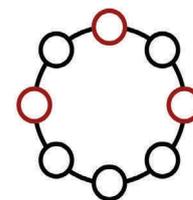


NCIS

Fatal Facts

Issue 27

NCIS Fatal Facts



NCIS

Fatal Facts is produced by the National Coronial Information System (NCIS) for public circulation. It contains case summaries and coronial recommendations for any cases that were investigated by an Australian or New Zealand Coroner and where the case was closed in a particular timeframe. *Fatal Facts* is intended as a tool for sharing information and outcomes about coronial cases from Australia and New Zealand. *Fatal Facts* is publicly available from the NCIS website. Case numbers are included so that persons with full access to the NCIS can review the complete details of a case as necessary. Publication of the entire coronial finding is often available from the relevant court website.

Reportable Deaths

All coronial jurisdictions in Australia and New Zealand investigate death in accordance with their respective Coroners Act (the *Act*). Each *Act* defines 'reportable death' to determine which deaths must be investigated by a coroner. Deaths determined to be 'reportable' may vary between jurisdictions and therefore it is not always possible to compare frequencies of certain types of deaths between jurisdictions. No conclusions can be drawn from comparing frequencies between jurisdictions without consideration of the definition of a 'reportable death' for the type of death of interest.

In addition, interpretation of a 'reportable death' according to the *Act* is at the discretion of the relevant State or Chief Coroner and may change over time.

For more information about the differences in reportable deaths between jurisdiction, please visit our website.

Fatal Facts Search

In addition to the newsletter, the NCIS maintains an online search tool, *Fatal Facts Search*. This tool is available from the NCIS website. *Fatal Facts Search* allows users to search by pre-defined case categories to identify all cases relevant to a selected category. A list of the case categories is available within the tool and also on the final page of this edition of *Fatal Facts*.

Fatal Facts Search works by users selecting categories using tick boxes for cases of relevance. A broad search (one category) will return many relevant cases. A narrow search (3 categories) will return relevant cases with the most matches at the top of the results. Cases currently included in the search tool are cases closed between 1st May 2007 and 31st December 2010. The NCIS are working to populate the tool with all past issues of *Fatal Facts* as well as including all recent issues and cases.

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.

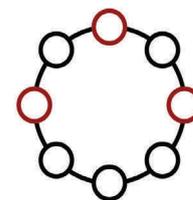
Despite this, it should be noted that they are not authorised summaries or exact replications of coronial findings. The original finding should always be accessed for formal reference.



Justice
and Regulation

The NCIS is governed by a Board of Management. Administrative support is provided by the Victorian Department of Justice & Regulation (DJR). The NCIS is funded by each State/Territory Justice Department in Australia and New Zealand, and the Australian Departments of Health & Ageing, SafeWork Australia, the Australian Competition & Consumer Commission, the Australian Department of Infrastructure & Regional Development and the Australian Institute of Criminology.

NCIS Fatal Facts



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Edition 27 October 2015

In this Edition

Fatal Facts Edition 27 includes cases that were investigated at inquest and where the Coronial Finding contains recommendations. Edition 27 includes cases that were closed between 1 October and 31 December 2010. *Fatal Facts* contains a précis of case circumstances and of the coronial recommendations and is produced by the staff at the NCIS. Every effort has been made to accurately summarise the case circumstances and findings. Despite this, it should be noted the summaries are not authorised or exact replications of the coronial finding. The original finding should be accessed for formal reference.

No personally identifying information is contained in the case summaries or recommendations.

Fatal Facts Edition 27 contains summaries of 82 cases where recommendations were made as part of the formal coronial finding. Of these cases, 41 are Australian cases and 41 are New Zealand cases.

All previous editions of *Fatal Facts* are publicly available from the NCIS website.

New Zealand cases are included from Edition 25 and are not included in prior editions.

What is a Coronial Inquest?

An inquest is a court hearing into a single or multiple deaths. The role of a coroner is to identify the deceased person and the circumstances and causes of that death. An inquest is an inquisitorial process to establish why a death occurred. Once the coroner has heard all the evidence, he or she will write a finding. A finding may include recommendations to a Minister, public statutory authority or entity to help prevent similar deaths.

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NSW.2006.5538 **Adverse Medical Effects/ Older Persons**

An elderly person died from a haemorrhage as a result of neurological surgery removing a pituitary tumour.

Recommendations

I recommend to the Minister for Health that NSW Health, when planning the introduction of the adapted World Health Organisation surgical safety checklist, also gives close consideration to including in its safe surgery protocol a standard procedure that a surgical team briefing including *all* members of the team take place before any procedure.

I further recommend that NSW Health considers adopting a standard procedure of members of new surgical teams introducing themselves by name and role before operations commence.

NSW.2007.2557 **Adverse Medical Effects/ Physical Health**

A person died from complications following colon surgery with a background of cirrhosis of the liver.

Recommendations:

To the Minister for Health and the Royal Australasian College of Surgeons

- I recommend to the Royal Australasian College of Surgeons and the NSW Minister for Health that they require that a copy of any operation notes made by a surgeon be placed in the relevant hospital records as soon as practicable following the operation.

To the Gastroenterological Society of Australia, the Australian and New Zealand Hepatic, Pancreatic and Biliary Association and the Royal Australasian College of Surgeons

- I recommend that the Gastroenterological Society of Australia and the Australian and New Zealand Hepatic, Pancreatic and Biliary Association, in conjunction with the Royal Australasian College of Surgeons, formulate guidelines for the assessment and management of cirrhotic patients undergoing surgery.
- In formulating such guidelines, I further recommend that the Gastroenterological Society of Australia, the Australian and New Zealand Hepatic, Pancreatic and Biliary Association and the Royal Australasian College of Surgeons undertake or sponsor a study of the questions of where medium- and high-risk surgery on cirrhotic patients is best undertaken and of what facilities ought be available for post-operative care if the patient is classified in the Child-Pugh A, B or C category.
- I recommend that any such general guidelines developed by the Gastroenterological Society of Australia, the Australian and New Zealand Hepatic, Pancreatic and Biliary Association and the Royal Australasian College of Surgeons address at least the following issues:
- Is the Child-Pugh system of pre-operative assessment of risk for cirrhotic surgical patients the optimal form of assessment or ought another be substituted or used in conjunction?
- If a cirrhotic patient previously assessed as being in the Child-Pugh A category suffers post-operative liver failure or decompensation, ought he or she be reclassified and his or her post-operative management be altered accordingly?
- Where should medium- and high-risk operations (as defined by the Royal Australasian College of Surgeons or other authoritative source(s)) on cirrhotic patients be performed? In particular, is it advisable that they be performed in high-volume hospitals with gastrointestinal review and back-up available?
- In determining the answer to that question, what facilities for post-operative care ought be available for patients assessed pre-operatively as being the Child-Pugh A, B or C categories?
- If a cirrhotic patient is operated on in a hospital without specialist gastroenterological review and care available, when should such a patient be transferred to a hospital where such facilities are available?

NSW.2007.2557 *continued*

- What is the appropriate fluid balance regime for management of post-operative ascites in cirrhotic patients? In particular, should saline be restricted? Should drainage be restricted? Should albumin be administered and, if so, when?
- Following an operation, what clinically significant 3 signs of possible liver failure or decompensation must practitioners be vigilant to look for? Signs of possible infection? Mental deterioration?
- At what point, if any, should the patient be reviewed by a gastroenterologist or physician following an operation? Within 48- 72 hours? Only when the clinical need arises?
- Ought the surgeon advise the cirrhotic patient of the specific increased risk of post-operative mortality and morbidity? If so, in what manner ought this advice ideally be given?
- Having regard to anticipated or potential post- operative complications, ought a simple post- operative care checklist of signs and symptoms be developed for cirrhotic patients who have undergone medium-to-high-risk surgery to ensure that post-operative care is focussed and complete? If so, what should the content of that checklist be?
- I also recommend that the guidelines for post-operative management of cirrhotic patients include a strong reminder to clinicians caring for such patients of the need to pay close attention to the concerns of family members about adverse changes in the patients.

NSW.2007.5608 **Adverse Medical Effects/ Older Persons**

An elderly person died as a result of a mechanical small bowel obstruction. The deceased died from this despite consulting with two different hospitals.

Recommendations

To The Minister New South Wales Department of Health

- That the [location] Hospitals Network gives specific consideration to the inclusion of graded assertiveness training as part of the establishment of the Simulation Centre at [location] Hospital.
- That the ISBAR principles (Identify, Situation, Background, Assessment and Recommendation) continue to be emphasized in the training of all medical staff in the [location] Hospitals Network.
- That the superseded telephone consultation check list for medical be incorporated into the training of medical officers in the [location] Hospitals Network as part of the ISBAR program.
- That the principle responsibility and authority for the transfer of patients from one hospital to another remains with the referring clinician and the sending hospital be emphasized to all medical staff and those staff involved in the patient transfer process in the [location] Hospitals Network.

NT.2008.238 **Adverse Medical Effects/ Physical Health/ Youth**

A young person died from acute asphyxiation as a result of obstructive sleep apnoea. The deceased died one week before she was set to receive surgery to fix the sleep apnoea. There was a delay in getting the deceased the surgery she needed due to waiting lists and staff miscommunications.

Recommendations

- That [location] Hospital adhere to the Northern Territory Hospital Network Waiting Time and Elective Treatment Services Policy and Guidelines particularly in respect of GP notification requirements.
- That [location] Hospital extends the services of the Paediatric Liaison nurses to complex adolescent cases.
- That the [location] Hospital Adelaide ensure the criteria for categorisation of referrals to the Ear, Nose and Throat (ENT) Clinic are strictly applied.

NZ.2009.3851 Adverse Medical Effects/ Physical Health

The deceased passed away during surgery for an angioplasty and stenting of the aorta. The deceased suffered from severe vascular disease due to lack of blood flow. During the surgery, a stent graft was deployed within a sheath, which was not removed. This broke, trapping it beneath the stent and the aorta. A cut was then made into the femoral artery to remove the sheath, but due to the deceased's vascular disease, the artery was friable, and the deceased lost a lot of blood. Due to this, the deceased had a cardiac arrest and was unable to be resuscitated.

Recommendations

I recommend to the [location] Health Board Interventional Department Mortality Meeting and the [Location] Health Board Mortality Review Committee that consideration is given to using only reinforced sheaths which would reduce the chance of them not being withdrawn by mistake as they are more radio opaque and thus apparent fluoroscopically. They are also less likely to split or break if they are mistakenly not withdrawn before the stent is deployed.

SA.2007.387 Adverse Medical Effects

A person died during surgery while removing a cancerous ovary. A part of the large intestine was perforated accidentally in the course of the operation, causing a generalised sepsis which was identified as the cause of death.

