NCIS Fatal Facts

Edition 24 - May 2014

NCIS

This edition of Fatal Facts features 37 coronial cases where recommendations have been made. These cases were closed between 1 January 2010 and 31 March 2010.

The case study in this edition focuses on children in care/children identified as at risk.

If you are seeking further information about any of the cases contained in this edition and you are an authorised NCIS user, you may log onto NCIS via the NCIS website and locate case information by clicking on the 'NCIS Search' tab and selecting 'Find Case'.

Should you require advice regarding NCIS Access, please contact the NCIS Access Officer 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 1/1/2010 & 31/3/2010) = 3306
* Number of findings on the NCIS (cases closed by a Coroner between 1/1/2010 & 31/3/2010) = 2927
* Number of cases with recommendations (cases closed by a Coroner between 1/1/2010 & 31/3/2010) = 37

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, the Australian Institute of Criminology and the New Zealand Ministry of Justice.

CASE STUDY—CHILD DEATHS IN CARE

NT.2007.150

At the time of death, the deceased was residing in foster care. The deceased experienced a minor sporting injury to the leg three weeks prior to death. No medical treatment was sought or provided during this time and the leg became infected. This infection led to septicaemia (blood poisoning) and death.

Recommendations

1. The Care and Protection of Children Act 2008 be amended to include a requirement that a child under the care of the CEO and who is residing in the Territory must be visited by a person authorised by the CEO at least once every 2 months.
2. Regulations should be promulgated under section 78(3) of the Care and Protection of Children Act 2008 which specify certain basic standards of care that must be provided to a child at the placement arrangement.
3. Section 70 of the Care and Protection of Children Act 2008 be amended to include that a care plan must refer to the basic standards of care specified in the Regulations. Consequential amendments should be made to section 76 of the Act.
4. Section 74 of the Care and Protection of Children Act 2008 should be amended to require the person conducting the six monthly review of the care plan to assess whether the carer is meeting the basic standards of care specified in the Regulations.
5. Section 12 of the Care and Protection of Children Act 2008 should be amended to include a sub-section specifying that a person with whom an Aboriginal child is placed be required to meet the basic standards of care specified in the Regulations.
6. Consideration should be given to amending the Care and Protection of Children Act 2008 to permit a regular court review of protection orders made under Subdivision 3 of Division 4 of Part 2.3 of the Act
7. Part 5.1 of the Care and Protection of Children Act 2008 should be amended to provide for a regular 2 yearly review of administration of the Act in so far as it relates to protected children and to confer more specific powers on the Children's Commissioner to enable him or her to conduct such a review.
8. Section 15 of the Care and Protection of Children Act 2008 should be amended to include a definition of "cumulative harm" to a child.
9. Professional staff at FACS should receive specific training concerning issues of identifying and dealing with issues of cumulative harm to children in the care of the CEO.
10. FACS should develop a written handover system when one caseworker takes over a new case. Such a system should include a short succinct summary identifying any risk factors or areas of concern pertaining to the child in care.
11. FACS should enhance its computerised information system to ensure that caseworkers can easily identify "red flag" issues or issues of concern in respect of each child in care.
12. FACS notify the NT police of the name and address of a carer with whom the CEO has entered a placement arrangement, and develop a protocol for the police to notify FACS in relation to any matters of interest relating to that carer or that address.
13. The carer application forms be amended to include information about all the children that have ever been in the care of an applicant for care.
14. FACS provide sufficient administrative support in terms of administrative personnel and equipment for caseworkers to enable caseworkers to focus on their core responsibilities of protecting children in care.

CASE STUDY—CHILD DEATHS IN CARE

NT.2007.188

An infant died from insufficient caloric intake resulting in failure to thrive which was caused by parental neglect. It is also possible that hypothermia may have contributed to the death as the deceased was found in a car during a journey. The deceased was a member of a family with a history of ongoing concerns for FACS (Family and Children's Services) about the care of children.

Recommendations

1. That adequate resources be given to fix concerns in relation to systems (including computer and hard copy files systems), staff recruitment and training and support in relation to the FACS operations in Alice Springs.
2. That the MOU (Memorandum of Understanding) between FACS and Police be formally signed off.
3. Many comments and recommendations contained in Case Number NT 2007 150 are relevant to these findings.

ADVERSE EFFECTS OR REACTIONS TO MEDICAL/ SURGICAL CARE

NSW.2006.5763

A newborn infant experienced sudden death in hospital. Prior to death, the deceased had been unsettled, unwell and not feeding properly. The mother of the deceased checked on the infant who was in a cot and alerted nursing/midwife staff to attend however resuscitation attempts were unsuccessful. The cause of death was found to be intestinal obstruction as a result of bowel atresia (a condition in which there is a congenital discontinuity of the bowel).

