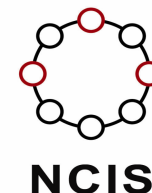




The NCIS is managed by the Victorian Institute of Forensic Medicine
on behalf of the State/Federal funding agencies.

The NCIS is funded by each State/Territory Justice Department around Australia,
and the Commonwealth Departments of Health and Ageing,
Employment and Workplace Relations, the ACCC, the ATSB and the
Australian Institute of Criminology.



Fatal Facts

A Publication of the National Coroners Information System

Edition 13 (June 2007)

This edition of Fatal Facts features 55 coronial cases where recommendations have been made. These cases were closed by a Coroner between 1 January 2007 and 30 April 2007.

Extensive recommendations were made regarding level crossing fatalities, deaths relating to the prescription of medication and deaths of children/unauthorised personnel on work sites. These cases have been highlighted in detail.

If you wish to seek further information regarding any of the cases contained in this edition, and you are an authorised NCIS user, it is recommended that you visit the NCIS website (www.ncis.org.au). Log on using your authorised user name and password, and find the particular case by clicking on the “NCIS Search” tab and selecting “Find Case”.

If you have forgotten your user name and password, or require advice regarding access to the NCIS database, please do not hesitate to contact our Access Liaison Officer, Marde Hoy, at mardeh@vifm.org or on (03) 9684 4323.

Should you not currently have access to the NCIS, or wish to enquire about an information search, please contact the NCIS team at ncis@vifm.org.

Jessica Pearse
Manager, NCIS.

NCIS at a glance

- Number of cases on the NCIS (notified to a Coroner between 1 July 2000 and 30 April 2007 inclusive): 127,729
- Number of findings on the NCIS for cases closed by a Coroner between 01/01/2007 and 30/04/2007: 1,918
- Number of cases with recommendations (closed by a Coroner between 01/01/2007 and 30/04/2007): 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 they are not authorised summaries or exact replications of coronial findings. The original finding should always be accessed if it is intended to be formally referred to.

Case No:

VIC.2004.2757, VIC.2004.2758,
VIC.2004.2759.

Date of Finding: 18 April 2007

Coroner: Graeme Johnstone

Summary

This incident involved the early morning collision of a Sprinter Train and motor vehicle at a level crossing, fatally injuring the vehicle occupants. The crossing was congested with vehicles and the motor vehicle involved in the collision was stationary on the railway tracks when it was struck by the train. At the time of the collision it was dark with street lights operating. Another collision that had occurred earlier a few metres east of the level crossing was being managed by Victoria Police at the time of this collision.

Recommendations:

Recommendation 1

That the rail and road safety authorities examine the feasibility of forming a multi-disciplinary group (with experts from outside the normal rail/road infrastructure) to freshly examine the design and other relevant safety aspects of high risk railway level crossings (similar in layout to the crossing at which the collision occurred) with a view to exploring the feasibility of other innovative or alternative safe design countermeasures.

Some examples of new approaches might be to use technology to warn train drivers of vehicles banking over or straddling level crossings when the safety warnings and systems are about to operate on the crossing and/or cameras designed to record motorists breaching the legislation by entering the crossing after the warning bells and lights have commenced to operate.

Also in the context of this recommendation it is worthy of note that the families raised some associated level crossing safety design suggestions for consideration. These are:

- Provision of emergency safe run-off bays;
- Gates set back from railway tracks with more space for motorists if trapped;
- No right hand turns (or just during peak hours);
- More explicit signage to highlight the risk (akin to cigarette advertisements);
- The new yellow cross marking system for level crossings - should be red in
- order to alert people to the danger;

Recommendations (cont.)

- Improved visibility and a longer time to clear tracks after the boom gates go down;
- Sensors to indicate clearance of track which would operate with light synchronisation;

- Cameras at level crossings to feed back to the trains so train drivers could be

alerted well in advance if the tracks are not clear.

Recommendation 2

That the rail and road safety authorities continue with the risky driver behaviour education campaign (and eventually add to that campaign the Yellow Box Marking system [or any modified marking system]).

Recommendation 3

That the road and rail safety authorities continue to undertake (and strengthen) the education campaign on motorist responsibilities under Road Safety (Road Rules) Regulations 1999. Any such campaign may need to be followed by targeted enforcement.

Recommendation 4

That consideration be given by the Transport Minister to changing the penalty structure for an offence under the Road Safety (Road Rules) Regulations 1999 (Regulation 123) with a link to consequences for the holder of a Driver's Licence.

Recommendation 5

The Chief Commissioner of Police consider participating in the Victorian Railway Crossing Safety Steering Committee.

Recommendation 6

The Chief Commissioner of Police consider continuing the development of police training in the area of risk management associated with traffic management and railway level crossings.

Development of future police training programs should involve the assistance of the Department of Infrastructure.

Recommendation 7

Victoria Police Command ensure that general and safety de-briefings occur following all serious traffic related incidents where police may have been either directly or indirectly involved in managing traffic. Police officers involved in the incident should always be advised of the outcome of any de-briefing.

Recommendation 8

Director, Public Transport Safety review the history and background of the 25 second delay factor to arrival of a train at a level crossing with a view to developing a better understanding of safety issues surrounding the management of level crossings, attendant warning devices and protective systems.

Recommendation 9

Director, Public Transport Safety, consider reviewing the lighting standards for trains approaching level crossings in the metropolitan or built up areas.

Case No: VIC.2002.24

Date of Finding: 10 April 2007

Coroner: Ronald Saines

Case summary:

The deceased had an extensive medical history and was taking a number of prescription medications for many years. She was found deceased on the floor of her kitchen. The cause of death was unascertained, however the coroner suggested multiple drug toxicity or myocarditis, either alone or in combination could explain the death.

Recommendations:

- that the prescribing of MS Contin 100 mg to the deceased and other prescribing which appears to have been inappropriate be referred to the Medical Practitioners Board of Victoria for further investigation.
- Having regard to risks of addiction and of overdose with morphine based analgesia, counselling, advice and warnings should be routinely given both by prescribing doctors and dispensing pharmacists with respect to such risks, particularly of overdosing and misuse.
- Medical practitioners and pharmacists should regularly engage in telephone or other communication, in any case where unsafe prescribing appears possible.
- professional associations representing doctors and pharmacists develop and publish protocols for there to be an accepted level of communication, with a view to minimization of risk in any case where it appears that an inappropriate prescribing decision has been made, or where there appears to be some issue of patient safety which arises from a prescription.
- the Federal Minister for Health undertake some investigation and appropriate action to identify and expose those who engage in "doctor shopping" for the purpose of abusing prescription indications. By means of online monitoring or similar, health authorities should be capable of identifying patients who obtain excessive quantities of certain classes of medications. Particularly opiates, benzodiazepines and other types of addictive or abuse potential medications.

Case No: VIC.2003.1413

Date of Finding: 8 February 2007

Coroner: Ronald Saines

Case summary:

The deceased had a medical history including cervical disc prolapse and despite surgery developed low back and leg pain. He was a truck driver, and was prescribed a number of analgesics to help him stay at work. Often these provided insufficient pain relief. The deceased was then prescribed Ordine analgesic in liquid form. Despite his doctor's and pharmacist's advice, the deceased apparently 'swigged' morphine from the bottle, rather than taking it in measurement doses. He died of cardiorespiratory arrest following excessive ingestion of the drug.

Recommendations:

The Coroner recommended the findings be distributed, for dissemination of information, and for education and discussion, regarding

- a) The preference for prescribing narcotic based analgesia in tablet form, in blister packs, to avoid or reduce risks of overdosing. Unless clinical reasons dictated otherwise.
- b) The proper counselling, advice and warning, which should routinely be given by both prescribing doctors, and pharmacists, with respect to
 - (i) Proper means of accurate measurement of dosage
 - (ii) Damages, and risks of misuse, particularly overdosing when narcotic based analgesia is prescribed, especially in liquid form, but also in general.