Recommendations

I make the following recommendations:

- That these findings be drawn to the attention of the chief executive officers or equivalent of the Department of Health, the South Australian branch of the Australian Medical Association and the South Australian Medical Board.
- That the said chief executive officers or their equivalent draw to the attention of members of the medical profession the findings in this matter.
- That the said chief executive officers or their equivalent advise members of the medical profession that in cases similar to this where faecal peritonitis is suspected in a patient, they should have regard to the following matters:
 - ◇ The need to avoid or minimise delay in surgery,
 - ◇ The need to identify a point in time at which optimal resuscitation has been achieved and at which further resuscitation would be futile,
 - ◇ The risk of acute deterioration in an otherwise apparently stable patient,
 - ◇ The need to consider a worst case scenario,
 - ◇ The need to consider admitting or transferring the patient, prior to surgery, to a hospital that has an intensive care unit
 - ◇ The need to consider obtaining a second medical opinion as to the appropriate clinical management of the patient

TAS.2009.14 Adverse Medical Effects/ Physical Health

A person developed tonsillitis type symptoms which made it hard to eat and drink. The deceased died from hypoglycaemia due to the combined effects of not eating and the medications taken for diabetes. The deceased refused all suggestions to seek medical assistance.

Recommendations

It is self-evident from the history that I have set out above that [deceased] was permitted to prematurely leave [location] Emergency Department and return home in the evening of [date]. Had the deceased remained in hospital for a longer period and been subject to close monitoring and to more intensive investigations then it is likely in my view that the seriousness of his condition would have become evident and life-saving treatment put in place. These matters give rise to the question whether the decision to permit [deceased] to go home without further monitoring and/or investigation was, in all the circumstances, a reasonable one?

TAS.2009.14 continued

The deceased presented to the Emergency Department with a history of having been unwell for at least the previous two weeks. During his time at hospital the deceased had ongoing hypotension and declining blood sugar levels. These factors together, in my view, required a cautious approach to be taken to his management and care. This necessitated, in the least, [deceased] being monitored in hospital until the decline in his blood sugar levels was reversed and stabilised. Had he stayed a little longer in hospital it would have soon become apparent that the expected elevation in the blood sugar levels as a consequence of the ingestion of the sandwiches was not going to occur thus firmly establishing the need for his admission and further investigation. In these circumstances the decision to permit [deceased] to go home at about 7.00pm on [date] was a regrettable misjudgement.

It is clear from the evidence of [deceased’s wife] that her husband had been suffering from declining health over an extended period, most particularly in the two weeks prior to his death. It is clear too that deceased resisted his wife’s repeated advice to seek medical help. Had he done so it is likely, in my view, that his deteriorating renal condition would have been detected and treatment commenced which in all probability would have avoided his later hypoglycaemia and its tragic consequences. The deceased’s death is a reminder of the need for sufferers of diabetes in particular to seek timely medical treatment when signs or symptoms of un-wellness present.

NSW.2008.674 Child & Infant Death/ Adverse Medical Effects

A newborn died from hypoxic ischaemic encephalopathy and multi-organ failure after a haemorrhage that was possibly caused by a vacuum extraction delivery three days prior.

Recommendations

I recommend to the [location] Area Health Service that its Observations: Neonatal policy document of September, 2008 be amended so as to eliminate any ambiguity therefrom and so as to require blood pressure monitoring at 15 minute intervals for four hours and then hourly until stable.

NSW.2008.6390 Child & Infant Deaths/ Physical Health

A young child with epilepsy died after an epileptic fit during a nap while at a day care centre. It is uncertain if the death took place at the centre or en route to the hospital.

Recommendations

I make the following recommendations to the Minister for Human Services, Community Services, namely:-

- That the NSW Department of Human Services, Community Services, use its best endeavours to take steps to encourage and assist the New South Wales Family Day Care Association and other peak bodies to inform and educate their member associations, whether by way of newsletters, seminars or other appropriate means, of the duties and obligations of licensees and authorised supervisors to comply with the provisions of the Children’s Services Regulation 2004 and, in particular, with:-
 - ◊ Clauses 25(5), 66(1) to (3) inclusive, 92 and 96;
 - ◊ Clauses 1 and 2 of Schedule 1; and
 - ◊ Clauses 9 and 11 of Schedule 1A thereof.

- Without limiting (1) above, that in any formulation of such information and education of such associations, guidelines are provided as to:-
 - ◊ The effective supervision of children being provided with care whilst both awake and asleep;
 - ◊ The requirement for licensees to develop procedures so as to ensure that the authorised supervisor, members of staff of the service and each family day carer who is registered with the services comply with the provisions of the Regulation that apply to them;
 - ◊ That the written records maintained with respect to each child be kept up to date at all times;
 - ◊ That such written records be maintained in a safe and secure area of the Association’s premises;
 - ◊ That such records clearly record any medical condition applicable to such child and the treatment to be given in the event of the child appearing to be severely affected by such condition while being provided with the service; and
 - ◊ That such records set out any special requirements concerning the child with respect to the child’s medical condition.

NSW.2008.6390 continued

In any such programme implemented, the Department endeavour to assist in any information or education programme so as to have the NSW Family Day Care Association and other peak bodies take steps to ensure that carers registered with each said association fully understand and comply with the obligations imposed upon them by the said Regulation.

NZ.2009.2384 Child & Infant Deaths/ Drugs & Alcohol

The deceased child took its mother's methadone pills while playing a game with siblings. The child was found the next day deceased.

Recommendations

To: The Hon Tony Ryall, Minister of Health, Parliament Buildings, Wellington

That Government give favourable consideration to the adoption of the *Draft Managing Director's Order, Child-Resistant Packaging of Therapeutic Products Australia New Zealand Therapeutic Products Authority (April 2006)*

Had the container holding [mother's] methadone been fitted with a child resistant closure or, in the absence of such closure, been placed in a locked cupboard, [the deceased's] death would have been prevented. The Court expresses to [mother] to [deceased's] father and to all members of the family its sincere sympathy on their loss. It makes no criticism of [mother] in all the particular circumstances. It is to be hoped that the publicity attendant upon the publication of these Findings will reinforce the need to ensure that harmful substances are kept at all times out of the reach of children.

NZ.2010.1525 Child & Infant Deaths/ Adverse Medical Effects

The deceased infant was breech and while being born, the head became stuck after the body had been delivered. The hospital attended by deceased's mother and her midwife did not have the specialist obstetric staff to cope with a breech birth that had complications. The infant was in poor health once birthed and later died.

Recommendations

Accordingly, I make the following recommendation:

That the [location] District Health Board consider including in its protocol for breech presentation at appropriate primary birthing units, a requirement for emergency medical staff to be notified as soon as it becomes apparent that there will be an imminent breech birth.

NZ.2010.1558 Child & Infant Deaths/ Leisure Activity

The deceased child had been mountain biking with a mentor and a group of other children when the deceased lost control around a corner and fell into low scrub, causing multiple traumas and died in hospital. The bike was examined and was deemed to be unsafe, as parts of the bike had been installed incorrectly.

Recommendations

With a view to reducing the chances of the occurrence of other deaths in circumstances similar to those in which [deceased's] death occurred I make the following recommendations:

To the [location] District Council:

I endorse the recommendations made by Mr [name] in his report to the [location] District Council relating to the [location] Park Reserve

To the Ministry of Consumer Affairs:

That the Ministry investigate whether there was compliance with The Product Safety Standards (Pedal Bicycles) Regulations 2000 (as amended in 2003) in relation to the bicycle used by [the deceased] on [date] 2010.

That appropriate renewed publicity be given to the Ministry's recommendation 'Buy a bike that is already assembled or have it assembled by a skilled Mechanic'.

VIC.2006.441 Child & Infant Deaths/ Animal

A young child with Down's Syndrome died after a dog attacked her while she was sleeping.

Recommendations

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation (s) connected with the death:

- Separate dogs from infants
 - ◊ That the Department of Primary Industries (DPI) , Department of Human Services (DHS) and Department of Education And Training (DEAT) work together to ensure that parents and guardians of infants are provided with a copy of the DPI booklet, "We are family". Potential points of distribution would likely include hospitals with obstetric departments, maternal and child health services, primary schools, pre-school/kindergarten/crèche and local councils (at the time of dog registration renewal notices), pet shops;
 - ◊ Victorian primary schools consider the implementation of the "Responsible Pet Ownership Education Program" developed by the Bureau of Animal Welfare.
- Emergency Department medical and nursing staff should attend a scenario based paediatric course along the lines conducted by [doctor]. The next course will address:
 - ◊ The necessity for major trauma calls be made when criteria is met (as in the case of deceased);
 - ◊ Intraosseous (IO) procedures will be demystified;
 - ◊ The innate ability of children to compensate and disguise the true gravity of the clinical picture.
- Ambulance Victoria consider training non- MICA (Mobile Intensive Care Ambulance) paramedics in paediatric IV insertion.

NOTE: Due to two cases of similar circumstances, where the child/infant died after becoming tangled in a blind cord in Victoria, the Coroner held a joint inquest with combined recommendations

VIC.2009.3786 Child & Infant Deaths

A toddler died from Hypoxic Ischaemic Brain Injury after becoming entangled in a window blind cord at home.

VIC.2009.4659 Child & Infant Deaths

A toddler died from neck compression from becoming entangled in a vertical blind cord at home.

Combined recommendations

It is apparent that the regulatory mechanisms discussed in this finding apply only to new curtains and blinds. It therefore follows that regulation alone will not be effective where blinds and curtains are already fitted. There is an important role for public safety authorities to provide ongoing information and warning campaigns to inform those who will become parents in the future and their families and friends, of the risks associated with blind and curtain cords to young children and the need for vigilance in relation to installation and maintenance.

In this regard I recommend that Consumer Affairs Victoria continue to publicise this risk by way of regular ongoing multi media campaigns and by distributing information regularly to facilities such as those already targeted, including maternal and child health and child care centres and maternity units.

I direct that a copy of this finding be provided to the Minister for Consumer Affairs, Consumer Affairs Victoria and to the [location] Hospital Accident Prevention Unit.

TAS.2008.452 Child & Infant Deaths

A newborn died while co-sleeping with an adult. It seems that the child was being breastfed at the time; the mother had fallen asleep and may have inadvertently smothered the child in her sleep.

Recommendations

- I recommend government and key stakeholder organisations give consideration to the issues and comments in this finding and give consideration to the development and implementation of strategies for the prevention of sudden infant deaths in Tasmania.

TAS.2008.452 continued

Specifically, I recommend that the Department of Health & Human Services adopt a lead role in:

- ◇ developing 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 deaths of infants;
- ◇ considering whether the Paediatric Mortality and Morbidity Sub-Committee of the Council of Obstetric and Paediatric Mortality and Morbidity should be responsible for drafting or advising on the guidelines, with continuing responsibility for drafting or advising on updates to the guidelines in accordance with current medical research;
- ◇ publishing the guidelines amongst the medical and nursing professions in both the public and private sector;
- ◇ publishing the guidelines in the wider community generally, including amongst current and future parents (e.g. in antenatal classes and secondary schools);
- ◇ conducting a Sudden Infant Death Syndrome (SIDS) education program state-wide (perhaps by employing a SIDS educator), with particular reference to any high risk sub-groups;
- ◇ implementing a requirement that all child health nurses/community nurses receive updated training about the guidelines, and;
- ◇ ensuring that SIDS risk assessments are conducted with parents upon the mother's discharge from hospital, with appropriate information about the guidelines provided to them."

I have, for the purposes of this finding, requested a response from the Department of Health and Human Services as to whether any of the recommendations have been considered. My request for this information was made on 3 September 2010 and acknowledged by the Department on 15 September 2010. However, I have not received any formal response since that time. I therefore am not aware of whether the Department has considered these recommendations.

