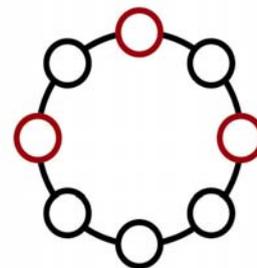


NCIS Fatal Facts

Edition 23 - February 2013



NCIS

This edition of Fatal Facts features 45 coronial cases where recommendations have been made. These cases were closed between 1 October 2009 and 31 December 2009.

As a number of recommendations involved deaths in custody or deaths during police pursuit, these are the focus for the case studies.

There were also a number of recommendations made regarding intentional self-harm deaths proximal to mental health service being provided where a) the person was in a mental health facility, b) on unaccompanied leave from a mental health facility or c) had recently been discharged from such a facility.

If you are seeking further information regarding any of the cases contained in this edition and you are an authorised NCIS user, log into the NCIS website and find particular cases by clicking on the 'NCIS Search' tab and selecting 'Find case'.

Should you require advice regarding NCIS access, please contact our NCIS Access Officer, Jo Cotsonis at joanna.cotsonis@ncis.org.au or on (03) 9684 4323.

If you do not currently have access to the NCIS and would like to enquire about an information search, please contact the NCIS team on ncis@ncis.org.au.

NCIS AT A GLANCE

- * Number of cases on the NCIS (cases closed by a Coroner between 1/10/2009 & 31/12/2009) = 3309
- * Number of findings on the NCIS (cases closed by a Coroner between 1/10/2009 & 31/12/2009) = 2613
- * Number of cases with recommendations (cases closed by a Coroner 1/10/2009 & 31/12/2009) = 45

Disclaimer: The précis of coronial findings detailed within this publication have been produced by NCIS staff, with the best efforts made to accurately summarise the circumstances, findings and recommendations made by the coroner in each case.

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

The NCIS is managed by the Victorian Department of Justice 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 & Ageing, SafeWork Australia, the ACCC, the Australian Department of Infrastructure and the Australian Institute of Criminology and the New Zealand Ministry of Justice.

CASE STUDY 1— DEATHS IN CUSTODY OR WHILE IN POLICE PURSUIT

Case: NT.2007.291, NT.2007.292, NT.2007.293, NT.2007.294, NT.2007.295 & NT.2007.296

NT Police were conducting a random traffic operation for the purpose of checking licences and registrations, breath testing drivers and searching vehicles for alcohol being illegally carried into designated dry communities.

The deceased persons had spent the afternoon drinking alcohol with friends and family at town camps. The designated driver was the least intoxicated of the group, and was an unlicensed and inexperienced driver. Seven people were travelling in a car intended to carry a total of five passengers including the driver.

As police signalled the driver to stop, the driver accelerated away from the area failing to negotiate a right hand bend. The car skidded off the road and rolled three times. All six passengers were ejected from the car and died from multiple injuries.

Recommendations:

1. That practical mock pursuit training be taught as part of either recruit driving training or an advanced driver training module which is regularly available to NT police members.
2. That the Police Commissioner ensure that the Coronial Investigation Unit in Alice Springs is appropriately staffed and resourced in order that the members of that Unit are able to, and do, exercise investigative, oversight and liaison functions in relations to deaths reported to the Coroner.
3. That the Police Commissioner put specific strategies in place to ensure that reportable deaths are investigated by police officers in the NT in a timely way, with the expectation being that a coronial investigation file of satisfactory quality will be submitted to the Coroner within 6 months from the date of death.

Case: SA.2006.685

The deceased died following a police high-speed pursuit while riding a motorcycle. The deceased failed to stop when police requested to do so.

Recommendations:

1. That the Commissioner of Police establish a panel to investigate the appropriateness or otherwise of police officers pursuing motorcycles at high speed.
2. That the Commissioner of Police in any event amend the General Order relating to high risk driving by including reference to the circumstances in which it would be considered appropriate and inappropriate for police officers to pursue motorcycles, by including specific references to the relevance of the identity of the registered owner of the pursued vehicle in any risk assessment, by making specific reference to existing police powers of investigation that might obviate the necessity for a pursuit and by specifically addressing the situation in which a police pursuit is being conducted by a sole officer in circumstances where an Incident Controller is unable to exert effective control of the incident and there is no secondary pursuit vehicle.
3. That the Commissioner of Police cause education programs to be devised in relation to the topics identified in Recommendation (2) herein with a view that the said programs be delivered to all police officers.
4. That the relevant government Ministers consider the introduction of legislation that would prevent the registration of vehicles in the names of persons who are not licensed to drive vehicles of the kind sought to be registered.
5. That the relevant Ministers at the same time consider the introduction of legislation that would render it an offence for the registered owner of a vehicle knowingly to cause or permit an unlicensed person to operate that vehicle.
6. That the relevant Ministers consider the introduction of legislation that would penalise the offence of failing to stop a motor vehicle having been directed to do so by a police officer by the imposition of a minimum period of licence disqualification that would be served consecutively upon any other period of disqualification.

CASE STUDY 1 — DEATHS IN CUSTODY OR WHILE IN POLICE PURSUIT

Case: NT.2007.310

The deceased suffered from long term bipolar depressive illness and chronic obstructive airway disease. The deceased was taken to hospital by police after displaying abnormal behaviour in the street. While in hospital for mental health assessment and still under police custody, the deceased attempted to leave the premises. Police forced the deceased down to the ground into a prone restraint position. The deceased lost consciousness and died.