Recommendations:

1. That NSW Health give close consideration to implementing the hypoglycaemia protocol developed by the Newborn Care Department in all NSW hospitals at which babies are delivered.
2. That NSW Health give close consideration to implementing or encouraging the adoption of the SCORPIO program, or a suitably modified version of it, or of an equivalent program, in all NSW hospitals at which babies are delivered or in all Area Health Services whichever is more appropriate.
3. That NSW Health encourages the adoption of standardised recording of assessments of newborns based on the Hospital model or some suitable alternative.
4. That the Hospital gives close consideration to the prevention of deskilling of midwives by broadening their professional development by rotation through ante-natal and post-natal wards or other suitable methods.
5. That NSW Health adopts a standard procedure for describing and recording vomiting or regurgitation in newborns in terms of colour, volume and timing rather than ambiguous terms such as "posits".
6. That, in conjunction with recommendations 2 and 5, NSW Health adopt a standard colour chart for describing vomits or regurgitations in newborns and that it encourage Area Health Services to install wall charts or provide other form(s) of easy reference to the standard colour chart (such as cards) in post-natal wards. Such charts ought to carry clear advice that yellow regurgitations can indicate bilious vomiting.
7. That, within the scope of its available resources, the Hospital or Area Health Service, whichever is more appropriate, give close consideration to developing a roster within the Newborn Care Department that would ensure that a senior paediatric Registrar, Fellow or Consultant is available on-site at all times.
8. That the Hospital develops a protocol concerning the management of newborns who do not pass meconium within 24 hours of birth.
9. That the Hospital develops a protocol or checklist for the taking of observations and assessment of babies by midwives or nursing that would specifically include practice of asking mothers whether they have any concerns about their babies and the recording of any concerns expressed.
10. I recommend that if such a protocol is developed, or if a current protocol is revised, that it also include a practice of recording of any vomiting or regurgitations in terms of colour, volume and timing (see recommendations 5 and 6).

ADVERSE EFFECTS OR REACTIONS TO MEDICAL/ SURGICAL CARE

TAS 2008 287

An infant died shortly after birth following a Ventouse vacuum assisted delivery. Ventouse is a vacuum device used to aid delivery. The child suffered a rare complication of a subgaleal haematoma.

Recommendations
I support each of the recommendations made by the review team (see below). In particular I support the recommendation that education sessions be conducted in the management and diagnosis of subgaleal haematoma and recommend that this be adopted by all hospitals in this State which provide obstretric and neonatal services.

The review team made these recommendations:

- Introduce a protocol and develop a form that can be signed by all women antenatally as part of their birth plan or during labour that explains the hospital's standard of care, universally accepted labour norms and hospital's diminished responsibility in the event that a patient wants to birth outside of these standards or ignores advice. When the labour management is inconsistent with peers and guidelines, a risk/benefit assessment of the alternative courses of action must be documented and discussed with the obstetric consultant (on-call or otherwise).
- Revise the current guidelines for calling the on-call obstetric consultant.
- Introduce a form that must be completed for documenting and auditing all instrumental deliveries including Ventouse extraction deliveries. This will include:
    - Time of application of vacuum (forceps),
    - Time of release of the vacuum,
    - Number of pulls,
    - Number of pop-offs,
    - Foetal heart rate at regular intervals,
    - Notes section for the indication of an instrumental delivery and parental consent discussed,
    - Notes section for the procedure itself – Diagram of foetal head with the sutures and fontanelles on which the position of the vacuum cup is drawn and,
    - Follow-up undertaken or follow-up schedule to be performed by midwife with inspection of the foetal head and condition.
- All babies who have had instrumental deliveries and vacuum extraction deliveries that are considered difficult must be treated with a high index of suspicion and observed in the nursery with close observation/monitoring until review by paediatrician. Develop a protocol for this purpose.
- Conduct education sessions in the management and diagnosis of subgaleal haemorrhage. Include co-ordination of such education sessions as part of the staff development role.
- Revise the differential diagnosis and management of fever in the labour ward.
- Revise protocols for paediatric attendance at delivery.

VIC 2008 5715

The deceased was admitted to hospital in a septic condition with a respiratory infection. The patient was later transferred to the Intensive Care Unit with septic shock secondary to pneumonia and was administered morphine. This was subsequently stopped late the next day, when it was realised there was a documented allergy to morphine. Shortly afterwards the patient was diagnosed with possible abdominal sepsis, acute renal failure, electrolyte imbalance and pneumonia. The decision was made to cease active management and the patient later died.

Recommendations:

- That the Hospital considers placing an allergy warning sticker on the front cover of medical records for all patients with known drug and food allergies.