Tasmanian Coordinator of SIDS and Kids, Ms Sharon Davis, has helpfully provided me with a detailed response regarding the extent to which she understands the recommendations have been implemented. I accept her analysis. Ms Davis indicates as follows:

- ◇ that Hospitals have become more vigilant in making certain that staff are giving consistent messages regarding safe sleeping. The Launceston General Hospital has recently completed a survey showing 100% compliance by staff with the safe sleeping message. Additionally the hospital's antenatal classes include a session on safe sleeping practices;
- ◇ that SIDS and Kids Tasmania has been working more closely and collaboratively with Child Health and Parenting Centres regarding training initiatives for those health professionals;
- ◇ that easy to read brochures and posters for parents have been produced. These particularly target those with low literacy. SIDS and Kids Tasmania have dispatched these to all hospitals, child health centres and general practitioners throughout Tasmania.

The Department of Health & Human Services has not provided funding for a SIDS and Kids Educator. Ms Davis states that this is very disappointing as there is still much work to be done to reduce the rate of sudden infant deaths. An educator would be able to work proactively in disseminating the message to all relevant avenues and to provide more training programs in faster time frames. The educator would also be able to develop "train the trainer" programs for training new health professionals entering the work force. The educator would also be responsible for information displays in shopping centres and schools to reinforce the correct message. Ms Davis states that it is very concerning that SIDS and Kids do not have the resources to implement strategies in respect of the teenage bracket, as it is at this age that the message should be initially absorbed. A funded educator would be able to focus upon this age bracket.

I commend the work of SIDS and Kids Tasmania in its continuing efforts to reduce preventable sudden infant deaths in this State. It is disappointing that the Department of Health & Human Services has not apparently taken initiatives to develop or fund a fully coordinated strategy for the prevention of infant deaths.

Tasmanian coronial records reveal that since the death of [deceased], there have been 14 sudden deaths of infants under the age of one year in Tasmania. While some of these deaths have not yet been the subject of formal findings, it appears that a high proportion are associated with unsafe sleeping practices, particularly co-sleeping; as such they are preventable. My previous research disclosed that Tasmania has the second highest rate of sudden infant deaths after the Northern Territory.

I strongly urge the Department of Health & Human Services to consider my 2008 recommendations as a matter of high priority with the aim of preventing further deaths of infants due to unsafe sleeping practices. I again urge the parents of infants under the age of 12 months not to sleep in the same bed with their infants, but to always place them on their back in their own cot to sleep.

TAS.2008.452 continued

I would encourage this simple but extremely important message to be disseminated repeatedly by involved government agencies, health professionals, and the media whenever it is appropriate. The evidence reveals that repeated reinforcement is necessary to be effective in preventing the tragic deaths of infants in our community.

TAS.2009.165 Child & Infant Death

A newborn died as a result of Sudden Infant Death Syndrome (SIDS).

Recommendations

In 2008 I made recommendations in a finding regarding four infant deaths. In that finding I recommended that the Department of Health and Human Services take a lead role in a coordinated approach to reducing the incidence of sudden infant death in Tasmania. I made detailed recommendations as to what could be considered in relation to steps to prevent further deaths. One of those recommendations was the funding for a full-time SIDS educator.

On 3 September 2010 I wrote to the Department of Health and Human Services asking for a response to those recommendations. I have received no detailed response as to whether those recommendations have been considered. My enquiries with SIDS and Kids Tasmania reveal that they have not been implemented.

In its 2008 Annual Report released in October 2010, the Council of Paediatric Mortality and Morbidity reported on the sudden infant deaths occurring in 2008. It noted that all five deaths were associated with risk factors. In particular, all infants had been co-sleeping with adults. In respect of sudden infant deaths the Council made the following recommendations in its report:

“In view of equivalent numbers of cases reported as Unexplained Infant Deaths in 2008 compared to 2007, the issue of safe sleeping practices continues to remain an important issue for the Tasmanian community and the universal distribution of educational material concerning safe sleeping practices would benefit all new parents.

It is recommended that parental toxicology screening for those parents of infants with suspected drug association should be carefully considered in reported cases of Unexplained Infant Deaths. In particular, prescription of highly sedating drugs to adults who are primary carers of infants/children should be carefully considered by practitioners.”

Since the beginning of 2008 alone, 15 Tasmanian infants under the age of 12 months have died suddenly. It appears that in a high proportion of this number preventable risk factors have been present. Such factors include co-sleeping with an adult, incorrect infant sleeping position and bedding and parental drug or alcohol sedation. I again urge that the Department of Health and Human Services consider implementing as a matter of priority a strategy to reduce the incidence of sudden infant death.

I would encourage this simple but extremely important message to be disseminated repeatedly by involved government agencies, health professionals, and the media whenever it is appropriate. The evidence reveals that repeated reinforcement is necessary to be effective in preventing the tragic deaths of infants in our community.

I would particularly urge consideration be given by government to the screening of television advertisements conveying basic safe sleeping for infants. Having the message conveyed orally and in pictorial form to a wide demographic may well be an effective way to instil correct safe sleeping practices, and therefore save the lives of infants in our community.

NZ.2009.1726 Drugs & Alcohol/ Water Related

The intoxicated and drug affected deceased had attempted to get from a dinghy to a yacht that was moored in a Marina. The deceased fell into the water, and due to an inability to regain security of the yacht or the dinghy, heaviness of clothing and the coldness of the water, the deceased has drowned.

Recommendations

I recommend that a copy of this Finding be forwarded to Water Safety New Zealand and to Maritime New Zealand for their information, as further examples of the fatal consequences of over indulging in alcohol (and cannabis) and boating.

NZ.2009.2580 Drugs & Alcohol/ Water Related

The deceased had been drinking with friends at a 21st birthday party. The bar shut and the deceased got into a fight with friends about getting a lift home. The deceased walked off and was discovered at the foot of a ladder up the side of a wharf in the water. It appears that the deceased has drowned.

NZ.2009.2580 continued**Recommendations**

I recommend that a copy of this Finding be forwarded Port [location]. It is emphasised that Port [location] are not found to be responsible, in any way, for the death of [deceased], but I ask that consideration be given to enhancing the safety of users of the inner harbour, specifically by investigating methods by which more convenient access could be obtained by persons who find themselves in the water of the harbour, for whatever reason, and have a need for egress to safety.

I recommend also that consideration be given to the affixing of safety lighting and other methods to more readily identify egress safety ladders and that consideration ought to also be given to the supply of a life ring and rope at the [location] Wharf.

VIC.2009.5659 Drugs & Alcohol

A person died from drinking an amount of un-prescribed Methadone. The deceased was not on the methadone program and had drunk a cousin's prescription.

Recommendations

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

- ◇ That regulatory authorities establish a clear mechanism of supervision of the safety arrangements for storage of take away dosage of methadone.
- ◇ That there be a prohibition upon take away methadone dosage unless a responsible regulatory authority is satisfied that safe storage arrangements are in place in the premises in which the drug is to be stored.

I direct that a copy of these findings be provided to the Honourable Mr David Davis MLC Minister for Health (Victoria); The Honourable Ms Mary Wooldridge MP, Minister for Community Services Victoria; The Health Practitioner's Board Australia and The National Pharmacy Board of Australia.

SA.2008.240 Drugs & Alcohol/ Law Enforcement

A person took an amount of cocaine which seems to have triggered a psychotic episode. The deceased proceeded to drive erratically, destroying property. The cocaine caused muscle meltdown and toxic proteins which affect the kidneys leached out from the muscle, exacerbating an undiagnosed heart disease. The man died while being apprehended by police for erratic driving.

Recommendations

Attached to the statement of [doctor] is a revised guideline concerning the administration of midazolam as a sedative. The principal difference from the guideline that was in existence at the time with which this inquest is concerned, is that the revised guideline contains the following:

'Do not administer midazolam to patients who are prone, rear handcuffed, under restraint using the physical weight of another agency member across the torso to control them or who are not yet safely apprehended to allow clinical examination. Only one drug should be selected and administered.'

As with the pre-existing guideline, the revised guideline does not say anything about the rate of administration. In addition, I notice that the revised guideline drops the reference to the need to administer it incrementally. However, other documentation that was apparently promulgated within SA Ambulance Service (SAAS) in the aftermath of this incident does make reference to this subject.

This appears to be a reflection of the kinds of issues identified by Professor White, namely that midazolam should be administered in such a manner so as to enable the person administering it to gauge in a gradual way the reaction of the patient. I would recommend that the Medical Director of the SAAS consider issuing a guideline that describes a method of administration in accordance with the evidence given by Professor Jason White, in particular that set out in paragraph 5.5 herein.

I also had the benefit of receiving into evidence the affidavit of Madeline Elizabeth Glynn who is an Assistant Commissioner with SA Police. In that document Assistant Commissioner Glynn describes a number of measures and initiatives that are designed to enhance training with respect to, and to minimise risk involved in, restraint by police officers. The document includes reference to positional asphyxia and excited delirium and describes the training directed to officers in respect of identification of the same and preventative measures that might be taken to ensure the safety of an arrested person who is handcuffed, and if the person is in a state of drug induced excited delirium. The measures and initiatives are to be commended.

In all of the circumstances I do not see any necessity to make any other recommendation in respect of this matter other than to suggest that these findings be distributed to all police officers so that they may be better informed about excited delirium and the possible effects of substances such as cocaine on a person's behaviour.

NZ.2009.106 & 107**Electrocution / Work Related**

The deceased persons were both electrocuted when a grain auger came into contact with overhead power lines on their farm.

Recommendations

The circumstances of these deaths highlight issues of minimum heights of overhead power lines as submitted by [person] at this hearing, and also the route of overhead power lines, particularly in relation to farm working yards.

The evidence is that there is considerable information in the public arena concerning the dangers of overhead power lines and the operation of machinery in proximity to those power lines.

- Although Electricity [location] Limited is discouraging the installation of overhead power lines on rural properties, the policy in my view needs to be extended to giving consideration to the safest route for overhead power lines, if they are to be installed on rural properties. I make particular reference to farm working yards. I formally recommend to Electricity [location] Limited accordingly.
- This issue is likely to have a wider context than just Electricity [location] Limited. There may well be action that the Department of Labour could take in support of this recommendation.

NSW.2008.5997**Falls/ Mental Illness & Health/ Older Persons/ Intentional Self-Harm**

An elderly person died from injuries sustained from falling from a hospital balcony. The deceased expressed suicidal feelings and had already made one attempt to take their life via the balcony before being stopped by staff. On the second attempt, staff were unable to intervene.

Recommendations

I recommend to the Minister for Health that consideration be given to ensuring that, where an in-patient in a hospital displays signs of significant distress related to his/her mental health or emotional well-being or, in particular, threatens or attempts self-harm, the medical officer responsible for the care of that patient and for the formulation of a management plan for that patient first consult, either face to face, or, if necessary, by telephone, and seek input from a mental health professional being a psychiatrist, psychiatric registrar or appropriately qualified clinical nurse consultant.