Recommendations:

1. The NT Police Custody Manual be amended to provide that members must take any apparently mentally ill or disturbed person apprehended under section 163 of the Mental Health and Related Services Act by the most direct practical route and as quickly as possible to a hospital or doctor for the purposes of an assessment.
2. The NT Police Custody Manual, the Police General Orders and the MoU dated June 2002 should be revised to offer clear guidance to operational police in relation to the handover of patients by police to hospital.
3. That the NT Police ensure operational police are trained and retrained using reality based training techniques to a sufficient degree to ensure a proper understanding of the dangers of sudden cardiac arrest and positional restraint asphyxia.
4. The NT Police should ensure that all members are trained and re-trained in strategies to deal with mentally ill persons both in custody and generally in the course of their duties.
5. The NT Police should amend the General Order on Transport of Persons in Custody, and Part 6 of the Custody Manual – Mentally Ill Persons- to include step by step instructions for police members on exercising the power of immediate apprehension for the purposes of a mental health assessment.
6. The NT Police should amend clause 6.1.2 of the Police Custody Manual – Deaths in Custody and Investigation of Serious and/or Fatal Incidents Resulting from Police Contact with the Public so that Clause reflects that where legal advice is sought by a member and it is not possible to obtain that advice before the end of the member's shift, the member should be interviewed as soon as reasonably practicable thereafter.
7. That the legislature consider amending section 34 of the Mental Health and Related Services Act to clarify police powers and responsibilities.

Case: SA.2005.2449

The deceased suffered multiple drug toxicity while on home detention bail.

Recommendations:

1. The Department for Correctional Services review the system of home detention bail with particular attention to the logistical difficulties imposed in ensuring proper supervision of bailees in regional areas.
2. The Department for Correctional Services and the Department for Health review the sharing of information between the two entities. They should give particular consideration to the creation of a statutory codification of the duties of clinicians in the Prison Health Service to recognise that there is a need to modify the ordinary obligations of confidence of medical practitioners when working with persons who are in custody, or on home detention bail.

Case SA.2007.561

The deceased committed suicide by hanging while in custody.

Recommendations:

1. That the Department for Correctional Services revise the prison stress screening form to contain a cleared statement that the result of the completion of the form was that the prisoner should be regarded as being at risk.
2. Elimination of hanging points at the [correctional centre].

ADDITIONAL CASES — DEATHS IN CUSTODY OR WHILE IN POLICE PURSUIT

Case: TAS.2007.544

The deceased was serving a term of imprisonment. The cause of death was identified as hypertensive cardiovascular disease with contributing factor being morbid obesity, bronco pneumonia and diabetes mellitus.

Recommendations:

1. That Justice Department in consultation with the Correctional Medical Services, Forensic Medical Services Wilfred Lopez Centre and Correctional authorities develop a clear protocol for the assessment of inmates who have special needs due to intellectual disability and whose wellbeing was therefore at particular risk within the prison population in order that they be dealt with in accordance with structured care or management plan.
2. Complex client support cases require a project management approach with clear lines of accountability, communications and reporting across all involved agencies whether public or private.
3. Case management should not be suspended while a person is an inmate in prison, but rather the plan needs to be capable of quantified application within the prison environment together with a formal and detailed hand-over to Correctional Services.
4. Discharge planning needs to be actioned whilst such person is an inmate in order that appropriate housing, supervision and care are in place upon a person's release.
5. There is need for a collaborative approach to ensure that various services areas, teams and individuals are working together. There must be a consistent line of inter-agency and intra-agency communication.
6. Where a key player in a person's care is a non-government organisation there must be a system of monitoring and assessment of their performance to ensure they adhere to the level of supervision and care required by the applicable case plan.
7. There needs to be particular support available during any legal proceedings by ensuring the appointment of a Forensic Disability Services Court Liaison Officer.

Case: TAS.2007.225

The deceased was serving a term of imprisonment. The cause of death was identified as severe atherosclerotic coronary vascular disease. The deceased suffered diabetes mellitus and was obese.

Recommendations:

1. That prison authorities attempt to identify a means whereby suitable products can be offered for sale to those prisoners wishing to address specific or general health issues at a cost that is not prohibitive.
2. That the Justice Department consider either ensuring that the statutory obligation of inspections of the [prison] is complied with or alternatively ensure the regulations are amended if such inspections are no longer deemed necessary.

Case QLD.2005.2548

The deceased died of natural causes while in the custody of the Department of Corrective Services.

Recommendation:

1. That the Department of Community Safety review its policy 'Managing traumatic events at work' to ensure that when CSIU officers are investigating an incident, staff undertake interviews with those officers prior to participating in critical incident stress de-briefing or incident de-briefing.

ADDITIONAL CASES — DEATHS IN CUSTODY OR WHILE IN POLICE PURSUIT

Case: SA.2007.196

Whilst detained in hospital under the Mental Health Act, the deceased developed symptoms that were reflective of the existence of complications of an hiatus hernia, became physically unwell and died. **Recommendations relating to medical treatment—See Adverse Medical Events.**

CASE STUDY 2 — INTENTIONAL SELF-HARM CASES OF PATIENTS WHO WERE IN, OR RECENTLY DISCHARGED FROM A MENTAL HEALTH FACILITY

Case: NSW.2007.5023

The deceased died of multiple injuries resulting from a fall from a bridge in an act of intentional self-harm. The deceased was hospitalised at the time for treatment of mental illness. At the time of incident the deceased had been granted an hours leave from the Psychiatric Unit of the facility.

Recommendations:

To the Minister for Health:

1. That the Area Health Service leave policy for scheduled in-patients be reviewed and amended to formulate a policy for the granting of short unaccompanied leave.
2. That the Minister consider reviewing current procedures at magistrates' mental health inquiries in the light of the evidence presented that they may have a detrimental effect on the therapeutic relationship between treating psychiatrists and scheduled in-patients. In particular, that consideration be given as to reducing the adverse effects of doctors, in effect, giving evidence against their own patients by providing legal representation for the doctors or by some other practical means.
3. That consideration be given by the Area Health Service to instituting "debriefing" of in-patients following an unsuccessful application for discharge at a magistrate's mental health inquiry.

To the Chief Executive Officer of the Legal Aid Commission:

1. That, in the light of the evidence of this inquest, the training of Legal Aid Commission lawyers and private practitioners briefed to appear on behalf of the Commission at mental health inquiries be reviewed.

