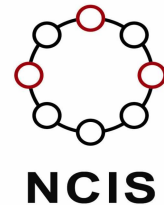




The NCIS is managed by the Victorian Institute of Forensic Medicine on behalf of the State/Federal funding agencies. The NCIS is funded by each State/Territory Justice Department around Australia, and the Australian Departments of Health and Ageing, Employment and Workplace Relations, the ACCC, the ATSB and the Institute of Criminology.



Fatal Facts

A Publication of the National Coroners Information System

This edition of Fatal Facts features 55 coronial cases where recommendations have been made. The cases covered in this edition were those closed on the NCIS between 1 July 2004 and 30 October 2004.

Two topic areas upon which several recommendations were made are highlighted in detail. These recommendations involve work-related deaths (with a specific focus on appropriate training and risk assessment), and bicycle-related fatalities.

If you should 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). Please log on using your authorised user name and password, and find the particular case by clicking on the "NCIS Search" tab and selecting "Find Case".

If you have forgotten your user name and password, or require advice regarding access to the NCIS database, please do not hesitate to contact our Access Liaison Officer, Marde Hoy, at mardeh@vifm.org 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

July 2006

Edition 10

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NCIS at a glance

• Number of cases on the NCIS (notified to a Coroner up to 30 June 2006):	114,505
• Number of findings on the NCIS for cases closed between 01/03/2004 and 30/06/2004:	3362
• Number of cases with recommendations closed between 01/03/2004 and 30/06/2004:	55

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

Case Study 1 - Work-Related Deaths

• *Lack of or Inadequate Training* •

Case No: SA.2003.2957

Date of Finding: 3rd September 2004

Coroner: Wayne Chivell

Summary: The deceased, a 73 year old man, and his wife were on their way into a shopping centre when they found a pink-coloured purse on the ground. The man picked it up, went to the Information Desk and reported that he had found the purse and that he would leave his name and number for the owner to contact him. He was told that he should leave it there. He declined to do so and walked away.

At this time, he was followed by a Security Officer employed by the Shopping Centre, who was a witness to the conversation. The guard, who felt the man's behaviour was suspect, followed him out of the Centre. Outside the shopping centre, the guard confronted the deceased. A physical altercation then took place between the two men during which it is alleged by several witnesses that the deceased was 'manhandled'.

The deceased became agitated during the exchange and collapsed into unconsciousness. He died shortly after of ischaemic heart disease due to coronary atherosclerosis.

Recommendations:

I therefore recommend that the level of training given to licensed security officers be reviewed by: Westfield Limited; The Minister for Business and Consumer Affairs to ensure that the likelihood of a repetition of such a tragic event is reduced.

Case No: NT.2003.15

Date of Finding: 1st October 2004

Coroner: Elizabeth Morris

Summary: The mother of the deceased was driving south on the Stuart Highway, at 120 kph in an unrestricted zone with her three children.

Her vehicle hit a metal plate on the roadway. The vehicle slid out of control, due to a punctured left rear tyre from the metal plate, rolled and fell into a river. The mother managed to escape the vehicle but was unable to free her 3 children, who subsequently drowned.

Investigations revealed that the metal plate was a "grouser plate" that had fallen off the back of a trailer in a road train earlier that day. The Coroner found a very junior member of the company staff with no experience and insufficient supervision was tasked to tidy up and

band pallets.

Recommendations:

From the evidence in this investigation, I make the following recommendations:

1) I recommend that the company continue to develop and offer training on loading particular materials on pallets.



2) I recommend that the company provide to staff formal training on load restraint methods and develop and document procedures for loading trucks in accordance with the load restraint guide.

3) I recommend that the NT Police continue to provide the Accident Investigation Unit staff with investigation and interview training as well as the other matters raised in the letter of Assistant Commissioner Kelly to the Territory Coroner on 17 August 2004, in an endeavour to improve the quality and timeliness of coronial investigations.

4) I recommend that a protocol be developed between the NT Police and NT WorkSafe in relation to the reporting and investigation of work related motor vehicle accidents.

5) I recommend that NT WorkSafe work with the trucking industry and related industries to provide information on standards and procedures in the industry in regard to use of pallets, banding of pallets and the development of formal training materials on the requirements of the load restraint guide.

Work-related deaths continued...

Case No: VIC.2003.2025

Date of Finding: 25th October 2004

Coroner: David Cottrill

Summary: The deceased, a 52 year-old man, was interviewed for employment in or about May, 2002. The co-director of the company states that he had known the deceased for about fifteen years and believed the deceased held a fork lift licence. The deceased also advised he held a fork lift licence. The deceased had also attended the Victorian Farmers Federation training course in respect to the use of front end loader and fork lift. The Co-director, however, did not sight a licence document held by the deceased.

A search of Worksafe Victoria records after the event confirmed that the deceased did not hold a fork lift certificate of competency or any other class of certificate of competency.

On the day of the incident the deceased was working in the company with another casual employee and had been performing maintenance work on various pieces of plant. There was a clear instruction from the Director that any employees working with the fork lift or performing maintenance work at height was to be carried out by two persons present together.

The other employee then departed for a cup of tea and the deceased advised him that he would stay and clean up. The deceased then raised the fork lift with the pallet attached to the forks, climbed through the body of the fork lift and past the fork lift mast onto the pallet.

Upon returning from the pallet to the ground the deceased has climbed backwards through the roll bar window "space". It is probable that the deceased either slipped or inadvertently touched the tilt lever with his foot causing the mast to tilt back to a more upright position, pinning the deceased between the mast and roll bar.

Recommendations: It is recommended that Workcover review the Victorian Farmers Federation training and information program for fork lift operators to ensure that participants clearly understand that attendance and participation does not constitute certification or the obtaining of an operator's licence.

Case No: ACT.2004.60

Date of Finding: 6th August 2004

Coroner: Phillip Thompson

Summary: The deceased was struck by the driver of a Toyota van while on his paper delivery rounds. The driver stated that he saw the deceased startle and move

to the right into his path. The driver braked and tried to avoid hitting the deceased, but was unable to avoid hitting the deceased due to an armco rail.

Recommendations: That this Brief and my findings be forwarded through the Attorney-General to A.C.T. WorkCover with a request that they investigate the company and its drivers and subcontractors in relation to the practice of loading delivery vehicles with newspapers in such a way as to restrict a driver's view such as occurred in this matter.

Case No: VIC.2003.3776

Date of Finding: 14th September 2004

Coroner: David Cottrill

Summary: A 55 year old man, had left the family home to begin work utilising a John Deere 4230 model tractor towing a hay rake to rake a recently mowed paddock of lucerne in preparation for baling. The deceased's wife later found the deceased lying on top of fallen trees with a massive head injury.

The deceased's son stated that the John Deere tractor had been purchased second hand in 1989. The tractor is designed with an inbuilt "inhibitor switch" which is intended to prevent the tractor being started whilst in a gear other than neutral. The inspection revealed that the inhibitor switch was disconnected and a piece of wire was attached to the wiring loom in order to bypass the switch. This bypass therefore allowed the tractor to be started in any gear.

Recommendations:

Deaths associated with incidents involving machinery and in which there has been modification to safety equipment (protective devices), are regularly the subject of coronial findings and investigations. Often second hand machinery has been purchased without the purchases having knowledge of such modification to safety equipment, generally where there has been no mechanical or safety report on the machinery prior to or after purchase. Farmers should not purchase or use second hand machinery without having the machinery checked for modifications or faults within protective safety devices on the machinery. This case highlights the high risk of continuing to use potentially dangerous farm machinery without appropriate safety checks.

Case No: VIC.2003.1531

Date of Finding: 4th March 2004

Coroner: Phillip Byrne

Summary: The deceased, aged 22 years was employed as a driver. He had been employed for approximately 1 year and was described by the Company's Production Manager as an experienced driver who was always keen and reliable. On the day of the incident,

Work-Related Deaths continued...

the deceased was driving his premix cement truck when he lost control of his vehicle after driving on to the white fog line. The truck progressively slid sideways across the road onto the grass verge on the southern side of the road and rolled.

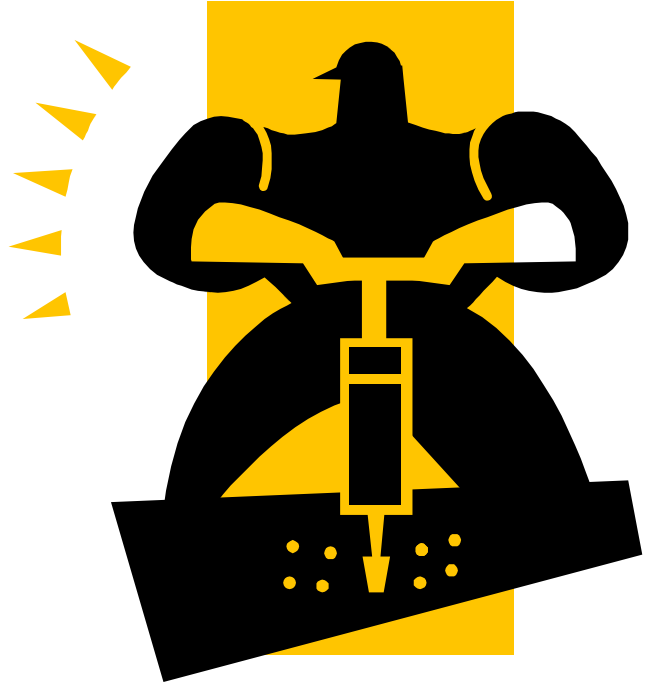
Upon inspection, it appeared that he was not wearing his lap sash seat belt prior to the accident. At the time of the accident the weather conditions were foggy with visibility down to approximately 50 to 100 metres. The road was wet and the traffic was light. Toxicological analysis revealed tetrahydrocannabinol (Cannabis) 4ng/mL. The presence of tetrahydrocannabinol (THC) in blood concentrations in excess of 2ng/mL strongly suggests recent use of cannabis (within a few hours).