The Coroner also directed that such bodies, as to whom these findings are distributed, report their response, and any action taken by them within a period of 3 months.



Case No: TAS.2005.229

Date of Finding: 6 February 2007

Coroner: Stephen Carey

Case summary:

The deceased had a history of illicit drug use since he was a teenager. He had been involved in a methadone program but his place on the program was cancelled due to his threatening violence towards his treating medical practitioner. Arrangements were made to gradually reduce his dose of methadone, however the deceased decided to abruptly end his place in the program. The deceased was found in his mother's house having overdosed on intravenous drugs. An autopsy revealed a contributing factor to the death was an undiagnosed lung condition.

Recommendations:

I recommend that if the Alcohol & Drug Service believe that the rate of prescription of take-away doses is too high then steps ought to be taken to reduce it. Options that may be considered are to establish explicit and rigorous rules concerning access to take-away doses, or that request for take-away doses be sanctioned by an expert panel independent from the prescriber. There also seems a need to provide appropriate monitoring and, if necessary, support to prescribing general practitioners. What must be achieved is a balance between the encouragement of rehabilitation by providing take-away doses and the opportunity to divert these doses for illicit use.

Given both the documented and anecdotal evidence concerning the misuse of prescribed narcotics in this State I recommend that the mechanisms in place to monitor the instances of prescription be improved in order to allow timely and accurate identification of any indications of inappropriate or unauthorised prescription or any other circumstances that may be of concern.

I also recommend that there be established some form of medical review body to carry out quality and safety review of cases involving patients at high risk of fatal drug abuse and instances of patient death involving use of prescription narcotics. Such assessments could provide ongoing review of clinical practice involving the prescription of narcotics.

I recommend that there be a review of the prescribing practice for Alprazolam in order to determine if this statistic is correct and if so whether such a rate is appropriate. If necessary, guidelines ought to be developed for doctors concerning the use of Alprazolam and other Benzodiazepines and other strategies identified that might help reduce or minimise the need to prescribe Alprazolam and other Benzodiazepines.

There is no direct method available to identify whether a person is obtaining multiple prescriptions of such drugs (Alprazolam together with other Benzodiazepines) from different doctors. I recommend that this issue be raised with the Commonwealth authorities in order to allow identification from their data of instances indicative of the abuse or misuse of prescribed drugs such as benzodiazepines.

The use of illicit drugs by persons on a pharmacotherapy program raises important issues. I recommend that consideration be given to whether or not persons receiving such treatment should be subject to screening for the use of other drugs. I accept that a balance needs to be achieved between the risk of patients leaving the program and the personal and community consequences of that action on the one hand and on the other, the need to identify those patients who may not be suited to the program or who may pose a real risk of misusing their prescription, eg take-away doses.

Finally, I observe that the provision of pharmacotherapy to a patient whose mood was violent or unpredictable imposes particular challenges. It is unlikely that such persons can be accommodated within the practice of a private general practitioner and consideration needs to be given to whether such persons are excluded from the scheme with the associated personal and community damage that would cause or rather their needs to be developed a facility capable of dealing with such persons.

Case No: VIC.2004.3884

Date of Finding: 21 March 2007

Coroner: Peter White

Summary

The deceased (aged 12 years) was at his father's workplace. An employee allowed the deceased to ride on a forklift. While on the forklift, the employee drove to the right side of speed bumps and then undertook a U turn. At this time the deceased (either intentionally or accidentally) pressed his foot on the accelerator which resulted in the wheel of the forklift hitting a 800mm deep uncovered storm drain. The deceased was thrown off the vehicle caught between the forklift and a brick wall, which resulted in his death at the scene from chest injuries.

The Coroner indicated that this case highlights the dangers involved in using machinery and other industrial equipment, for purposes for which they were not intended, and for employers to make special arrangements to accommodate children, when they are invited into a work place, to ensure that they are always supervised and always remain protected from potential danger.

Recommendations

The Coroner recommended that Workplace Victoria give consideration to instituting a public awareness program to highlight the dangers which can occur when children enter the workplace without proper supervision.

The Coroner further noted that this program should include reference to forklift vehicles in particular, but not necessarily be limited to same, and should also put emphasis on the danger to unsupervised children presented by machinery. Further, this danger should be highlighted in such a manner as to provide a warning to employers, parents and children alike, and by extension to others who might also be tempted to use equipment in an inappropriate manner.

Case No: TAS.2004.449

Date of Finding: 23 March 2007

Coroner: Rodney Chandler

Summary

The deceased, a learner driver, drove a neighbour, a boiler attendant, to work each day to gain driving practice. One day at the neighbour's workplace, the deceased used a forklift truck to deposit ash from the boiler in a bin. The truck overturned and the deceased was pinned by its canopy. He died from head injuries sustained in this accident.

Recommendations

- It is incumbent upon the occupiers of all workplaces, particularly those which utilise hazardous plant and machinery, that they have in place processes which ensure that all persons working on the site including contractors, their employees and any others in their company are identified, their precise duties established and their qualifications and/or capacity to perform those duties proven.
- Only persons who hold the appropriate Certificate of Competency or are properly supervised trainees should be permitted to operate forklifts.
- The occupiers of workplaces which utilise forklifts must ensure that they have in place processes which:
 - Prevent forklifts being accessed by unauthorised persons and
 - Provide a current record of the detail of all persons authorised to operate forklifts, either solo or under supervision.



Child Deaths

SA.2003. 3412	Missing person, considered a suspicious case. See medical treatment (health care/adverse effects) related section.
VIC.2003. 2616	Deceased involved in motor vehicle accident. Cause of death was intra-abdominal hemorrhage due to ruptured spleen. See medical treatment (health care/adverse effects) related section.
VIC.2004. 3884	Deceased died due to the inadvertent administration of an inappropriately high dose hep-lock while in surgery. See medical treatment (health care/adverse effects) section.
WA.2005.81 9	<p>The deceased was an Aboriginal five month old baby girl. The deceased's parents had a long history of alcohol abuse. Two months prior to her death, relatives of the deceased had requested the Department of Community Development intervene to protect the health of the child. The day prior to the death, the parents left the deceased with a relative who lived close to the family home. Late that night the mother of the deceased collected her baby and returned home. The following morning the mother woke to find the deceased unresponsive. It was found the baby died in circumstances of extreme neglect, with the cause of death being pneumonia.</p> <p>Recommendations</p> <p>I recommend that Department for Community Development (DCD) review the criteria for the provision of emergency care at the group homes or otherwise take steps to ensure that there can be immediate care provided to small babies left by alcoholic parents in situations where appropriate care is not otherwise immediately available.</p> <p>I recommend that DCD review the approach taken by its officers in cases where aboriginal children are at risk of harm in order to ensure that the legislative provisions which require that the interests of the child be paramount are in fact applied, not merely given lip service, and that reliance only be placed on extended family members providing protection to children when there are identified family members who are able and willing to provide such protection.</p> <p>I recommend that DCD conduct a review of its practices with a view to ensuring that in future all significant concerns raised by other organisations or individuals receive appropriate attention and where those concerns relate to issues bearing on child safety or child death investigations, responses are provided on a sound basis and legitimate concerns are acted upon.</p> <p>I recommend that the State Government review the provision of alcohol rehabilitation services within the (...) region where the deceased lived and particularly give consideration to the setting up of an alcohol rehabilitation centre in the (...) area where the deceased lived.</p>
NSW.2006. 1042	Child deceased due to driving forklift at father's work, and being thrown from vehicle when it entered a storm drain. See Work Related section.

