongoing coagulopathy, surgical intervention was not considered a viable option. The deceased's condition worsened and a meeting of medical practitioners and the deceased's family was held where treatment options were discussed. The deceased later died following the withdrawal of treatment.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> To reduce the prospect of a similar occurrence in the future, the Coroner recommended all Intensive Care Units adopt a protocol/procedure similar to that introduced by [-] in relation to the withdrawal of treatment / removal of life support. It is imperative that plain, blunt unequivocal language be adopted. <p>The Coroner also noted that in recent times, in a number of inquests, he had observed some confusion in the minds of lay people, in particular concerning the concept of "Not for Resuscitation, withholding treatment and withdrawing treatment.</p>
VIC.2005.4690	<p>Natural cause death, contributed to by a recent operation and laparotomy due to a misplaced gastrostomy tube.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> That the Department of Human Services develop a standard for the care and management of PEG (Percutaneous Endoscopic Gastronomy) tubes.
VIC.2004.3308	<p>The deceased had a medical history that included chronic renal failure and cardiac failure. His history also included some degree of self-neglect and alcohol abuse. The deceased was taking Warfarin for atrial fibrillation. The deceased died from hypovolaemic shock secondary to gastrointestinal bleeding, caused by over anti coagulation on a background of severe ischaemic heart disease.</p> <p>Recommendations:</p> <p>The Coroner recommended that consideration be given to highlighting and implementing where appropriate the following comments and suggestions arising from the review of medical management conducted by the Clinical Liaison Service.</p> <p>"It is ideal to have blood test to check the INR within 3-5 days after changing the warfarin dose.</p> <ol style="list-style-type: none"> Monitoring of stable patients ideally should be done anywhere between 2-6 weeks, however, there is debate about the frequency of blood tests in the medical literature. A system appeared to be in place to deal with abnormal tests but it is uncertain whether a system existed to ensure patients who had a request to attend pathology do actually attend. Even if the circumstances were ideal the INR may change due to alcohol or diet. The cardiologist indication for warfarin seemed to be appropriate. Complexity arises because the cardiologist usually initiates the warfarin and determines when to cease it. The pathology conducts tests and the general practitioner has to order the tests and adjust the dose as required. Objective methods for evaluating compliance do not exist in a practice setting. (The deceased's) INR had always been low rather than high." <p>That the guidelines from the Medical Journal of Australia be considered (The Consensus Guidelines on warfarin management, MJA. Volume 181 Number 9. 1 November 2004).</p> <p>Potential for improvement in the following areas:</p> <ul style="list-style-type: none"> Communication between the cardiologist and the local doctor; Better systems between local doctors and pathology services, especially follow-up of patients who do not attend the pathology service; and Better consideration of management of risk versus management in non compliant patients.
Motor vehicle accidents	
QLD.2002.1570, 1594, 1595, 1596, 1597 & 1598	Inquest into the deaths of 6 persons in a single-engine Piper Cherokee Six aircraft crash. See page 2.
QLD.2003.1856 (also 1855 & 2579)	Inquest into the deaths of three persons during a medical retrieval flight when the helicopter crashed into the sea approximately 3.2 nautical miles east of Cape Hillsborough near Mackay in Queensland. See page 2/3.