Recommendations:

As a result of Senior Constable Michael Harrison, Hume Traffic Management Unit's investigation into the circumstances of the accident he has made the following recommendations to Hume City Council;

1. Adequate signage be erected warning motorists of approaching intersection,
2. Ripple strips placed across the road with road surface upgrade,
3. Reduce speed limit from 100kph to 80kph,
4. Adequate lighting to illuminate the intersection,
5. Armco railing to be installed behind the chevrons at eastern end on Mt. Ridley Road to avoid any vehicle overshooting the intersection and colliding with vehicles on the Hume Highway.

Adoption of these recommendations may well reduce likelihood of accidents at this location. However in relation to this death, it is clear that the prevailing weather conditions, failure to wear a seat belt and the presence of tetrahydrocannabinol assuredly contributed to his death.



DID YOU KNOW?

Since July 2005, the Work-Related Liaison Service (WRLS) has been assisting the Victorian Coroner's Office to investigate industrial deaths that are work related (along with other related fatalities). The WRLS have a quarterly publication called 'Workwise' which summarises selected Coronial cases of interest to workers. Workwise can be accessed from www.vifm.org/workwise and the WRLS can be contacted via wrls@vifm.org.

Case Study 2– Bicycle Accidents

Case No: VIC.2004.403

Date of Finding: 27th September 2004

Coroner: Graeme Johnstone

Summary: The deceased was riding his mountain bike home from work in the far left lane of three lanes. He swerved to the far right of the left lane prior to collision with a white Mitsubishi van. The van was travelling in the same direction along the Hume Highway at a speed between 70 and 80 km/h. The van driver stated: "I was travelling down the left lane and there was a guy on a bicycle and it was dark and I didn't see him. I didn't even have time to skid and I hit him". The Coroner noted that the bicycle had no head lights and a dim red light in the rear. The deceased was dressed in dark clothing and wore no protective helmet or reflective gear. The headlights of the van were on. The clothing of the deceased was described by an ambulance officer who had seen him on the Hume Highway shortly before the incident as "a faded yellow construction worker's vest."

Recommendations:

1) Research be conducted on the issue of the bicycle rider's perception of the motorist's view of visibility (in order to identify other potential countermeasures) in the event that the cyclist's perception equates to that of the American research indications for pedestrians. If the research identifies a significant perception problem then there may need to be further work on education and related countermeasures for cyclists.

2) That the "Share the Road" campaign and its focus on cyclist visibility is supported. The program (and its exposure) may need to be regularly revisited as part of the overall road safety message "Arrive Alive." Regular and selective enforcement in Metropolitan Melbourne and Country Victoria is part of any program to gain an acceptable level of compliance and reduce the injury rate. There is an important community role for police across the State to be aware of the preventable nature of many of the night-time bicycle related deaths (due to visibility problems) and regularly deliver this message to the cycling community. The issue of enforcement as a potential deterrent is relevant in the circumstances of this case.

3) No doubt all employers have considerable potential to assist in delivering a road safety message to employees who use this particular method of transport.

Case No: VIC.2003.2979

Date of Finding: 29th July 2004

Coroner: Graeme Johnstone

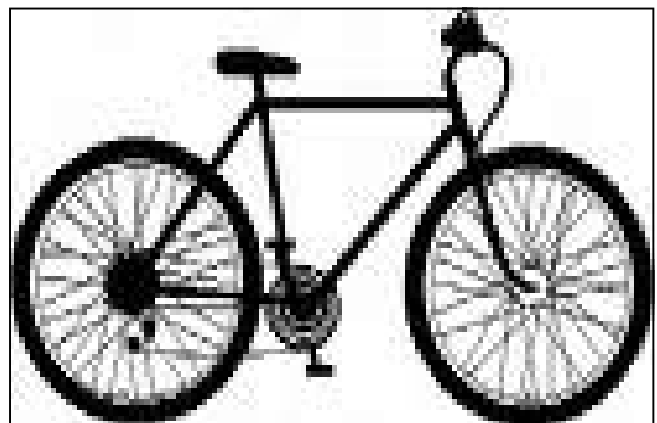
Summary: The deceased, aged 25, was riding his bicycle in a westerly direction. He crossed an intersection when the light was green, in the left lane and gained a fast speed as

he was coming down a decline. On the other side of the intersection a 3 axle, 12.5 tonne truck was headed in the same direction, in the centre lane. The deceased would have been about 5 metres behind the truck at this stage when it indicated left to make a turn into a driveway. The deceased then apparently realised he would hit the truck and attempted to brake immediately. His back wheel locked and he skidded for 16.8 metres. He lost balance and was flung over the handlebars of the bike, hitting the truck on the left passenger side, approximately one metre from the first rear axle. At this stage, the driver still had no knowledge of the collision and continued driving, consequently running over the deceased with his rear tyres. This caused extensive injuries to the deceased's head and shoulders, damaging his helmet.

An inspection of the bicycle showed poor front and rear brakes and a worn rear tyre. The front brake was not operating effectively indicated by only the rear tyre causing skid marks.

Recommendations:

This death may have been prevented by "Side Life Guards" being fitted to the side of the truck. These "life guards" were fitted to early buses (in the 1920's) in order to prevent this type of incident. The guards were referred to in early reports of English Coroners. Side life guards may have prevented [the deceased] falling under the wheels of the truck (see reference in the Journal of The Australian Coroners Society "Inquest" Issue 1, October 2002 at page 107). It is also possible that properly maintained brakes and tyres on [the deceased's] bicycle may have enabled him to avoid the outcome.



Child Deaths

<p>VIC.2003.3787</p>	<p>The deceased, aged 14 months, was playing in his parents bedroom with other family and cousins. His mother entered the room and discovered the deceased with the curtain cord around his neck and he was not breathing. The deceased was transported to the Royal Children’s Hospital however died three days later when life support was removed. It appears that the deceased had played with the curtain cord on several past occasions despite his parents' efforts to keep it out of his reach.</p> <p>Recommendations:</p> <p>Safer design options would help to prevent future deaths of young children from blind and curtain cords. Had safe design solutions been implemented many years ago when these types of "accidental" deaths began to occur, it is likely that the death of [the deceased] would have been prevented. Accidental child strangulations or hangings with blind and curtain cords are not unusual and have been happening for many years. Last year, prior to the death of [the deceased] an issue of concern was raised by a researcher (Associate Professor James Harrison, National Injury Surveillance Unit, South Australia) with the National Coroner’s Information System (NCIS) following a search of the NCIS. On receipt of the notice advising of the issue of concern all State and Chief Coroners and the Victorian Attorney General were advised in early August 2003. Professor Harrison also provided some information on developments with countermeasures and this information was given to the relevant authorities.</p> <p>The finding in one case example (Death 3), was delivered by Tasmania Coroner Helen Wood on 19th December 20034. The Coroner has examined, in some detail, similar deaths in other jurisdictions (some Australian and overseas countries). Three recommendations have been made by the Tasmanian Coroner and this court adopts, in principle, those recommendations. Essentially the recommendations deal with a public awareness program (similar to that adopted by NSW), modification of existing cords and mandatory safety standards for new cords. It suggested that the Tasmanian Coroner’s recommendations be considered in Victoria. There is an indication in the Coroner’s file on the death of the deceased that the parents may have had some difficulty with English. It is important, as with any countermeasure, to ensure that parents and carers from a non-English speaking background be considered in any public or general information and awareness campaign. It is noted that the inquiry by the Blind Markers Association of the NCIS for data is one of the first uses of this information system by an industry group.</p>
<p>VIC.2002.1634</p>	<p>In 2002 the deceased was a five year-old preparatory student at Primary School. His school days commenced with travel to the primary school in a school bus with his brother. On the day of his death, the deceased's brother did not go to school that day and his usual prep teacher was also excused from teaching duties at lunch time, due to ill health. Due to these factors, the normal procedures for supervising children who took buses to and from school did not seem to occur. On the day of his death, the deceased had told his friend that he was walking home. A witness observed the deceased looking at the traffic going north and then he 'walked out into the flow of traffic'. A truck passing by then struck and killed him.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. The Department of Education is urged to investigate the possibility of conducting some additional form of supervision for preparatory school students who use bus travel in regional and country areas. It is apparent that this might be done by formulating a student roll particular to preparatory students, detaining these very young children in a group, checking them off a roll, and then guiding them to the bus at the end of the day, at least when they are in their first year of school. Some form of rallying point could be considered which would not necessitate the employment of additional staff given the relatively few preparatory students who appear to use the bus service. The list of school students which has currently been compiled at the primary school should become a part of the school protocols and form a formal part of the discussions at the parent orientation meetings with a view to informing parents of the potential for problems. Any such list should be up dated regularly.