Deaths in custody

NT.2006.20	<p>The deceased died in the Intensive Care Unit of (-) Hospital almost one month after sustaining serious injuries in a single vehicle accident (when the vehicle he was driving crashed off the side of the Highway).</p> <p>At the time of that crash the deceased had a blood alcohol reading of 0.285. A short time before the vehicle crashed off the Highway, the NT police had been in pursuit of the vehicle.</p> <p>The police had followed the vehicle, with lights and sirens activated. The pursuit was terminated after the vehicle being driven by the deceased negotiated a bend and police lost sight of it.</p> <p>Recommendation(s):</p> <p>That Police communications be upgraded to a standard comparable with the larger centres to enable the automated recording of police radio communications.</p>
------------	---

Deaths in Custody (cont.)

QLD.2003.2059	<p>Hanging in custody. Occurred the day after the deceased's cell mate was transferred to another cell.</p> <p>Recommendation(s):</p> <ul style="list-style-type: none"> • that authorities at the (-) Correctional Centre review the mechanisms and procedures which they use to reassess prisoners who have previously been assessed to be "at risk" before the person is removed from close observation to ensure that the decision has a sufficient evidence base. • that the operators of the (-) Correctional Centre review the resources of the HRAT to enable a more careful and extensive consideration of each of the matters that come before the team. • that as a matter of urgency the Department of Corrective Services cause the cells at the (-) Correctional Centre to be modified to remove hanging points.
SA.2003.644	<p>Hanging in custody (in the cells of a Police Station) after being arrested the previous evening.</p> <p>Recommendation(s):</p> <ul style="list-style-type: none"> • that staff at (-) Police Station be provided with proper training in relation to operation of the CCTV surveillance system within the station on a regular and continuing basis to ensure that all staff have a working knowledge about the operation of the system, particularly so that they are in a position to readily and easily manipulate the system to display any given cell or exercise area on any given monitor or to scroll through all cells and exercise areas sequentially.
SA.2005.1693	<p>Natural cause death (ischemic heart disease due to severe coronary atherosclerosis) occurring in custody (remand centre).</p> <p>Considered at inquest was whether the deceased had requested medical attention during his stay at the remand centre, and if this had occurred, whether an officer or officers failed to carry out the duty of ensuring that he attend the Infirmary for medical examination.</p> <p>Recommendation(s):</p> <ul style="list-style-type: none"> • that the Department for Correctional Services commence negotiations with the Public Service Association and the Correctional Officers Legal Fund with a view to developing a protocol under which some greater level of cooperation with coronial inquiries might be achieved. <p>The Coroner noted that 'a simple expedient would be for officers to advise that they do or do not have any useful information to provide, always reserving the right to decline to answer questions that might incriminate them. This could be achieved without the need for each officer to be interviewed by a police officer in the presence of a solicitor, most obviously in cases where the officer has no knowledge or information to impart'.</p> <p>The Coroner noted that if such a protocol could not be settled upon within the time at which a report is required pursuant to section 25(5)(a) of the Act to be laid before each House of Parliament giving details of any action taken or proposed to be taken in consequence of this recommendation, it would be recommended that a subsequent report be laid before each House of Parliament at a point where such a protocol exists or efforts to negotiate for one have been abandoned by the Department for Correctional Services, and that a copy of any such further report should also be provided to the State Coroner.</p>
SA.2004.333	<p>Asphyxia resulting from the combined effects of neck compression from hanging and suffocation from a plastic bag. Deceased was in prison on remand for murder and arson. (See SA.2004.296 under the Interpersonal Violence section).</p> <p>Recommendation(s):</p> <ul style="list-style-type: none"> • that the Minister for Correctional Services and the Chief Executive of the Department for Correctional Services give consideration to the issue of non-tearable blankets and sheets within South Australian prisons.

Deaths in Custody—cont

QLD.2003.50	<p>The deceased was admitted for involuntary assessment to hospital A for a Bipolar disorder and was to be transferred to hospital B for treatment. That night, the deceased became agitated as he did not want to go back inside the hospital building and stayed on the balcony outside. Early the next morning the nursing staff heard a noise outside and found the had fallen about 5 to 6 metres from the balcony to a cement driveway. The deceased was transferred to hospital C to the Intensive Care Unit for further treatment for injuries. The deceased was in Intensive Care for approximately 2 weeks, with his condition deteriorating. The deceased came down with Pneumonia, and passed away. The intent of the deceased was found to be unlikely to be known.</p> <p>Recommendation(s):</p> <ul style="list-style-type: none"> • that Queensland Health review the current contractual arrangements concerning the position of “Medical Superintendent” at the (-) Hospital. • that Queensland Health review the practice of telephone handovers between doctors in regional, remote and small hospitals except where the patients have very uncomplicated illnesses and particularly where patients have been prescribed and given a range of medications including a number of mood-changing and anti-psychotic or sedatives as in this case. • that Queensland Health give very clear directions that <u>all</u> patients are to have physical observations performed on admission and at specified intervals and particularly where anaesthetic-type drugs such as Midazolam are prescribed. • that Queensland Health direct all staff to carefully and clearly date and time all file notes and ensure that the notes are accurate as to important events, e.g. time of call to on-call doctors, details of all important conversations. • that Queensland Health carefully review all protocols and arrangements with external bodies and <u>invite</u> agencies such as police to attend to investigate serious events rather than to positively discourage such investigations. • that Queensland Health review the need for “care plans” or similar documents for use by nurses when doctors are on-call and not available on site. • that Queensland Health prohibit <u>all</u> patients going onto outside balconies, etc., at night time and specifically prohibit patients sleeping in all places except their assigned beds. • that Queensland Health prepare a training course for all overseas trained doctors concerning the use of external agencies such as police and Royal Flying Doctor Service and other Queensland Health institutions such as Mental Health Services. • that Queensland Health review the information and documents which should be sent to other medical services on discharge from one institution to another.
-------------	---

Drowning

TAS.2006.355	<p>The deceased (who had been a mental illness) sustained fatal injuries and drowned after falling from the Tasman Bridge. Intent unlikely to be known.</p> <p>Following the death, members of the family suggested that additional cameras be installed on the bridge to monitor pedestrian traffic which could assist families and authorities in assisting to determine whether a reported missing person may have walked across, jumped or fallen from the Tasman Bridge, thereby conclusively verifying at a very early stage their movements and actions.</p> <p>The investigation surrounding the death incorporated the suggestions provided by the family in respect to addressing the issue relating to cameras on the Tasman Bridge.</p> <p>Recommendation(s):</p> <p>The Coroner recommended that that further investigations be undertaken by the Traffic Signals department of Department of Infrastructure, Energy and Resources in relation to the issue of cameras of the bridge. This may take the form of a properly structured legal study reviewing the feasibility of pedestrian cameras and/or associated relevant devices on the Tasman Bridge.</p>
--------------	---