ADVERSE EFFECTS OR REACTIONS TO MEDICAL/ SURGICAL CARE

TAS 2008 209

The deceased had been taking medication for depression and bi-polar disorder in addition to pain relief medication after having their tonsils removed. The deceased died from a toxic response to multiple drugs which was thought to be complicated by a condition of obesity.

Recommendations

- A general caution notice be issued to all medical practitioners of the increased risks of the accumulation/storage of drugs in the adipose tissue of obese patients and the possible resultant depressant effect on their respiratory system.

VIC.2007.487

The deceased died in hospital from widespread invasive aspergillosis (a fungal infection) following renal failure. There was a possible reaction to anticonvulsant medication, Lamotrigine. The deceased had a history of lupus, numerous other medical conditions and mental health issues and had been referred to a new doctor for treatment and counselling. The deceased had been admitted to hospital prior to death but discharged themselves.

Recommendations

- That the Medical Practitioner's Board of Victoria considers the circumstances surrounding the individual's death but specifically the prescribing methods of the treating doctor and take whatever action it deems appropriate.

TAS 2007 126

Sudden Unexpected Death of newborn infant whilst still in hospital care—see Child Deaths section.

CHILD DEATHS

TAS.2007.126

A 1 day old newborn experienced Sudden Unexpected Death in Infancy with acute bronco-pneumonia being a contributing factor.

R***ecommendations***

- Put in place a clear protocol for the observation of babies for the first 2-4 hours after birth with observations continuing until they are normal and the baby is stable. Re-appearance of any abnormal signs require regular observations to be reinstated.
- Adopt clear models of care for the examination of new born babies. They need to be in place. i.e. it must be clear as to whether the physical examination is to be performed by the obstetrician, the midwifery staff, or a pediatrician.
- The process for referrals to pediatricians needs to be clarified. There must be a clear path stating whether the referral is acute or routine. It is preferable, but not mandatory, that all referrals should be from the obstetrician to the paediatrician personally but all acute referrals must be by personal contact.
- A review of standards of documentation is required with the development, implementation and regular audit of clear guidelines for documentation."
- I acknowledge that the Hospital conducted its own Root Cause Analysis into the circumstances of the death and has already implemented some improvements to its practices including some of those identified by a consultant paediatrician. I note too that it has now stipulated that continuous foetal monitoring be undertaken for all syntocinon augmented labours. I support each of those improvements identified by the consultant paediatrician and recommend that they be fully adopted by the Hospital if it has not already done so.

CHILD DEATHS

NSW.2006.1470

- A child drowned in a spa pool located within an apartment complex—see Product Related .

TAS 2008 287

An infant died shortly after birth following a Ventouse vacuum assisted delivery—see Adverse Effects or Reactions to Medical and or Surgical Care.

NSW.2006.5763

A newborn infant experienced sudden death in hospital -—see Adverse Effects or Reactions to Medical and or Surgical Care.

NT.2007.150

The deceased child died of septecaemia and was at the time residing in foster care—see Case Studies—Child Deaths in Care.

NT.2007.188

An infant died from malnutrition—see Case Studies—Child Deaths in Care.

DIVING, SCUBA & SNORKELLING

TAS 2007 499

An abalone diver/deckhand died from exposure to the elements of hypothermia after trying to swim to an island following a boat sinking incident. The boat on which the deceased and a colleague were working was expected to return to shore in the afternoon but took on water and overturned. Attempts were made to right the boat, call for help and set off flares without success. Rescue services found one survivor and the deceased the following morning.

Recommendations

- The Minister for Workplace Relations and Director of Industry Safety investigate and consider the creation of a Code of Practice pursuant to s22 of the Workplace Health & Safety Act 1995 and/or directives pursuant to s39 of that Act to control the manner in which abalone taking and harvesting is conducted in order to ensure the safety of those engaged in this industry and upon vessels which are workplaces for the purposes of that Act.
- The abalone industry develop an operational requirement that after an established time of the non-arrival of a vessel at the agreed time there be a formal response initiated by those awaiting the return of the vessel.
- Tasmania Police conduct periodic training Statewide in relation to the initial action requirements set out in the Tasmanian Police Manual of the roles and duties of attending police officers in cases of marine incidents.
- Tasmania Police ensure that up-to-date search and rescue plans are in existence and are able to be implemented as provided by s6.14.5.2(5) of the Tasmanian Police Manual.
- That the abalone industry and any developed Code of Practice ensure that VHF radios are not only fitted to commercial dinghies but also that procedures are in place to ensure periodic contact is maintained with operators throughout a trip.
- That EPIRBs be fitted to the hull of the vessel in accordance with the manufacturer's recommendations or alternatively carried in a floatation container attached by lanyard to the vessel.
- Marine and Safety Tasmania after consultation with the abalone industry establish a program to upgrade the minimum level of certified competency of those operating a commercial dinghy to Coxwain Restricted to ensure the safety of those within the abalone fishing industry.
- Marine and Safety Tasmania ensure that all surveys of commercial dinghies where an alteration has taken place which is likely to increase the weight of the vessel will require a recalculation of the amount of fitted buoyancy required in that dinghy.
- Marine and Safety Tasmania ensure that at regular intervals the condition of a commercial dinghy's internal buoyance foam be determined and any rectification be required to be carried out.
- Marine and Safety Tasmania immediately apply By Law 168 in calculating maximum loads for commercial dinghies and that in liaison with Tasmania Police such limits be enforced.
- Marine and Safety Tasmania impose a requirement that commercial dinghies be fitted with an automated bilge pumping system capable of removing the amount of water normally expected in dinghies during abalone diving trips.