Motor vehicle accidents—cont

<p>SA.2002.747 (also SA.2001.2526 & 2527)</p>	<p>Joint inquest into the deaths of four persons in three separate vehicle collisions (1 pre NCIS) which occurred in similar circumstances and at approximately the same location.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the Minister for Transport and the Minister for Police, do what is reasonably necessary to improve the quality of relevant information provided to the Department for Transport from South Australian Police regarding vehicle crashes. In particular, attention should focus upon the manner in which the precise location of collision sites is recorded which will facilitate the transfer of accurate and consistent information. • That the Minister for Transport, undertake an audit of the Road Crash Unit database by a suitably qualified person, to rectify existing errors within the database as far as possible and to devise and implement systems which will make it a valuable and reliable resource for road safety purposes. • That the State Government and the vehicle manufacturing industry consider ways in which the potential benefits of electronic stability control devices might be promoted and do what is necessary to facilitate their inclusion as standard features in new vehicles as soon as is reasonably possible.
<p>TAS.2005.549</p>	<p>Vehicle towing a trailer collided into the rear of the deceased's vehicle, pushing the vehicle into the path of a truck. The initial collision was found to have resulted from momentary inattentiveness on the part of the driver, which caused him to delay the braking of his vehicle until it was too late to safely avoid the deceased's vehicle. The combined weight of the trailer and its load significantly exceeded the recommended maximum towing weight for the vehicle, which the Coroner believed increased the safe braking distance of the vehicle.</p> <p>Recommendations:</p> <p>The Coroner supported the following recommendations made by Tasmania Police:</p> <ul style="list-style-type: none"> • The Department of Infrastructure, Energy and Resources (DIER) conduct an investigation of the road width in the area of the accident with a view to widening it. As has been noted above the road lanes in that area are 2.90m and 2.65m wide respectively. The average width of a log truck is 2.5m. There is therefore little room for driver error when vehicles, particularly log trucks, pass each other in that area when travelling in opposite directions. • DIER give consideration to the erection of a guard rail or steel cable barrier in the area of the accident to reduce the prospect of vehicles entering the 3m deep culvert.
<p>TAS.2006.166, 167, 168 & 169</p>	<p>(Four person fatality following a motor vehicle collision and fire). Whilst negotiating a moderate right hand sweeping bend on the downhill slope Vehicle 1 commenced to rotate clockwise and in so doing has crossed to the incorrect side of the road. As a result, the front bumper bar collided with the Armco railing on the western side of the road. The vehicle then slid passenger side first south into the left northern bound lane causing the passenger side of the vehicle to collide with the front of Vehicle 2. The impact caused Vehicle 2 to rotate and be forced backwards, coming to rest in the left north bound lane facing in a south-easterly direction. Vehicle 1 came to rest in the same lane facing in a general south-westerly direction approximately 1 metre from the rear of Vehicle 2.</p> <p>As a result of the impact, Vehicle 1 has been engulfed in flames which have then spread to Vehicle 2 via radiant heat. Attempts to free the occupants were unsuccessful and all occupants died at the scene.</p> <p>The causative factor of this accident was one of excessive speed by the driver of vehicle 1 (a provisional licence holder).</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • The Coroner recommended that investigations be undertaken by DIER in respect to the erecting of a physical barrier separating the opposing lanes at this location. • A number of other recommendations had also been formulated and implemented by DIER, or were in the process of being undertaken or considered.
<p>TAS.2006.244</p>	<p>Fatal two vehicle accident. A major contributing factor was the road and weather conditions, with the deceased losing control of his vehicle in wet and slippery conditions, colliding into another vehicle. The deceased was the holder of a first year Tasmanian Provisional Drivers licence, and had had his licence for a period of less than 8 weeks.</p> <p>Recommendations:</p> <p>The Coroner noted that the Victorian State Coroner and Monash University Accident Research Centre have also recommended the fitment of ESP to all new cars, and encouraged the motor vehicle industry consider the fitting of this life saving technology to all cars, both local and imported.</p>