I recommend to the Minister for Health that consideration be given to ensuring that, where special nursing is prescribed by a medical officer as part of a management plan for an in-patient in a hospital and it becomes clear that no special nursing will be available, nursing staff promptly so advise that medical officer or the medical officer who has come on duty in his/her place so that the management plan can be reconsidered and amended.

NZ.2008.1757**Falls/ Physical Health**

The deceased was a patient in a care home, suffering from anaemia and autism. The deceased fell through a plate glass window and was found with cuts to the torso and was hypothermic. Despite being taken to hospital, the deceased was discharged not long after in the care of the care home manager. Despite still being tired and lethargic, no further medical treatment was sought, and the deceased was found deceased in their bed the next day.

Recommendations

- That the Intellectual Disability Empowerment in Action (IDEA) Service look to amend its protocol with respect to the possible hospitalisation of a client/patient by instructing staff to call the Ambulance Services immediately whenever an injury or resident distress of some magnitude is sustained.
- Secondly that the staff be instructed not to attempt to influence Medical Staff with respect to urging a patient/client discharge.
- That the [location] Hospital review its note taking process to include all information of steps taken on patient care and that the staff not be influenced by overcrowding or external pressures to discharge a patient until they are medically certain that the discharge is in the patient's best interests.

NZ.2009.1497 Falls/ Older Persons/ Physical Health

The elderly deceased had been admitted to hospital with pneumonia and chronic renal failure. While in hospital, the deceased fell out of the hospital bed but claimed there were no injuries to the head. The deceased's condition subsequently deteriorated, and the deceased passed away.

Recommendations

I recommend that a copy of this Finding be forwarded to [location] Hospital with a request that same be considered as a warning for the continued vigilance for hospital staff in respect of the potential hazard represented by falls by vulnerable patients.

NZ.2009.2969 Falls/ Older Persons/ Adverse Medical Effects

The elderly deceased was found on the side of the road having fallen over. They were taken to hospital, but the deceased was not given a CT scan and was discharged the next day. The deceased complained of pain and was sleeping a lot, and after seeing the local GP, was re-hospitalised. The deceased then deteriorated and died three days later.

Recommendations

That the [location] District Health Board review its guidelines as to the steps to take in providing a CT scan on elderly patients who have been known to have been hospitalised as a result of a fall where they have hit their head and in particular are known to be on Warfarin or similar treatment.

VIC.2007.3709 Falls/ Intentional Self Harm

A person died from an accidental fall from a height at a shopping centre. The deceased had a history of suicide attempts and had been recently released from a hospital Intensive Care Unit (ICU) for injuries relating to a previous attempt.

Recommendations

- Putting to one side the question of whether [deceased] might properly have been referred under the Act, I recommend that [location] Hospital undertake a review of its procedures for assessing the suitability for discharge of patients with multi-faceted presentations. Such review should be undertaken with a view to ensuring that those patients suffering from mental illness receive a full medical appraisal of that condition, based upon a complete medical history and a consideration of treating specialist's reports.
- Should a review indicate that release (rather than referral to a psychiatric unit) is appropriate, there remain two further issues for consideration:
 - ◇ The need to provide the receiving Community Mental Health Service with sufficient time to meet with a patient and evaluate and devise an appropriate post release management plan;
 - ◇ the need to provide the receiving Community Mental Health Service with sufficient time to arrange appropriate accommodation, either within family provided accommodation, or in some other appropriate situation.
- In this regard, I recommend that a lengthier period of notice be given to the relevant Community Mental Health Service, and should always include a similar notification to family members.
- I consider that any notice of less than two weeks in duration, might reasonably be viewed as inadequate.

NZ.2009.1862 Fire Related

The deceased received burns when he entered a burning shed on a property to retrieve a new ski boat. The opening of the door into the shed led to oxygen making the fire more intense and speeding it up. The fire came from a potbellied stove that had been left on and subsequently caught fire. The deceased later passed away from injuries sustained in the fire.

Recommendations

I recommend that a copy of this Finding be forwarded to New Zealand Fire Service (NZFS) to continue with advice to the public that people be warned not to enter, or re-enter, a burning building, and (following what has been advised to us by Fire Officer, [name]) to keep combustible materials at least one metre away from a heat source.

NSW.2002.5748**Homicide & Assault**

A person died from a homicidal attack at the hands of a person or persons unknown.

Recommendations

That the Commissioner of Police offers a reward for information that may lead to the identification and conviction of {deceased's} killer or killers.

WA.2007.1586**Indigenous Deaths/ Law Enforcement/ Natural Cause Death**

An Indigenous person died of ischaemic heart disease and a blood clot in one of the arteries in the heart while in custody. The deceased also suffered from Type 2 diabetes which was not monitored or managed in a satisfactory fashion while in custody.

Recommendations

- I recommend that in the case of deaths in custody when a prisoner has died from natural causes a detailed statement or report should be taken from the treating medical practitioner. I further recommend that when statements are taken from treating doctors or nurses the notes (or copies) are available for reference.
- I recommend that the Department of Corrective Services put in place measures to ensure that appropriate investigations for diabetes monitoring take place shortly after reception of diabetic prisoners in accordance with the Diabetes Careplan document.
- I recommend that all Indigenous prisoners over the age of 35 years be given an ECG shortly after being received into custody.
- I recommend that the Department of Corrective Services put in place procedures which would assist medical practitioners and nurses in their communication with Aboriginal persons. In that context I suggest that consideration be given to involving Aboriginal Health Workers or at least Aboriginal persons coming from the relevant areas and familiar with the language and culture of Aboriginal prisoners to assist with the practicalities of asking questions necessary to complete a Diabetes Careplan documentation, obtaining comprehensive medical histories and conducting other similar tasks.
- I also RECOMMEND that consideration should be given to ensuring that doctors unfamiliar with obtaining histories from Aboriginal prisoners, as part of their induction, work with a doctor experienced at obtaining medical information from such prisoners.
- I recommend that the Department of Corrective Services communicate with representatives of [place] with a view to determining whether any of its resources could be accessed by prisoners housed at the [location] Prison
- I recommend that the Department of Corrective Services liaise with appropriate Aboriginal organisations and Aboriginal Health Care Workers with a view to designing diets which, while compliant with the requirements of a diabetes diet, would be reasonably appealing to Aboriginal prisoners.
- I recommend that the Department of Corrective Services closely monitor prisoners in minimum security prisons who are permitted to self-medicate to ensure that the medications are being taken as prescribed

WA.2008.1768**Indigenous Deaths/ Homicide & Assault/ Law Enforcement**

A young Indigenous person died after being involved in a fight, where the attacker kicked the deceased in the head several times with steel cap boots, causing a left intra-cerebral haemorrhage. Police arrested the deceased and the deceased's brother. Initially, the deceased was taken to hospital and received care for the injuries sustained however was released from hospital. The police then re-arrested the deceased and the brother for the incident from beforehand. The deceased died in a police cell.

Recommendations

- I recommend that in cases where police arrange for an injured victim of a crime of violence or an injured person in custody to be taken to a hospital, police and nursing staff ensure that a reliable history is taken prior to departure of police, particularly if the injured person is under the influence of alcohol.

WA.2008.1768 continued

- I recommend that the Custody Handover Summary require entry of a summary of any medical treatment or medical assessment made in respect of any prisoner who has been seen by a medical practitioner shortly before being taken into custody or while in custody.
- I recommend that WA Police ensure that CCTV coverage of cells in police stations is recorded so that in the event of a death in custody or serious incident within the cells that recording will be available.

NSW.2006.4539 Intentional Self-Harm/ Mental Illness & Health

A mentally ill person died from hanging while in a mental health unit at a hospital.

Recommendations

To the Minister for Health

- I recommend that NSW Health consider using the Information Protection Principles (IPP) Consulting Report prepared for the [location] Mental Health Unit as the foundation for a review of the standard NSW Health “Access to Means of Suicide and Deliberate Self-harm” checklist.
- I recommend that NSW Health include in the “Access to Means of Suicide and Deliberate Self-harm” checklist a reference to a visitor search policy.
- I recommend that NSW Health adopt a visitor search policy for all psychiatric units under its control providing for mandatory search of visitors or, in the alternative, the securing of bags and containers and items that may constitute a risk to the safety of patients in secure lockers provided at an appropriate location in the unit.
- I recommend that signs at the [location] Hospital Mental Health Unit listing banned items be enlarged.
- I recommend that NSW Health considers adopting the response of the [location] Mental Health Unit to the death of [deceased] as a case study to assess and improve management plans for responding to critical incidents occurring in NSW psychiatric units.

NSW.2007.1202 Intentional Self-Harm/ Mental Illness & Health

A person died from hanging while in the care of a hospital psychiatric unit for schizophrenia and depression.

Recommendations

To the Minister for Health:

- I recommend that NSW Health adopt a visitor search policy for all psychiatric units under its control providing for mandatory searching of visitors or, in the alternative, the securing of bags and containers and items that may constitute a risk to the safety of patients in secure lockers provided at an appropriate location in the unit.
- Whether or not NSW Health adopts Recommendation 1 as a general policy, I recommend that the Area Health Service does so in relation to all mental health units under its control.
- I recommend that NSW Health also require that visitors to mental health units be registered.
- I recommend that the Area Health Service institute such a practice whether or not NSW Health adopts Recommendation 3 as a general policy.
- I recommend that NSW Health patient search protocols be amended to provide for a full property list to be kept of property brought into a mental health unit by a patient whenever he or she returns to the unit.
- I recommend that the Area Health Service consider fitting two-way latches or outward-opening doors on all patient bedrooms and bathrooms in the [location] Centre.
- I recommend that NSW Health reviews its “Access to Means of Suicide and Deliberate Self-Harm Facility Checklist” using the Information Protection Principles (IPP) Consulting report of December 2006 on the facilities at the [location] Mental Health Unit as a reference point.
- I recommend that, regardless of whether NSW Health adopts Recommendation 7 as a general policy, the Area Health Service does so.
- I also recommend that the senior management of the [location] Centre studies the IPP Consulting report with a view to conducting a safety audit of their own facilities.
- I recommend that NSW Health consider adopting a simple “sentinel event” or “critical incident” checklist for senior management and staff of psychiatric units to be used as an aide memoire in such crises.
- I recommend that NSW Health acquire or equip all mental health units with hooked rescue knives (as now used at the [location] Centre or some similar implement).

NSW.2007.1202 continued

- I recommend that the Commissioner of Police and NSW Health consider developing a protocol or Memorandum of Understanding governing procedures to be adopted when police are investigating critical incidents in NSW hospitals. Such a protocol might be expected to cover the taking of statements from relevant witnesses, the securing of “crime scenes” (that is, the physical location of the incident) and the securing of exhibits and relevant documents.
- I recommend that NSW Health eliminate laundry bags with detachable drawstrings from mental health units in NSW. Alternatively, such bags ought to be secured from patients at all times.

To Commissioner of Police I recommend that the Commissioner of Police and NSW Health consider developing a protocol or Memorandum of Understanding governing procedures to be adopted when police are investigating critical incidents in NSW hospitals. Such a protocol might be expected to cover the taking of statements from relevant witnesses, the securing of “crime scenes” (that is, the physical location of the incident) and the securing of exhibits and relevant documents.