Case: NSW.2007.6282

The deceased had a history of mental health issues including previous suicide attempts. The deceased underwent two mental health assessments in the month prior to their death. Following an act of self harm the deceased was admitted to the emergency department of a hospital, where they remained for assessment. The deceased suffered hypoxic brain damage which occurred following a further attempt to take their life by hanging while in hospital. The coronial investigation focused on issues including confusion over risk assessment of self harm and the legal status of voluntary/involuntary patient, the communication of risk of self harm of a patient between health professionals, the supervision of those at risk (and the difference in supervision policies for risk of harm versus voluntary status), the availability of mental health nurses at the hospital to complete a mental health assessment and finally the availability of mental health beds at the hospital.

Recommendations:

1. Efforts to be made to substantially increase funding in order that the number of beds available be increased to better reflect the optimum number suggested by the New South Wales Clinic Care Model.
2. Appropriate educational resources be continued to be provided in order to ensure medical, nursing and other staff are fully aware of the policies and procedures developed for the treatment of mental health patients, especially those who are at risk of self-harm or suicide.
3. That regular audit procedures be conducted to ensure that the policies and procedures referred to in (1) above are implemented.
4. The implementation of the recommendations be further reviewed in October 2010.

CASE STUDY 2— INTENTIONAL SELF-HARM CASES OF PATIENTS WHO WERE IN, OR RECENTLY DISCHARGED FROM A MENTAL HEALTH FACILITY

Case: SA.2006.1385

The deceased was described as having “a lengthy and complex” history of mental illness. The deceased was hospitalised twice that year for mental health issues. On discharge from the second hospital admission the deceased committed suicide by hanging shortly after being released from the hospital. Issues examined at coronial inquest included circumstances surrounding the discharge of the deceased from hospital, the appropriateness of evaluation and treatment of the deceased during their admission, and the adequacy of the public health system to deal with the psychiatric needs of the patient during admission.

Recommendations:

1. That the circumstances of this be drawn to the attention of the wider medical community as an example of the pitfalls that are to be encountered in maintaining psychiatric patients in facilities and environments that are unsuited to their needs.
2. That if a facility such as a short stay unit is ever again created that checks, balances and protocols be established to ensure that patients do not remain in the facility in circumstances where their clinical needs are not met.
3. That in future cases involving an inability to properly accommodate a psychiatric patient within an appropriate therapeutic environment in the public hospital system, that consideration be given to placing the patient within the private hospital system with the expense of the same being met by government.
4. That the Minister for Mental Health design and promulgate protocols to ensure that patients who have exhibited suicidal ideation during the course of a hospital admission are psychiatrically evaluated by a psychiatrist or psychiatric registrar on the day of their discharge and that their suitability for discharge be carefully assessed immediately prior to the patient leaving the hospital.

ADDITIONAL CASES—INTENTIONAL SELF-HARM

Case: NSW.2005.5818

The deceased committed intentional self-harm two days after attending a self-development course.

Recommendations:

Clearly recommendations should be directed to regulating practitioners offering services for self-development in order to protect vulnerable members of the public.

To the Minister for Health New South Wales

1. That consideration be given to the restriction by regulation of the provision of self-development services by:
 - a. the introduction of a legal requirement:
 - to have recognised tertiary qualifications in medicine (psychiatry), psychology, psychotherapy, social work, nursing, welfare, counselling or other appropriate qualifications from an institution accredited by either Commonwealth or NSW Education Authorities (or by an overseas course recognised at the same level in Australia) before providing psychotherapy or counselling services, irrespective of whether those services are described as comprising psychotherapy or counselling, but excluding ad hoc counselling or psychotherapy as an incident to providing other professionally recognised services; **or alternatively**
 - to have such qualifications as a pre-condition for legally providing such services for payment or other reward;
 - b. the creation of a system of registration and accreditation of psychotherapy or counselling services by one of the following means:
 - seeking the inclusion of psychotherapists and counsellors in the scheme for national registration and accreditation of the health professions which is the subject of the Council of Australian Governments (**COAG**) **Intergovernmental Agreement** between the Commonwealth, States and Territories, dated 26 March 2008; **or alternatively**
 - the creation of a statute-based scheme of registration and accreditation of psychotherapists and counsellors in New South Wales; **or alternatively**
 - the creation of a statute-based mandatory regime of self-regulation of psychotherapists and counsellors in New South Wales, having regard to the terms of the Schofield Report.
2. That for the purposes of considering introducing the legal requirements set out above and for the purposes of considering a system of registration and accreditation, as set out above, consultation take place with the Royal Australian & New Zealand College of Psychiatrists, the New South Wales Psychologists Registration Board, the Sydney Branch of the Australian College of Clinical Psychologists, the Australian Psychological Society, the Australian Psychology Accreditation Council and the Psychotherapy & Counselling Federation of Australia.

ADVERSE EFFECTS OR REACTIONS TO MEDICAL/SURGICAL CARE

Case: VIC.2008.5831

The deceased was diagnosed with an ectopic pregnancy. The deceased received initial treatment in a rural district hospital and was later transferred to another medical centre for surgery. The deceased's condition deteriorated and she passed away. The deceased died due to complications following a ruptured ectopic pregnancy.

Recommendations:

1. Hospital facility descriptions, summarising the facilities available at rural hospitals, should be created and utilised by Ambulance Victoria. These hospital descriptions need to be readily available to dispatchers.
2. The use of term 'emergency department' should not be used for small rural hospitals with only urgent care facilities and a limited ability to respond to medical emergencies.
3. Ambulance Victoria increases the number of ambulances available in the [region] on evening and night shifts.
4. Ambulance Victoria undertakes a complete system review to determine the optimum ratio of dispatching staff to ambulance vehicles on each shift.
5. Clear lines of responsibility and decision-making should be mapped out between Ambulance Victoria and hospitals with respect to the delivery of clinical information and requests for priority upgrades. Where there is disagreement, or the dispatcher is considering not providing an upgrade, there should be a structured decision making process which should include communicating the decision to the treating doctor.
6. That information on the response time of Air Ambulance needs to be available to dispatchers before a decision to use Air Ambulance is made. This information should be obtained and considered before a decision to use Air Ambulances. This assessment should be mandatory when the transport of a patient is time critical. Ambulance officers should consult the treating doctor if a decision may result in a delay in transport, so all issues can be considered.
7. Ambulance Victoria and the Victorian Government develop a viable method of providing blood products in emergencies in rural communities.