DRUGS & ALCOHOL

SA.2009.538 & 539

Two people died when the car they were travelling in crashed into a brick wall. At the time of the collision the car was unregistered, uninsured and being pursued by police. The two deceased were found to be intoxicated with alcohol and/or cannabis.

Recommendations

- That the Commissioner of Police define and exemplify the expression 'minor traffic matters' as utilised within the current General Order relating to police high risk driving, and provide police with some guidance within the document, as well as general training, relating to the need to avoid conducting high risk driving including pursuits in the investigation of offences of driving an unregistered and uninsured motor vehicle;

- That the Commissioner of Police amend the said General Order by including specific reference to the need to avoid conducting high risk driving including pursuits on unfounded supposition that the pursued vehicle might be stolen or that the occupants of the vehicle might be engaged in illegal activity;
- That the Commissioner of Police amend the said General Order by including specific reference to the need, in any risk assessment when conducting a pursuit, for the pursuing police officer and any incident controller to consider the real possibility that the driver of the pursued vehicle may have an impaired driving ability by reason of that person's consumption of alcohol or drugs and that a pursuit should not be conducted where there is a suspicion that the driver of the pursued vehicle is so impaired, unless there are exceptional circumstances where the need to apprehend the driver of the pursued vehicle, or its occupants, outweighs the danger that may be presented by a pursuit;
- That the Minister for Transport initiate such public awareness campaigns designed to draw the attention of the general public to the folly connected with, the extreme dangers presented by, the futility of and the likely tragic outcomes associated with intoxicated drivers of motor vehicles endeavoring to evade police.

TAS.2009.13

A truck driver died after losing control of the vehicle on a bend and rolling it into a roadside ditch. The deceased was trapped inside the cabin. It was later shown that the driver had taken ecstasy.

Recommendations

- I strongly recommend that all employers in the transport industry adopt an alcohol and drug policy to assist in the prevention of this type of accident occurring in the future. This policy should incorporate the provision for random testing of employees.

WA.2009.1217

The driver of a car died as a result of crossing to the incorrect side of the road and crashing into a very large tree situated near the edge of the road. It is likely that the deceased was tired at the time of the incident. The deceased was found to have alcohol, 'ecstasy' (MDMA) and cannabinoids in his system at the time of death and was not wearing a seatbelt. The road environment may possibly have contributed to the severity of the collision.

Recommendations

A crash report commissioned by Main Roads WA and dated 12 November 2009 concludes that the road environment may possibly have contributed to the severity of the collision. The deceased's vehicle collided with a tree located 2m from the edge of the road seal. The report states that the effective clear zone at the site of the collision, determined using Austroads methods is 6m. The report recommends the removal of non-frangible items from the clear zone or the provision of suitable protection for errant vehicles in accordance with Austroads and Main Roads WA guidelines. I recommend that this work be undertaken.

TAS.2009.326

The deceased was riding a motorized bicycle up the centre of a dual carriageway under the influence of cannabinoids and had an alcohol level four times the legal driving limit when he was struck and killed—see Transport.

FIRE-RELATED

NT.2009.71, 72, 75, 144, 145

Five people drowned at sea following a deliberately lit fire engulfed the vessel they were travelling on—see Water.

INTENTIONAL SELF HARM/MENTAL HEALTH ISSUES

NSW.2006.6039

The father of the deceased approached local police for help after the individual, who appeared intoxicated, made threats of self-harm. Police attended the home of the deceased who was then taken to hospital for a mental health assessment. The deceased made the decision to be discharged from hospital contrary to medical advice and without having received a mental health assessment from a doctor with psychiatric qualifications or experience. The deceased returned home and died from a self-inflicted gunshot wound to the head.