Motor vehicle accidents—cont

VIC.2004.4301 & 4302	<p>Head-on collision between a Kenworth 9 axle B Double and a Freightliner 6 axle semitrailer on the Western Highway, Lawloit. The collision was the direct result of fatigue. The two vehicles involved in the collision crossed interstate borders frequently in the days preceding the event.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the various law making bodies, in conjunction with the National Transport Commission and other similar bodies, and the corresponding State bodies, review the relevant laws with a view to having Federal laws to protect the worker or consistent laws across the various States. This should include consistent provisions across the borders for the retrieval of information from various agencies and Safe-T-Cam data. • That all heavy vehicles be fitted with a mobile and Portable data terminal type device that may record information including - <ol style="list-style-type: none"> i. current location and status of vehicle; ii. monitoring drivers breaks and idling times; iii. on-site time and loading/unloading times; iv. accident information. <p>Legislation could also be introduced to make this (and other) information available to law enforcement agencies in certain circumstances. It would assist in enforcing the "Chain of Responsibility" legislation because the employers would be aware of the vehicle movements and the device could be programmed to identify and alert to any breaches of the law.</p> • A review should also take place as to what fatigue detection technology is available that could be integrated with the device mentioned in recommendation 2. • In the event that recommendations 2 and 3 are not pursued, I recommend that Safe-TCams are installed at appropriate locations in Victoria to compliment those installed in our neighbouring States. • An appropriate number of well resourced Truck Stop locations be established on the Western Highway between Ballarat and the South Australian border.
SA.2004.3039	The deceased threw himself in front of a truck after absconding from the [-] Hospital. See page 7.
VIC.2006.936	<p>The deceased was a pillion passenger on a Suzuki motor cycle being ridden by her husband. The motorcycle was travelling north when it struck a vehicle which was pushed, as a result of an earlier collision, into its path. The intersection where the collision occurred has been recognised by VicRoads as a Black Spot intersection.</p> <p>Recommendations:</p> <p>The Coroner indicated that the following matters raised by the investigating Police Officer may need review by the appropriate road safety agency, and that of particular importance is the potential for a speed reduction countermeasure for the Road in the vicinity of the intersection (as a possible interim measure):</p> <ul style="list-style-type: none"> • The Road Management Act is amended to include: <ul style="list-style-type: none"> - A set standard to classify a road or roads as a Black Spot location; <ul style="list-style-type: none"> • A classification as above should be regarded as a "trigger event" which initiates regulated procedures (including response times) for safety improvements to be made to reduce the risks of collisions and/or injuries sustained, whilst long term treatments are pending; - Once declared a Black Spot that location should be signed as such and that sign should display the following information: <ol style="list-style-type: none"> i The location number; ii The Responsible Road Authority iii Contact details for the Responsible Road Authority including phone, postal, email and internet site (if applicable), iv The date the location was established. • Each Road Authority should provide improved liaison for not only public inquiries but for other agencies as well. This would also promote public confidence by providing more transparent management of Black Spot locations.
VIC.2006.1458	<p>The deceased was the driver of a motor vehicle which collided with a truck approximately 1.8 kms from the NSW border. The deceased had suffered blackouts due to a medical condition, and prior to the collision had been observed by a fellow motorist swaying over the road.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • The Coroner recommended that as a matter of urgency VicRoads replace the 100 km per hour sign at the entrance to the Victorian Border to past the scene of the collision until the bends are finished with 80 kilometre per hour signs. <p>The Coroner further noted that this stretch of road carries the second highest volume of traffic apart from the Hume Freeway for vehicles travelling between Melbourne and Brisbane. Over a 3 kilometre stretch in the present 100 kilometre per hour zone there are three signs with a 75 kilometre per hour advisory sign and two facing south bound traffic with 65 kilometre per hour advisory signs and one 65 and one 55 kilometre per hour advisory sign for north bound vehicles. A very large number of heavy vehicles use this highway.</p> <p>The Coroner also asked that the authorities look at the question of installing flashing amber lights where the current 55 kilometre per hour advisory speed sign is now erected.</p>