Case: QLD.2007.63

The deceased was stillborn. After the deceased's mother was admitted into the labour ward, the baby's heartbeat was scanned showing a fluctuating and then declining heartbeat. The deceased's mother's water was broken, discovering meconium of a tan colour. As a result, an emergency Caesarean was performed. The cause of death was identified as meconium aspiration.

Recommendations:

1. That Queensland Health consider the acquisition of a second CTG scanner for the [hospital]. The provision of a second CTG monitor would provide a critical safety factor and obviate the need for a single machine to be needed for multiple presentations at the one time.
2. That Queensland Health provide recurrent funds to the [hospital] to enhance the primary health care approach in antenatal clinics with a particular emphasis on the implementation of screening for smoking, alcohol, and drug use to improve access for mothers. In particular, antenatal information provided to expectant mothers should include a warning that a change in foetal movement, be it a decrease or increase in movement, be promptly reported to the doctor.
3. That Queensland Health review the current practice of emergency callout to include codes to clearly signify the degree of urgency.
4. That Queensland Health and the Queensland Police Service review any existing MoU or protocol to ensure the efficacy and timeliness of coronial investigation undertaken by police on behalf of the Coroner.

ADVERSE EFFECTS OR REACTIONS TO MEDICAL/SURGICAL CARE

Case: SA.2007.196

After suffering a relapse of her schizophrenia, the deceased was admitted to hospital under the MHA. While in hospital, the deceased became physically unwell and died from gastric necrosis and perforation (due to strangulated diaphragmatic hernia).

Recommendations:

1. That the hospital develops and implements measures to ensure that X-ray reports prepared by radiological registrars and specialists are prepared and made available in a timely manner so as to ensure that any abnormality detected is acted upon before the health of the patient is compromised.
2. That the Minister for Health cause a review of X-ray report delivery in all public hospitals to ensure that final X-ray reports are delivered in a timely manner.
3. That written interim X-ray reports are kept as part of a patient's clinical file in order to provide a record of what was known about the results of the X-ray at a time before delivery of the final report.
4. That the hospital take necessary steps to ensure that when specialist medical or surgical review is directed or recommended, that it be sought and provided with the necessary degree of urgency and by the most efficient means of communication available.

Case: SA.2005.2142

The deceased was elderly with an extensive medical history that included heart disease, emphysema, recurrent urinary tract infections and atrial fibrillation for which the deceased was prescribed Warfarin. The deceased underwent a catheter transfer in a supported residential care setting. Complications encountered in this procedure led to his admission at hospital where the deceased died of multi organ failure (due to septic shock complicating urinary tract infection and traumatic bladder catheterisation).

Recommendations:

1. That the Department of Health, the Medical Board of South Australia and the Nurses Board of South Australia draw the circumstances of this case to the attention of members of the medical and nursing professions.
2. That the Department of Health undertake a review of the circumstances in which it would be appropriate or inappropriate for catheterisation procedures to be undertaken in nursing homes and to design protocols accordingly.
3. That the Department of Health and the Nursing Board of South Australia encourage nursing agencies who provide catheterisation services in nursing homes to amend their protocol and nursing alerts to include reference to the need to be aware of a patient's anticoagulation status.
4. That the Department of Health and the Medical Board of South Australia cause medical practitioners to be reminded to consider (a) the desirability of antibiotic therapy and (b) the patient's anticoagulation status when performing catheterisation procedures.
5. That the Department of Health, the Medical Board of South Australia and the Nursing Board of South Australia remind their respective constituents to consider the need or desirability to transfer a patient to hospital in difficult cases of catheterisation and in particular, in instances where bleeding occurs.

Case: VIC.2005.2539

After developing a cough and temperature, the deceased was found by their father to be unresponsive and pulseless. The deceased had been diagnosed with croup. Post Mortem examination identified the cause of death as bronchiolitis and bronchopneumonia secondary to influenza A infection.

Recommendation:

1. That the Department of Health give consideration to preparing and disseminating clinical practice guidelines, similar to those available in NSW, for placement in all hospitals and facilities required to assess or manage children with acute croup.

ADVERSE EFFECTS OR REACTIONS TO MEDICAL/SURGICAL CARE

Case: QLD.2002.2423

The deceased was a 10 year old child who fell from a bunk bed. The deceased was taken to hospital after experiencing a sore head and vomiting. The deceased was sent home following a policy non-admission of children for observation. The deceased's neurological condition deteriorated and they subsequently died.

Recommendations:

1. That the 'Neville Report. An Investigation into the adequacy of the health complaint mechanisms in Queensland, and other systemic issues identified as a result of the death of [name of the deceased], aged 10 years' be released and made public.
2. That Queensland Health conduct a review of the capacity of rural or remote hospital facilities or regions to perform emergency neurosurgical and vascular surgical procedures, and to identify what staff, training and technology would be required to allow medical procedures to take place.
3. That the proposal presently with Queensland Health for funding for medical crewing of retrieval teams for aircraft be approved and implemented as soon as possible.
4. That the proposed delivery of the single pilot Instrument Flight Rules helicopter to the Sunshine Coast retrieval service proceed at the earliest opportunity.
5. That the telemedicine project be brought on line across the state, and be adequately resourced in money and staff terms.
6. That the request for a half to one FTE senior medical officer for the Emergency Department at hospital be approved.
7. That a CT scanner be installed at hospital.
8. That the Medical Board of Queensland progress with some priority to the development of a Standard or other suitable policy alternative regarding the regulation of excessive working hours for doctors in the public and private hospitals sectors.
9. That the warning label on bunk beds as provided by the Australian Standard be reviewed by the Office of Fair Trading and other relevant authorities as soon as possible with a consideration that if there is to be a label for bunk beds it should not be age specific or at the very least increasing the age categories for the warning to up to age 14.
10. That the working party set up to consider the feasibility of establishing and promoting government funded programs focussing on removing unsafe bunk beds from private residences proceed to completing its deliberations as soon as possible and the outcome be made public.
11. That the Office of Fair Trading conduct awareness campaigns directed towards the domestic market concerning the standard for bunk beds and the risks and dangers associated with non-compliant beds particularly for children.
12. That all bunk beds used in Queensland Government agency owned, managed or funded establishments comply with the Australian Standard.
13. That the Regulatory Impact Statement process commenced in June 2006 be finalised with priority.