Recommendations:
1. To the Commissioner of Police.
That the training of officers in dealing with persons who are taken to a hospital for a mental health assessment under the Mental Health Act 2007 emphasise that family members may be able to provide important background medical and other information that would be helpful in the undertaking of a mental state assessment and as such should, where they wish to do so, be encouraged to make contact with the hospital to which the person is taken for assessment.

2. To the Commissioner of Police and NSW Department of Health.
That consideration be given to whether or not the handover forms under section 22, Mental health Act 2007 should have space for police to insert contact details for persons who may be able to provide further information about the subject patient.

3. To the Hospital.
That the Hospital give consideration as to whether or not its "Suicidal Behaviour Policy" should be amended to suggest that relevant information may be obtained from the family or other persons without the consent of the patient where it is considered that the family or another relevant person may provide the medical practitioner with relevant information that the patient is unable or unwilling to provide and there is a risk to the patient if such information was not available.

4. To the Area Health Service and the Hospital.
That training of medical practitioners employed in emergency departments of hospitals emphasise the application of the Mental Health Act 2007, the powers of medical personnel assessing patients with psychiatric conditions and the circumstances in which family and other relevant persons should be contacted without the consent of the patient.

TAS.2009.94

The deceased jumped from a coastal cliff and died, an action attributed to the ongoing effects of mental illness. The deceased had a long history of problems with anxiety and depression complicated by alcohol and drug abuse together with problem gambling.

Recommendations
1. The medical profession and allied professionals such as psychologists who are dealing with patients who are at risk of suicide to consider establishing clear guidelines to allow such warnings to be given in appropriate circumstances. This would recognise that there are circumstances when the interests and safety of a person are best served not by maintaining their right to privacy but rather ensuring that others who are providing care and support to that person are made aware and can take such reasonable steps as they are able to in order to lessen the chance of a tragic outcome.

INTENTIONAL SELF HARM/MENTAL HEALTH ISSUES

VIC.2006.3917

Police responded to a report of an individual threatening intentional self-harm. Police conveyed the individual to the local police station and arranged for an assessment by a Crisis and Assessment Team. The Crisis and Assessment Team found no welfare concerns and the deceased was released into the care of a friend who took the deceased home. A short time later, the deceased intentionally took their own life by gunshot to the head.

Recommendations

- That the Minister for Health and/or the Secretary to the Department of Health consider a review of the Crisis and Assessment Team risk assessment methods and tools to achieve a set of guidelines/protocols/procedures/ for recommended methods of acquiring the best quality information available to enhance the risk assessment processes.
- That the Minister for Health and/or the Secretary to the Department of Health consider overseeing the development of agreed guidelines, protocols and procedures for appropriate safe release of apprehended persons which take into account that person's family and/or friends and community.
- That the Minister for Health and/or the Secretary to the Department of Health consider providing a statutory capacity in the Mental Health Act to enable a limited 24 hour assessment and safety order to enable a more thorough assessment of a person's level of risk of suicide, and safe release if considered appropriate.

VIC.2007.3058

The deceased had a long-standing diagnosis of hyperkalaemic periodic paralysis (periodic high potassium levels causing paralysis) which often led to hospitalisation and chronic pain in the upper neck and body. The deceased also suffered from depression associated with the disability and was receiving psychiatric support, in addition to medication for pain management. Following admission to hospital for generalised weakness and an inability to self-care, the deceased discharged themselves after 4 days. The deceased was re-admitted shortly thereafter but again discharged themselves contrary to medical advice. The deceased later deliberately ended their own life by drug overdose.

Recommendations

- I note with approval that, partly as a result of this death, a full review of administrative processes has been undertaken at the hospital and the integration of the centre's pain management patient histories with hospital patient histories has been achieved, through the introduction of the organisation-wide electronic Patient Administrative System.
- I also note that because of this initiative, information regarding a patient's past and ongoing clinical activity is now readily available throughout the hospital.
- The connection between mental illness and the untreatable nature of some neurological conditions is acknowledged. Over and above the Patient Administrative System, I recommend that a psychiatric consult is actively sought in all cases where neurological inpatients have a current psychiatric history managed by the centre.

VIC.2007.128

The deceased was found face down in a creek while on unescorted leave from the ward of a psychiatric institution. The actual cause of death is unascertained.

Recommendations

- I recommend that the Chief Psychiatrist guideline entitled "Inpatient Leave of Absence" be distributed to approved mental health services.