Drugs or Alcohol

ACT.2005.185	Intentional overdose on prescribed medication by a person subject to a Psychiatric Treatment Order. See Mental Health Issues section.
VIC.2005.4699	<p>Deceased was a resident at a supportive care facility due to his chronic alcoholism. The deceased was found by another resident at laying on the ground near the front entrance. A staff member attended and when she could not rouse him she placed a pillow under his head and covered him with a blanket. She believed he would eventually wake up and return to his room. Half an hour later staff tried to rouse him but still got no response. He was checked again half an hour later and was still snoring. At 09:00 he was still non-responsive so an ambulance was called & he was conveyed to the box hill hospital. The cause of death was found to be intracranial haemorrhage and skull fracture.</p> <p>Recommendation</p> <ul style="list-style-type: none"> • That the Department of Human Services consider introducing into its courses for SRS staff and proprietors the factual elements surrounding this incident in order to highlight the caution needed when dealing with clients who appear to be affected by alcohol.
VIC.2002.24	Deceased found on floor of kitchen. Cause of death multiple drug toxicity, myocarditis or a combination of the two. See Case Study 2.
TAS.2005.229	Overdose on intravenous drugs by a man who had recently left a methadone program. See Case Study 2.
VIC.2003.1413	Deceased overdosed on liquid morphine which had been prescribed for low back and leg pain. See Case Study 2.
QLD.2003.2125	<p>The deceased suffered from an auto immune condition. He was prescribed and was dependent on medication for the pain caused by this condition. The coroner suggested the cause of death may have been due to Oxycodone toxicity but this could not be determined given the deceased's history of dependence on and tolerance of the drug. The coroner found that the Drugs of Dependence Unit, part of Queensland Health contributed little to the monitoring and control of the deceased's treating doctor's prescribing practices.</p> <p>Recommendation</p> <ul style="list-style-type: none"> • the internal audit section of Queensland Health conduct a sample audit of files from the Drugs of Dependency Unit relating to Schedule 8 drugs to ascertain whether the unit is adequately discharging its statutory responsibilities.

Falls

VIC.2006.949	<p>The deceased (aged 86) was a resident at a Nursing Home. She tripped over a garden hose which had been left on a concrete pathway outside her room, with the hose turned on. As a result she fell to the pathway, thereby sustaining injuries to her head and arm, and immediately slipping into a state of unconsciousness.</p> <p>She was treated at the scene and then transferred by ambulance to Hospital where she was diagnosed with subarachnoid and intercerebral haemorrhage. Her prognosis was later discussed with family members and she died peacefully the following evening.</p> <p>Comment:</p> <p>The Coroner commented that this accident again underlines the need for care to be taken in regard to the use of equipment at or near places where the elderly may normally be expected to frequent. The grounds staff at the Nursing Home should be made particularly mindful of this need.</p>
--------------	--

Falls (cont.)

TAS.2006.32	<p>The deceased sustained head and chest injuries as a result of a fall from a scaffold which occurred at his home. The scaffold was constructed from two extension ladders placed against the rear wall of the house. On the rungs of each ladder were two metal brackets that housed upon them a wooden plank, which formed a scaffold. The plank extended out over the metal brackets at both ends. The deceased fell approximately three metres downward. At the time of the fall the deceased was wearing a crash helmet, however it came off in the fall. A review by inspectors of Workplace Standards Tasmania found that the scaffold did not comply with the applicable Australian Standard.</p> <p>Recommendations:</p> <p>Based upon advice received from officers of Workplace Standards Tasmania in the course of this investigation, the Coroner recommended that the following safety precautions be taken before embarking on domestic maintenance work:</p> <ol style="list-style-type: none">1. Take care to comply as far as possible with any Australian Standard applicable to the task at hand so as to reduce the risk of injury or death. Members of the public are encouraged to seek advice by telephoning the Workplace Standards Helpline on 1300 366 322. Copies of publications to assist with safety, such as use of ladders and working at heights, are available by request through the helpline or via the Workplace Standards website at www.wst.tas.gov.au.2. Take regular breaks from the work. As a general rule a break of approximately 10 minutes every hour is advisable. This could vary depending on many factors such as age and physical make up. Many persons working on or around their homes are prone to work for long periods to achieve their desired objective. Regular breaks reduce the fatigue that may cause a loss of concentration. This precaution becomes more important for persons in the older age group.3. Realistically assess physical capability to perform the work. Consider whether any particular physical or mental limitations or disabilities may give rise to safety concerns or risk of injury in any given task. Review carefully whether the work can or should proceed safely in light of any such limitations.4. Conduct a risk assessment. That is, take time before commencing to identify potential safety hazards in the proposed work. It is important to also consider in this assessment the “worst case scenario” in respect of potential for injury. Steps should then be taken to minimise the risks of the occurrence of those events. In the event of uncertainty as to the best response to the risk, members of the public are welcome to contact Workplace Standards for assistance.
-------------	--

Fires, scalds or burns

SA.2004.3370	<p>The deceased (who resided in a nursing home) sustained burns after the hot water bottle she had been provided with by a nursing home carer split.</p> <p>The deceased was admitted to hospital with burns resulting in blisters to her left arm, buttocks and back. Within a few days the deceased developed renal failure. The deceased had a number of comorbidities, and stated that she wanted to have palliative care rather than aggressive treatment.</p> <p>Her condition deteriorated and she died approximately 12 days after the incident.</p> <p>Recommendation(s):</p> <ul style="list-style-type: none">• that the Minister for Consumer Affairs consider the promulgation of a public education campaign, particularly directed towards the elderly, warning of the dangers of the improper use of hot water bottles, including, but not necessarily limited to, the practice of filling hot water bottles directly from sources of boiling water, and failure to expel all air and steam from the hot water bottle before fixing the stopper.
--------------	--

Intentional self-harm

VIC.2006.2674	The deceased jumped from the Westgate Bridge. Recommendation(s): <ul style="list-style-type: none"> The Coroner noted that the issues discussed in the report 'Westgate Bridge Deaths' (prepared by a suicide researcher at the State Coroner's Office) be considered by a range of expert agencies including the Victorian Department of Human Services, Office of the Chief Psychiatrist, VicRoads and Victoria Police.
ACT.2005.185	Intentional overdose on prescribed medication by a person subject to at Psychiatric Treatment Order. See Mental Health Issues section.
QLD.2003.2059	Hanging in custody occurred the day after the deceased's cell mate was transferred to another cell. See Deaths in Custody section.
SA.2003.644	Hanging in custody after being arrested the previous evening. See Deaths in Custody section.
SA.2004.333	Intentional asphyxia in a person in prison on remand for murder and arson. See Deaths in Custody section.

Interpersonal violence

SA.2004.296	The deceased sustained fatal injuries (combined effects of blunt force head injury and asphyxiation) inflicted by her former partner. The partner died in custody some months later while on remand. Joint inquest. (See SA.2004.333).
VIC.2004.803	<p>The deceased (a part time taxi driver) was stabbed by a passenger.</p> <p>Recommendation(s):</p> <p>A number of recommendations were made to the Coroner by the Transport Workers' Union (TWU). The following observations were made by the Coroner (for consideration by the Taxi Industry Taskforce):</p> <ul style="list-style-type: none"> a physical barrier in the taxi (although it has design, operational and environmental difficulties for both drivers and passengers) has significant potential to reduce the risk of harm in circumstances similar to those which cost the deceased his life. <p>However, in order to solve the problems created by the insertion of a barrier in a standard passenger car, in the longer term the design and layout of the taxi may need to be reconsidered by the industry and vehicle manufacturers. The creation of a vehicle that is specifically designed for the purpose with in-built driver safety would be the aim.</p> <p>A pre-payment system</p> <p>It is noted that, in the circumstances, the requirement for a pre-payment arrangement for passengers may have resulted in the particular passenger not being transported (and may possibly have avoided the outcome).</p> <p>Use of actual incident examples for risk management purposes - the need for incident reporting and investigation</p> <p>A website and electronic newsletter is being developed for the industry. The use of actual case incident examples (de-identified) with suggestions as to how to avoid the incident or outcome may be a useful risk management tool for drivers. It is observed that incident examples are used to effect as a risk management tool in the aviation industry through that industry's newsletters.</p> <p>For industry based risk management systems to be effective, incidents (including near misses) need to be reported and investigated. With the development of a reporting and investigation system a database of incidents can be created. From such an information system countermeasures can also be considered by government and the industry. In this regard it is noted that the TWU in its submission to the Coroner suggested an active role for Victorian Taxi Directorate (VTD) in the investigation of verbal and physical assault on taxi drivers.</p> <p>The need for industry and community support for the Taskforce</p> <p>Historically, significant improvements in overall safety culture and positively altered outcomes in any industry, is achieved by consistent and long term co-operation at all levels of the particular industry concerned along with the support of government safety agencies. The Taskforce process appears to have this ultimate aim.</p>