Case: NT.2007.269

While in hospital, the deceased stood from their wheelchair, which then overbalanced causing the deceased to fall and fracture their hip. **See Falls section for recommendations.**

Case: SA.2004.2117

The deceased was 10 weeks of age at the time of death. Previous to the deceased's death, there was a complaint of child abuse. **See Child Deaths section for recommendations.**

AGED CARE

Case: QLD.2004.571

The deceased was found dead in the general eating and common area of the aged care facility where the deceased was residing. It was a very hot day with a recorded maximum temperature of 40.9 degrees. The facility was only ventilated by open windows. The medical cause of deaths was determined to be heat stroke.

Recommendations:

1. That where a doctor has a financial interest in a level three accredited facility in which the doctor treats a resident, the doctor is not to issue a cause of death certificate for that resident, or alternatively the certificate is to be countersigned by another independent doctor.
2. That a review be undertaken by the accrediting authority for level three accommodation to consider an appropriate ration of residents to staff, and an appropriate level of training of staff and procedures.
3. That level three facilities which distribute medication are required to properly document this process and that consideration be given to some form of audit to ensure medication is being received regularly by the residents.

Case: TAS.2008.524

The deceased died as a result of a head injury sustained in a fall at a nursing home. *See Falls section for recommendations.*

Case: TAS.2009.24

The deceased tripped and fell whilst in supportive accommodation for senior citizens, which resulted in the deceased's death. *See Falls section for recommendations.*

Case: VIC.2007.3009

The deceased suffered burns which resulted in their death after a fire was started by a lit cigarette in an aged care setting. *See Fire section for recommendations.*

Case: VIC.2008.1034

The deceased had an unwitnessed fall in an aged care facility which resulted in their death. *See Falls section for recommendations.*

Case: SA.2005.2142

The deceased underwent a catheter transfer in a supported residential care setting. Complications encountered in this procedure led to his admission at hospital where the deceased died. *See Adverse Medical section for recommendations.*

CHILD DEATHS

Case: SA.2004.2117

The deceased was 10 weeks of age at the time of death. The cause of death was identified as 'streptococcus pneumoniae' sepsis complicating retropharyngeal abscess'. The deceased presented also fractured bones and bruising. Previous to the deceased's death, there was a complaint of child abuse.

Recommendations:

1. That the Minister of Health and the Minister for Families and Communities work together to ensure that Families SA workers and general medical practitioners are educated as to the symptomatology of shaken baby syndrome and, in particular, in respect of the need to perform X-rays whenever such an allegation is made.

Case: SA.2005.2302

The deceased's head became wedged in the space created between the pillow and the side and base of an inflated mattress. The deceased's airway was blocked by contact with the plastic of the side or base of the mattress causing the deceased to die of suffocation. The deceased was 5 months of age.

Recommendations:

1. That the Minister of Families and Communities and the Minister for Health act upon, and provide the funding for the implementation of, the recommendations of the Child Death and Serious Review Committee as contained within the Committee's annual report for the years 2005-2006 and 2006-2007, namely:
 - That a public health campaign for young parents be developed concerning safe sleeping.
 - That a product safety analysis be undertaken as soon as possible if the death of a child has been attributed to a product such as a bed or cot.
 - Every infant be provided with a safe sleeping environment.
 - State-wide programs or campaigns be developed and resourced to build the knowledge and confidence of parents or carers so that they know how to provide safe sleeping arrangements for infants.
 - State-wide programs be developed and resourced to provide safe sleeping environments for infants in disadvantaged families, including if necessary the provision of appropriate cots or beds and ongoing support to ensure that safe sleeping arrangements be maintained.
2. That the Minister for Families and Communities and the Minister for Health cause to be developed a single set of consistent guidelines that define the appropriate strategies to be implemented by parents, carers and health professionals for the reduction of risk factors in sudden unexpected death in infancy (SUDI).
3. That the Minister for Health and the Minister for Families and Communities cause to be developed strategies for the educations of the wider community as to safe and unsafe sleeping practices.
4. That the Minister for Families and Communities and the Minister for Health cause educational programs to be directed to the nursing profession, carers and other health professionals concerning safe sleeping practices for infants so as to enable members of the nursing profession, carers and other health professionals to properly, accurately and consistently impart to parents and families the essentials of safe sleeping practices for infants.
5. That the Minister for Families and Communities and the Minister for Health undertake the necessary measures to direct the nursing profession, carers and other health professionals, who provide advice on how to get infants to sleep, to ensure that the safe sleeping message imparted to parents and families is consistent and in accordance with the recommendations of SIDS and Kids, Kidsafe and the Women's and Children's Hospital, and in particular to disseminate advice (a) that infants should be slept on their backs from birth, and (b) that parents should only deviate from what is considered to be a safe sleeping practice upon advice from a medical practitioner.
6. That the Minister for Families and Communities and the Minister for Health develop strategies to identify new parents who are, or might be, at particular risk of their infant being subjected to an unsafe sleeping environment, that this risk assessment be conducted prior to the mother's discharge from hospital and that appropriate and accurate information is provided to parents who are identified as at risk in order to minimise that risk.