INTENTIONAL SELF HARM/MENTAL HEALTH ISSUES

VIC.2008.2614

The deceased attempted to commit suicide by hanging in the presence of police officers. The police officers tried to save the individual but did not have any cutting equipment in their personal equipment or vehicle with which to cut the rope that suspended the body of the deceased. The officers found a glass bottle which they smashed and used to cut the rope but could not cut the ligature

Recommendations

- Victoria Police continue to support the review currently being undertaken by their Health Safety and Wellbeing Division
- Human Resource Department and take into account the facts surrounding the individual's death.
- Victoria Police include adequate strong scissors and/or other cutting equipment in the personal protection kits carried in police cars.

WA.2006.943

The deceased voluntarily sought admission to a psychiatric hospital and during their stay began talking about suicide and plans to act upon them. It appears that the deceased obtained a hose from a garden section within the ward prior to death. A doctor instituted 30 minute observations of the deceased which were intended to ensure safety for the individual. At some point, the deceased left the ward and used the hose previously placed outside the ward to hang themselves from a footbridge located nearby.

Recommendations

- I recommend that in all future plans for mental health units there be provision for authorised beds and the construction of the units should be such that staff are able to monitor all persons entering or leaving the ward.

MISCELLANEOUS

NT.2008.191

The deceased was set upon by a pack of dogs at a town camp and suffocated to death after an attack to the throat by one of the dogs.

Recommendations

- That funding for the continuation of the dog management program on the town camps presently being conducted by the ASTC by virtue of funding from FaHCSIA be continued. I would be extremely concerned if, after having heard all of the evidence during this inquest about the success of that program, funding did not continue via some Government authority post 30 June 2010.

The current program is clearly an important program for the benefit, and improvement in the quality of life, of the residents in the town camps and should continue into the future. Whilst accidents can always occur, it is clear from the evidence before me that when dog numbers are high, the risk of injury, harm or even death to humans increases exponentially. In these circumstances all reasonable efforts should be made to ensure that appropriate funding is provided to allow a program such as the one presently known as "Team Town Camps" operated by ASTC to continue into the future.

NT.2008.213

The individual died of a heart attack and shortly after death, was attacked and eaten by a number of dogs. The event took place at a town camp.—Recommendations as per NT.2008.191

NATURAL CAUSE DEATHS

NT.2008.213

The individual died of a heart attack and shortly after death, was attacked and eaten by a number of dogs. The event took place at a town camp.— See Miscellaneous.

VIC.2007.487

The deceased, who had a history of lupus and numerous other medical conditions died in hospital of a fungal infection—see Adverse effects or reactions to medical/surgical care.

POLICE PURSUITS/ DEATHS IN CUSTODY

NT.2009.71, 72, 75, 144 & 145

Five people drowned at sea following a deliberately lit fire that engulfed the vessel they were travelling on. The deceased were suspected of illegal entry into Australia and the incident occurred in the context of apprehension of the boat and detention of it's passengers and crew by the Australian Defence Force .

Recommendations

- Review of manuals;
- Development of separate standing risk profiles for Suspected Illegal Entry Vessel (SIEV) and Foreign Fishing Vessel (FFV) boardings reflecting lessons learned from the vessel in this case.
  The need to explain any change to operating patterns or circumstances to passengers with reassurance;
- A recommendation that matches and cigarette lighters be confiscated;
- That all inflammable fuel to be secured and removed if necessary.

NSW.2007.6294

The deceased was involved in a police intervention following a report of domestic violence. The deceased died of a self-inflicted gunshot would to the head. The deceased was taking a break from negotiations at the time of incident and action was not expected in the context of lowering tensions between the parties at the time. The coroner was unable to determine whether this act was intentional.

Recommendations

- I recommend to the Commissioner of Police that recognition be given to the bravery and professionalism of Leading Senior Constable [police] and Constable [police] for the manner in which they discharged their duties on [date of incident].

SA.2009.538

Two people died when the car they were travelling in crashed into a brick wall whilst being pursued by police—see Drugs or Alcohol.

PRODUCT RELATED

NSW.2006.1470

A child drowned in a spa pool located within an apartment complex. The deceased became caught on the cover of the main drain while bathing. A blockage to the drain had occurred during construction of the wall and floor of the spa pool which caused a significant build-up of pressure and resulted in the deceased's entrapment and subsequent death.

Recommendations

To the Minister for Fair Trading or such other Minister with responsibility for the regulation of the design and construction of pools and spas in NSW:

- That action is taken to prohibit the inclusion of an active main filter drain in the floor of spa pools in future constructions, and;
- That media action be taken to inform the public as to the potential dangers associated with active main filter drains in the floor of spa pools.
- That action is taken to require the certification of pools and spas as being in compliance with statutory and other building requirements as well as being safe for proposed use by an appropriately qualified and independent expert prior to the pool or spa being handed over for use by occupants of the property on which the pool or spa is constructed.
- That action be taken to ensure that where a pool and/or spa forms part of a property development an occupation certificate not be issued by the relevant Principal Certifying Authority unless and until that Authority has satisfied himself or herself that the pool and or spa has been constructed in accordance relevant statutory and other building requirements and is safe for proposed use.