Child Deaths—cont'd

<p>VIC.2002.1634 (cont.)</p>	<p>2. Having regard to the observations of Sergeant Bellion the City of Greater Shepparton is urged to place some form of barrier around the particular traffic island or median strip from which the deceased stepped into the oncoming traffic on the day of his death. The inquest heard that children could be seen using that median strip as a crossing point. The particular intersection is very busy and congested at the time of day that this accident occurred and many children use the sidewalks as pedestrians. Any form of barrier considered should be significant enough to discourage this sort of use by school students.</p> <p>3. The City of Greater Shepparton is urged to consider making the speed limits on Echuca Road (which is a busy commercial road at both school starting and closing times.) more uniform in the stretch of road which passes the school zone. Echuca Road has a range of speed limits from the northern boundary of the Mooroopna Secondary College to the intersection of Treacy Street. These do reflect the need to slow traffic at school closing and opening times but they vary along that stretch of road. Greater uniformity might be considered given the amount of pedestrian student traffic, including the potential for students from the O'Brien Street Primary School to use that stretch of road.</p>
<p>VIC.2003.3113</p>	<p>The deceased, a ten year-old boy, was at home with his brother when their mother returned from work. After a period of time and following some teasing by his brother, and a firm direction by his mother to go and get some hay bale string from the shed, he left the house. The deceased was absent from the house for longer than was necessary to get the string, so his mother started calling for him to come inside. His mother eventually went to the shed and found the deceased hanging by a nylon cord around his neck, that was tied back to a roof truss.</p> <p>The primary focus of the inquest was the appropriateness of the ambulance response time to the request for assistance. The first ambulance unit (MICA 13) arrived approximately 25 minutes after the call was logged, significantly exceeding the MAS benchmark (13 minutes). This prolonged time was due to the distance required to be travelled by the two units that the ECV Dispatcher determined to be the most appropriate to respond.</p> <p>Recommendations:</p> <ul style="list-style-type: none"> i) That an independent assessment be undertaken as to the adequacy of ambulance services currently provided in areas such as Bacchus Marsh, that are on the cusp of metropolitan and regional responsibility. ii) The hearing heard of an oversight by [the Emergency Services staff] in failing to identify the presence of BMO97 as a closer unit to those dispatched. It is recommended: That ECV examine the practicality of modifying the CAD system in order to prevent such an occurrence by, for example, introducing a prohibition on further use of the system until acknowledgment of a closer unit's presence is recorded. iii) The hearing heard of an error made by [a Paramedic] who inadvertently administered Maxolon instead of Atropine, as part of the drug therapy protocol. It is recommended: That manufacturers give consideration to modifying the shape and or size of these ampoules, in order that they may be more clearly differentiated.
<p>NT.2004.55</p>	<p>The deceased was a fifteen year old girl with a previous history of experimenting with alcohol, marijuana, petrol sniffing and prescription medication. It was found the deceased took a quantity of her stepfather's medication and was found deceased the next morning. On the day of her death, the deceased's step father observed that the deceased was very wobbly on her feet. On observing the deceased's behaviour, he told her to go to bed. The deceased's step brother told his father that he had seen the deceased crush up some tablets and put them into a bottle of coca-cola but when questioned, the deceased ignored her stepfather.</p> <p>Recommendations:</p> <p>It is my recommendation that Family and Children Services investigate very carefully the suitability of the stepfather's guardianship of the deceased's siblings in particular what measures he has put into place to avoid those children having access to his prescription medication as the deceased did.</p>

Deaths in Custody

<p>SA.2001.1073</p>	<p>The deceased contacted the Control Room from his cell in the Adelaide Remand Centre ('ARC') using the intercom system, calling for help. He told a Correctional Services Officer that he had cut himself. Three Correctional Services Officers attended the cell. They could see through the viewing panel that the deceased had wounds to both arms and there was a large amount of blood in the area. The correctional services officers obtained surgical gloves and towels and then entered the cell. The deceased resisted their attempts to stop the bleeding. Two Registered Nurses arrived at the cell. The deceased was carried to the Infirmary. Upon arrival in the Infirmary, the deceased was in cardiac arrest.</p> <p>Recommendations:</p> <p>I therefore recommend, pursuant to Section 25(2) of the Coroners Act, 1975 that the Director, Forensic Health Service, in consultation with the Chief Executive Officer, Department for Correctional Services:</p> <p>Examine the time available to clinicians to ensure that there is sufficient time to carry out an appropriate mental state examination before a prisoner is assessed as not being at risk of self-harm;</p> <p>Consider whether a special arrangement needs to be put in place when a prisoner is being considered for transfer out of an area set aside for surveillance of 'at risk' prisoners so that an adequate assessment of a prisoner's mental health takes place before a decision is made.</p>
<p>VIC.2003.5</p>	<p>The deceased, a 38 year old man, was arrested for being drunk in a public place. He was lodged in a prison van, being the only occupant at the time. Two other individuals were subsequently arrested and placed in the prison van and it was discovered that the deceased had hanged himself with his belt which has been inserted in the internal grill in the ceiling of the police brawler van. Police immediately took the deceased down and administered first aid. The Coroner found the response that followed to be professional and appropriate.</p> <p>Recommendations:</p> <p>As earlier indicated, all new vehicles obtained by Victoria Police are subject to evaluation and risk assessment, prior to being commissioned into service. Over time however, through day to day wear and tear, and possibly vandalism, the safety of such vehicles may be compromised. It is recommended that a protocol of regular evaluation and risk assessment of all vehicles be implemented with a view to maintaining appropriate safety levels for police members and members of the public.</p>

Deaths in Custody

<p>SA.2001.2285</p>	<p>The deceased, a 36 year-old male, was found hanging in his cell, 11 months after initial incarceration. The deceased was not cut down, nor was resuscitation attempted by the Corrections Officers due to their assessment that the deceased was already dead. The police and ambulance were notified and entered the Cell shortly after where they pronounced life extinct.</p> <p>Recommendations:</p> <p>Pursuant to Section 25(2) of the Coroners Act 1975, being satisfied that to do so might prevent, or reduce the likelihood of a recurrence of an event similar to this before me, I recommend:</p> <p>That DCS and Group 4 review the language used in the relevant procedures to ensure that there is no uncertainty among custodial staff about their duty to resuscitate a prisoner in an emergency situation;</p> <p>That Group 4 either: Provide a nurse qualified to provide emergency treatment to a prisoner should be available 24 hours per day, 7 days per week at Mount Gambier Prison; Alternatively, Group 4 ensures that custodial staff are adequately trained and equipped to provide appropriate emergency treatment to a prisoner pending arrival of ambulance officers;</p> <p>That Group 4 take appropriate steps to ensure that, in accordance with principles developed in the 'safe-cell' project, cells used to accommodate prisoners at Mount Gambier Prison are designed to ensure that hanging points are kept to a minimum;</p> <p>That DCS and Group 4 put appropriate consultative procedures in place so that changes in DCS practices and procedures are implemented in Group 4-operated prisons without delay;</p> <p>That Group 4 put appropriate procedures in place to ensure that prisoners do not have access to hanging materials such as timber straps, etc.</p>
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Deaths in Custody (cont.)

<p>VIC.2004-348</p>	<p>The deceased was aged 29 when he died, 13 days after he was released from prison on an intensive parole order. He was a known drug user and suffered from Hepatitis C. He underwent pre-parole preparation whilst in custody and was assessed by ACSO (Australian Community Support Organization) who referred him for a first appointment with Voyage Drug and Alcohol Services 3 days after release.</p> <p>The deceased failed to attend his appointment as arranged with Voyage. A message was left by the Voyage worker for the deceased's Parole officer to that effect. The deceased attended his subsequent appointment with his parole officer, but he was late and in such a drug affected state that the meeting was very brief and could not deal with any of the issues under the parole order.</p> <p>The next week the deceased was again drug affected but to a lesser extent than before, so an Individual Management Plan questionnaire was completed. The answers and discussion with his parole officer revealed that he was further offending, resistant to treatment and a high risk. Apart from a further appointment being made with Voyage in the presence of the deceased for a few weeks time, no other action was taken.</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1) "it is expected that a significant part of the case management for an offender who has attended under the influence of illicit substances, will include either the implementation of drug and alcohol treatment options or timely follow up where non attendance at these programs has occurred" 2) "it is expected that an attendance under the influence of an illicit substance should result in that attendance being rescheduled, as soon as possible. Equally, ancillary issues such as the notification to treating agencies of a relapse in drug use should occur as a matter of priority" 3) "it is expected that verification of attendance at treatment agencies is also actioned by CCS staff, immediately following a scheduled attendance. Equally, it is subsequent treatment appointments are rescheduled as a priority" 4) "Should an offender present in crisis or at significant or imminent risk, there are several options available to jointly manage an offender" including using the Senior CCO, Location Manager, rostered duty officer or consultant in-house psychologists. 5) A report of Offender Deaths in Community Correctional Services Victoria 1999-2004 concludes in part that " parolees are at greater risk of dying in the community than offenders on other Order types. Further research is recommended in order to identify those parolees at the highest risk of dying upon release and therefore provide them with targeted intervention strategies in order to reduce the likelihood of their death in the community." <p>I recommend that Community Correctional Services responses highlighted in the above Comments be widely disseminated amongst all relevant staff involved in the supervision of parolees.</p> <p>I recommend that consideration be given to making available sufficient resources for the further research highlighted in paragraph 5 in the above Comments, " to identify those parolees at highest risk of injury upon release and therefore provide them with targeted intervention strategies in order to reduce the likelihood of their death in the community".</p>
<p>VIC.2003-3153</p>	<p>The deceased, aged 57, suffered from an Intellectual Disability and was non-communicative and blind. The deceased was under the care of the Department of Human Services. On the day of the incident he was taken on a day outing with a group of four other disabled individuals by two instructors from the his Centre. The instructors decided to go to the Drouin Nature Reserve.</p> <p>The group arrived at the reserve at about 11am and the weather was reported as being "still nice but it was a getting bit greyish and the wind was pretty still, there may have been a breeze in the air..." They decided to go under the main shelter and morning tea was served at about 11.20am. "All of a sudden...heard a cracking sound..." looked around and "saw a tree coming towards the shelter...". The Instructor said the roof caved in "right where the deceased was standing."</p> <p>Recommendations:</p> <p>Where an area is being managed by a public authority (such as Gippsland Water, Councils and Shire [e.g: in parks, etc]) or by a private organisation (e.g.: a caravan park) and (like in the circumstances of this case) the public is encouraged to use the facilities and may congregate under a shelter or around a B.B.Q. area, practical measures need to be adopted to manage the risk. By way of example Gippsland Water's "Management of Public Open Space Policy" [a two page document] is attached and may be considered as a useful approach. General safety management measures would include:</p> <ul style="list-style-type: none"> • Adoption and documentation of a risk management policy; • Ensuring the policy, once adopted, is followed, audited (and updated where appropriate); • The policy would need to consider including issues like (but not limited to): A regular (and documented) review of the area by an appropriate expert (an arborist); • A tree planting program that recognises and minimises the longer term risk; • Where a building or B.B.Q area is likely to be constructed an appropriate mechanism should be established for identifying potentially dangerous trees in the immediate area and reducing the risk. • Any policy would, no doubt, have to take into account the overall amenity of the public area and practically balance the safety issues.