Medical treatment (health care / adverse effects)

SA.2002. 3268	<p>The deceased was injured in a motorcycle accident, and died in hospital 17 days later.</p> <p>Cause of death: Pulmonary thromboembolism due to left deep vein thrombosis complicating left lower leg and pelvic fractures.</p> <p>Recommendation(s):</p> <ul style="list-style-type: none"> • The Department of Health advise surgeons visiting public Hospitals that they are encouraged to contact the Forensic Science Centre to inquire as to the cause of death in cases where their patients have died and a post mortem has been directed by the Coroner. • The (-) Hospital conduct a review of the existing structure of the Orthopaedic Units with a view, having regard to (-)'s evidence, to improving registrar supervision of interns, and to require that responsibility and accountability for the performance of a particular intern be reposed in a designated registrar. • The Medical Board of South Australia consider these findings so far as they touch on the registration of overseas trained doctors.
SA.2003. 3412	<p>The deceased was a 16 year old passenger in a motor vehicle which left the road and rolled. The deceased was transferred by ambulance to the nearest hospital, which was only equipped for day surgery. The deceased was then later transferred to a better equipped hospital for surgical treatment. The cause of death was found to be intra-abdominal haemorrhage due to ruptured spleen.</p> <p>Recommendation</p> <p>That the Minister for Health consider these findings, and conduct a review of the systems for stocking O negative blood in rural hospitals generally, with a view to considering whether existing stocking practices are adequate.</p>
VIC.2003. 2616	<p>The deceased (aged 17 years) received a combined bilateral lung/kidney transplant. Over two months later a hickman's catheter was inserted to facilitate continued antibiotic therapy. The catheter was locked with a strong heparin concentration. A second procedure was performed to insert a right bronchial stent. 2 hrs later the deceased was administered intravenous arlamine. She suffered a coughing episode & severe bleeding which precipitated a cardiac arrest. She was resuscitated. It became apparent that the high dose heparin lock that had been used for the hickman's catheter insertion procedure had been inadvertently administered. She was given intravenous protamine to reverse the effects of heparin. Over the following days her condition deteriorated and she passed away.</p> <p>The death could have been prevented had the inadvertent administration of an inappropriately high dose hep-lock not occurred.</p> <p>Recommendation(s):</p> <p>That the Hospital and appropriate professional organisations should consider:</p> <ul style="list-style-type: none"> • Expanding the training and accreditation of surgeons to incorporate the use and locking of a catheter and not just the technical skill of tunnelling and insertion. • Simplifying and standardising operating preference cards with the agreement of all surgeons to avoid confusion. • Looking at systems to encourage health professionals to speak up when errors occur in hospitals as a patient would be entitled to expect. • Training health professionals to be receptive and respond with explanation when queried or challenged. • Further examining the most appropriate method of creating a central catheter lock. • Further reviewing Hep-lock protocols to ensure that they are applicable and readily available to both doctors and nurses. • Notifying other Hospitals and ascertaining whether they have reviewed their locking protocols.

Medical treatment (health care / adverse effects) (cont.)

VIC.2004.1097	<p>The deceased originally presented to hospital complaining of upper back pain. Diagnosed with muscular skeletal pain and discharged. Over the next nine days the deceased re-presented at hospital two more times complaining of chest pain—in both cases discharged. Found unresponsive at home by wife the day after the final re-presentation. The deceased's wife commenced CPR but the deceased was dead upon ambulance arrival.</p> <p>Cause of death: Myocardial infarction; Coronary artery thrombosis.</p> <p>Recommendation(s):</p> <ul style="list-style-type: none"> • That all hospitals consider the facts outlined in this case and, if appropriate, consider adopting the practices and procedures developed by the (-) Hospital for assessment of representations (with the same apparent problem or variants) as a minimum standard. <p>The Coroner noted that it is essential that if patients re-present with the same problem (or possible variants of the same problem) that "caution" be considered as being the appropriate "diagnostic practice." Caution dictates discussion with another experienced clinical colleague. When the re-presentation is for the third occasion then advice needs to be sought from a consultant or senior clinician. Senior clinical supervision is essential. It is noted that the new guidelines for the (-) Hospital make the point that "very significant caution is required if a patient presents a third time with the same problem."</p> <ul style="list-style-type: none"> • That the health sector who may be managing patients in this potential situation (IHD) consider applying a risk emphasis to diagnosis by excluding ischaemic heart disease from possible diagnostic alternatives. • That all hospitals consider the facts outlined in this case and, if appropriate, consider adopting the "Discharge at own risk - guidelines" developed by the (-) Hospital as a minimum standard. <p>The Coroner also commented that the existence and detail of the guidelines may also need to be re-enforced with nursing staff.</p>
VIC.2006.2691	<p>The deceased, a 48 year old man, suffered from Downs Syndrome and intellectual disability. He had lived in permanent care all his life. One evening staff at his residential unit became concerned about the deceased's wellbeing. The deceased was diagnosed with an upper respiratory tract infection. His condition began to improve following the administration of medication. He was later found deceased by the staff of his residential unit. The cause of death was found to be bilateral pneumonia with contributing factors of Downs Syndrome, low weight and hypothyroidism.</p> <p>Recommendation</p> <p>The Coroner recommended that the Department of Human Services undertake a review of the documentation practices and procedures in all its residential care units.</p>
VIC.2002.761	<p>The deceased was a 47 year old man who collapsed at home. The cause of death was found to be ischaemic heart disease and adult polycystic kidney disease. It was suggested by the deceased's family that previously diagnosed proteinuria was not investigated appropriately when initially diagnosed. The coroner found a number of deficiencies in the treating doctor's management of the deceased prior to his death.</p> <p>Comment</p> <p>Not only is proper recording of information important in relation to diagnosis, prognosis and treatment but it might also become an important issue in other areas such as compensation claims by patients or indeed inquests.</p> <p>Recommendation</p> <p>The Coroner recommended that that his Comment be sent to the professional colleges of all medical associations for distribution to their members.</p>

Medical treatment (health care / adverse effects) (cont.)