NSW.2007.2001 Intentional Self-Harm/ Law Enforcement/ Mental Illness & Health

A person died from hanging while in the care of a hospital psychiatric unit after being arrested for violent offences. It was identified that the deceased would harm themselves and thus was moved to the high observation room in the psychiatric unit.

Recommendations

It is a core police function to investigate deaths on behalf of the coroner. Such investigations should be efficiently undertaken so that when an inquest is necessary that may occur at the earliest time possible. Responsibility for doing so rests both with the police force and the Coroners Court. Since [deceased’s] death procedures have been introduced at the Coroners Court to ensure that briefs are prepared in a timely manner and as such the difficulties that arose in this matter are unlikely to occur now. It is thus unnecessary for me to make recommendations concerning this issue

NSW.2007.5192 Intentional Self-Harm/ Falls/ Mental Illness & Health

A person died from multiple injuries resulting from jumping off a cliff with the intention of ending their life. The deceased suffered from severe depression and anxiety.

Recommendations

I intimated during the Inquest that I was going to make recommendations relating to the adequacy of counselling provided to Officers of the [location] Local Area Command. It has been pointed out that I made recommendations in a previous inquest involving another death at the [location] and that the Commissioner of Police had responded to that recommendation. I accept that and do not propose to take the matter any further.

The issue of funding for the completion of work at [location] is vital in my view. I know the member for [location] the [name] has called for the funding to be made available and the evidence that has been given at this Inquest about [location] supports his call.

I direct that a copy of the findings and executive summary be sent to the Honourable Member for [location], as he may be able to use some of the evidence that was given in assisting the [location] Council if further Federal funding is required to finalise the ‘Gap Suicide Minimisation Plan’.

A number of vitally important aspects relating to the assessment and treatment of depression were uncovered during this Inquest that should be brought to the attention of general practitioners, counsellors, psychologists, psychiatrists and others (who I will call collectively “health professionals”) who may be called upon to treat people presenting with signs and symptoms of depression.

They include:

- The need for increased awareness by health professionals of the need to exclude a bipolar disorder in all patients presenting with signs and symptoms of depression.
- The need for assessment tools for bipolar conditions being readily available to all health professionals treating patients with signs and symptoms of depression.
- Stress on the importance of all health professionals treating patients with signs and symptoms of depression to provide all relevant information to other health professionals to whom a patient may be referred for ongoing treatment.

NSW.2007.5192 *continued*

- Stress on the importance of all health professionals treating patients with signs and symptoms of depression to keep referring health practitioners informed of their management of the patient.
- Critical consideration of the use of “contracts” between health care professionals and patients whereby the patient promises not to self-harm and to contact the health care provider if they are feeling suicidal. These could usefully be replaced with “commitments to treatment” which are less coercive.
- Discouragement of any indication by a health care professional of being available to patients 24 hours a day, 7 days a week as this can obscure the therapeutic relationship.
- The provision to patients who have suicidal thoughts but are not thought to be at risk of suicide at the time of a “crisis plan” with details of who to contact and how if their condition worsens if the usual treating health professional is not available. This applies to patients being released from hospitals.
- That health professionals stress to the patient the importance of involving family members or similarly placed persons to monitor any side effects associated with having drugs supplied for the first time or any increase, decrease or change of medication because sometimes the patient may not be able to recognise these effects for what they are.

The peak bodies that represent general practitioners, psychologists and psychiatrists were not represented and were not asked to make submissions to the inquest so I cannot fashion these important findings into recommendations to be actioned by them.

However, I would urge the peak bodies to carefully consider the findings because advising their membership can only result in an increased awareness of how important certain aspects of the assessment and treatment of depression are and in the end reduce the number of suicides and attempted suicides as a consequence.

I direct that copies of the findings and executive summary be forwarded to the Royal Australian College of General Practitioners, the Counsellors and Therapists Association of New South Wales, the Australian Psychological Society and the Royal Australian and New Zealand College of Psychiatrists.

NSW.2007.6288 **Intentional Self-Harm/ Mental Illness & Health**

A person hung themselves in a state forest the same day that he was released from hospital. It was determined that the deceased was not in need of psychiatric care, despite the deceased having a history of psychotic behaviour.

Recommendation

To the Minister for Health

- I recommend that consideration be given to amending the *Mental Health Act 2007* to enable clinicians to discharge patients previously detained for assessment into the care of an appropriate person conditions or with appropriate undertakings, for example, that the patient will be presented to a community mental health service within a certain time.
- Regardless of whether such a statutory amendment is ultimately introduced, I recommend that the Area Health Service establish supervised waiting areas in psychiatric units or Emergency Departments for patients being discharged to carers following a mental health assessment.
- I recommend that the Area Health Service consider introducing the [location] Hospital "Green Card" system (or suitably adapted version) and, if so, whether it could or should include patients who combine first episode psychosis with self-harming behaviours.
- I recommend that NSW Health and the Area Health Service review and, if deemed appropriate, amend information packs provided to families and carers of mental health patients cared for and treated by the Service. In particular, recommend that NSW Health review its information packages with specific regard to First Episode Psychosis and Early Episode Psychosis.
- I recommend that the Area Health Service consider introducing a clinical guideline that "authorised medical officers" not to refuse to detain patients brought in for mental health assessment unless reasonable steps to obtain relevant histories have been taken from persons other than the patient.
- I recommend that, where it is reasonably practicable, a Registrar or consultant psychiatrist refusing to detain a patient under the *Mental Health Act* speak to the family or carers of the patient explaining the diagnosis and plan, providing advice as to what signs to be alert for, explaining what they should do if they have further concerns and answering any further reasonable queries the family may have. This conversation ought to preferably take place face-to-face when the patient is being collected by the family or carer.

NSW.2007.6288 continued

- I recommend that the Area Health Service obtain legal advice to ensure comprehensive understanding of the requirements of the *Mental Health Act 2007* and full compliance with it at senior management level.
- I recommend that the Area Health Service review its training programs and materials concerning the *Mental Health Act* to ensure that all staff exercising powers or functions under the Act are full conversant with its procedures and requirements and conduct an audit to ensure that all relevant staff have undertaken such training.
- I recommend that the Area Health Service consider introducing a guideline that patient without a firm diagnosis but who may have suffered a first episode psychosis be reviewed by a consultant psychiatrist as soon as reasonably possible and preferably within a time to be determined on specialist advice.
- I recommend that the Brief Assessment and Plan document be amended by NSW Health to include a checklist to be completed by a medical officer who is responsible for any decision to discharge a patient who is initially detained at a hospital pursuant to sections 19-26 of the Act to be completed before the discharge. The checklist would seek to ensure that all relevant steps required under the Act have been taken in proper sequence, all relevant documents completed, relevant histories taken from persons from persons other than the patient, risk assessments made, a management plan developed and family and carers briefed.

NSW.2008.1126 Intentional Self-Harm/ Law Enforcement/ Weapon

A person took their own life by means of a gunshot wound to the head. This occurred when the deceased made it evident that he had a high powered gun at a populated mall. Police intervened and the deceased then shot themselves.

Recommendations

To: The Minister of Police:

- That the procedure for the granting of a licence to possess firearms be reviewed so as to ensure that prior to the granting of such a licence, and at each renewal thereof, applicants undergo a mental health assessment by a general medical practitioner, or other appropriate professional, so as to ensure that they are not suffering from any previously undiagnosed mental health condition that would render the applicant unsuitable for the holding of such a licence.
- That organisations that provide facilities for the secure storage of firearms maintain a register of all firearms that are located in such facilities and, if taken from the storage facility, the dates of removal and subsequent return of the firearm.
- That each time a firearm is removed from a storage facility the currency of a firearms licence held by the person removing the firearm be confirmed by the facility operator.

NSW.2009.682 Intentional Self-Harm

A person died from excessive bleeding from a self-inflicted wound in bushland. Police were called prior to this occurring but were unable to reach the deceased in time.

Recommendations

To: The Minister of Police: That the Commissioner of Police review the education of Police Officers in the field of the tracing of telephone calls, in particular, to triangulation and last call details, with respect to their use, interpretation and employment in the process of police investigations.

NZ.2008.16 Intentional Self-Harm/ Mental Illness & Health

A patient with a mental illness was found bleeding after intentionally breaking a glass and cutting their throat and neck. Despite efforts by medical professionals, the deceased suffered massive blood loss and was unable to be revived.

Recommendations

I recommend that a copy of this Finding (and extracts from the file if the Director considers it appropriate) be forwarded to the Director-General of Mental Health for further consideration and his investigation into the provision of a more suitable "halfway house" for patients with symptoms such as [the Deceased]. Such patients are obviously in need of treatment but the provision of both a secure and safe environment, and a therapeutic environment, needs further exploration.

NZ.2008.16 continued

- I recommend that [hospital]:
 - ◇ Consider the circumstances of the admission of [the deceased] as a learning tool for its future actions. As has been stated by the family and referred to by Consultant Psychiatrist, [doctor], it may be that [deceased] did not actually "fit" at [facility] and may have been more safe in another facility.
 - ◇ Communicate more frequently and more effectively with the family of its patients, both from the perspective of the family (and their need to be updated and involved) but, more importantly, from a therapeutic perspective. There will be times where family contact or involvement would be inappropriate for a patient, but I observe that, in the case of [the deceased], the involvement and support of family would have been immensely valuable as a part of the therapeutic in his care.
 - ◇ Consider the Ministry of Health Guidelines referred to in the evidence and integrate these Guidelines more fully into the [hospital] Risk Management Strategy.
 - ◇ Ensure that, in future, during handover of a patient from an existing GP (and such specialists consulted) [hospital] staff take the necessary steps to obtain all necessary clinical information from an existing clinician and, as appropriate, provide feedback.
 - ◇ Although I do not consider that the specific failure by Dr [name] to conduct a focussed interview with [the deceased] on a more frequent basis was a circumstance of his death, hindsight allows us to see that one or more additional assessments may have resulted in any greater suicide risk being identified. I accept the difficulty in that [the deceased] saw interviews with [the doctor] as distressing. Strategies could be employed to allow a psychiatrist to observe and interact with a patient less formally or arrangement made for the patient to be assigned to a different psychiatrist when this would facilitate better assessment and treatment.

NZ.2008.348 Intentional Self-Harm/ Mental Illness & Health

The deceased intentionally took their own life by hanging after suffering from depression and anxiety.

Recommendations

To: The President New Zealand Law Commission [Address] AND to The Privacy Commissioner

- That the present provisions of Rule 1 1(2)(d) of the Health and Information Privacy Code 1994 be the subject of review and amendment so that they may act as an effective instrument for the prevention of harm to individuals and the public.

NZ.2008.1730 Intentional Self-Harm/ Youth

The deceased youth intentionally took their own life by hanging. The deceased had been missing for a week, and had been brought to the police station to reunite with family. The deceased had been released into the family's custody, despite the family asking for a mental health welfare check.

Recommendations

I am aware that a national review is under way into how mental health authorities and Police work together. It is my recommendation that review incorporate procedures for Police where someone, who is not in custody, is regarded by a member of the public as being suicidal or having suicidal tendencies. If Police are contacted and asked for advice, it is my recommendation that police should adopt a conservative approach which treats the person as being at risk until it is clear following assessment by a specialist service that the risk no longer exists.