Drowning	
VIC.2003.413	<p>The deceased was 27 years of age at the time of his death, where he drowned in the 25 metre swimming pool at an Aquatic and Recreation Centre. The deceased was a reasonably competent swimmer and approximately 1.75 metres tall but drowned in approximately 1.6 metres of water. Although the Coronial enquiry could not determine how the deceased drowned in water that he could stand in, it did consider the issue of pool supervision as an important factor.</p> <p>Recommendations:</p> <p>The provision of adequate supervision is a matter for management. In a matter I heard last year (Coroners Case No. 3758/00) I made the following observation which is pertinent in the context of this inquest: "It must be remembered the Royal Life Saving Society publication provides guidelines only. Whilst it may be viewed as aquatic industry best practice, on occasions initiative must be exercised by those individuals responsible for pool management. Thorough training is imperative, lifeguards need to have a practical understanding of the guidelines and, just as importantly, understand the rationale and objects behind them."</p>
ACT.2000.315	<p>The deceased was a 34 year old man, who had gone with his friends to a dam to catch yabbies. They had been swimming in the area at the top of the wall for about five minutes before moving down to the slip way. The deceased turned from the wall and swam back against the current towards a small retaining wall. He then shouted "I'm stuck, I can't do nothing" and was swept towards the centre of the slipway. He went limp and went under the water and was not sighted again. Police searched the water for approximately one hour when they found the deceased below a rock ledge underneath the surface of the water.</p> <p>Recommendations:</p> <p>I recommend that one Authority should be responsible for the maintenance and security of the whole of the dam area including the surrounds, dam wall, stilling pond and spillway rather than the existing arrangements where three Authorities are involved. I further recommend that consideration should be given to fencing off the area from the public and to the posting of universally recognised no swimming signs.</p>
VIC.2004.431	<p>The deceased, aged 23 months, drowned in the family farm when he wandered out of sight of his mother and grandfather.</p> <p>The dam is located 10 to 15 metres from the house and is fenced off by an electric fence. The bottom wire is 400mm off the ground. The dam paddock is fenced off by a barbed wire fence and this fence was close to the area where the mother and grandfather had been working. The barbed wire fence starts 300mm from the ground. The edge of the dam is quite steep, which may have proved difficult for the deceased to negotiate, but the fences would have been easy for him to crawl under.</p> <p>Recommendations:</p> <p>Future public awareness campaigns by water-safety organisations should be broadened to include safety messages that account for the differences between rural and urban water hazards, in particular the use of the "be dam careful" slogan should be reconsidered by the Victorian farming industry;</p> <ul style="list-style-type: none"> · any public awareness campaign should address carers consciousness of how quickly toddlers can get into danger, especially those most at risk in the one to three years age bracket; the idea of creating "child safe areas" on properties containing dams should be widely publicly promoted; and · the feasibility of conducting Home Safety Parties in rural towns such as Ballarat, Bendigo, Echuca, Warrigal, Geelong and Horsham should be undertaken by the Victorian Farmer's Federation (VFF) in conjunction with the Royal Children's Hospital Safety Centre, the Country Women's Association (CWA) and Kidsafe to determine whether they would be a successful forum for educating carers and disseminating information on appropriate safety measures for children. The Department of Human Services has recently funded the FarmSafe Alliance to action the recommendations related to assisting to raise awareness of the dangers dams pose to young children and to assist with the promotion of "child safe play areas" on properties containing dams. In addition the Rural and Regional Services and Development Committee (RRSDC) (a Joint Investigatory Committee of the Parliament of Victoria) is conducting an inquiry into the main causes of death and injury on Victorian farms. The issue of drowning of young children in dams is part of this inquiry, which is due to report to Parliament later this year. Life Saving Victoria (formerly Royal Life Saving Society) is seeking funding to manage an advertising campaign structured around the rural and regional version of their toddler drowning awareness program "Keep Watch" · This would build on the links with Farm Safe Australia and Farm Safety Alliance Victoria and consist of materials to assist in promotion of the Keep Watch across Victoria.

Fall related deaths

TAS.2003.266	<p>The deceased, a 59 year-old woman, and her husband drove to visit friends at a shack at Eaglehawk Neck. The house was a timber and weatherboard shack where the friends they were visiting were staying. The shack was built on a slope with the front some metres off the ground. Running along that entire front and down one side was a timber balcony with a timber guardrail.</p> <p>When the deceased and her husband greeted their friends upon arrival at the shack, with the deceased leaning against the balcony guard rail while doing so. Almost immediately, the top rail of the balcony gave way and the deceased and her friend fell onto stones and rocks below, approximately 2 metres down.</p> <p>Recommendations:</p> <p>This was a tragic accident which resulted in the death of one person and the serious injury of another. It would appear that had the balcony railings been built with more care this accident is unlikely to have occurred. It should be a reminder to all builders and home renovators of the paramountcy of safety considerations when building or renovating.</p>
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Fire

ACT.2003.255	<p>The deceased was found dead in fire damaged premises. The cause of death was smoke inhalation and probably, in the opinion of the pathologist, contributed to by ischaemic heart disease (severe coronary artery disease). The Coroner found that the death was accidental. However, it was noted that the deceased had been diagnosed with schizophrenia and at the time of her death was subject to an involuntary psychiatric treatment order issued by the Mental Health Tribunal and received regular anti-psychotic medication by way of intramuscular injection. The cause of the fire was probably from a cigarette igniting a slow smouldering fire on the sofa in the lounge room.</p> <p>Recommendations:</p> <p>That consideration be given in appropriate circumstances to wiring smoke detectors in premises owned by A.C.T. Government and used for aged care purposes – back to a monitored base if at all feasible.</p>
NT.2004.90	<p>The deceased child, who was 2 years old, was left in the care of her uncle in a community house while her primary caregiver (her aunt) went shopping.</p> <p>A fire subsequently started in the house and the strongest evidence supports a finding that the fire was accidentally started by the child when she was playing with matches while her uncle slept nearby.</p> <p>Recommendations:</p> <p>I note that there were no smoke alarms installed in any area of the house. It may be that the presence of an alarm in the hallway and/or bedrooms would have given an early warning as all witnesses speak of the large amount of smoke generated by the fire. There was also no proper means of extinguishing a fire and valuable time was lost trying to get a garden hose to work. The fire investigation report prepared by the Northern Territory Fire and Rescue Service noted that there is a fire hydrant situated on the road in front of the house but without the appropriate equipment it was of no use during this fire. I recommend that the Community Government Council consider seriously their options for improving fire safety in the future. Options to consider could include community education, the instalment of smoke alarms and/or the purchase of appropriate fire-fighting equipment.</p>

Healthcare/Hospital Care

NT.2002.271	<p>The deceased was a 55 year old man who was in an acute care ward after a fall at home. The deceased suffered a number of subsequent falls at the hospital after climbing out the end of his bed (which had side rails erected).</p> <p>Surgery was conducted to release the build up of pressure within the skull caused by bleeding of the brain, however deceased did not regain consciousness and died after the surgery. During the inquest into the death, it was found that the hospital was extremely busy due to patients being flown in from the Bali bombings and a PCA (patient care assistant) was not available to aid the deceased at this time.</p> <p>Recommendations:</p> <p>I recommend that any emergency management plan or contingency plan of the Hospital contains staffing arrangements adequate to cater for the appropriate care and supervision of patients and that such plans include the provision of additional patient care assistants.</p>
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Healthcare/Hospital Care (Cont.)