TRANSPORT RELATED

TAS.2009.326

On a rainy evening, the deceased was riding a motorised bicycle up the centre of a dual carriage way when it was struck by a passing vehicle. The deceased was thrown onto the roadway and struck by several passing vehicles. The cyclist was intoxicated and not wearing a helmet, nor were there any lights on the bicycle. The bicycle was fitted with a 70cc two stroke petrol engine which had an estimated power output of approximately 3000 watts, exceeding the 200 watts permitted by the Vehicle and Traffic Act 1999. The motor had been fitted by the deceased.

Recommendations

- I recommend that the current legislation in relation to power output be amended under current legislation as it is difficult to determine when a vehicle, such as a motorised bicycle becomes a motor vehicle for the purposes of the traffic laws. In my view, a more appropriate assessment would be to assess its classification according to a maximum speed when operating under the power of a fitted motor, rather than on the basis of output measured in watts. Police Officers would then have the ability to check the output of these bicycles utilising current speed measuring devices.
- If a motorised bicycle is capable of travelling at a speed greater than 30km/h (under the power of the engine), the bicycle should be treated as a motor cycle/vehicle. This would enable Police to prosecute offenders, particularly those who are disqualified from holding or obtaining a drivers licence due to offences committed against the Traffic Road Rules/ Road Safety (Alcohol and Drugs) Act. Disqualified drivers are highly represented in serious and fatal crashes and are obviously removed from our roads for serious breaches. Currently drivers are able to purchase these type of devices and have no fear of prosecution.
- I further note there are already regulations in relation to:
  - ⇒ Riding without a helmet
  - ⇒ Riding at night without lights
  - ⇒ Riding under the influence
  - ⇒ Riding a pedal cycle with an auxiliary motor with a power output greater than 200 watts.

TRANSPORT RELATED

VIC.2007.4037

The driver of a truck laden with concrete lost control of the vehicle on a mountain road descent and died from multiple injuries sustained when the truck crashed at high speed.

Recommendations

Although the deceased had experience of the gradient from ascending slowly in low gear, signage at this location could have potentially reminded the driver of the more stringent demands of descent. The "Trucks Use Low Gear" sign seems clearest to me and targets a section of the public perhaps most at risk that is heavy vehicle drivers unfamiliar with the gradient. I therefore recommend that VicRoads consider further upgrades to the signage on the mountain road, with particular regard to the role played by a nearby lane as de facto U turn (or even lay-by) facility for heavy vehicles.

WA.2007.660

A front seat passenger in a four wheel drive motor vehicle died when thrown from the vehicle as it rolled over. The vehicle was provided to staff by the department for business use. The tread on the rear tyre had separated from the tyre causing the vehicle to shake and the driver to lose control.

Recommendations

- Four wheel driver training should be relevant to the road conditions and circumstances in which the vehicle user is going to be driving. Such training should provide comprehensive instruction on how to drive on unsealed roads in the particular remote area and should include strategies for driving in the event of a problem such as a tyre blowout as well as training on how to care for the vehicle and its tyres. Such training also should take specific account of the requirements of the Remote Teaching policy.
- A principal posted to a school in a remote area should be given training additional to the four wheel driving course in relation to his or her responsibility for managing the Department's vehicle and keeping it in good working condition.
- A vehicle log book should be kept in each Department vehicle based in a remote area which records among other things:
  - ⇒ the date and reading of each tyre pressure measurement
  - ⇒ the name of the person carrying out the tyre pressure reading, and;
  - ⇒ details of any maintenance/action taken in relation to the tyres.
- Vehicle users must be directed to record in the log book all details required by the Department in a timely and legible manner.
- The vehicle log book should be audited every six months by the District Office responsible for the remote area.
- Tyres on all vehicles located in remote areas should be of light truck (LT) grade construction. Safeguards should be put in place to ensure that a vehicle being transferred to a remote area from another location does not escape this minimum standard requirement.
- A tyre pressure gauge should be placed in each Department vehicle operating in a remote area, with such gauge to be kept in the vehicle along with clear instructions for its use and the recommended tyre pressure for the conditions in which the vehicle is operated.
- Tyre pressures on a Department vehicle operating in a remote area should be checked with a tyre pressure gauge at least once a week, and always before travelling outside a community in a remote area.
- An air compressor should be readily available at a school in a remote area and should be equipped with an appropriate connection so that tyres found to be under inflated, or deflated, and not suffering from a puncture, can be restored to their correct pressure level.