CHILD DEATHS

Case: TAS.2006.526

The deceased died as result of sudden unexpected death in infancy while co-sleeping with an adult.

Recommendations:

1. That the Perinatal Registry Act 1994 be amended so that a coroner may be provided with any information or documents held by the Council of Paediatric Mortality and Morbidity or committee of Council which touches upon or is relevant to the death of a child who is the subject of a coronial investigation.

To Child Protection Advice and Referral Service:

1. That there be a regular audit of unallocated list so that all notifications are allocated and investigated within set time frames.

Recommendations made by the Department of Health and Human Services and adopted by Coroner:

1. That no priority one child protection assessment is to be completed and/or the file closed, without the subject child(ren) being sighted by the child protection officer responsible for the decision.
2. Facilitate ways to obtain formal input from professional experts in the relevant field to assist with decision making in complex cases where neglect, bonding/ attachment, drug and alcohol, disability, neurodevelopment or mental health issues are factors.
3. For cases involving an overlap of services, establish formal pathways for liaison between Child Protection Services and Mental Health Services, Alcohol and Drug Services, and Disability Services at a state, area and local level.
4. In cases where services other than Child Protection Services are monitoring and providing support, develop a formal protocol and pro-forma to make explicit the expectations on each service. Implement a process where roles and expectations are formally discussed, documented, acknowledged and accepted.
5. Develop a process for Child Protection Services to provide written advice to caregivers detailing the conditions which need to be fulfilled in order to prevent further action/ intervention from Child Protection Services.

Case: TAS.2009.178

The deceased was aged 2 months and died as a result of sudden infant death syndrome (SIDS).

Recommendations:

1. Provide safe sleeping environment for babies:
 - Put baby on his/her back from birth. Do not sleep baby on its tummy or its side.
 - Keep your baby in a smoke free environment during pregnancy and beyond.
 - Avoid letting your baby get too hot.
 - Breastfeed your baby if possible.
 - Use light bedclothes. No doonas, pillows or cradle bumpers.
 - Use a firm well-fitting mattress.
 - Tuck bedclothes in securely.
 - Make sure baby's head is uncovered.
 - Place baby's feet at the bottom of the cot.
 - Bed sharing with baby may be unsafe. The risks of sharing a sleep surface include overlaying of the baby by another person, entrapment or wedging and suffocation from pillows and blankets.

Case: QLD.2002.2423

The deceased was a 10 years old child who fell from a bunk bed. The deceased was taken to hospital but not admitted and later died. **See Child Deaths section for recommendations.**

CHILD DEATHS

Case: ACT.2005.13

The deceased was a 2 year old child who drowned in the swimming pool of a sports and aquatic centre. *See Water Related section for recommendations.*

Case: VIC.2005.2539

After multiple hospital presentations the deceased, a young child, died of bronchiolitis and bronchopneumonia secondary to influenza A infection. *See Adverse Effects or Reactions to Medical/Surgical Care section for recommendations.*

Case: QLD.2007.63

The deceased was stillborn following an emergency Caesarean. *See Adverse Effects or Reactions to Medical/Surgical Care section for recommendations.*

DOMESTIC LEISURE

Case: VIC.2006.1170

The deceased was the pilot of a kit-built helicopter which crash landed. *See Transport section for recommendations.*

DRUGS

Case: NSW.2006.6042

The deceased died of respiratory depression and obstruction of airways induced by an accidental overdose of prescription drugs.

Recommendation:

1. That consideration be given to reformulating the question in the 'Drug of Addiction Form' relating to whether a patient is 'drug dependent'.

Case: SA.2005.2449

The deceased suffered multiple drug toxicity while on home detention bail. *See Deaths in Custody case study for recommendations.*

FALLS

Case: NT.2007.269

While in hospital, the deceased stood from their wheelchair, which then overbalanced causing the deceased to fall and fracture their hip. The deceased's condition deteriorated and they subsequently died.

FALLS

Recommendations:

1. A systematic process for investigating and responding to sentinel events, such as falls, unexpected injury or death needs to be entrenched and maintained in the hospital.
2. Staffing levels in hospitals ought to be assessed as demographic change produces larger numbers of old and fragile patients.
3. The process of assessment of falls risk during inter-unit transfers is an important measure and its implementation should be encouraged and maintained.
4. The observations of lay persons, usually family members, who know patients well are often accurate and may be a valuable diagnostic tool.

Case: TAS.2008.524

The deceased died as a result of a head injury sustained in a fall from the first floor balcony of their suite at a nursing home.

Recommendations:

1. That the nursing home ensures that specific strategies identified as being necessary for the safety of individual residents are speedily implemented.
2. That the nursing home reviews its practices as they related to the ongoing re-assessment of its residents and the possible need for their re-location to a facility better able to provide a safe residential environment.

CASE: TAS.2009.24

The deceased lived in a facility which provided supportive accommodation for senior citizens. The deceased tripped and fell whilst folding laundry. The deceased suffered acute subdural haematoma and died while in hospital.

Recommendation:

1. All patients presenting at hospital on Warfarin therapy and with head trauma to undergo a CT scan of the brain together with the testing of their anti-coagulation levels.

Case: VIC.2008.1034

The deceased resided in an aged care facility. The deceased had an unwitnessed fall. The deceased was using a wheeled walker at the moment of falling. The deceased was conveyed to hospital where a CT scan identified a fractured skull and left sided subdural haematoma. The deceased's condition deteriorated and they subsequently died.

Recommendation:

1. Setting up a register to indicate the status of mobility aids at regular intervals.

FIRE

Case: VIC.2007.3009

The deceased resided in an aged care centre. The deceased was a smoker and had been previously instructed not to smoke unsupervised. The deceased was found by a staff member in the courtyard with their upper clothing alight. The deceased suffered facial and chest burns. The deceased suffered a myocardial infarction and died.