VIC.2004.3803	<p>The deceased had a fall at her home and presented to the emergency department of a hospital to be assessed. She was sent home after observation but during the next day her condition worsened. She was taken back to hospital and passed away. The deceased had previously been diagnosed with a brain tumour (no operation required) which affected her balance and probably contributed to the fall.</p> <p>Recommendations</p> <p>In the event that it is the case that there is no consistent policy at (...) Hospital in regard to such cases I would recommend that consideration be given to the adoption of the Canadian CT Head Rules which I set out herewith:</p> <p><i>"A CT scan is required for any patient with a minor head injury and any one of the following seven characteristics:</i></p> <ol style="list-style-type: none"> <i>1. Reduced mental, verbal, or eye response two or more hours after the injury</i> <p><i>(Glasgow Coma Scale 13-15).</i></p> <ol style="list-style-type: none"> <i>2. Suspected open or depressed skull fracture.</i> <i>3. Any sign of basal skull fracture (for example, raccoon eyes).</i> <i>4. Two or more episodes of vomiting.</i> <i>5. 65 years or older.</i> <i>6. Amnesia before impact of 30 or more minutes.</i> <i>7. Dangerous mechanism (for example, flying through a car windshield)."</i> <p>Further, the Coroner suggested that the adoption of any such policy or guideline should also include an additional separate category for patients who present with a head injury and who are taking anti-coagulant medication at the time.</p> <p>In other words this group should be accepted as an eighth category of patients who are to be referred for an immediate CT scan, following an injury to the head.</p>
VIC.2005.850	<p>The deceased was an 84 year old man who was very frail and was hospitalized. He was transferred from hospital A to hospital B after showing sexually inappropriate behaviours with aggression and violence. An involuntary treatment order was made. The deceased died from aspiration of food (a sandwich) with a contributing factor of coronary artery atherosclerosis.</p> <p>Recommendation</p> <p>Given the overall circumstances surrounding the death, the Coroner recommended that (the) hospital review their induction, training and supervision of nursing staff to ensure they are aware of all elements of their food management system, with particular emphasis on the procedures for notifying changes in diet made by the Dietician and/or Speech Pathologist, and their heightened responsibilities for dietary intake during night shift.</p>
VIC.2006.2008	<p>The deceased had a medical history including cancer and chronic obstructive pulmonary disease. He was diagnosed with cancer of the bowel and admitted to hospital. Following a hemicolectomy, blood and fluid started oozing around his tracheostomy site. The deceased require multiple suctioning of his tracheostomy tube but suffered a hypoxic arrest due to a blocked tracheostomy.</p> <p>Recommendations</p> <p>The Coroner noted that the deceased was discharged from the ICU within one day of his tracheostomy, and that ENT Doctors were not informed of his transfer from the ICU to the ward, although the ENT unit had at the request of the ICU, undertaken this tracheostomy.</p> <p>Given that certain facilities such as the use of a warm humidifier for tracheostomy cannulas, are not readily available in the wards, the ENT unit should be consulted before transfer of a patient who has been under its care, takes place.</p> <p>The Coroner also recommended that the hospital reviews its arrangements for tracheostomy care, to ensure that all tracheostomy related nursing is undertaken or directly supervised by tracheostomy certi-</p>

Medical treatment (health care / adverse effects) (cont.)

TAS.2007.12	<p>The deceased female was a chronic alcoholic who had been vomiting for three days and called an ambulance to request assistance. Ambulance attended and left soon after when the deceased did not answer her door or telephone, based on the understanding that her children were with her and she had probably previously left the house with them. The children had earlier been taken away by a friend of the deceased, and the deceased was still in the house. She was found the next day deceased. The cause of death was found to be complications of chronic alcoholism and severe alcoholic liver disease.</p> <p>I strongly urge the Ambulance Service to implement those systemic improvements which it has identified following the root cause analysis. Hopefully their implementation will minimise the prospect of other deaths occurring in like circumstances.</p>
-------------	---

Mental Health Issues

ACT.2005.185	<p>Intentional overdose of prescribed medication (Olanzapine). At the time of his death, the deceased was subject to a Psychiatric Treatment Order.</p> <p>Recommendation(s):</p> <ul style="list-style-type: none"> • That a protocol be developed with regard to the sharing of information between all psychiatric facilities, both private and public, and involved community services, concerning patients and their risk factors. • That a review be conducted of discharge processes from ACT psychiatric facilities to ensure that all agencies involved in the patient's ongoing care are cognisant of all risk factors identified and strategies relevant to ensuring the patient's safety and well-being. • That clear protocols are adopted to ensure timely access to a patient's residence where they are assessed as being at a moderate or higher risk of self harm. Information concerning such strategies should be communicated to all involved in the patient's care.
VIC.2004.3986	<p>The deceased with a history of long term institutional care from early teenage years had commenced living independently with Outreach support in 1991 under the care of DHS and Yooralla. After an incident of aggressive and uncontrolled behaviour in the community the deceased was admitted as an involuntary patient. Despite disagreements from DHS and Yooralla, the deceased was discharged a day later. The deceased was found at home after being un-contactable by mental health workers for several days after discharge.</p> <p>Recommendation</p> <p>Mental Health Workers should consider the need to develop and or review their protocols for the preparation, management and execution of Discharge Plans particularly when dealing with vulnerable or intellectually disabled patients.</p>

Motor vehicle accidents

ACT.2005.323	<p>The deceased was the driver of a vehicle involved in a motor vehicle collision when he attempted to turn right and was hit in the driver's side by another car.</p> <p>Recommendation:</p> <ul style="list-style-type: none"> • That the Director of Public Prosecutions consider offences of one headlight and speeding.
NT.2006.20	<p>The deceased died in intensive care one month after sustaining serious injuries in a motor vehicle accident while being pursued by police. See Deaths in Custody section.</p>

Motor vehicle accidents—cont

SA.2002.3268	Deceased injured in a motorcycle accident and died in hospital 17 days later. See Medical Treatment (health care/adverse effects) section.
TAS.2006.118	<p>The deceased was driving a 2002 prime-mover which was drawing two Vawdrey tri-axle trailers.</p> <p>In the course of negotiating a downhill section of highway with a long sweeping curve, the prime-mover overturned rolling onto the Armco railing and continuing to travel west before coming to rest partially blocking the overtaking lane for westbound traffic. Both trailers also rolled onto their right sides and came to rest across both eastbound lanes. The rear trailer caught fire. The body of the deceased was located underneath the cabin of the prime-mover. He had not been wearing a seatbelt.</p> <p>The Coroner found that this accident occurred because the deceased attempted to negotiate the accident bend at a speed which was at or near the legally permitted speed but which nevertheless was excessive because of the type of vehicle he was driving and the roadway's physical configuration. This occurred in circumstances where unfamiliarity with the roadway and driver fatigue, either together or in combination, probably led to the deceased's failure to approach the left hand curve at a safe speed.</p> <p>Recommendation(s);</p> <ul style="list-style-type: none"> • that the findings be brought to the attention of the manufacturer of the Iveco prime-mover with the further recommendation that it carry out a review of the Electronic Control Unit (ECU's) fitted to its vehicles with a view to ensuring that the data produced by them is readily capable of interpretation by accident investigators. • that the Commissioner of Police take steps to ensure that at all times each of the three Accident Investigation Squads operating within the State has an officer or officers attached to it who is properly qualified to make an expert calculation of the speed of vehicles involved in serious road traffic accidents. • that DIER make the speed limit in the area of the accident 90 km/h (down from 110 km/h) permanent. <p>The Coroner endorsed DIER's recommendations that an investigation of the road surface condition be undertaken with a view to identifying any warranted treatments including resurfacing, and that an investigation be undertaken into the appropriateness of the super-elevation through the curvature of the accident bend. And that if either or both of these investigations identify any remedial work that needs to be undertaken, then such work should be carried out as soon as possible.</p> <p>The Coroner supported a recommendation made by officers of both AIS and DIER that the existing Armco railing be replaced with a more substantial barrier capable of resisting considerable impact.</p> <p>The Coroner also supported a recommendation made by the investigating authorities that options be investigated for the development, design and installation of "slippery when wet" flashing light warning signs that automatically activate during periods of wet road conditions.</p> <p>The Coroner finally endorsed recommendations made in the course of investigating this accident that two additional light standards be erected and that additional guideposts and retro reflective pavement markers be installed.</p>
TAS.2006.305	<p>Two vehicle collision on a main arterial highway. The deceased (an elderly female) was driving alone when her vehicle veered onto the incorrect side of the road, into the path of an oncoming 4WD. The deceased was not wearing the fitted seat belt correctly as it appeared to be draped over her right shoulder and not securely fastened.</p> <p>Recommendation(s):</p> <ul style="list-style-type: none"> • That the public awareness campaigns of the past to wear a correctly fitted and fastened seat belt when travelling in a vehicle be revisited.