VIC.2002.2605	<p>The deceased was born by emergency caesarean section. She was born severely growth restricted with major respiratory and gastrointestinal problems and with a weight less than the 10th percentile for her gestational age. She died 6 days after her birth following multiple medical procedures. The death was reported with the provisional cause of death as cardiac tamponade as a consequence of right atrial perforation by umbilical catheter. Prematurity was also listed as a contributing factor.</p> <p>Recommendations:</p> <p>A matter of great concern for the family requires comment. The child's parents were upset and distressed by the hospital's failure to notify them earlier of their daughter's deterioration, thereby depriving them of the opportunity to be with her before she died. Their distress is understandable and their implied criticism appears to be justified, as they had left four contact numbers with the hospital in order to ensure their attendance should such circumstances arise. Whilst I am satisfied multiple contact attempts were made, I find it highly unlikely that all contact numbers were tried. It is recommended that in similar circumstances the hospital ensures that every effort to achieve notification is made by pursuing all reasonable avenues available to them.</p>
VIC.2003.726	<p>The deceased was stillborn. The cause of death was perinatal asphyxia due to obstructed labour. It was found that the asphyxia most likely developed during the labour, possibly during the prolonged second stage. The type of monitoring of the fetal heart rate undertaken, known as intermittent auscultation, was noted by the Coroner as not a particularly sensitive way of assessing fetal well-being. It is possible that asphyxia developed during the second stage of labour which unfortunately was not detected by the heart rate monitoring. It was noted that had this baby been monitored by continuous electronic fetal monitoring, evidence of fetal compromise may have been detected sooner. This in turn may have led to the decision to intervene earlier and may possibly have led to a different outcome.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1) The hospital labour wards be appraised of this case and staff be reminded that in cases of prolonged second stage labour recourse to continual electronic fetal monitoring be given serious consideration.2) That a mobile or portable baby heart monitor be made available for mothers giving birth at this Hospital.
VIC.2002.1016	<p>The deceased, a 77 year old man, was admitted to a private hospital for a transurethral resection of the prostate. This operation was an appropriate procedure for his symptoms of urinary retention.</p> <p>After the operation, the deceased was transferred to the recovery room in a satisfactory condition. Within ten minutes he became hypotensive with evidence of continuing blood loss to the point of cardiac arrest. Bleeding continued throughout this period. Blood loss was estimated throughout the operation period as 300 millilitres by the surgeon; however it is likely that this was a significant underestimate in a procedure where blood loss estimates are quite difficult to make during the course of the operation.</p> <p>Please see the CORONIAL COMMUNIQUE - how accurate estimates of blood loss? for a detailed case summary & discussion</p> <p>Recommendations:</p> <p>Sergeant D.N. Jessup assisting the Inquest made the strong submission that recommendations be made that greater attention be paid to the issue of correctly estimating blood loss during these operations and I accept this submission wholeheartedly.</p>

Healthcare/Hospital Care (cont.)

VIC.2003.3734	<p>The deceased, aged 94, fell in the dining room at an Aged Care Facility. She was subsequently x-rayed at a Radiology Centre and the pelvic x-rays were found to be inconclusive. She returned to the Aged Care Facility and was then sent to the Monash Medical Centre the next day where on re-x-ray an undisplaced fracture of her right inferior pubic ramus (part her the pubic bone) was discovered. It is noted that the Facility conducted an investigation into the deceased's fall, which was not witnessed. The deceased was admitted to Hospital for 6 weeks rest in bed. She was confused and refused to eat. She subsequently died.</p> <p>Recommendations:</p> <p>Recommendation 1: That consideration be given to developing a comprehensive falls management program, guide or Code of Practice (or eventually a Standard), that as far as is practicable, applies to all aged care facilities. Any such program, guide, Code or Standard could be structured to provide a basic system and (as a matter of predictability) allow for the development of variations under the system where it is required by a particular facility or group. The Victorian Quality Council information package should be considered in this process. There are a range of agencies that would need to be involved in the development of a comprehensive approach including the Commonwealth Department of Health and Aged Care, the Victorian Department of Human Services and the various interest groups representing the aged care homes, consumers and staff, etc.</p> <p>Recommendation 2: That, in the interim (pending the development of an overall approach as referred to in Recommendation 1), the Catholic Homes for the Elderly give consideration to developing a comprehensive, standardised falls management program across its homes. The Victorian Quality Council information package should be considered in this process.</p>
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Level Crossing Deaths

VIC.2004.141	<p>The deceased, aged 52, suffered profound deafness and speech impediments throughout his life after contracting German Measles as an infant. He also had a condition affecting his peripheral vision. It is believed that on the day of the incident, the deceased was going about his daily errands when he saw what he thought was his intended train approaching the Railway Station. It appears that he has either crossed through the pedestrian crossing by forcing the closed safety gates, or walked around the pedestrian crossing. However the train, a Melbourne-bound express train proceeded through the station and into the crossing, with the deceased running into the path of the oncoming train.</p> <p>Recommendations:</p> <p>There have been other Coroner's findings dealing with persons with disabilities interacting with rail infrastructure. The death of another individual in 1997 has some similarities with this case as to how a disability [visual] may effect a person's decision making process and awareness of impending danger. In that case there was no pedestrian gate and in this case there was a gate which was breached. The finding should be forwarded to disability groups (especially representatives of the visually impaired) as an example of risk perception and how a misconception of risk can lead to disaster.</p>
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VIC.2002.1902	<p>A 6-year old boy had left home to attend school with his 10 year-old brother, and another student, aged 11 years. The deceased was wearing a beanie under his helmet as he was recovering from a left ear infection, which may have impaired his hearing. All the boys had ridden to the crossing and dismounted from their bikes and entered the pedestrian crib, with the deceased's bike being approximately a metre in front of the other two. The deceased entered onto the area of the track after opening a wire gate that he had to pull toward him in order to pass through the opening. It appears shortly before being hit, the deceased turned in an attempt to get out of the path of the oncoming train.</p> <p>The crossing at the time of this incident was in the process of being upgraded with all work complete except the commissioning of the booms and pedestrian gate.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. That consideration be given to making a Traffic Safety Education Program (with parent participation) a compulsory component of the primary school curriculum and that appropriate resources be made available for the implementation of such a program. It appears most parents overestimate their childrens' capabilities in relation to traffic safety and need to be aware of their developmental limitations when determining the degree of supervision needed. Parents should not assume that learning in a school environment is a substitute for a real traffic environment, as a child's ability to apply their knowledge to their behaviour, is poor.2. That the Victorian Department of Infrastructure, in conjunction with VicRoads, give consideration to an advertising campaign aimed at highlighting the developmental limitations of young children and the need for parental supervision of the young when interacting with traffic. The importance of the parent as a 'role model' would be a crucial component of the campaign. The railway crossing involved in this tragedy is in close proximity to the primary school [the deceased] was attending, with the school principal stating that about 50 of his students used the crossing twice daily, as pedestrians. The age of these students ranged from five to twelve years and while the road crossing directly outside the school was supervised, the rail crossing approximately 50 metres away was not.3. That Local Councils give consideration to providing railway crossing supervisors, similar to their School Crossing Supervisor Program, at selected crossings that are in close proximity to primary schools and where significant numbers of students use the crossing.
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Motor Vehicle Accidents

<p>VIC.2004.817</p>	<p>The deceased, aged 64 year-old man, was riding a 1990 Harley Davidson Ultra Classic motor cycle with modified sidecar attachment in an easterly direction when he lost control of the motorcycle on a tight left hand bend was thrown off and seriously injured. The sidecar had just been attached.</p> <p>Recommendations:</p> <p>The is death was preventable by modified driving behaviour and speed. Unfortunately, the deceased's error in not taking the tight left hand corner at a considerably slower pace (in view of his inexperience in riding a motorcycle with side car attached) resulted in his death. This finding is to be distributed to key motorcycle associations as a matter of information. The various associations may choose to highlight the facts of this case in their newsletters as a matter of warning to other motorecyclists who may occasionally be riding a motor cycle with side car attached. Coroners regularly see inexperience with new or modified equipment as a significant factor in incidents that result in death. By way of example the areas where deaths occur may include general work with machinery, on the roads and in the air (hanggliders, aircraft).</p>
<p>VIC.2004.1342</p>	<p>The deceased was driving a Ford Fairlane along the Western Highway when his wife retrieved a bottle of water for the deceased to drink from. The vehicle driven by the deceased ran into the back of a Nissan Utility which was stopped at an intersection, without leaving any skid marks.</p> <p>The Coroner found that the collision occurred in a 100 km per hour zone and there was no provision at the intersection for vehicles turning right to be in a discrete lane. The absence of a discrete lane for right-turning vehicles forces vehicles overtaking from the rear to veer left into a left overtaking lane.</p> <p>Recommendations:</p> <p>I find this collision was caused by the momentary inattention of the deceased combined with the poor design of the intersection which does not provide the best protection for vehicles making a right turn. I recommend my finding be brought to the attention of all the appropriate Authorities so that consideration might be given to re-designing the intersection in order to make it safer.</p>
<p>VIC.2003.638</p>	<p>The deceased and two other men were driving to work at a nearby tomato farm and had been working in the area fruit picking for several months. The passengers recalled the car "veering to the left of the road" and when the driver tried to "correct this by steering the wheels towards the right side of the road." He then collided with a gum tree.</p> <p>The Coroner noted that the deceased was not wearing a seatbelt at the time of the collision. Both the driver and other passenger were wearing belts and survived the collision with relatively minor injuries. During the investigation, it was found that the primary issue involved in the accident was the fact that the road had been graded the day before and this had caused a distinct change in the road surface. It was thought to contribute to the vehicle sliding off the carriageway and colliding with the tree.</p> <p>Recommendations:</p> <p>There may be a broader need for Local Government authorities to urgently examine the issue of speed limits on these types of unsealed roads (especially, but not necessarily limited to, roads where road maintenance work practices such as grading, have recently been undertaken). It is unclear as to the level of work undertaken on the Coroner's recommendations in the Local Government area following the delivery of the finding in Jankovic (VIC case 0020/1998—a similar finding) in March 1999.</p>
<p>VIC.2002.3856</p>	<p>The deceased, aged 52 years, was supervising a road work construction site on the Melbourne bound carriageway of the Geelong Freeway. On the day of the incident the deceased was sitting in a stationary Toyota Hilux Utility within the construction zone, when his vehicle was hit from the rear by a fast moving Mitsubishi rigid tray truck. The impact caused the utility to be lifted and rolled onto its side, with the deceased being partially ejected and sustaining life threatening injuries.</p> <p>The driver of the other vehicle was an insulin requiring diabetic who had been on medication for his condition for approximately 22 years. It appeared from the evidence that the deceased suffered a hypoglycaemic event and had been driving erratically prior to the incident.</p>

Motor Vehicle Accidents (cont.)