Recommendation:

1. That the aged care centre develop and implement a smoking policy, designed to protect patients who are mentally and/or physically impaired. The policy should aim to address issues of access to cigarettes and lighters, as well as ensuring appropriate supervision protocols are in place.

HOMICIDE

Case: NSW.2007.883

The deceased died from injuries inflicted by a person or persons unknown. Evidence does not allow to make findings as to the direct cause of death.

Recommendations:

TO THE COMMISSIONER OF POLICE:

1. That consideration be given to setting up a special task force or unit (possibly attached to the Homicide Unit) with sufficient resources to investigate long term unsolved homicides and suspected homicides of missing persons.
2. That consideration be given that the investigation of homicides in rural areas be managed, funded and resourced by a lead agency that will be responsible for the preparation of a brief of evidence to the Coroner.
3. That consideration be given that the further investigation into the murder of [name of the deceased] is prioritised and the expertise and knowledge currently in the possession of [name of police officer] be utilised as best considered appropriate.
4. That consideration be given to seeking approval from the Government of NSW to post a reward of \$200,000 to be paid to any person or persons who might provide evidence that may lead to the arrest and conviction and any person or persons responsible for the death of [name of the deceased].

INTENTIONAL SELF-HARM &/OR MENTAL HEALTH

Case: SA.2006.1385 , NSW.2007.5023 & NSW.2007.6282

See case study on Intentional Self Harm Deaths With Recent Contact With Mental Health Services at beginning of publication for recommendations.

Case: SA.2007.561

See case study on Deaths in Custody at beginning of publication for recommendations.

Case: NSW.2005.5818

See case study on Intentional Self Harm Deaths With Recent Contact With Mental Health Services at beginning of publication for recommendations.

Case: NT.2007.310

NATURAL CAUSES

See case study on Intentional Self Harm Deaths With Recent Contact With Mental Health Services at beginning of publication for recommendations.

Case: TAS.2007.225, TAS.2007.544 & QLD.2005.2548

The deceased persons died of natural causes (various) whilst in correctional facilities. *See case study on Deaths in Custody at beginning of publication for recommendations.*

SA.2007.196

The deceased died of gastric necrosis and perforation whilst admitted to hospital under the Mental Health Act . *See Adverse Effects or Reactions to Medical/Surgical Care section for recommendations.*

QLD.2004.571

The deceased died of heat stroke in an aged care facility. *See Aged Care section for recommendations.*

PROCEDURAL

Case: NT.2007.291, NT.2007.292, NT.2007.293, NT.2007.294, NT.2007.295 & NT.2007.296

The deceased persons died during a police pursuit. *See case study on Deaths in Custody at beginning of publication for recommendations.*

QLD.2007.63

The deceased was stillborn following an emergency caesarean. *See Adverse Effects or Reactions to Medical/Surgical Care section for recommendations.*

PRODUCT RELATED

Case: QLD.2002.2423

The deceased fell from a bunk bed and died of resulting head injuries. *See Adverse Effects or Reactions to Medical/Surgical Care section for recommendations.*

TRANSPORT

Case: NT.2008.261, NT.2008.262, NT.2008.263 & NT.2008.271

The deceased persons were all passengers in a car. The driver, who was unlicensed, inexperienced and had never travelled the section of road before, lost control of the vehicle while attempting to negotiate a sweeping left hand bend in a dirt road.

Recommendations:

1. A strong stance needs to be taken in all communities to avoid similar incidents in the future. Even the most simple of actions, such as reporting unlicensed driving to police and not allowing young people to have the keys to the vehicles, are sort of steps that need to be taken.
2. Although the speed limit is 110kph, this should not imply that all roads can, or should, be driven at that speed.
3. That there be adequate provision made for young people to be able to access relevant and necessary programs to enable them to obtain their licences.
4. That there be further funding considered for programs to learn to drive.

Case: WA.2009.168

The deceased was the driver of a vehicle which collided with a station wagon. The collision occurred in daylight hours and the weather was fine. The site of the collision is a straight and open section of highway. The speed limit at the point of the MVA is 110 km/h. An overcorrection in the vehicle driven by the deceased caused the rear of the vehicle to slide out of alignment with the front driving wheels. The deceased's vehicle went into a slide across the sealed road and slid for 20m before impacting with the station wagon.

Recommendation:

1. That pavement widening be undertaken to achieve a 1.0m sealed shoulder in accordance with Austroads and Main Roads guidelines.

Case: VIC.2008.1099

The deceased was walking along a highway and was observed attempting to flag down cars. The deceased was struck by a vehicle when it travelled in the right-hand lane of the highway. It was dark and there is no street lighting in the area. The speed zone applicable to vehicle traffic at the point of impact is 100 km/h.

Recommendations:

1. That D24 operators be trained generally, and specifically at their local regional level, to be able to identify and prioritise the urgency of 000 calls.
2. That a sergeant be on duty for each shift of D24 (or be easily accessible to members on duty there) to supervise Local D24 operations.
3. That Standard Operating Procedures be reviewed to clarify and simplify steps and obligations upon operators at D24 [region].
4. That the Standard Operating Procedures as reviewed at [region], be taken to a recommended review at State level to standardised the procedures of D24 centres across Victoria.

TRANSPORT

Case: VIC.2006.1170

The deceased was the pilot of a kit-built helicopter which crash landed in a heavily treed area. Following the licensing of the aircraft, the deceased continuously experienced problems. The deceased's own relevant experience and training was minimal.