This should involve the matter being referred immediately to a member of the Psychiatric Assessment Team for direction, and if appropriate for detention and transportation at the direction of a Duly Authorised Officer (DAO).

I have had an opportunity of viewing the draft proposed protocols, but the emphasis in those protocols is on persons in custody. I recommend that they be reviewed to extend the situation to persons not in custody, where contact is made with Police by a member of the public seeking assistance.

I note that [the deceased] did not take his life immediately after leaving the police station. [The deceased] died 4 days later. There was opportunity for specialist advice to be obtained, but there does not appear to be any further indication given by [the deceased] to his parents of suicidality which would have prompted them to seek further assistance. Better assistance could have been provided by Police to [parents], at least by providing contact numbers for the Psychiatric Assessment Team, and preferably by making direct contact with the Psychiatric Assessment Team/DAO for direction.

NZ.2010.1568 Intentional Self-Harm/ Mental Illness & Health/ Drugs & Alcohol

The deceased suffered from depression and drug addiction and had recently been having relationship troubles, of which the deceased had moved away from. The deceased was taking methadone and antidepressants, both at therapeutic amounts, but was still having problems, and was subsequently found in the garage after taking their own life by hanging.

Recommendations

[Location] Health Services is committed to ensuring people who have or may have more than one diagnosis have this recognised, to ensure that the individual care package includes support to mitigate any real or potential risks identified and that they are in place.

The following strategies are endorsed to support this:

- ◇ Audit the current health records of all people using the methadone programme to ensure expected documentation has been completed and where there are failings to ensure this is actively corrected and ensure that regular audit is ongoing. Note this has now been completed.
- ◇ A new leadership structure has been proposed and is currently under consultation, which will see Community Teams and Addiction staff working closer together.
- The [name] (the National Centre for Mental Health Research, Information and Workforce Development) Let's Get Real programme will be implemented which provides a framework to describe the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services. This will be led by managers of our teams.
- Establish staffing core competencies and qualifications and consideration for registered practitioner's role in the methadone programme workforce and based on the Let's Get Real framework.
- Consider as part of ongoing business framework for 2010/2011 financial year an external review of the addiction service to look at best practice within New Zealand and to understand the needs of the community to develop a plan which will ensure that all people who use the methadone programme and their families have an assurance that they receive a comprehensive package of care.'

I recommend the adoption of those strategies. [The deceased] was prescribed the anti-depressant Citalopram on [date], two weeks prior to his death, and this drug was detected in [the deceased's] blood at post mortem at a level consistent with therapeutic use. [The deceased] was also receiving separate counselling for pain management. While [the doctor] notes that a full mental status exam was not carried out just prior to [deceased's] death, but [deceased's] mental state was well known, I believe that a comprehensive risk assessment would have been desirable. I accept that such assessment and any supportive action taken following an assessment may possibly not have altered [the deceased's] decision to end his life. However, in the light of the fact that [the deceased] was treated for depression but took his life by hanging, any steps that can be taken in future to assess a person's mental state, particularly when antidepressants are being considered, may assist in reducing the chances of the occurrence of other deaths in circumstances similar to those in which the death of [the deceased] occurred. The strategies recommended to be taken by [location] District Health Board should assist in achieving that aim. Dr [name] also supports an external audit of [location] Methadone Programme

NSW.2005.689 Law Enforcement/Older Persons

An elderly person died in custody from complications from infection from the bloodstream. This was attributed to a lack of care for the [deceased's] health with regards to moving within the NSW Correctional system.

Recommendations

Under s.82 of the Coroners Act 2009, I make the following recommendation both to Minister for Corrective Services NSW and to the Minister for Health responsible for Justice Health NSW: -

- That Corrective Services NSW, in consultation with Justice Health NSW, develop protocols to ensure that sentencing courts are provided with sufficient relevant information regarding any special needs of a person who is to be considered for a custodial sentence, where those special needs result from a significant physical or mental disability.

I note that Corrective Services NSW has (already) engaged in deliberations/consultations with the Judicial Commission of NSW to assist in developing such protocols.

NSW.2006.5093**Law Enforcement/ Natural Cause Death**

A person died from dilated cardiomyopathy where the heart becomes enlarged and weak, thus not being able to pump blood efficiently around the body. It appears this took place while the deceased was in custody of NSW Correctional Services.

Recommendations

The annual budget allocation to Corrective Services ought be escalated on the basis of increases in the full time inmate population. The population has significantly increased over the past decade. Variations in the budget to accommodate increases in the inmate population are based on the average daily full time inmate population. This approach to determining the increase in the budget does not have regard to fluctuations in the inmate population. Neither does it recognise that a funded vacancy buffer is required to enable the front end of the correctional system to manage spikes in the inmate population and absorb all receptions. I therefore recommend that NSW Treasury Officials should meet with Corrective Services NSW Executive to discuss changes to the funding model that recognises the need to maintain a funded vacancy buffer as a contingency to absorb increases in the inmate population.

NZ.2009.3713**Law Enforcement/ Work Related/ Transport & Traffic Related**

A law enforcement officer died while carrying out police duties. The deceased was attempting to lay road spikes to stop a dangerous driver who had stolen a car, when the car hit the deceased, throwing him into the air and causing extensive injuries. The deceased was not able to be revived.

Recommendations

I endorse the recommendations made by the Department of Labour at Paragraph [33] of this Finding (The Policy for the wearing of high visibility vests be reviewed internally by the New Zealand Police. The review should determine the appropriateness of the current policy for the wearing of high visibility vests, and ascertain the circumstances when the Police Officers may choose not to wear high visibility vests. The results of the review should be disseminated to staff and incorporated in training but with the exception that I believe there should be no doubt as to there being any option to wear or not wear the high visibility jackets.

SA.2008.345**Law Enforcement/ Natural Cause Death/ Physical Health**

A person died while in custody from an epileptic fit causing hypoxic encephalopathy. The deceased was revived however suffered brain damage from lack of oxygen to the brain. Further to this, it was found that the deceased had brain tumours.

Recommendations

I make the following recommendations:

- That the Minister for Health and the Minister for Correctional Services cause a database to be established that contains the medical histories of all prisoners who have been held both in police custody and custody within correctional institutions and that the database be accessible by authorised personnel of SAPOL, the Department for Correctional Services and the Prison Health Service;
- That the Department for Correctional Services and the Prison Health Service so far as is considered necessary for the proper management of a prisoner, develop protocols and procedures for the sharing of information between those entities regarding the medical histories and clinical presentations of individual prisoners in Department for Correctional Services custody;
- That the Minister for Health and the Minister for Correctional Services introduce such legislation as may be necessary to overcome confidentiality considerations in respect of the implementation of Recommendations 1) and 2);
- That the Prison Health Service develops a protocol for the clinical management of prisoners who are known to suffer from epilepsy;
- That in respect of prisoners who have a diagnosed condition and history of epilepsy, that the Prison Health Service conduct a medical review of each such prisoner upon his or her induction into a Department for Correctional Services custodial facility. The review should include an assessment of the efficacy of their anticonvulsant medication, a review of recent history of seizures and an assessment of risk having regard to known risk factors for epileptic seizure including disturbed sleep patterns, failure to take prescribed medication and recent history of seizure;
- That officers of the Department for Correctional Services be made aware of an individual prisoner's diagnosis of epilepsy and any adverse risk assessment regarding risk of seizure in respect of an individual prisoner;
- That officers of the Department for Correctional Services be trained in relation to epilepsy and its possible fatal consequences, and in respect of the risk factors that may exist in relation to seizure;

SA.2008.345 continued

- That Department for Correctional Services Standard Operating Procedures be amended to include a separate and specific direction to correctional services officers that any episode of unconsciousness or unresponsiveness exhibited by an individual prisoner should be regarded as a medical emergency requiring immediate intervention and the provision of medical treatment without delay;
- That Department for Correctional Services officers be reminded both verbally and in writing that the calling of any Code Black, or the identification of any medical emergency, requires the immediate notification of medical staff and an immediate assessment of the need to call emergency services;
- That Department of Correctional Services officers be advised both verbally and in writing that they should not resist or otherwise question clinical decisions made by staff members of the Prison Health Service in respect of an individual prisoner and that they should facilitate without delay all such clinical decisions;
- That medical staff, including medical practitioners and nurses, employed by the Prison Health Service in custodial institutions be equipped with Department for Correctional Services radios to enable them to be advised of a Code Black as and when it is called;
- That the Minister for Correctional Services introduce such legislation that would amend section 36 of the Correctional Services Act so as to prohibit the delegation of section 36 powers and responsibilities to officers of the Department for Correctional Services below the position of General Manager of a custodial institution or a person acting in that position or capacity;
- That the Minister for Correctional Services introduce such legislation that would amend section 36 of the Correctional Services Act so as to require both the said Minister and the Chief Executive Officer of the Department of Correctional Services to be regularly informed of the current circumstances of a prisoner in respect of whom an order has been made that the prisoner be kept separately and apart from all other prisoners;
- That Department of Correctional Services Standard Operating Procedures be amended so as to contain a requirement that the General Manager of a correctional institution regularly review the circumstances of a prisoner to whom section 36 of the Correctional Services Act applies.

NSW.2009.3301 Leisure Activity/ Fire Related/ Domestic

A person died from accidental carbon monoxide poisoning after exposure to fumes from barbecue briquettes indoors.

Recommendations

To The Department of Services, Technology and Administrators that: (through the Fair Trading Division) it ensure that all barbecue charcoal briquettes whether imported, manufactured or sold in Australia, carry the following:

Warning "The burning of BBQ Charcoal can give off Carbon Monoxide, which has no odour, and can be Lethal. NEVER BURN CHARCOAL INDOORS OR IN VEHICLES OR TENTS. When burning BBQ Charcoal, ensure BBQ Area is well VENTILATED. Keep out of reach of Children. Please take Care when burning" and further consider the utility of extending this Warning requirement to portable barbecues.

NZ.2009.1971 & 3374 Leisure Activity/ Geographic

The deceased tourists died after glacial ice fell on the deceased persons while walking within a glacier. They had walked away from family to take pictures on the terminal face, when the ice cracked and enveloped them.

Recommendations

Pursuant to section 57(3) of the Coroners Act 2006:

- The following recommendation applies if the Department of Conservation's monitoring of visitor safety directions since these fatalities indicates non-compliance (even at a low level) with the hazard warning signs designed to prevent persons approaching the [location] terminal face,
- I recommend the Minister of Conservation takes steps by creation of a bylaw or bylaws to restrict or close public access to part of the National Park at the terminal face, I recommend that such action allows access in limited circumstances such as when a person is in the presence of an accredited guide, or a park ranger, or is authorised by a park ranger.
- I recommend that such measures apply at times when the [location] terminal face is considered particularly dangerous such as occurs when the glacial terminal face is upright as was its state in January 2009

NZ.2009.1971 & 3374 continued

- I further recommend that coupled with the making of such bylaws enforcement processes such as those included in a draft bill known as the Conservation (Authorisations Compliance and Enforcement) Bill be considered with particular reference to the imposition of infringement fees ("instant fines") for non-compliance.
- I further recommend that the Department of Conservation ensures through its accrediting procedures that guided groups in the [location] Valley be distinctively clothed so that at a distance it is clear that they are under the control of an accredited guide.