Motor vehicle accidents—cont

WA.2003.1220, 1221,1222 & 1223	R44 helicopter crash. See page 4.
WA.2005.170 & 196	<p>Single vehicle collision – double fatality. The vehicle was travelling in a south easterly direction round a right hand curve in the road when the vehicle failed to take the curve and slide sideways into a tree. Contributing factors to the collision were excessive speed and alcohol. The deceased driver was also not wearing a seatbelt.</p> <p>Recommendations:</p> <p>The Coroner indicated that if a recommendation he had made in 2003 had been adopted by WA Police, the unfortunate failure to capture scene evidence regarding this double fatality would not have occurred.</p> <p>The Coroner repeated his earlier recommendation (see below) and for purposes of clarity added that particularly in the context of country investigations of serious motor vehicle collisions, especially if the Major Crash Investigation Section may not be able to attend, instructions to attending police officers should clearly identify a number of steps which should be taken to ensure reasonable evidence capture.</p> <ul style="list-style-type: none"> • “..that the Major Crash Investigation Section review procedures in place in such cases to ensure that a number of basic investigative steps are always taken. Those procedures should also involve the taking of photographs which would be of assistance to skilled officers...in providing opinion evidence and in reconstructing the circumstances of motor vehicle crashes”. <p>The Coroner also recommended that WA Police provide officers who may be called on to attend at serious motor vehicle crash scenes with a check list or clear guidelines which will ensure that –</p> <ul style="list-style-type: none"> • Tape measures or other reliable means are used to measure the length of any tyre marks (pacing is not acceptable; Distances between tyre marks are measured accurately; • The start point of tyre marks is identified early (before these marks fade) and are marked with chalk and photographed (close-up); • That there are a number of close-up photographs of any tyre marks showing any changes in the appearance of those marks; • That a significant number of photographs are taken of the scene, if possible using a digital camera; • That the interiors of involved vehicles are photographed clearly showing gear position, light switches, handbrake positions etc prior to movement of the vehicles and certainly prior to the vehicles being towed from the scene; and • That at a very early stage all persons present are questioned in order to determine whether involved vehicles have been touched or handled and, if so, by whom and in what way. It is particularly important to determine whether after the crash any of the controls have been operated e.g. whether the lights have been switched off or the ignition switch has been turned to the off position.

Psychiatric treatment/Intentional Self-Harm

VIC.2003.259	<p>The deceased had a long history of alcohol, benzodiazepine, solvent, cannabis and heroin abuse, and had served ten separate terms of imprisonment for drug related offences. Two months prior to his death (while in prison) correctional mental health care professionals determined that the deceased was not suffering from a psychiatric condition. The prison psychiatrists withdrew his prescribed medication and transferred him out of accommodation which provided specialist psychiatric services. Although his unusual behaviour continued intermittently throughout the rest of his last sentence, these services were not restored.</p> <p>He was released 9 days before his death without referral to community psychiatric services and without access to appropriate medication.</p> <p>Cause of death: hanging.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • The Corrections Victoria and the Department of Human Services develop a strategy to increase the number of secure approved mental health service beds available to prisoners with severe mental health problems. • The Government of Victoria work towards establishing a new sub-acute mental health facility for male prisoners in Victorian prisons as soon as practicable. • The Correctional Services Commissioner, the Royal Australian and New Zealand College of Psychiatrists and the Office of the Chief Psychiatrist establish a joint consultative committee to establish appropriate legislation, policies and procedures to enable prisoners and parolees who otherwise meet the criteria for involuntary treatment under sections 8 of the <i>Mental Health Act 1986</i> to be managed in the same way as they would be managed in the wider community. • The Correctional Services Commissioner commission a scoping exercise to determine how best to coordinate the mental health services and the drug and alcohol services in prisons so that prisoners with these dual disabilities receive an integrated service. • Corrections Victoria, the Adult Parole Board and the Community Forensic Mental Health Service further review their pre-release protocols to ensure that prisoners who will be subject to mental health treatment conditions on parole are referred to, assessed by and arrangements made to manage their transition to the appropriate community mental health services prior to their release from prison.
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Psychiatric treatment/Intentional Self-Harm—cont

WA.2004.271	<p>Ligature Compression of the Neck</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • Where a prisoner declines a follow up appointment a record is made of this for future reference. <p>The Coroner also indicated that a recommendation was made previously in relation to community orders that offenders disclose all medical services accessed within a period of 24 months with an authorisation for their supervisors to approach those services for information which may assist in constructing appropriate management plans for those offenders.</p> <p>The Coroner further noted in relation to this that hopefully it would not be necessary to make a similar recommendation in this matter, particularly in light of evidence presented at the inquest that an electronic system is under development allowing an encrypted discharge summary to be posted on a secure electronic bulletin board accessible to all health professionals, with a limited view (similar to a medic alert) being accessible generally to Community Corrections staff.</p>
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Sport/leisure activities