Recommendations:

1. That the responsible federal authorities distinguish the position of kit build helicopters from the legal framework set up to apply to other so called 'experimental' aircraft and that instead of existing arrangements, the need to develop a separate and different legal framework for kit build helicopter enthusiasts, is now recognized. The issue which then arise should be addressed having primary regard to the physical safety of kit build helicopter pilots and to those others likely to be effected by an aircraft component or maintenance failure.
2. That as an interim measure CASA issue an Airworthiness Directive under CASA Regulation Part 39 (and/or uses such other powers as it may deem appropriate), to prohibit the flying of all Rotorway Exec 162 aircraft with immediate effect, with such prohibition to remain in force until the manufacturer, satisfied design (and build) standards to be established by CASA, following consultation with the manufacturer, and until each owner demonstrated to CASA in a test which includes flight testing, that any particular individual helicopter satisfies that airworthiness standard.
3. No further permissions are to be given for the building of, or future maintenance of, either existing or newly built Rotorway Exec 162 aircraft, by persons who are either non-LAME qualified persons, (or non-CASA approved, qualified persons).
4. No further pilot licences or licence upgrades or licence renewals, to fly Rotorway Exec 162 aircraft are to be issued until pilots receive appropriate endorsement level training in Rotorway Exec 162 aircraft, or in such other similar aircraft as may be approved by CASA.
5. CASA places such additional limitations on the future licensing arrangements, relating to the Rotorway Exec 162, that CASA may consider are needed to provide a reasonable level of safety for pilots, passengers, and any other person likely to be effected by component or maintenance failure.
6. That the Office of the Deputy Premier and Attorney General in the State of Victoria, provides the Federal Minister of Transport with a copy of these findings, comments and recommendations, and further liaises with the Federal Minister as appropriate.

Case: NT.2007.291, NT.2007.292, NT.2007.293, NT.2007.294, NT.2007.295 & NT.2007.296

The deceased persons died during a police vehicle pursuit. *See case study on Deaths in Custody at beginning of publication for recommendations.*

WATER RELATED

Case: ACT.2005.13

The deceased was a 2 year old child who drowned in the swimming pool of a sports and aquatic centre.

Recommendations:

1. All public pools in the ACT must have an audit by the Royal Life Saving Society of Australia and implement any recommendations in respect of that audit.
2. Risk assessments should be done especially when there is large numbers in the CISAC swimming pool and the assessments should be recorded. Recommended minimum ratio of lifeguards to people in the water is 1:100, but a risk assessment should be completed to vary this ratio taking into consideration a range of factors such as weather, holidays, size, number and layout of pools, surface reflection, average attendance, anticipated attendance, swimming capabilities, special needs individuals and groups, the number and distribution of users, and recreational activities (programmed or spontaneous). All areas of the pool, including the pool floor must be scanned and scrutinised on a regular basis.
3. Signage in relation to parental or adult supervisor responsibility must be well signposted in large lettering. It should be posted prominently in areas of danger to encourage adults to keep their children at arm length, and posted at reception on the —Conditions of entry and then, on entry to the aquatics area on the —Aquatic Rules . It should state that —Children under 10 must be supervised by an adult at all times when in the aquatics area .
4. Signage in relation to pool behaviour should also be prominent and should be in an area where it is able to be well visualised such as the entry turnstiles and also on the pool deck.
5. Educational pamphlets should be available at the entry to the pool.
6. Depth indicators should be displayed in the area where depth is changing with signage such as ‘DEPTH INCREASES – 0.6 TO 1.2M PARENTS KEEP CHILDREN AT ARMS LENGTH’.
7. Sufficient lifeguards should be provided to ensure that all the areas of water and people therein can be supervised easily without obstruction from any object. Blind spots and areas where there is sun glare must be considered when deploying lifeguards.
8. Where the whirlpool entry is restricted by a lane rope, there should be a sign posted to indicate that the area is closed. Preferably, the sign can read as —No Access beyond this point. Whirlpool Closed to Public: No Swimming in this area
9. Consideration should be given to
 - recording every incident which resulted in the intervention of a lifeguard;
 - setting a limit to the number of users of different areas of the pool and that limit be effectively monitored by staff;
 - having at least two lifeguards constantly moving in the area between the shallower and deeper area of the pool, giving particular attention to children who cannot swim;
 - highlighting changes in gradient of the pool floor with a contrasting colour, in particular area between the toddler/leisure pool and the area outside of it; and
 - providing a minimum of four training sessions per year to lifeguards at quarterly intervals, directly related to the aquatic facility of which the lifeguard is employed, and the training should include, but not limited to:
 - ⇒ revision and practice of emergency procedures
 - ⇒ practice of initiative assessment of and response to simulated incidents
 - ⇒ revision of lifesaving skills
 - ⇒ resuscitation
 - ⇒ oxygen equipment
 - ⇒ first aid
 - ⇒ retrieving a person from the deepest part of the pool
 - ⇒ special needs populations
 - ⇒ public relations; and
 - ⇒ practical water work.

Even if all safety arrangements are in place, it is important for a parent accompanying a child who cannot swim to know that the result of momentarily losing sight of the child could be fatal, as had happened in this case.

WORK RELATED

Case: TAS.2005.558 & TAS.2005.559

The deceased persons attended an oil recycling establishment to fit a volume sensor in an oil tank. While in the process of welding a metal socket onto a hole made in the top of the tank, sparks or heat generated ignited vapour that existed between the top of the liquid in the tank and the top of the tank. This ignition caused an explosion of significance force, throwing the deceased persons from the top of the tank where they fell to the concrete base some 10 metres below the top of the tank.

Recommendations:

1. That Workplace Standards Tasmania take appropriate steps to ensure that those responsible for occupational health and safety issues at work sites are aware that their obligations do not end with the development of formal written procedures or structured processes, but rather their obligation continues in ensuring that those processes and procedures are in fact implemented at the work place and there audit steps taken to ensure ongoing compliance and application
2. Workplace Standards Tasmania must also ensure that where an obligation is imposed in respect of a number of different classes of persons, for example employees, contractors and visitors, it is made clear that this obligation co-exists and that it is not acceptable that the person or corporation charged with that obligation determine to fulfil its obligation to one class, taking no or minimal steps in relation to the other classes to which it has an obligation.

INDEX

The following is an index of recommendations (by broad topic area) summarised by the NCIS within the 23 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 - 20 of Fatal Facts can be found on the NCIS website at:

http://www.ncis.org.au/web_pages/publications.htm#a1

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

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