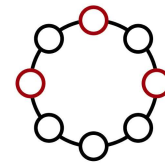


Fatal Facts

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



NCIS

Welcome to the new-look Fatal Facts!

Welcome to the new look Fatal Facts! We have revised the format and feel of Fatal Facts, to make it more user friendly, better targeted and hopefully enhance its value as a publication for coroners around Australia.

Rather than attempting to document every finding made, which was resulting in a lengthy publication, Fatal Facts will now focus in detail on those cases where recommendations were made. Readers however can still see at a glance the number of total cases available on the system, and the number of findings available on the system for cases closed during the relevant time period.

In depth summaries of certain cases have been provided, and occasionally within these summaries, references to other similar cases of interest will be made. These in depth case studies are also supplemented by brief summaries of all recommendations made during the relevant time period.

Recent information requests received by the NCIS team are also highlighted, should you wish to request a copy of the information produced as a result of these searches. Finally, NCIS search tips have been included to encourage your experimentation with the system.

The cases referenced list the relevant NCIS identifying number. If you wish to obtain further information regarding a particular case, you can access the case through the "Find Case" search option on the NCIS interface, a process demonstrated in the search tips section of this edition.

If you have any queries regarding "Fatal Facts" or the NCIS, please do not hesitate to contact the NCIS team on ncis@vifm.org or Ph: (03) 9684 4414.

Jessica Pearse
Manager, NCIS.

January 2005

Edition 6

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Fatal Facts

January 2005

General Details

In this edition of *Fatal Facts* we have looked at recommendations made within coronial findings for cases closed on the NCIS between 01/05/2003 and 31/07/2003.

If you seek further information regarding any of the cases contained in the proceeding pages, it is recommended that you visit the NCIS website at 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”. The process in which to do this is demonstrated in the Search Tips section of this edition.

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 Applications Officer, Marde Hoy, at mardeh@vifm.org or on (03) 9684 4323.

NCIS at a glance

- ▶ Number of deaths on the NCIS (as at 4 January 2005): 85,237.
- ▶ Number of findings contained on the NCIS for cases closed between 01/05/2003 and 31/07/2003: 2,411.
- ▶ Number of recommendations made for cases closed between 01/05/2003 and 31/07/2003*: 18.

* For a list of case reference numbers for these recommendations, please refer to page 8.

Disclaimer: The precis of coronial findings detailed within this publication have been produced by NCIS staff, with the best efforts made to accurately summarise the circumstances, findings and recommendations made by the coroner in each case. Despite this, it should be noted that the material produced in this publication is not an authorised summary or exact replication of coronial findings, and as such, the original finding in its entirety should always be accessed should any reference to the content of a coronial finding be made.

Case Studies

Case Study 1:

Police Pursuits – Communications and Risk Assessment.

NCIS Case Number: NT.2002.28

Local Case Number: A0008/2002

Finding Delivered: 31 July 2003.

Coroner: Territory Coroner, Greg Cavanagh.



Summary:

The deceased was a rear seat passenger in a vehicle containing 9 other passengers in addition to the driver. Due to the number of unrestrained passengers in the vehicle, and hearing screaming or yelling coming from the vehicle, passing police decided the vehicle warranted further investigation. When the vehicle failed to stop at a stop sign, a pursuit entailed involving activated emergency lights and sirens.

During the pursuit the officers radioed in to Communications to report the pursuit. In that first radio call Communications were advised of the location, traffic conditions, and the speed of the other vehicle, however the reason for initiating the pursuit, the number of passengers in the vehicle, and the fact that some of these passengers may have been unrestrained was not noted. Throughout the remainder of the pursuit, the police did not radio back to Communications that the Ford had passed vehicles on the wrong side of the highway.

Entering a bend in the road at excessive speed, the rear of the pursued vehicle slid with the rear tyre blowing out. Colliding with a kerb, the vehicle then rolled, with the deceased thrown from the vehicle, subsequently suffering a severed spine.

Assisting the passengers after the accident, it was discovered that the police car was missing some emergency equipment, although this did not prevent the officers spending considerable time performing CPR on the deceased.