Motor vehicle accidents—cont

VIC.2006.155	<p>The deceased (a student/taxi driver) died in a single vehicle collision.</p> <p>Investigations revealed that the deceased was not wearing a seat belt at the time and no evidence was found that indicated braking could be associated with the collision. Fatigue a factor.</p> <p>Recommendation(s):</p> <ul style="list-style-type: none"> • An audible seat belt warning system that sounds an alarm when a seat belt is not worn by the driver be fitted to all new vehicles.
VIC.2006.1128	<p>The deceased was at a market browsing through goods offered for sale. A motor vehicle entered the car park with the intention of parking. While driving towards a park, the driver of the vehicle suffered an epileptic fit, losing consciousness. His car then crashed through the mesh wire gate and into a number of shoppers, including the deceased.</p> <p>Recommendation(s):</p> <ul style="list-style-type: none"> • The Coroner recommended that VicRoads move immediately to suspend the driver's license. <p>Further, the Coroner suggested that should VicRoads be requested to re-issue his license at some point in the future, then it should, through its medical review process, first require him to be re-examined and tested by a new and independent Neurologist, before again determining whether he is a fit person to hold a Victorian Drivers Licence.</p>
TAS.2006.25	<p>The deceased, an overseas tourist on holiday, was being driven in a rented vehicle by a family friend, who temporarily fell asleep at the wheel. As a result the vehicle ran off the road at a left hand bend before entering a culvert and colliding head on with a large gum tree. The deceased, not wearing a seatbelt, was thrown to the front of the vehicle and killed instantly.</p> <p>Recommendation</p> <p>This very sad incident highlights the importance of taking a break from driving upon the onset of drowsiness. The deceased had experienced a brief period of falling asleep 5-10 minutes before this accident but nevertheless elected to keep driving. If he had taken a break immediately upon the onset of drowsiness this accident may not have occurred.</p>
TAS.2006.582 and TAS.2006.583	<p>Two female occupants (driver and passenger) both died when their car fishtailed off the road at a left hand bend onto the gravel verge and then back into the path of an oncoming vehicle. The first vehicle became wedged under the front of the second vehicle and was struck by a third vehicle that had been travelling behind it.</p> <p>Recommendation</p> <p>That the relevant authority improve road conditions in the area by replacing the painted edge lines with audible edge lines and widening the sealed shoulders on both sides of the highway.</p>

Sport/leisure activities

TAS.2007.60	<p>The deceased and his grandson launched a 5.2 metre long aluminium boat which the deceased had purchased second-hand one week previously into a lake. The boat was powered by a 90 hp Johnson outboard motor and a 9.9 hp Johnson auxiliary outboard.</p> <p>Witnesses observed the vessel begin to lay to its right about 150 metres from the shore and then to start taking on water in the area of the right rear. At this point the vessel slowed and began sinking. The grandson was rescued, however the deceased was not located until the next day by the police dive team.</p> <p>Computer modelling undertaken by MAST established that the vessel would have capsized if its bilges contained 75 litres of water and its two occupants moved to the starboard side.</p> <p>Neither the deceased nor his grandson was wearing a personal flotation device at the time of the sinking.</p> <p>The death was found to be the result of a natural cause, namely atherosclerotic coronary vascular disease, and unrelated to the boating activity being carried out at the time of his death.</p> <p>Recommendation(s)/Warning:</p> <p>The Coroner noted that this incident is an opportunity to remind all boat owners of the need to ensure that personal flotation devices are worn by all boat users as required by the legislation, and that all boat users should ensure that their boats are drained of any excess water before launching.</p>
-------------	---

Work-related

TAS.2004.449	<p>Deceased died when he was pinned by the forklift truck he was driving at his neighbour's work. See Case Study 3.</p>
TAS.2006.14	<p>Injuries sustained when struck by a falling blackwood branch whilst carrying out commercial timber felling. The Coroner noted the following:</p> <p>'Records retained by Workplace Standards Tasmania show that in the sixteen year period from 1990 twenty two persons have died in Tasmania in workplace accidents involving falling trees or limbs. The death of (the deceased) is the sixth to have occurred within the last three years. These bald figures do demonstrate that tree-felling is an inherently dangerous occupation. They demonstrate too that deaths within Tasmanian forests are continuing to occur all too regularly and this is so despite the forestry industry's occupational safety initiatives. These matters lead me to conclude that there is a real need for all stakeholders within the forestry industry, in conjunction with Workplace Standards Tasmania, to put in place a practice whereby the mechanical harvesting of trees becomes the norm, at least in those areas with trees of small to medium diameter. I appreciate that the widespread implementation of mechanical harvesting may impose short term challenges for the industry but these are challenges which its stakeholders together will need to address and overcome if the number of Tasmanian forestry deaths is to be minimised'.</p>
TAS.2006.118	<p>The deceased was driving a prime mover which overturned. He was not wearing a seatbelt at the time of the incident. See Motor Vehicle Accidents section.</p>
TAS.2006.149	<p>The deceased was a retired farmer who undertook basic tasks on his sons' farm. He had been previously diagnosed with Parkinson's disease which affected the use of his legs. The deceased was pinned under the right wheel of a tractor while delivering hay bales to the cattle on the farm. He had stopped the tractor without applying the handbrake and it subsequently rolled on him.</p> <p>Recommendation</p> <p>That the rural community be educated as to the negative results of not complying with the manufacturer's instructions, particularly with regards the application of handbrakes.</p>

Work-related—cont

VIC.2003.1649	<p>The deceased (a sub-contractor who was digging a trench) tripped over an agricultural pipe and fell under the rear wheels of a slow moving tip truck.</p> <p>The Coroner found the death to be potentially preventable, with the following factors/failings contributing:</p> <ul style="list-style-type: none"> - failure to have in place an effective method of overall supervision of site safety by the principal contractor and thereby to ensure that pedestrians working at the site were effectively segregated from moving mobile equipment like the tip truck. - failure of safety supervision of subcontractors by the principal contractor, including drinking on site by the deceased, the lack of site induction of the tip truck driver and the problems with the safety vests. <p>Recommendation(s):</p> <p><i>Recommendation 1 (and by way of supporting comment for industry based training)</i></p> <p><i>The death of the deceased emphasises the need for principal contractors working in the building and construction industry to take a holistic approach to overall site safety and risk management in order to ensure that sub-contractor safety is appropriately considered and addressed at all times throughout the job.</i></p> <p><i>The circumstances of the incident also reinforces the need for employers in the building and construction area to use appropriately qualified supervisors who understand both production and occupational health and safety management issues.</i></p> <p><i>It is noted that there are existing safety courses run by industry groups covering occupational health and safety for supervisors. Attendance at these courses should be encouraged as standard practice throughout the building and construction industry. These courses should be directed towards all levels of supervision from the project manager, works supervisor, engineering supervisor to the foreman.</i></p> <p><i>Clearly from a Coroner’s perspective, any course aimed at ‘SUPERVISION FOR SAFETY AND PRODUCTION’ needs to deliver examples of what supervision means in the practical sense along with real case examples of how to identify and manage common risk situations (coroners’ findings may be useful).¹ <i>It must also be remembered that the importance of the safety relationship and responsibility between the principal contractor and its subcontractors should always be considered in such courses.</i></i></p> <p><i>Recommendation 2</i></p> <p><i>Separation of pedestrian traffic and work areas from moving machinery like trucks should be regarded as the standard work practice on all construction worksites. A Job Safety Analysis establishing the separation methodology should occur as a matter of course before any work commences. The work needs to be regularly monitored to ensure that any changed work patterns do not result in the work safety systems (separation) being breached.</i></p> <p><i>Recommendation 3</i></p> <p><i>That WorkSafe, Victoria Police and the Coroner develop a pilot investigation guide for work-related fatalities in the building and construction sector. The guide should cover the investigation of factors in a variety of areas that are usually found to be factors in construction fatalities such as works supervision, implementation of safety systems, equipment design and/or maintenance, application of codes or standards, induction, working alone, training and training systems, etc.</i></p> <p><i>The fatality investigation guide should be developed with appropriate consultation between the key investigatory agencies and the peak employer and employee associations.</i></p> <p><i>Recommendation 4</i></p> <p><i>The use of under-run protection on trucks as a safety design countermeasure is supported</i></p>
VIC.2004.803	<p>The deceased, a part time taxi driver, was stabbed by a passenger. See Interpersonal Violence section.</p>