NSW.2004.5776	<p>Accidental drowning after exhausting air supply while undertaking a recreational dive.</p> <p>Recommendations / Comments:</p> <p>To the Minister for Industrial Relations</p> <ul style="list-style-type: none"> • The recreational diving industry should be regulated under the purview of the Minister for Industrial Relations, with Workcover as the appropriate regulatory authority. • Provided Standard AS/NZ 2299.3.2003 is amended as recommended below to include all recreational diving activities at a workplace, I suggest that its inclusion in the Occupational Health and Safety Regulation 2000, similar to AS/NZ 2299.1, would be an appropriate means of implementing this recommendation. <p>To Standards Australia</p> <p>In respect of Standard AS/NZ 2299.3.2003:-</p> <ul style="list-style-type: none"> • Section 1.1(b) should be amended to ensure that the Standard applies unambiguously to all recreational diving that occurs at a workplace unless another Standard applies. • Section 2.1 should be amended to include a requirement for all divers to notify the dive supervisor of any special needs, such as excessive air consumption. <p>To PADI</p> <ul style="list-style-type: none"> • PADI instructors should ensure that any compromised air situation experienced by a student in the course of a dive is recorded in the “Comments” section for that dive in the logbook. • There should be a Special Needs section in the logbook to record any specific characteristics of the student diver, such as excessive air consumption. • There should be a requirement for an annual assessment of a diver’s medical fitness to engage in recreational diving and for such certification to be recorded in the logbook.
VIC.2003.2615	<p>The deceased was accidentally shot by a friend while deer hunting.</p> <p>Recommendation:</p> <p>The Coroner indicated that (leaving aside the issue of membership of a deer hunting association being mandatory to obtain a Game Licence) he believed there to be sufficient merit in the State Coroner’s earlier recommendation (2575/94) in relation to hunters wearing conspicuous clothing to formerly adopt it in the present finding.</p>
VIC.2005.4356	<p>The deceased (a confident kite surfer who had been involved in the sport for about a Year) sustained head and spinal injuries after being pulled into rocks by wind. The Bureau of Meteorology predicted that Victoria would have a Strong Wind warning for that day. The deceased was not wearing a helmet.</p> <p>Recommendation:</p> <p>That those involved in the sport of Kite Surfing consider advising participants of the need to wear protective helmets and adopt some risk management planning around setting up in the area for kite surfing.</p>