The pursuit occurred over a 3 to 4 minute period and covered a distance of 9.2 km. The driver was breath tested following the accident, returning a reading of .172% alc/vol.

Recommendations:

Emergency Equipment:

The Northern Territory Police should reconsider their current systems to ensure that each vehicle is regularly checked that it has the correct equipment.

Urgent Duty Driving Policy:

“I would recommend that the NT Police put greater emphasis in training on the information that should be provided to Communications during pursuits. The NT Police should also consider whether the current NT draft policy ought include more specific details on the importance of the information provided (as is in the QLD policy).”

In my view, a short blunt resume of what is to be expected is necessary and the starting premise should be that such pursuits ought be rare, exceptional and to be avoided if at all possible. This recommendation is made not only for the safety of the public, those pursued but also the pursuing police officers. The work place safety of such police officers (who are mostly junior) is not to be glossed over.”

Ongoing review of (a) the need for such dangerous practices as high speed pursuits, (b) the method of such pursuits, (c) the supervision of such pursuits, (d) the training of police in such pursuits, and I recommend that this occur.

Case Study 2:

Emergency processes following invasive surgery

NCIS Case Number: SA.2000.1728

Local Case Number: 1719/2000

Finding Delivered: 8 May 2003.

Coroner: State Coroner, Wayne Chivell.

Summary:

In mid 2000 the deceased, a 66 year old female with a history of a history of heartburn and reflux, underwent an elective gastroscopy. Following surgery the deceased remained stable overnight although she required continuing oxygen therapy and some further morphine doses. By the following morning she had developed a mild fever and was transferred by ambulance to the Royal Adelaide Hospital.

Initial assessment suspected, and subsequently confirmed on a barium contrast study, oesophageal rupture following the endoscopy. As such, surgical exploration and repair was then carried out, with a large amount of fluid discovered in the left pleural cavity with appearances consistent with oesophageal perforation. A 1.5cm perforation was also found approximately 5cm above the gastro-oesophageal junction. The perforation was repaired although the tissue was found to be extremely friable. Two large pleural drains were also placed to allow continued drainage of the mediastinum. A gastrostomy was inserted to decompress the stomach and a feeding jejunostomy inserted to allow enteral nutrition. While the deceased achieved satisfactory progress over the next few days, her condition then deteriorated and investigations revealed a moderate sized pericardial effusion. Death then resulted from "acute necrotising haemorrhagic mediastinitis", with antecedent causes later identified as "oesophageal perforation (surgically treated) due to gastroscopy procedure".

At inquest a number of issues arose in regards to the standard of treatment provided to the deceased at various stages throughout the endoscopy operation and subsequent treatment. Amongst the conclusions reached by the coroner was the fact that, although the deceased re-presented at the hospital the day after the procedure suffering from significant pain, she was treated with pain

relief and antibiotics rather than being urgently transferred to a major teaching hospital for corrective surgery. In addition it was noted that the treating Consultant had left the hospital by the time the deceased's complications became apparent, thereby impacting on his ability to supervise the deceased's treatment.

The similarities between this case, and that of an inquest conducted in South Australia into a death arising from complications after laparoscopic surgery were also noted. In addition, comments made by the coroner in the earlier matter were agreed upon by the coroner in the latter.

Recommendations:

- 1) That where medical specialists perform invasive surgical procedures in rural and remote areas, they should develop appropriate arrangements with a major teaching hospital for emergency evacuation and transfer to that hospital in the event of an emergency.
- 2) Such specialists should also develop a clear and unambiguous emergency plan in the event that they are no longer present in the area where the procedure was carried out after the standard recovery time has elapsed, whereby immediate and effective contact between the general practitioner and the specialist can be established, and an evacuation to a major teaching hospital can be implemented if required.



**Case Study 3:
Aircraft operations:
improvements in practices and procedures.**

NCIS Case Number: SA.2000.1752

Local Case Number: 1743/2000

Finding Delivered: 24 July 2003.

Coroner: State Coroner Wayne Chivell

Summary:

The deceased, along with 6 other passengers, was travelling aboard a Piper Navajo Chieftain Aircraft from Adelaide to Whyalla when a Mayday call was received at Adelaide Flight Information Service from the aircraft's pilot.