TRANSPORT RELATED

VIC.2007.2511

On a dark rainy morning along a thickly vegetated road, a motorist drove straight through the intersection and into the path of an oncoming vehicle sustaining fatal injuries. The driver was not speeding and the road markings and stop signage applicable to the deceased were found to be deficient.

Recommendations

I recommend that VicRoads conduct an audit of the manner in which it meets its statutory obligations, to ensure deficiencies in road markings and signage at intersections are identified and rectified.

VIC.2008.422

The deceased was driving along the highway when a surfboard attached to the car's roof rack fell off onto the road. The deceased pulled into the emergency lane and got out of the car to retrieve the board. At the same time, a VicRoads road maintenance worker in a van sighted the surfboard and reversed towards it with the van's flashing overhead lights activated. The VicRoads van hit the deceased, who died from a head injury.

Recommendations

- VicRoads consider routinely fitting their road maintenance vehicles with an externally audible alarm which operates when the vehicle is reversing

NSW.2003.6417

A solo pilot died of multiple injuries sustained in an air crash while practising skills flying a Victa Airtourer 180 aircraft.

Recommendations

- The Civil Aviation Authority conduct such investigations as are necessary to determine the reliability of the figure of 1.3 litres shown as the quantity of unusable fuel for Victa Airtourer aircraft in that aircraft's approved flight manual.
- The Civil Aviation Authority require such changes to the content of the flight manual for the Victa Airtourer as may be required by the outcome of those investigations.

WA.2009.1217

A driver under the influence of drugs and alcohol died when his car crossed the wrong side of the road and crashed into a tree—see Drugs & Alcohol.

SA.2009.538 & 539

Two people, found to be under the influence of drugs &/or alcohol died when the car they were travelling in crashed into a brick wall during a police pursuit.—see Drugs & Alcohol.

TAS.2009.13

A truck driver under the influence of drugs died after losing control of his vehicle—see Drugs & Alcohol.

NT.2009.71, 72, 75, 144, 145

Five people drowned at sea following a deliberately lit fire engulfed the vessel they were travelling on—see Police Pursuits.

WATER RELATED

NSW.2006.1470

A Child drowned after becoming entrapped in a spa—see Product Related.

NT.2009.71, 72, 75, 144, 145

Five people drowned at sea following a deliberately lit fire which engulfed the vessel they were travelling on—see Police Pursuits/Deaths in Custody.

WORK-RELATED

VIC.2001.2320

A foreman-carpenter died from injuries sustained in an industrial accident while installing panels on a construction site. The panel installation equipment included an elevated work platform (scissor lift) and a forklift. A rope attached to the platform was used to assist in steadying the panels. The rope became entangled in the forklift and pulled the platform over. The deceased was in the platform when it fell to the ground.

Recommendations

- That no rope or line of any type be affixed, attached or tied to any elevated work platform when the Elevated Work Platform is in use.
- That all Elevated Work Platforms have warning stickers located in a prominent position on railings prohibiting the affixing, attaching or tying of any type of rope or line.
- That a Work Method Statement and a Job Safety Analysis be required prior to commencement of any construction work and that they describe in detail the manner in which the work is being performed, the identification of risks and a description of the risk elimination or reduction measures to be adopted.
- That the operating instructions in relation to the safe operation of the plant and equipment being used on a construction site be expressly referred to in the Work Method Statement and the Job Safety Analysis.
- That the Work Method Statement and Job Safety Analysis be legislatively required to be located at the site where the work is to be performed and that it be read by or to each employee prior to their commencing work on the site.
- That where a Forklift and Elevated Work Platform are operating in close proximity in the installation of pre-form panels, that there be a lookout appointed, or camera device fitted to ensure distance and separation of equipment.

TAS.2006.342

The deceased was at work, undertaking inspections and repairs to wagons in a rail repair workshop. The individual was lying under a train wagon when it moved forward unexpectedly and pinned the deceased beneath the wheel resulting in death.

Recommendations

- I recommend that the annual compliance audits conducted by the Rail Safety Regulator include a compliance audit of procedures and safety instructions for the Wagon Repair area.
- I recommend that the rail company conduct regular formal Staff Briefings concerning Safety Notices, compliance practices and procedures.
- I recommend that an audit system be developed by the Rail Safety Union to ensure that the rail company conducts briefings on a regular and ongoing basis.

INDEX

The following is an index of recommendations (by broad topic area) summarised by the NCIS within the 24 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 - 24 of Fatal Facts can be found on the NCIS website at:
http://www.ncis.org.au/mortality-data-from-the-ncis/fatal-facts/
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