Work-related

NSW.2002.5493 & 5494	<p>The deceased persons were assisting in the concrete pour of the roof of a 16m tower, when there was a catastrophic formwork collapse. One died as a result of 'Anoxia due to emersion in concrete which caused left ventricular heart failure and bilateral pulmonary congestion', while the other died from a penetrating blow to the head sustained in the fall.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • That the Department of Commerce ensures an independent review of all critical incidents is undertaken similar to the NSW Police where the reviewer or reviewing team is drawn from another region. • That protocols be developed by the Department to prevent and/or minimise conflict where the one representative is tasked with two portfolios. These protocols are to be strictly adhered to an enforced. • I direct that the coronial file concerning the deaths be referred to the WorkCover Authority for further consideration under the OHS&R Legislation and its Regulations.
VIC.2003.3146	<p>The deceased was operating a tractor towing a spray unit powered by a "power take-off shaft." He alighted the tractor, leaving the power take-off operating, and moved near to the power take-off shaft. As he was doing so his loose clothing became tangled in the universal end of the operating shaft. Cause of death: multiple crush chest injuries.</p> <p>Recommendations:</p> <p>The Coroner noted his support for "...the general direction that WorkSafe are developing on farm safety and the need for the farming community and its representative organisations to be vigilant on the need for the management of known hazards such as PTOs."</p> <p>The Coroner also suggested that the following comments may need to be considered by the appropriate industry group and/or government agency:</p> <ul style="list-style-type: none"> · Manufacturers (and or retailers) of farming equipment need to consider joining with WorkSafe safety awareness programs in helping to regularly advise the farming community either through the individual distributor networks, or via the local media of the safety issues and solutions associated with dangerous equipment such as power take-offs. · Limited government funded programs (like the Tractor Rollover rebate in the mid 1990s) directed towards assisting to encourage the fitting of after-market guards to power take-off shafts and post hole diggers may be useful to consider in order to support and highlight the need for compliance. This approach would need to be carefully considered in the light of continuing fatalities, injuries or near misses from this cause. <p>A number of recommendations made by a consultant engineer engaged by WorkCover were also referred to in the Coroner's finding.</p>
VIC.2004.4301 & 4302	<p>Head-on collision between a Kenworth 9 axle B Double and a Freightliner 6 axle semitrailer on the Western Highway, Lawloit. See page 15.</p>
VIC.2004.2736	<p>The deceased was working with a friend as a labourer restumping houses. On the day of his death the deceased was working at a house which had been raised the day before using hydraulic jacks whilst the old stumps were removed. At the beginning of the day the remainder of the old stumps were removed and the house was balanced on the hydraulic jacks. No secondary support systems were put in place. Without warning the house collapsed whilst the deceased and a co-worker were working underneath.</p> <p>Recommendations / Comments:</p> <p>The Coroner referred to the guidance notes (Guidance Note WorkSafe - Restumping of Buildings) prepared by Victorian WorkCover Authority (VWA), and indicated that whilst the notes were comprehensive and timely, they left the activity of restumping unregulated.</p> <p>Given the number of similar deaths, the benefits of consistency and uniformity and the portability of the workforce, the Coroner suggested that Workcover Authority should seriously consider sponsoring an Australian Standard for restumping. If in fact a Standard is to be developed it would seem necessary to consult with all relevant state and national bodies involved in the industry.</p>

Miscellaneous

VIC.2006.577	<p>The deceased was working on a 1974 Citroen outside his home. The vehicle had hydraulic suspension that allows the vehicle to be lifted upon starting and lowered when stopped. Whilst the deceased was working on the vehicle the hydraulic suspension has failed causing the vehicle rapidly lower and crush the deceased (who was working underneath).</p> <p>Recommendations / Comments:</p> <p>The Coroner commented that the death was potentially preventable, and that there had been numerous deaths investigated by Coroners of home mechanics occurring when either the jack failed (or was inadequate) or, the base was inappropriate. The Coroner also noted that warnings on these issues have been frequently delivered by the relevant government and safety agencies and Coroners support these warnings as working under vehicles all too frequently can have tragic results.</p> <p>As a result of this death, the Coroner indicated that there may also need to be an additional and specific warning about working under cars like the Citroen that are fitted with an adjustable suspension.</p>
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The following is an index of recommendations (by broad topic area) summarised by the NCIS within the 12 editions of Fatal Facts produced thus far.

Please note that cases can often involve multiple topic areas or themes, and therefore may be included in the list below more than once.

Editions 6 - 11 of Fatal Facts can be found on the NCIS website, at:
http://www.ncis.org.au/web_pages/publications.htm#a1

Editions 1 - 5 of Fatal Facts are only available in hard copy format. To request a copy of any of these editions, please contact Stephen Morton at the NCIS on (03) 9684 4442 or via email: stephenm@vifm.org

Topic/theme	See Fatal Facts Edition(s)...
Adverse effects or reactions to medical/surgical care	All
Aged care	11, 6
Child deaths	12, 11, 10, 9, 8, 7, 6, 4
Diving, scuba diving, snorkeling	11, 9
Domestic/leisure incident	12, 9, 8, 4
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Electrocution	8, 7
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Product-related	11, 7, 4, 3
Sports-related	12, 11, 10
Transport-related	All
Water-related (general)	All
Water-related (recreational fishing/boating)	11, 10, 9, 7, 6, 5, 1
Work-related	All