An extensive search and rescue effort was established in response to the Mayday call, with Australian Search and Rescue supervising the process and South Australia Police coordinating the surface search. The bodies of the pilot and 6 passengers were located within the preceding hours, with the cause of death ranging from multiple injuries to salt water drowning. Thus far the body of the deceased, while initially sighted in the water, has yet to be recovered.

As the deaths of the deceased's fellow passengers and the pilot were notified to the Coroner prior to 1 July 2000 they are therefore not contained on the NCIS.

An examination of the wreckage by the Australian Transport Safety Bureau (ATSB) established that the left engine of the aircraft had suffered a total fracture of the crankshaft, and the right engine had suffered a holed No.6 piston due to melting of the piston material. In their final report, ATSB postulated that the bearings in the left engine began failing much earlier than during the fatal flight, with a fatigue crack forming approximately 50 flights prior.

Subsequent evidence of material defects in crankshafts in Textron Lycoming engines (the type fitted to the aircraft in question) then emerged following the issuing of a Special Advisory Bulletin in November 2000. Following this extensive recalls of engines was undertaken.



Of alarming concern also was the fact that five days before the ATSB final report was published, the right engine in an aircraft identical to the one in question failed. In addition over one dozen other crankshaft failures in Textron Lycoming engines occurred since the incident.

Recommendations:

Engine operating procedures set out in the various versions of the Pilot Operating Handbooks and Flight Manuals for Piper Chieftain Aircraft be reviewed with the object of ensuring:

- (a) accuracy of the detonation limiting conditions;
- (b) clarity of all engine operating procedures.

CASA and the ATSB consider how lines of communication could be improved so that communication continues to flow even in circumstances where litigation might be threatened.

CASA consider how the development of On-Board Recorders suitable for use in light commercial aircraft might be facilitated. Should fitment of On-Board Recorders in these aircraft become feasible, it was further recommend that their use be mandatory in the carriage of passengers for payment, or at least in RPT operations.

The ATSB and CASA undertake a research program to ascertain whether it is feasible to fit a self-deploying ELT system to all aircraft engaged in carriage of fare-paying passengers, whether by RPT or charter operations, over water. If it is feasible, the use of such instruments in those circumstances should be mandatory.

CASA amend the Civil Aviation Orders to make it mandatory that aircraft should carry lifejackets and/or a life-raft for the protection of fare-paying passengers whenever the aircraft is operating beyond the distance from which it could reach the shore with all engines inoperative.

Case Study 4: Reversing Tractor Fatality.

NCIS Case Number: TAS.2002.563

Local Case Number: H0290/2002

Finding Delivered: 31 July 2003

Coroner: Ian Roger Matterson

Summary:

In late 2002 the deceased was in the midst of spraying the property he worked upon with herbicide using the Case tractor and a boom spray. At some stage during the afternoon it appears he alighted from the tractor on flat terrain and has left the tractor running whilst he inspected the boom sprayer. The tractor gear system has then become engaged in reverse and moved off, with the deceased chasing after the tractor before being run over by the front wheels.

Following this incident the deceased was located lying at the edge of a road by local tourists, and was conveyed to hospital. Despite undergoing an emergency laparotomy, the conditions of the deceased deteriorated and he passed away the following day.

During the course of the investigation a fault was identified with the forward/neutral/reverse selector of the tractor, along with a broken level retaining spring. Subsequent testing confirmed that 'a simple bump to the steering wheel or closure of the cabin door was sufficient to engage the automatic gear box, causing the tractor to move off'. In addition the investigator's already discovered that the hand throttle had been wedged into position with a screw driver to maintain approximately 1600 RPM.

Recommendations:

"Whilst I accept that it is a common occurrence on many farms that heavy vehicles are left running while their operators alight to perform tasks that require a minimal amount of time, the unfortunate death of (the deceased) is a timely reminder of the dangers of such practice. I recommend that when it is required for the operator to leave the cabin of heavy vehicles the machine should be switched off to prevent a similar occurrence happening."

Interested in tractor-related deaths?