The above recommendations might also have application at the [location] Valley and terminal face.

NZ.2010.58 Leisure Activity/ Water Related

The deceased was visiting a beach where they were swimming and fishing. The weather started to get windy and waves became bigger. While searching for mussels on the rocks, the deceased was washed off the rocks and into the sea. Despite attempts to throw a life jacket to the deceased, he was swept away and his body discovered two weeks later.

Recommendations

The surf life-saving report contains recommendations to make this particular area safer for the public. I endorse those recommendations, and in turn recommend that those recommendations be implemented as soon as possible.

NZ.2008.1710 Mental Illness & Health/ Intentional Self-Harm

A mentally ill patient hung himself in his hospital room, and was unable to be revived.

Recommendations

The Court makes the following recommendations:

To: The Chief Executive Officer, Auckland District Health Board,

- That the Board give early consideration to a review of the document titled Increased Observations contained in its Mental Health Services Policy and Procedures Manual, with a view to providing better guidance to clinicians through the use of clearer language in the indications for increased observation at the varying levels set out therein and to striking a better balance in the Guiding Principles between the principle of patient autonomy and the need for decisive intervention in high risk situations. The document should emphasise the principle that patient safety must be the paramount consideration at all times.
- That patients with complex histories, whose progress is seen to be delayed, should undergo regular Multidisciplinary Team review and, if thought necessary, be referenced for independent psychiatric opinion/peer review

NZ.2008.2300 Mental Illness & Health/ Intentional Self-Harm

The deceased had been brought to the attention of police and mental health services by family as there were repeated threats of self-harm due to mental health issues and a relationship breakdown. The deceased was not admitted to hospital in the first instance, but on a subsequent visit to hospital, ran off and could not be located. The deceased was classed as a missing person and was found almost a month later having hung himself from a tree.

Recommendations

I endorse the recommendations made pursuant to the section 95 review, and they are included in the following recommendations.

- When a Duly Authorised Officer (DAO) receives a section 8A and 8B certificate, that officer should automatically be designated to be the responsible DAO and be responsible for ensuring immediate steps are taken on an *urgent* basis to see the process through to its conclusion. If that DAO is unable to see that process through as above, they are required to ensure that a replacement DAO is *immediately* (emphasis added) appointed N B: I have added in the words immediate and *urgent* (emphasis added) as I believe time is of the essence,

NZ.2008.2300 continued

- That both the Police and the Ministry of Health carry out an extensive review of the Memorandum of Understanding previously referred to in this Finding to ensure that both parties to it comply with the Mental Health Act, particularly focusing on the area of Police assistance in locating, assessing and transporting patients or proposed patients. That Memorandum needs clarity with respect to the need of a timeline priority to ensure the type of time lapses that occurred in [the deceased's] situation does not eventuate in the future,
- Where clinical reviews of sentinel or adverse events are undertaken these should be carried out by senior staff representing ill disciplines or professions whose conduct and judgement may be subject to review, i.e. if nurses are involved then a senior nurse should have input.
- The review should ensure that the perspective of service users and/or family be sought and given serious consideration during the review,
- That given the availability of the public to the worldwide net information, where a person comes to the attention of the Mental Health Authorities during a crisis situation and that person attributes their condition to a self-determined mental health syndrome (such as, but not restricted to, an Autism Spectrum Disorder (ASD) type analysis) the Mental Health Services, particularly where there is no known pre mental health record; note that a person's diagnosis when proceeding to deal with the matter, so as to ensure an all-encompassing diagnosis is made,
- That the Mental Health Directorate draw to the attention of the mental health staff to the ASD guidelines and commend it to such staff as a resource that they should become familiar with.

NZ.2008.3416 Mental Illness & Health/ Drug & Alcohol/ Intentional Self-Harm

The deceased had suffered from mental illness, including borderline personality disorder. The deceased had been suffering from chronic pain, including pelvic pain and migraine headaches, and had visited numerous doctors for pain relief. The deceased took these pills intentionally after a relationship breakdown and was discovered deceased in the home.

Recommendations

- That the [location] District Health Board review the usage of the names of the Crisis Assessment Treatment Team (CATT) teams so as to enable a clear delineation between the respective local Health Board's involvements with a patient/client.
- That the Health Board Authorities expedite the IT interconnection of a patient's medical records so that such material is instantaneously available to the medical staff when assessing a patient. Not only will this integrated approach be advantageous to both staff and patients in the longer term, it must be financially beneficial. It is noted however that this IT project is underway for the six District Health Boards within the lower North Island and that this should be implemented by 2014.

NZ.2009.1282 Mental Illness & Health/ Intentional Self-Harm

The deceased was suffering from mental health issues and marriage breakdown. This affected the deceased's work as a nurse and was moved to other duties away from front line nursing. The deceased was distraught at this and the marriage breakdown and subsequently took their own life by carbon monoxide poisoning.

Recommendations

- Having set out the above views, I recommend that when the District Health Board is faced with a medical staff member attending on its' own services with a mental health issue strict confidence should be maintained at all times and an alternative service provide the mental health care of that staff person.
- Secondly, again in relation to an employment determination of staff member who has been diagnosed with a mental health issue that is to affect employment, a more considerate method of delivering an employment determination be undertaken rather than a letter by way of a courier.

NZ.2009.1421**Mental Illness & Health/ Intentional Self-Harm**

The deceased suffered from long term mental illnesses including schizoaffective disorder and borderline personality disorder. The deceased had previously been hospitalised due to self-harm. The deceased had complained of being tired and short of breath shortly before being found deceased. The deceased had intentionally taken an overdose of anti-depressant medication.

Recommendations

Pursuant to section 57(3) of the Coroners Act 2006 I make the following comments and recommendations. The person the subject of this inquest had taken as much as 100 times the permitted level of the antidepressant drug venlafaxine. Clearly she had access to a large quantity of medication. I have recently completed another similar case. Database entries from the Ministry of Justice indicate overdose of the medication resulted in three deaths by suicide in New Zealand in 2007, and that venlafaxine is one of several medications involved in each of three other overdose deaths since 2008.

These cases are additional to the two cases I have referred to. I will refer these Findings to the Ministry of Health as to the incidence of venlafaxine overdose in comparison to deaths from other similar medications in the event that the above information gives rise to any concerns as to the availability and prescribing of the medication.

NZ.2009.3255**Mental illness & Health/ Intentional Self-Harm**

The deceased had suffered from mental health issues including delusions that people were trying to kill him. The deceased had presented to a police station with these delusions, and was assessed by mental health professionals who did not deem the deceased at risk, despite the mention of drinking anti-freeze. The deceased was not admitted to hospital and subsequently drank the anti-freeze 3 months later, and was discovered deceased.

Recommendations

I now need to turn to the issue of making recommendations as to matters of protocol.

One important thing that a Coroner can do is to make recommendations, having as their purpose the reduction of deaths in similar circumstances in the future. I have considered this aspect in relation to this decision very carefully, particularly because there is little point in making recommendations that are fanciful or artificial and which in consequence are simply unworkable and, therefore, useless.

In this regard I am indebted to the submissions of counsel for District Health Board (DHB) which I found both helpful, sensible and I might say, restrained. I make the following recommendations.

Firstly, that the Mental Health Service of the DHB should consider a review of the 'life time' of disclosure consent forms. I would suggest that they be restricted to a particular time span, say three to six months from the date of signing, unless revoked earlier by the patient.

Secondly, that the DHB should consider a process whereby when a patient is discharged from treatment on the basis or understanding that the patient will comply with an agreed course of action, whether as a condition of the discharge or not, there will be, at a minimum, some active follow-up by the DHB within a reasonable time to determine, so far as it is possible to determine, if there has been compliance, and, if so, the outcome. If there has not been compliance, there should be a proactive attempt, at the very least, to engage the patient further and [subject to the patient's consent] his family.

Thirdly, and this follows on from the second recommendation, if the DHB does in fact hold an unrevoked patient consent to disclose, then any lack of compliance with an agreed action discovered by the DHB should be disclosed to family.

NSW.2005.6130**Older Persons/ Natural Cause Death/ Mental Illness & Health**

An elderly person died from a large pulmonary embolus after falling in hospital. The deceased had presented at the hospital with blood in urine, severe depression and was unable to look after himself, after previously having been discharged from the same hospital.

Recommendations

- I therefore recommend the appointment of an overall person to be responsible for the holistic management of patients, such as [deceased], during their admission to [location] Base Hospital and [location] District Hospital.

NSW.2005.6130 continued

- I recommend the appointment of an overall person to be responsible for the implementation of the [location] District Hospital's plans/policies in relation to patient discharge (such as [deceased's] discharge).

NSW.2006.5701 Older Persons/ Natural Causes/Mental Illness & Health

An elderly person died from coronary heart disease and hypertension while in care at a hospital psychiatric unit.

Recommendations

- I recommend that NSW Health develop a guideline on time standards for assessments to be conducted by consultant psychiatrists of patients newly detained under the Mental Health Act.
- I recommend that, in the light of this case, NSW Health consider how best to implement the "Between the Flags" policy in psychiatric units and to review its policies to provide greater clarity as to the circumstances in which patients should be transferred from psychiatric units to medical wards and the process for doing so, with emphasis on enabling such transfers to be made readily and at too short notice.
- In particular, I recommend that NSW Health considers whether to introduce a policy that if any of the basic physical observations required (i.e. blood pressure, respiration rate, oxygen saturation level, temperature and pulse) are unable to be taken for any reason in relation to a patient in a psychiatric unit who may have significant medical conditions related to or in addition to the psychiatric reason for admission, the patient must be reviewed urgently by a medical registrar with a view to considering the patient's transfer to a more appropriate ward where such observations can be properly taken.
- I recommend that the Area Health Service investigate whether there remains a delay in the reporting of blood test results at the [location] Hospital or between the laboratories and [location] and, if necessary, take urgent remedial action.

NZ.2007.383 Older Persons/ Adverse Medical Effects/ Natural Causes

An older person died of congestive cardiac failure, with contributing causes being intractable right pleural effusion, cardiomegaly and Type 2 diabetes in hospital. It appears that there may have been toxicity to the digoxine that was administered in hospital, which counteracted with the Warfarin that the deceased was taking.

Recommendations

A copy of my finding be forwarded to [location] Hospital for future reference relating to possible medical interactions

NZ.2009.1397 Physical Health/ Natural Causes/ Adverse Medical Effects

The deceased suffered from asthma, and had called an ambulance citing breathing difficulties. There appeared to be technical issues which created delays in the ambulance attending, with the ambulance arriving 25 minutes after the call was made. The deceased was unable to be revived after going into cardiac arrest.

Recommendations

I recommend that this finding be circulated to St John Ambulance, to [location] Medical Centre and to Junction Health Limited for the information of each organisation and to ensure that the undertakings given are kept.

NZ.2009.2085 Sports Related/ Youth/ Falls/ Transport & Traffic Related

The deceased youth had been a flag marshal at a raceway meet. He was cleaning up for the day and being transported on the back tray of a ute. The driver moved sideways for another vehicle. The subsequent gear change caused the deceased to lose his balance and he has fallen off, hitting his head. The deceased did not regain consciousness.