<p>VIC.2002.3856 (cont.)</p>	<p>Recommendations:</p> <p>1. It is recommended that the guidelines for medical examiners in relation to Commercial Vehicle Drivers be reviewed and the criteria for driving in respect of Type 1 diabetes ought to be more stringent such that applicants who require insulin therapy shall not be entitled to hold commercial or passenger carrying vehicle licences unless the following criteria are satisfied:</p> <p>(a) the patient retains an appropriate specialist that he/she is required to attend four times per year (or with such other regularity as the specialist certifies as appropriate);</p> <p>(b) the patient submits to regular Hb A1c testing as the specialist deems appropriate;</p> <p>(c) the patient provide regular proof to the specialist of blood sugar level testing (ideally a downloaded log from a memory equipped blood glucose meter) as regularly as the specialist deems appropriate;</p> <p>(d) the specialist certify to VicRoads on a yearly basis that the patient's diabetes is under control;</p> <p>(e) the patient adhere to an appropriate diet and regime of medication that may be established by the specialist;</p> <p>(f) in the event of the patient suffering any hypoglycaemic episode involving loss of consciousness or loss of control of motor ability, the specialist, or any other medical practitioner, or the police, should formally report the matter to VicRoads and the person's commercial licence should be suspended;</p> <p>(g) in the event of a hypoglycaemic episode as above, the licence should not be reinstated unless the specialist certifies that:</p> <p>(i) a period of 12 months has elapsed during which there has been no further hypoglycaemic episodes;</p> <p>(ii) the specialist is satisfied as to the cause of the previous hypoglycaemic event;</p> <p>(iii) the specialist is satisfied no further hypoglycaemic event will occur without there being some fore-warning to the patient.</p> <p>2. That VicRoads clearly communicate the above criteria to the diabetic driver so that he/she is aware that the commercial driver's licence is conditional upon meeting and abiding by the criteria, and that any breach will result in a suspension of the licence.</p>
<p>VIC.2003.3854</p>	<p>The deceased, aged 63 years, was walking his dog along the road with his back to approaching traffic when he was struck by a motor vehicle, receiving fatal injuries. The driver was heard to say, "I didn't see him" on several occasions to one of the persons who had attended the scene to render assistance.</p> <p>An examination of the records of the driver's mobile telephone revealed that she had received an SMS message from her boyfriend's mobile telephone, within 60 seconds of the phone call she made to 000 seeking the assistance of an ambulance. The driver pleaded guilty to a charge of careless driving.</p> <p>Recommendations:</p> <p>This death would appear to be another instance of a fatal motor vehicle collision where it is alleged that a mobile phone had been used to receive or send a telephone text message shortly before or at the time of collision. The Transport Accident Commission has for a number of years conducted a media campaign indicating the danger of using mobile telephones while driving. It is recommended that the campaign be extended to show that persons who receive or send SMS text messages results in drivers being distracted for significant periods of time which substantially increases the risk of collision. It may also be beneficial if such a campaign would indicate clearly the consequences of the use of mobile phones. i.e. the potential death of passengers and other road users and possibly conviction and imprisonment for culpable driving.</p>
<p>VIC.2003.4240</p>	<p>The deceased, a 49 year old male, was in a fatal head on collision. He had been travelling on the incorrect side of the road for what was believed to be about 2 kilometres prior to being involved in the collision. It was noted by the investigating police officer that the lanes at the deceased's exit are marked with straight only arrows on the road. There are two signs on the traffic lights, which direct drivers to stop at the red signal. However, there is NO sign stating NO LEFT TURN. At night, it was considered that a person could easily miss the white arrow on the road.</p> <p>The Coroner also noted that the deceased had a Blood Alcohol content of 0.02% and an unroadworthy vehicle. It was also unknown where the deceased had been prior to the collision or his state of mind.</p>

Motor vehicle accidents—cont'd

VIC.2003.4240 (cont.)	<p>Recommendations:</p> <p>The report of Senior Constable Geoffrey Yeo (dated 6th January 2004) is attached as a matter of information. If not already investigated by VicRoads and/or the Springvale City Council, the issues raised in the Senior Constable's report may require attention.</p> <p>(Excerpt from the report) <i>"I am of the opinion that the deceased has accidentally turned into this section of road and missed all the street markings. I feel that a number of signs should be erected as soon as possible to avoid this type of incident occurring again. I believe that there should be a NO LEFT TURN sign erected in Springvale Road at the intersection with the south east bound lanes (Photo 1.). Approximately 30 metres into the south bound lanes should be large WRONG WAY GO BACK signs erected (Photo 2). These wrong way signs should also be erected north of the intersections of Rowan Road (Photo 3.) and also at Spring Road (Photo 4) just to be sure that all motorists are aware of the road. Also a NO LEFT TURN sign at the intersection of Spring Road (Photo 5) and a No LEFT TURN sign at the intersection of Rowan Road (Photo 6)."</i></p>
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Police pursuits

VIC.2002.244	<p>On the night of the collision, the deceased, a 34 year old man, was being followed by a police car after consuming a considerable amount of alcohol and driving in a severely compromised manner. The driver of the police vehicle claims that as they travelled along the Goulburn Valley Highway he "had no plans to pull the car over, but to follow it until the driver stopped himself". Eventually, the deceased lost control of the motor vehicle on the Goulburn Valley Highway and the car colliding head on with a roadside tree.</p> <p>Recommendations:</p> <p>Without wishing to be seen to be contravening the "Harmsworth principle", (Harmsworth v. State Coroner 1989) VR 989, I merely observe without further comment that even though there was compliance with the Victoria Police Manual, a fatality occurred following this pursuit. At the very heart of the issue of police pursuits is the ability of an operational police person to make an efficacious risk assessment "in the heat of the moment", "at the coal face". That in my view involves a combination of intuition, experience and training. The latter issue was canvassed recently by my colleague Deputy State Coroner West. I support and adopt his observations on that fundamental issue.</p>
SA.2001.1332	<p>The deceased aged 18 years was the driver of a 1974 Holden Sedan, who held a probationary licence for approximately six months. Police driving a marked vehicle had followed the Holden and attempted to intercept the deceased for traffic offences. The excessive speed of the deceased's vehicle led to the decision to intercept it, however in attempting to do so, the high speed of the deceased's vehicle (160-180 km/h) led the police to subsequently abandon trying to intercept it.</p> <p>As the deceased's vehicle entered a sweeping left hand bend, the vehicle lost traction and commenced to rotate anti-clockwise, sliding off the carriageway and impacting a road sign and trees before coming to rest on the centre plantation. The deceased sustained multiple injuries and died shortly after.</p> <p>Recommendations:</p> <ol style="list-style-type: none">1. That the pursuit training program comprise both a theoretical and practical component;2. That the pursuit training program be undertaken by all members licensed to engage in urgent duty driving;3. That no member engage in a pursuit until obtaining accreditation in both the theoretical and practical components of the training program and4. That there be regular refresher training and evaluation of pursuit driving skills.

Intentional Self-Harm/ Psychiatric Care

VIC.2002.4056	<p>The deceased was aged 40 years when he died. He had been admitted as a voluntary patient to a private mental health clinic with apparent depression for three weeks. During his hospitalisation he was assessed as a low suicide risk. He remained in hospital until his discharge. The day following his discharge he took his own life. The deceased had a long history of depression and had been hospitalised on previous occasions for his condition.</p> <p>Recommendations:</p> <p>Good case planning in the mental health sector, involving the person with the mental illness and those that care for that person is essential. Although this tragic death occurred following voluntary admission to a private clinic it nonetheless highlights the importance of the Chief Psychiatrists Guideline on Discharge Planning for Adult Community Mental Health Services.</p>
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Intentional Self-Harm/ Psychiatric Care (cont.)