The following are a sample of relevant cases:

NSW.2000.7979

NSW.2001.1707

NSW.2001.4620

NSW.2002.3657

NSW.2002.5254

NT.2001.57*

QLD.2001.4891

QLD.2001.4953

QLD.2001.786

QLD.2001.965

TAS.2001.142

VIC.2001.1185

VIC.2001.439

VIC.2002.3490

VIC.2004.730*

* Indicates the case has a finding of interest, with the Victorian matter also containing as an attachment the inquest findings into farm tractor deaths during 1990.



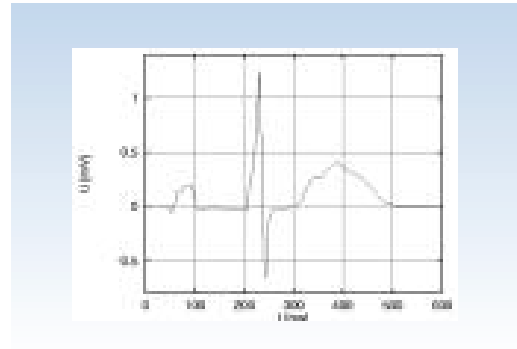
**Case Study 5:
Adverse Hospital
Equipment Processes.**

NCIS Case Number: VIC.2002.2773

Local Case Number: 20022714

Finding Delivered: 2 May 2003

Coroner: Deputy State Coroner, Iain West.



Summary:

The deceased was an 80 year old male with a medical history of coronary artery disease, diabetes mellitus, chronic obstructive airways disease, hypertension and stroke. After collapsing at home he was transported to hospital and diagnosed as having suffered another stroke.

While in the Emergency Department of the hospital the handle of an ECG monitor broke off, causing the machine to fall onto the deceased, striking him on his head and shoulder region. Losing consciousness, the deceased was transferred to another hospital for neurosurgical treatment after a CT scan showed extensive subarachnoid and intraventricular haemorrhage of the brain. With his condition not improving, the deceased passed away the following day.

During the post mortem examination the cause of death was determined to be related to an intracerebral and subarachnoid haemorrhage, with a ruptured Berry Aneurysm.

In investigating the death of the deceased an independent medical opinion was provided by a consultant neurosurgeon who supported the pathologist's causal relationship determination through identifying the link between the deceased having been struck by the 7.5kg ECG monitor and the re-rupture of the aneurysm.

Recommendation:

“Following the unfortunate and tragic death of (the deceased) I would recommend that when treating patients with any heavy equipment medical professionals should avoid carrying or moving such equipment over the patients head and if possible body area.”

Case Study 6: Recreational Boating.

NCIS Case Number:

VIC.2002.2828 & VIC.2002.2872

Local Case Number:

20022769 & 20022813

Finding Delivered: 7 July 2003

Coroner: Phillip Byrne

Summary:

During a family visit to Lake Eildon, the two deceased (an adult nephew and uncle) decided to take a ride on the nephew's Malibu inboard ski-boat. Within a matter of seconds both men were seen to be in the water with the skiboat, unmanned, travelling at full throttle around them. An alarm was raised by the family, with a search commencing for the missing men. Although the body of the uncle was retrieved, the nephew has been unable to be located.

With no eyewitnesses as to how the two men came to be thrown into the water, the possibilities at inquest included the nephew having executed an extreme manoeuvre outside the capabilities of the vessel, or the boat having struck a submerged object. On the balance of probabilities the former was deemed to have been the most likely scenario in the chain of events leading to the deaths of the two men.

Additional matters investigated by the coroner included:

- the consumption of alcohol by the nephew prior to navigating the skiboat,
- the failure of both men to wear personal flotation devices, and
- the necessity for a "dead man switch" on inboard motors to ensure vacant boats cannot continue on unmanned and out of control to the danger of the public at large and occupants of a boats who may have been tipped out.

Recommendations:

"Marine Safety Victoria, as the regulating body of the safety equipment required to be carried on board recreational vessels in Victoria, should seek to have amended the Marine Act 1988 and Marine Regulations 1999 to require occupants of recreational vessels in Victoria to wear a PFD Type 1 at all times in the event that PFD Type 1 standards are raised to at least the level of the International Standard.