Work-related—cont

VIC.2004.1473	<p>The deceased (a process worker) was driving the forklift truck to stack polystyrene pods in the loading area of the factory. Normally the polystyrene pods are stacked 4 high, however during the shift they had been stacked 2 high. Due to the lack of room, stacking the polystyrene pods was becoming an increasingly difficult task and the deceased and a colleague had decided to use the forklift to stack the pods 4 high. The deceased was reversing the forklift truck around a tight corner in the loading area of factory when the forklift overturned and tipped to the left, causing the deceased to fall out of the forklift truck. The deceased was crushed by the roll over protection bar attached to the forklift. The deceased was untrained and unlicensed to operate a forklift, and had not been wearing a seatbelt.</p> <p>Comments made by the Coroner:</p> <p>To prevent unnecessary deaths such as the deceased's it is essential that companies such as (...) implement strategies and regulations that requires strict compliance with guidelines; such as adequate training and licensing of workers and clear policies and procedures that ensure a safe working environment.</p> <p>A Fatality Investigation Report from the Work-Related Liaison Service found:</p> <p><i>"The prevention option in this case is a reminder of the current best practice guidelines that state that users of forklifts must be fully trained and licensed and must wear seat belts at all times during the use of a forklift.</i></p> <p><i>For this particular workplace, a further prevention option includes clarification to all workers of the policy for stacking the polystyrene pods in a manner that leaves the working area clear."</i></p>
VIC.2004.3884	<p>The deceased died while driving a forklift truck at his father's workplace when it hit an uncovered storm drain. See Case Study 3.</p>
VIC.2004.4153	<p>The deceased (who worked as a milker) was located trapped between a hydraulic gate and the roof of the dairy.</p> <p>Recommendation(s):</p> <ul style="list-style-type: none"> • The Victorian WorkCover Authority identify dairy farms using this and other similar type gate systems and issue a prohibition notice and an improvement notice.
VIC.2005.3258	<p>The deceased was welding frame work to a galvanised steel false ceiling. During the construction of this, the deceased utilise an hydraulic scissor lift which was located at the premises. At an unknown time the hydraulic lift was raised to the ceiling level, impacting the deceased. The cause of death was found to be postural asphyxia.</p> <p>Recommendation(s):</p> <p>The Coroner found that whilst the investigation into the death could not determine the precise factual scenario that precipitated the death, that is was possible that the deceased tripped, thereby inadvertently raising the platform, and accordingly the Coroner recommended:</p> <ul style="list-style-type: none"> • that manufacturers or operators of Elevated Work Platforms consider the fitting of a "dead man" foot control; a safety device that prevents any function from operating unless it is activated in conjunction with the primary controller.
VIC.2006.155	<p>The deceased died in a single vehicle collision, and was not wearing a seat belt at the time of the incident. See Motor Vehicle Accidents section.</p>
VIC.2001.3793	<p>The deceased was employed as a microbiologist for many years. The deceased used his security pass to access the airlock at his organisation that allowed further access to a liquid nitrogen store room. The deceased collapsed within the airlock. There was a problem with the air flow system that supplies oxygen to the airlock room.</p> <p>Recommendations</p> <p>The Coroner recommended that the organisation perform a cost benefit analysis of implementing an expansion of its CCTV coverage particularly within the biological secure area given the potential adverse consequences for employees and the public at large in the event of breaches of security.</p> <p>The coroner further recommended that the organisation perform similar like analysis for the purposes of introducing additional distress buttons within the facility.</p>

Miscellaneous

NSW.2005. 5218	<p>Missing person. The Coroner indicated that, notwithstanding that there is no evidence to support that a homicide had occurred, there is still the possibility that that occurred.</p> <p>Recommendation(s):</p> <ul style="list-style-type: none"> • to the Commission of Police: that there should be a reward posted for further information that might lead to information concerning the disappearance of the deceased. • that the matter be referred to the Homicide Division as a cold case for periodic review.
NSW.2006. 1042	<p>This case relates to a sixteen year old female missing since 1987. The coroner considered that the disappearance should be looked at as being suspicious, therefore possibly necessitating referral to the Homicide Squad as a cold case for periodic review.</p> <p>Recommendation</p> <ul style="list-style-type: none"> • The Coroner recommended a reward for further information.
TAS.2005.491	<p>The deceased lived in a bus that had been converted into a residence. After failing to attend an appointment, the deceased was located deceased in his bed. The cause of death was found to be Anoxia/Suffocation. An examination of the gas installation of the camper found a leak in a gas fitting underneath the bus which lead to propane gas entering the bus interior through a hole in the buses sub floor directly underneath the bed on which the deceased was lying.</p> <p>Recommendation(s):</p> <p>The Coroner concurred with the following recommendation made by Workplace Standards Tasmania:</p> <ul style="list-style-type: none"> • <i>That the Delegate of the Competent Authority notifies all Tasmanian registered gasfitters who intend to install, alter or repair LPG systems on caravans that the work must be performed in accordance with regulation 57 of the Dangerous Goods Act 1998.</i> <p>The Coroner also recommended that all persons use appropriately qualified gas fitters and these gas fitters comply with all relevant legislation and guidelines to prevent such incidents occurring in the future.</p>

The following is an index of recommendations (by broad topic area) summarised by the NCIS within the 13 editions of Fatal Facts produced thus far.

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

Editions 6 - 12 of Fatal Facts can be found on the NCIS website, at:
http://www.ncis.org.au/web_pages/publications.htm#a1

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

Topic/theme	See Fatal Facts Edition(s)...
Adverse effects or reactions to medical/surgical care	All
Aged care	13, 11, 6
Child deaths	13, 12, 11, 10, 9, 8, 7, 6, 4
Diving, scuba diving, snorkeling	11, 9
Domestic/leisure incident	13, 12, 9, 8, 4
Drug/alcohol related	13, 12, 11, 9, 7, 6, 5, 4, 3, 2
Electrocution	8, 7
Falls	13, 12, 11, 10, 8, 4
Fire-related	13, 12, 11, 10, 7, 5, 3, 1
Homicide/interpersonal violence	13, 12, 11, 9, 8, 7, 5
Intentional Self-Harm	13, 12, 11, 10, 9, 8, 5, 4, 3, 2, 1
Mental health issues	13, 12, 11, 10, 9, 8, 4, 3, 2
Miscellaneous	13, 12, 11, 8, 5, 4, 3, 1
Natural cause deaths	13, 12, 9, 5, 2, 1
Police pursuits/deaths in custody	13, 12, 11, 10, 9, 8, 7, 6, 3, 2, 1
Product-related	13, 11, 7, 4, 3
Sports-related	12, 11, 10
Transport-related	All
Water-related (general)	All
Water-related (recreational fishing/boating)	13, 11, 10, 9, 7, 6, 5, 1
Work-related	All