<p>VIC.2002.820</p>	<p>The deceased was a 40 year old woman with a history of mental illness extending over a period of approximately twenty years. Her diagnosis was one of chronic paranoid schizophrenia complicated by polysubstance abuse and episodes of depression. She had two previous suicide attempts in 1994 and in 2000. Her previous overnight stay with her mother, while successful, had resulted in concerns by the deceased's mother and flat-mate about leaving the deceased alone in the flat. When sent on a subsequent overnight stay, after her flat-mate went to bed, the deceased sustained fatal injuries after placing herself in the path of an oncoming train.</p> <p>Recommendations:</p> <p>The evidence satisfies me that it is appropriate to make the following recommendations:</p> <ul style="list-style-type: none"> • that clinicians in exercising their function pursuant to Section 40 of the Mental Health Act to allow an involuntary patient leave of absence from the inpatient service, remain vigilant in evaluating whether sufficient mechanisms are in place for their patient's health and safety, • that clinicians remain attentive to the contribution able to be made by carers and incorporate into their decision making process, the carer's knowledge of their loved ones, patterns of behaviour and thinking, • that medical and nursing staff ensure that important clinical information, including concerns of families and carers, is appropriately documented in the patient's medical file.
<p>SA.2001.1332/ SA.2001.1325</p>	<p>The deceased was a 20 year-old man with paranoid schizophrenia and substance abuse problems, who had been in treatment since 1999. After a number of concerning episodes he was held for a period under a detention order but was released after he argued to the Guardianship Board that his thoughts of harm had stopped. He also promised to take oral medication, and to avoid illicit drugs. A number of weeks later the man and his girlfriend were found dead. The Coroner found that he had shot the woman in the head, thereby causing her death, and then shot himself, causing his own death.</p> <p>Recommendations:</p> <p>Although I cannot be satisfied that anything would necessarily have prevented this tragic outcome, I make the following recommendations which might prevent similar events in the future:</p> <ol style="list-style-type: none"> 1) to the extent to which the treating doctor's actions in wrongly labelling the deceased's illness as 'first episode psychosis' in order to obtain earlier treatment for him discloses insufficient resources available to NWAMHS to properly treat patients with established schizophrenia, the Department for Human Services should review the resources available to avoid the necessity for such actions in the future; (2) the Director of Mental Health Services should consider whether the input of a forensic psychiatrist would be appropriate when 'homicidality' is an issue with a patient with a mental illness, as was the deceased; (3) the Director of Mental Health Services should consider whether the practice of obtaining 'safety guarantees' still exists among ACIS workers, and, if so, whether steps can be taken to avoid such practices in future; (4) the Commissioner of Police and the Director of Mental Health Services should ensure that the Memorandum of Understanding regarding the interaction between police and mental health workers is executed and implemented without any further delay.
<p>VIC.2002.3864</p>	<p>The Deceased, was a 43 year-old woman with a ten-year history of psychiatric problems, substance abuse and numerous suicide attempts. The deceased advised a psychiatric nurse attached to a Base Hospital that felt she was vulnerable and at-risk, so it was decided, in conjunction with her GP, to admit her to another Hospital. When she arrived at the second Hospital for her stay, there was an immediate handover to the afternoon nursing shift, with the reason why she was being admitted recorded as alcohol detoxification.</p> <p>She was a well known patient at that hospital. The nurse in charge of the deceased in the afternoon did a suicide risk assessment, not because of any information she had in relation to the admission, but because she knew the patient. The assessment showed the deceased to be at high risk. However, because of her frequent admissions, the fact that she was known to members of the nursing staff and that her difficult behaviour and her appearance were consistent with other admissions, the risk was monitored infrequently. The Deceased was discovered later that night with wounds to her neck, the inside elbows, groin and ankles, and also a plastic bag over her head. She was not breathing and no resuscitation was attempted.</p> <p>Recommendations:</p> <p>Pursuant to s.19 of the Coroner's Act, I make a recommendation that the hospital and medical practitioners look at a system of notification to the hospital of all details relevant to the admission, in writing, so the oral admission is immediately followed by faxed notes and reasons to avoid any ambiguity. The procedure probably would not have made any difference all to the death of the Deceased, as a suicide risk assessment was carried out, but there may well be situations in the future where people are not in the same position as the Deceased in that they are well known to hospital staff. Patients may have some psychiatric reference, are admitted by their GP, and details may be omitted in the course of orally communicating information.</p>

Intentional Self-Harm/ Psychiatric Care—cont'd

<p>VIC.2003.3389</p>	<p>The deceased was 30 years old at the time of her death and had an extensive psychiatric history with a diagnosis as a paranoid schizophrenic in the early 1990's. In 2000 the deceased disengaged from treatment until June 2001 when she re-presented. The deceased lived in supported residences, was seeing a psychiatrist at a Community Health Centre and was case managed by a worker from another Community Health Centre.</p> <p>At approximately 1.15am on the day of the incident the deceased presented at the Emergency Department of a hospital claiming she had taken an overdose of prescribed medication, but had since vomited. The deceased was given a triage category 3 on the National Triage Scale. The expectation is that a category 3 patient should be seen by a doctor within 30 minutes. The Triage Nurse observed the deceased go outside the Emergency Department to have a cigarette. At approximately 2.50am a cubicle became available and the deceased was "called" by the Registrar. She did not answer the call - it became obvious she had left without advising staff. It would appear the deceased left 1¼ hours after being "triaged". The "call" came 1 hour and 40 minutes after her initial attendance. The Coroner found the internal review conducted by the hospital to be comprehensive, objective and most helpful. He acknowledged and adopted the recommendations which are relevant to his role and annexed the relevant pages of the Root Cause Analysis Report to the finding. The deceased died from multiple injuries after jumping from an overpass.</p> <p>Recommendations:</p> <p>It seems to me important that broad details of the circumstances of the death, the review and the refined procedures be expeditiously disseminated throughout the whole health system rather than kept "in house".</p> <p>As I understand the position, a function of the Department of Health presently is to disseminate coronial recommendations. However, the point is, a formal inquest would in all likelihood be concluded long after the event so that there is an inordinate delay in dissemination of recommendations which may well mirror or at least be similar to conclusions reached upon internal review/audit. Consequently, it would make good sense as Assoc. Prof. Doherty suggested to establish a Review Panel or Committee to examine all reviews and give advice across the board as to refined systems, practices, protocols that may be implemented to reduce the incidence of suicide within the Mental Health System. Assoc. Prof Doherty stated: "I am strongly of the view that we should have a more in-depth central review of suicides throughout the mental health system, occurring long before the coroner enquiries, so that the reviews of the individual hospital are given consideration and the dissemination through the Chief Psychiatrist's office, of recommendations is put in place. Other states, particularly New South Wales in recent times, has a serious incidence review panel of experts who look at homicides and suicides of the mentally ill and is in the process of changing practice because of that. Tasmania, where I was recently has a suicide prevention committee which is thinking about taking on the tasks of reviewing suicides in Tasmania. Such a committee in Victoria would be of some advantage because of the dissemination of information about the state, with regard to what we learn when we review adverse outcomes, could be better considered and disseminated.</p>
<p>SA.2001.2506</p>	<p>On the day of the incident a 43 year old man was seen at a railway station running along the platform and yelling. He jumped off the platform, over a fence and into a small creek, while yelling. Police attended and tried to clear his airway but were unable to.</p> <p>On the basis of this evidence, the Coroner found that the deceased most likely died while he was suffering from a severe psychiatric disturbance. From the available evidence, it seemed to be a manic episode, in the course of his bipolar disorder.</p> <p>Recommendations:</p> <p>In this case, the deceased's doctor thought that the deceased might have been suffering a relapse of a psychiatric illness which needed treatment (bipolar disorder), and indeed he thought he had developed a 'precursor' to that state which required further assessment. He thought that, since the present requirements of the Mental Health Act for detention were not present, such an assessment had to be done in the community. Unfortunately, that did not happen. In my opinion, the decision made by the deceased's doctor should have been made by a psychiatrist after a proper assessment of the patient's condition. In my opinion, where police officers exercise their powers pursuant to Section 23 of the Act, an automatic 24 hour detention of the patient should follow so that a proper assessment of the patient by a psychiatrist can occur, and the order can be either confirmed or revoked.14.I recommend that the Minister for Health consider such an amendment to the Mental Health Act 1993</p>
<p>VIC.2003.2706</p>	<p>The deceased was aged 36 at the time of his death. He had a significant psychiatric history and had twice attempted suicide in the past. During his most recent inpatient admission, just days before his death, he had been assessed as a chronic although not acute risk of suicide. He was placed on a Community Treatment Order and his care was being managed by a CAT team.</p> <p>The psychiatrist gave evidence that he advised the CAT team to actually dispense the deceased's medication given previous compliance issues. However, this was not evident from an examination of the hospital file or the discharge plan and the CAT team gave evidence they were not aware of this. The deceased was located under a city bound train carriage on the Dandenong line later that day. The Coroner found that he intentionally took his own life.</p>

Intentional Self-Harm/ Psychiatric Care—cont'd

<p>VIC.2003.2706 (cont.)</p>	<p>Recommendations:</p> <p>The Royal Australian and New Zealand College of Psychiatrists should consider:</p> <ol style="list-style-type: none"> 1. Devising a strategy that would prevent any unilateral changes to Management Plans (particularly medication management) during any transitional care phase without prior approval of the Consultant Psychiatrist who oversaw the preparation of the Discharge Plan. 2. Formalising a process for developing Management Plans that ensures input from key players including the patient, family/care giver and original treating team. Those responsible for the future care and treatment should have a clear and detailed notion of what is proposed in the form of future care and treatment and what should be done, not only in the case of an emergency, but in situations where treatment appears to be breaking down.
<p>VIC.2003.808</p>	<p>The deceased, aged 40, had a long history of mental illness and had previously attempted to take his own life. He was discovered dead in his car by a Melbourne Water employee who was undertaking a routine patrol.</p> <p>The deceased was subject to a two year Community Based Order (CBO) which was issued at for Breach of Intervention Order and Making Threats to Kill. The Order specified that he was to undergo assessment and treatment for alcohol and drug addiction and participate in assessment and treatment by Forensicare.</p> <p>The doctor who took over as the Psychiatric Consultant had about 120 patients to arrange to see and was due to have a consultation with the deceased the week after he took his own life.</p> <p>Recommendations:</p> <p>Whilst the outcome might not have altered, the importance of communication between the public mental health system and Forensicare was an issue in this case. Clearly, the agencies were aware of respective roles in the management but do not appear to have regularly exchanged information that might have been of assistance towards improving the management of the deceased's problems. The deceased's difficulties of coping with the Christmas period appears to have been managed (as a result of being made an involuntary patient). However, the anniversary of his birthday was not recognised by clinicians working in the public mental health sector as a having a potential for a similar problem. Clearly, in hindsight it was. The family had recognised this issue and their knowledge again demonstrates the value of taking a detailed collateral history from the family as an essential part of patient management in the case of mental health patients.</p> <p>It is also noted that there has been a recent Monash University Accident Research Centre report by Routley, Short and Ozanne-Smith (June 2004) entitled "Motor Vehicle Exhaust Gassing Suicides in Australia: An Update" which details the ongoing extent of the problem for the community. In relation to countermeasures, the report makes a number of recommendations which are worthy of consideration by the appropriate authorities, manufacturers and suppliers of motor vehicles (see report attached).</p>
<p>ACT.2003.144</p>	<p>The deceased was a 29 year old man, who was receiving treatment for severe depression and anxiety and had been a voluntary patient at a local hospital. The deceased and a female companion were seen walking on a pedestrian walk way on the left hand side of a roadway. The deceased was then seen to raise his hands above his head then either stepped out or dived out in front of a vehicle.</p> <p>Recommendation:</p> <p>That a copy of the Brief, including hospital records and other exhibits be forwarded to the A.C.T. Minister of Health together with a copy of the Transcript for consideration in conjunction with representations made by the family of the deceased.</p>