As is apparently the case with outboard motors I recommend recreational vessels with inboard motors be fitted with a "dead man switch".

* Following recommendations made by the Victorian State Coroner's Office concerning the mandatory wearing of PFD Type 1s by all occupants of recreational boats, Marine Safety Victoria (MSV) has conducted a review into the use of PFDs by recreational boaters in Victoria.

A copy of the 'Personal Flotation Device Review: Bulletin 1' is available from the following website:

www.marinesafety.vic.gov.au.



NCIS Case Number	Summary of incident
ACT.2002.206	<p>Head injuries sustained by Deceased driver in collision with vehicle exiting a car yard carpark. Recommendations made in relation to the Minister for Urban Services considering whether or not a 50 KPH speed zone be implemented in the area, and review of parking policies with respect to cars being parked on nature strips outside car yards in the area.</p>
NSW.2001.2051	<p>Motor vehicle swept off weir by flood waters, resulting in drowning of driver. Recommendation made to local council that they review the safety aspects of public access to the weir as a matter of urgency.</p>
NT.2002.28*	<p>During course of police pursuit of vehicle carrying 11 occupants the vehicle left the road and overturned, resulting in one of the rear passengers being thrown from the vehicle, sustaining a severed spine. Recommendations made concerning review of the need for high speed pursuits, along with the method, supervision and training of police in such pursuits.</p>
NT.2002.161	<p>Following hospitalisation for pneumonia and a bladder neck incision, the deceased was discharged from hospital and sent home by bus, to be cared for by relatives until his death later that month. Cause of death: acute renal failure with associated severe acidosis and hyperkalemia. Issues raised during inquest regarding the quality and quantity of communication between medical and nursing staff at the hospital in relation to the pre-discharge state of health of the deceased and the discharge planning for the deceased. Recommendations made in relation to the hospital reviewing and enhancing its admission and discharge procedures, that procedures be introduced to facilitate reporting of renal patients to, and review by the renal team prior to discharge.</p>
SA.2000.1728*	<p>Acute necrotising haemorrhagic mediastinitis resulting from complications following an elective endoscopy operation. At inquest issues arose concerning the standard of treatment given to the deceased at particular stages after the endoscopy operation. Recommendations made concerning the establishment of appropriate arrangements for emergency evacuation and transfer of patients in rural and remote areas and greater communication between general practitioners and specialists.</p>
SA.2000.1752*	<p>Fatal crash of Piper Navajo Chieftain Aircraft with eight persons on-board. Examination of the wreckage and report prepared by the Australian Transport Safety Bureau. Evidence that more than fifteen crankshaft failures in Textron Lycoming engines had occurred since the Piper Navajo crashed. Recommendations made concerning Pilot Operating Handbooks and Operators Manuals, International Communications between regulators, On-board recorders, Self-deploying Emergency Locator Transmitters and Lifejackets.</p>
TAS.2002.563*	<p>Chest and abdominal injuries sustained by deceased in tractor accident. Recommendation made that operators leaving the cabin of heavy vehicles switch off the machine to prevent similar occurrences happening.</p>
VIC.2000.3623	<p>Deceased was arrested by police for drunkenness and conveyed to Custody Centre. Later found by custodial staff to be pulseless, cyanosed and not breathing. Death resulted from aspiration of vomit due to alcohol and drug toxicity. Issues arising during investigation: the appropriateness of the decision to lodge the deceased at the Custody Centre, the management of the deceased while in custody, policies and procedures in handling intoxicated persons, and the emergency response and resuscitation effort. Recommendations made relate to ACM Policies and Procedures, monitoring by senior staff, and the establishment of a 'hand-over' between police and custodial staff in relation to drug and alcohol affected persons.</p>

NCIS Case Number	Summary of incident
VIC.2000.4184	<p>The deceased was a crew member of a vessel competing in a yacht race. During a strong wind squall the deceased was swept overboard. Although rescued by the crew of another yacht, the deceased was unable to be revived. Key issues addressed during the investigation were the failure of the deceased to wear a personal flotation device, along with failed 'man overboard' and general rescue procedures. Lengthy recommendations concerning issues such as the mandatory wearing of PFD's by the yachting community, the review of the Australian Standard in relation to the design and style of PFD's, encouragement for the use of Personal Locator Beacons, and changes to race and radio management amongst others.</p>
VIC.2001.1016	<p>Death of 7 month old infant from meningococcal septicaemia following earlier hospitalisation and discharge of brother.</p> <p>Recommendations pertain to the hospital developing and instituting a training program to ensure staff are aware of the core elements of the guidelines relating to the treatment of suspected meningococcal disease and for consideration to be given to having the Clinical Educator or a Clinical Nurse Specialist attend the Advanced Life Support course with a view to becoming better equipped to adequately train other staff.</p>
VIC.2002.225	<p>Double recreational boating fatality. Issues regarding the hire of the aluminium boat, the lack of safety equipment (including PFD's) and briefing provided to the party by the hire company, and level of alcohol intoxication of the deceased were raised during the investigation. Adoption of earlier recommendation concerning the mandatory wearing of PFD's by the recreational boating community encouraged.</p>
VIC.2002.1173	<p>Cardiac failure following acute respiratory arrest following aspiration of food occurring at nursing home. Recommendation that reportable deaths not being reported be brought to the attention of the AMA for educational purposes.</p>
VIC.2002.1332	<p>Double recreational boating fatality. Issues regarding the hire of the aluminium boat, the lack of safety equipment (including PFD's) and briefing provided to the party by the hire company, and level of alcohol intoxication of the deceased were raised during the investigation. Adoption of earlier recommendation concerning the mandatory wearing of PFD's by the recreational boating community encouraged.</p>
VIC.2002.2773*	<p>Deceased collapsed at home and was transferred to hospital. Whilst in the Emergency Department the handle of an ECG monitor machine fell onto the deceased, striking his head/shoulder region, leading to a loss of consciousness. Recommendation relating to safety practices of treating patients with heavy equipment.</p>
VIC.2002.2836	<p>Double recreational boating fatality.</p> <p>Recommendation made concerning the definition of "Coastal waters" within the Recreational Boating Safety Handbook.</p>
VIC.2002.2857	<p>Double recreational boating fatality.</p> <p>Recommendation made concerning the definition of "Coastal waters" within the Recreational Boating Safety Handbook.</p>
VIC.2002.2828*	<p>Double inboard ski-boat fatality. Recommendations made concerning the amendment of the Marine Act 1988 and Marine Regulations 1999 to require occupants of recreational vessels in Victoria wear a PFD Type 1 at all times, and that recreational vessels with inboard motors be fitted with a "dead man switch".</p>
VIC.2002.2872*	<p>Double inboard ski-boat fatality. Recommendations made concerning the amendment of the Marine Act 1988 and Marine Regulations 1999 to require occupants of recreational vessels in Victoria wear a PFD Type 1 at all times, and that recreational vessels with inboard motors be fitted with a "dead man switch".</p>

Recent Research of Interest

- Adverse Reactions to Clozapine:
Requested by Coroner Heather Spooner, Victoria.
- Update of All Terrain Vehicle / Quad Bike search:
Requested by Coroner Arnold Shott, Tasmania.
- Electrocution from contact with overhead power lines:
Requested by State Coroner John Abernethy, NSW.
- Epilepsy-related Motor Vehicle Accidents:
Requested by Coroner Jane Hendtlass, Victoria.
- Infant Overlaying Deaths:
Requested by Coroner Phil Byrne, Victoria.
- Logging Deaths:
Requested by the NSW State Coroners Office.
- NSW Rock Fishing Fatalities:
Requested by the NSW Department of Sport and Recreation.
- Deaths involving Percutaneous Endoscopic Gastrostomy Tubes (PEG):
Requested by Professor Stephen Cordner,
Victorian Institute of Forensic Medicine.
- Ultralight Fatalities:
Requested by State Coroner Graeme Johnstone, Victoria.