Sport-Related

VIC.2002.524	<p>A 59 year-old man received serious injuries in a motor racing collision involving an historic racing car at Phillip Island Motor Racing Circuit.</p> <p>The deceased had apparently clipped another competitor's vehicle and became airborne. The deceased's car then caught fire in the air and crashed to a grassy area at the track side. The deceased was attended at the scene by a trackside medical team and evacuated by helicopter to Hospital. He died from these injuries shortly after his arrival at the hospital.</p> <p>Recommendations:</p> <p>That the Confederation of Australian Motor Sport (CAMS) and/or the Federation Internationale de l'Automobile (the FIA) re-consider the issue of permitting historic racing vehicles (that cannot be appropriately and safely modified by adding protective safety equipment) to race in historic events. Ultimately any decision on this issue is a matter for the individual, the sport's organisers (and in some circumstances the relevant government regulator). Historic motor racing Safety: Information and Driver Training. In the meantime, motor racing organizations like CAMS may seek to exercise their duty of care and to distribute a summary of the facts surrounding this death to all competitive historic racing car owners and drivers as an example of how incidents occur and promote an understanding of the countermeasures that should be used. The description of the circumstances surrounding this death should be used (along with other incident summaries) as a component in racing driver training courses. Clearly, the issue of racing driver training (for historic events) may be a potential area for improvement. Passing a slower moving vehicle in an historic race on the inside where another vehicle is passing slightly ahead and between two slower moving vehicles is fraught with risk and creates a real problem for all drivers in the pack. It is understood that, in the competitive and fast moving environment of a race (even of historic vehicles), errors may be made by an aggressive and skilled driver. The potential for some errors can be anticipated and avoided by studying the detail of factors involved in an incident, like those occurring in this case. Again, the incident clearly shows why it is necessary to fit rollover protection and a full harness to an historic vehicle engaged in a competitive race.</p> <p>That CAMS (and/or the FIA) consider developing an instruction package for historic car racing that demonstrates the lessons from a particular incident or near miss. The package may include videos [or interactive computer aided scenarios] illustrating the areas of risk and alternative options or techniques, etc). Recommendation That CAMS (and/or the FIA) consider further restrictions on the mixing of the class of vehicles, so that vehicles of a different capacity or class do not, where practicable, race together.</p> <p>That CAMS (and/or the FIA) consider the potential issue of fuel mix and safety in the incident involving the deceased, in the broader risk management context, in relation to the racing of historic vehicles in the future.</p>
VIC.2004.503	<p>The deceased, aged 43 years, died in a hang gliding incident when flying an advanced high performance glider borrowed from a friend.</p> <p>Recommendations:</p> <p>The circumstances surrounding this death should underscore this principle and demonstrate the need for further highlighting of the following points (to improve safety in the sport):</p> <ol style="list-style-type: none">1) Do not attempt to use new, unfamiliar or advanced equipment without instruction by a qualified instructor;2) Do not lend equipment to another hang-glider pilot (even a close friend or colleague) without first being satisfied that the pilot has the appropriate level of training and experience (on that equipment);3) If advice is sought on how to operate the equipment this should be treated as an indication that the pilot may not have the appropriate level of familiarity, training and experience;4) Hangliding colleagues should not hesitate to advise against a flight when in doubt;5) A "cross-checking" procedure should be considered by the sport as one possible method for adopting these principles. The facts of this case should be described in the sport's newsletter to demonstrate the need to follow the sport's Operations Manual. Often well described (and appropriately illustrated) actual factual scenarios help to reinforce the need for a particular rule and to highlight to a wider group of readers as to why compliance is necessary.

Work-Related

Please see Case Study 1 for additional work-related cases

VIC.2004.957

The deceased, aged 73, had a history of diagnosed mesothelioma and had previously been treated with chemotherapy. He presented with evidence of extensive bony metastases with tumour and problems with thrombocytopenia. He had been admitted firstly to Hospital for treatment, and then for palliative care in association with his terminal illness. He was provided with supportive care and pain relief from the time of his admission until his death. The deceased had been employed as a builder/carpenter for approximately 30 years. During the course of his employment, the deceased extensively used and sawed flat asbestos cement sheets and was required to cut them to size for use. Approximately 3 years ago he was diagnosed with having asbestos related cancer-mesothelioma.

Recommendations:

I believe that a manufacturer or supplier of asbestos products, which were likely to be used in such a way that fine airborne dust was created, should have foreseen that users of such products had the potential for excessive exposures. Options available to manufacturers and suppliers would have included:

1. Urgent research to be able to eliminate asbestos from fibro products.
2. Placement of warning labels on the fibro products, in the interim, especially in relation to the use of power saws.
3. Provision of a safe working procedure with recommended dust masks and list of preventive procedures to be adopted when handling the products, in the interim.
4. Removing surface dust from the fibro materials prior to sale."

From a Coroner's perspective it appears that these observations are still relevant today (whether the exposure has related to the work or home environment). There remains a continuing need to ensure that all members of the community who may come into contact with asbestos products that have been used in the home construction area (as used by the deceased in his work as a carpenter/building supervisor) are well aware of the continuing risk in the home of asbestos sheet and other related products and take the appropriate steps (by using qualified asbestos removal contractors) to deal with these products. It is understood that the issue of home renovation and exposure to asbestos is already in the process of being considered by a number of government agencies in Victoria.

Psychiatric Care

VIC.2002.300

The deceased, aged 31 years was located by a social worker, lying unresponsive on the kitchen floor of his home, with incised injuries to his wrist. A suicide note was located. Issues raised during the inquest included the deceased's family who felt excluded, by not being sufficiently involved in his management and care and the adverse side effects of the deceased's medication. The Coroner found that the concerns raised were appropriately addressed and that the evidence did not support a finding of sub-optimal care, or departure from recognized standards.

Recommendations:

The evidence satisfies me that it is appropriate to make the following recommendations:

- that clinicians remain attentive to the contribution able to be made by the family and incorporate into their decision making process, the family's knowledge of their loved one's patterns of behaviour and thinking.
- that medical and nursing staff ensure that important clinical information, including concerns of family, is appropriately documented in the patient's medical file.
- that health professionals as far as is practicable, fully investigate the environment into which a patient suffering mental illness, is to be discharged.

Psychiatric Care (cont.)

VIC.2004.66	<p>The deceased was a 60 year old man, who had been diagnosed with prostate cancer in 2000. He had been told at that time he only had twelve to eighteen months to live. After living with considerable pain, it appears the deceased shot himself. The deceased held a Category 'A' Firearms Licence. Although he advised the Firearms Registry of a change of address, which should result in a request being sent to the local Police District Firearm Officer (to check firearms and ammunition storage etc.) there is no record of this having been done.</p> <p>Recommendations:</p> <p>Whilst there is no evidence to suggest that a different outcome would have resulted had firearms and storage issues been checked by Police, there are indications that procedures (for whatever reason) were not followed. As this office has not examined this aspect in any further detail it may remain an issue that needs to be considered by the appropriate area of Victoria Police.</p> <p>In addition, it would be useful for Victoria Police and the State Coroner's Office to develop an investigatory protocol relating to recording more detail where fatalities relate to firearms (including licence details, type of firearm, firearms and ammunition storage compliance and checking, etc.). It is noted that, over the years, many briefs of evidence on firearms related matters do not contain potentially valuable detail from the Police Firearms Registry. This investigation was no exception.</p>
VIC.2004.646	<p>The deceased, aged 40 years, had a history of depression, alcohol and prescription drug abuse. He was found deceased in his brother's car from motor vehicle exhaust asphyxia.</p> <p>Recommendations:</p> <p>It is noted that there has been a recent Monash University Accident Research Centre report by Routley, Short and Ozanne-Smith (June 2004) entitled "Motor Vehicle Exhaust Gassing Suicides in Australia: An Update" which details the ongoing extent of the problem for the community. In relation to countermeasures, the report makes a number of recommendations which are worthy of consideration by the appropriate authorities, manufacturers and suppliers of motor vehicles. Previously, a copy of the report has been forwarded to relevant authorities by the State Coroner's Office.</p>
Other	
VIC.2003.3725	<p>The body of the deceased, a 32 year-old man, was located at the base of cliffs with massive head injuries.</p> <p>The deceased's father stated that his son had been under psychiatric care for the previous six months, however he did not appear suicidal or give any cause that he may harm himself.</p> <p>The Coroner found that the deceased has either jumped or fallen from the cliff and onto rocks below causing head injuries. There is no evidence that can conclusively show one way or the other if the deceased has jumped or fallen.</p> <p>Comments:</p> <p>The Coroner made comments surrounding a delay of 6 months in receiving the autopsy report from the VIFM.</p> <p>Recommendations:</p> <p>I respectfully suggest that the jurat at the end of the Autopsy Report be signed and dated in each case. I also suggest that after 6 weeks from the date of an autopsy the relevant Coroner's Office be informed of any delay in preparing the report. I have noted in the Deputy Director's letter to the deceased's father that there is currently a review of case management within the Institute of Forensic Medicine. It would have seem to me desirable that each Coroner who regularly does coronial work be given a copy of that review.</p>