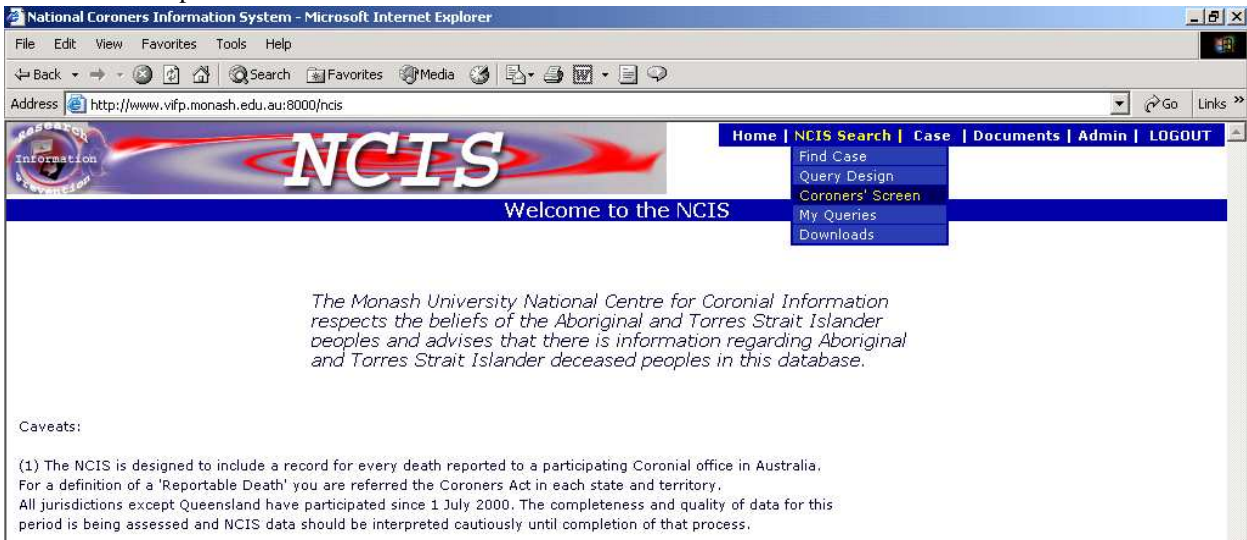
Search Tips

HOW TO FIND A CASE USING THE NCIS NUMBER

To log onto NCIS

To log onto the NCIS, follow these steps:

1. Go to the NCIS web address of www.ncis.org.au, and select the option “NCIS Access for Authorised Users”.
2. Enter your username and password.
3. You will be presented with the NCIS welcome screen.



Finding cases using the NCIS number

The NCIS number is a number given to a case to uniquely identify it on the NCIS, and it consists of three components being Case State, Case Year and State Sequence

Once you have logged into NCIS, to find a case using the NCIS number:

1. Select “Find Case” from the NCIS Search Menu on the top right hand corner of the Welcome screen.
2. On the Find Case Screen enter the Case State, Case Year and State Sequence (as detailed in the NCIS number) into the appropriate sections of the search fields and click search.

The example below shows how to find a case with the NCIS number of NT.2000.169

The screenshot shows the 'Find Case' search form on the NCIS website. The form is titled 'Find Case' and contains several input fields and dropdown menus. The 'Case State' dropdown is set to 'NT', 'Case Year' is set to '2000', and 'State Sequence' is '169'. Other fields include 'Case Status' (set to '---'), 'Local Case Number', 'Surname', 'Firstname', 'Sex' (set to '---'), 'Court' (set to '---'), 'Post Mortem No.', and 'Create User'. A 'Search' button and a 'Back' button are located at the bottom of the form. The user's name 'User: jessicap' is displayed at the bottom left of the form area.

Fatal Facts Feedback Form

SPECIAL EDITIONS

Please indicate any areas of interest you would like to see featured in future special editions i.e.: Drowning in swimming pools.

ADDITIONAL COMMENTS / SUGGESTIONS ABOUT FATAL FACTS

Name

Address

Please return to:

National Coroners Information System
C/- Victorian Institute of Forensic Medicine
57-83 Kavanagh Street
SOUTHBANK VIC 3006
Fax: 03 9682 7353

Phone