NZ.2009.2085 continued

Recommendations

Pursuant to section 57(3) of the Coroners Act 2006, I recommend that MotorSport New Zealand:

- Ensures that its members adopt the rule change made by the [location] Car Club namely that "any person carrying out duties for and on behalf of [the club] that involves operating any of the club's vehicles are to hold a Full Driver's Licence".
- Makes a strong recommendation to its members that young volunteers do not ride on the rear of utilities or trucks. Those that do must ensure that they do so in the safest possible manner and with the full knowledge of the driver.
- Advises its members that supervision of young volunteers is necessary to ensure that tasks are done as required, and safely (to adopt the Department of Labour position).
- Amends its guidelines that in the event of an injury accident the two officials (clerk of the course and accident investigation steward) consult at the earliest opportunity and decide whether any further action is necessary, and this to include immediate notification to the police in the event of serious injury.

NT.2009.290 Transport & Traffic Related/ Drugs & Alcohol/ Law Enforcement/ Work Related

The deceased was a young person who was employed as a truck driver. He had been drinking and taking drugs recreationally. The deceased encountered a Random Breath Test (RBT) station while driving. The deceased chose to do a U-Turn and avoid the RBT. The police pursued the deceased who was speeding away. The car rolled and the deceased driving was thrown from the vehicle as he was not wearing a seat belt. The coroner has used the extended definition of 'custody' in this case as the deceased was being pursued actively by police at the time of his death and therefore falls into the 'extended definition of a death in custody'.

Recommendations

- That the Northern Territory Police Service Urgent Duty Driving and Pursuit Policy 2004 be comprehensively reviewed and rewritten.
- That consideration is given to including "non-pursuit" categories in the Policy, where the risks associated with engaging in pursuits cannot be objectively justified.
- That there is an increased focus on training and re-training for officers involved in applying the Urgent Duty Driving and Pursuit Policy. Only trained officers who have demonstrated that they understand and can apply the Policy should be involved in pursuits.

NZ.2009.85 Transport & Traffic Related

The deceased was riding a motorcycle when they crashed into a car that had been turning out of a driveway. The deceased did not have a motorcycle license and was not an experienced motorcycle rider. On travelling over a speed bump the deceased did not reduce speed, which culminated in the motorbike hitting a car that was turning slowly out of a driveway. The deceased was rushed to hospital but was unable to be revived. It was discovered that the deceased may have been affected by prescribed medication with a sedative effect.

Recommendations

- That the [location] City Council inspect [location of accident], and give consideration as to whether:
 - ◇ Trees on the grass verge and overhanging from private properties require trimming to improve visibility for drivers pulling out of driveways;
 - ◇ Parking on the roadside should be prohibited to improve visibility for drivers pulling out of driveways
- That [location] City Council posts advisory speed signs prior to any speed humps on [location] Road.

NZ.2009.1030 **Transport & Traffic Related/ Drugs & Alcohol**

The deceased was driving with two passengers when they were hit by a passenger train at a railway crossing. The driver, who had evidence of cannabis in the bloodstream may not have seen the train due to a hedge that could have blocked the view of the approaching train.

Recommendations

Pursuant to s57(3) of the Coroners Act 2006 I recommend that the rail authority (Ontrack - New Zealand Railways Corporation) and the road authority ([location] District Council) examine the safety aspects of the rail crossing at [location] with particular reference to the presence of a gorse hedge on the north side up to approximately 26.8 metres short of the railway line for vehicles approaching from the east [location highway].

NZ.2010.1397 **Transport & Traffic Related/ Drugs & Alcohol**

The deceased had been drinking and was lying on the train platform at [location] station. Due in some part to alcohol consumption, the deceased was unable to avoid an approaching train.

Recommendations

I recommend that a copy of this Finding be sent to Alcohol Advisory Council of New Zealand (ALAC) and to Professor [name], National Addictions Centre, [location]. Not all deaths associated with the consumption of excess amounts of alcohol are a result of motor vehicle crashes. Those persons consuming alcohol to excess must realise the other dangers to which they put themselves when unable to control the actions they take and the consequences of those actions.

TAS.2009.149 **Transport & Traffic Related/ Sports Related**

A person died from multiple blunt traumatic injuries in a motorcycle crash while participating at a motorcycle racing competition.

Recommendations

- Review of the location of the Flag Marshal at Turn 3.

It is clear in my view that having considered the race line and the direction of the track at this point, there is little opportunity for riders to observe a flag if being waved. The fact that only 1 of 18 riders observed the yellow flag highlights the ineffective placement of a Flag Marshal at the current location. I am aware of some suggestions that riders may have deliberately ignored the yellow flag through fear of losing their placing in the race. Whilst one or two may be of that mind (I hasten to add that I am unaware of any rider having this belief) I am not satisfied that professional riders would place themselves and other in jeopardy merely to maintain their placing in a particular event. I believe that such conduct would readily become known and such person or persons would be precluded from partaking in future events.

- Warning lights in lieu of or in addition to flags

It is obvious that the inability of riders to see the warning flag has played a significant role in the death of [deceased]. While I acknowledge that flag marshals have been used for many decades as a warning and instruction system for riders and in a vast majority of cases have provided a sufficient level of safety, race bikes have developed into precision machine and the clothing worn is now more like something that would be worn in out of space, I am concerned as to whether safety precautions have advanced at the same pace. Having toured the track at [location] it would seem that the placement of warning lights, either instead of or in addition to effectively placed flag marshals may reduce the likelihood of a similar situation as has taken the life of [deceased]. Having perused the 2009 Manual of Motor Sport, I note that Paragraph 12.13.0.3 provides that flag signals may be supplemented by light signals namely, 1 or 2 flashing yellow lights, green light, and a red light to correspond with the yellow, green and red flags currently used. The placement of lighting systems at flag marshal locations at various other locations around a track may reduce the number of incidents such as have occurred at [location].

- Run Off or 'Bus Stop' design between turn 3 and 4

In light of the concern raised by [name] I would recommend that an immediate review be undertaken of this section of the track with particular reference to the fact that riders will be accelerating along the stretch adjacent to it and the effect of the closeness of the barrier and air-fence. I make this recommendation in accordance with Section 28(2) of the Coroners Act 1995.

TAS.2009.149 continued

- Displaying of Red Flag

Under the current practice the responsibility of directing the display of the red flag rests in the Clerk of Course and as can be seen from the present Inquest, there was a delay of 17 seconds after the fall before the red flag was displayed and this being 8 - 8½ seconds after the collision between [competitor's] motorcycle and [deceased]. As I have found, this collision occurred 7 - 7½ seconds after the yellow flag was displayed. For that entire time of 7 - 7½ seconds, [deceased] was in a very dangerous location on the race line with a number of riders following that same race line. In my view there was ample time for a red flag to be displayed, and whilst it is highly unlikely that its display would have altered the outcome of this matter, it is a matter which should be addressed. It is equally clear that a time delay must occur with the relaying of information back and forth between a flag marshal and the Clerk of Course which increases the risk of a serious incident arising.

A method of overcoming this delay would be to give discretion to the Flag Marshal that where a rider has fallen and is on the track that without reference to the Clerk of Course that he either wave the red flag or activate the red light. While I acknowledge under the current rules a red flag causes the disruption of the race and requires a restart, it is my view that such an impost is of little significance if it saves a life. The concern which may be expressed as to such a discretion being used too readily could be addressed by adequate training of Flag Marshals.

- Accurate Recording and Investigation of Incidents during Race Meetings.

Motorcycling Australia should review the existing practice of recording incidents during race meetings. This Inquest has revealed that race incidents have not been accurately recorded. It is only with the accurate recording of these incidents that issues relating to track design may be highlighted and properly investigated. Whilst I have not found that track design is an issue in this Inquest, the availability of accurate records of incidents, such as high-side crashes, would be of significant benefit to race organisers to ensure tracks are as safe as practicable.

The importance of these recommendations can be gauged by posing the following question- "If Flag Marshal [name] had been located in a more efficient location, and if he had and had used a discretion to display a red flag, or more importantly, activate a red light, and if warning lights had been installed around the track, could the result have been different?." In my view, whilst one cannot speculate on such matters it is highly probable there would have been a different outcome.

VIC.2009.2681 Transport & Traffic Related/ Older Persons

An elderly pedestrian died from hitting their head on the ground after being hit by a car. The deceased also suffered from ischaemic cardiomyopathy.

Recommendations

- That Vic Roads may wish to review the access point from the side road into [location] Road as to its suitability and safe
- That Vic Roads give consideration to a reduction of the speed limit applicable to the section of [location] Road between [location] Road and the pedestrian crossing at [location] Park to 50 kilometres per hour.

VIC.2009.2712 Transport & Traffic Related/ Weather Related

A person lost control of their vehicle, not taking into consideration speed and road conditions after recent rain. The deceased's vehicle collided into another vehicle. The driver died at the scene.

Recommendations

It became apparent to me during the conduct of the Inquest, including my attendance at the scene for the purpose of conducting a view that the location where the accident occurred was and remains unique in a rural setting. The uniqueness stems from [a business's] close proximity to the bend and the associated movement of vehicles, including large slow moving transports in and out of [business].

These two factors when combined with interrupted lines of sight for vehicle travelling in both directions create an ongoing danger for road users. To reduce the dangers posed by the presence of [business] and its operations, I make the following recommendations which are directed to [location] City Council and Vicroads.

VIC.2009.2712 continued

Speed Limit Reduction:

Although the speed limit of 100kph appears to be generally an appropriate one for [location] Avenue that limit should be reduced to 80kph for an appropriate distance leading up to [business] for vehicles travelling in either direction.

In support of this recommendation I rely on:

- The opinion of Senior Sergeant [name] that a responsible road authority should look at reducing the speed limit
- The opinion of Senior Constable [name] that [location] Avenue in the vicinity of the bend and [business location] is not a suitable 100kph zone for west bound vehicles whether conditions are wet or dry.

He based his opinion on:

- The presence of [business] and the movement of heavy vehicles including large trucks in and out of their premises.
 - The rise and then fall of [location] Ave. for west bound traffic giving drivers less opportunity of observing the bend and [business] beyond it than would otherwise be the case.
 - The presence of undulations prior to, during and after the bend.
 - The presence of a clump of trees on the northern side of [location] Ave. at or close to the eastern end of [business] which obstructs or at least interferes with the line of sight that west bound drivers should ideally have of vehicles approaching [business] from the opposite direction.
 - The unanimous views of long term users of the road that the bend is not a 100kph bend.
- The results of speed histograms obtained in November 2001 and June 2009 which reveal that the 85th percentile speed in both instances was marginally below 100kph.

Improvement to sight line:

The clump of trees on the northern side of [location] Avenue at or close to the eastern end of [business] should be either removed or substantially thinned to improve the line of sight for vehicles travelling in either direction on [location] Ave. The trees in question are clearly depicted in photos SP10 and SP12 forming part of initial report.

Road Markings:

- An unbroken white line should be painted down the centre of the road prior to and around the bend to clearly delineate the west and east bound carriageways. In addition more guide posts should be added to the existing ones to further delineate the bend.

Road Signs:

- A sign carrying a warning of trucks entering the highway ahead should be placed east of the bend for west bound traffic and west of [business] for east bound traffic. The present sign posted east of the bend bearing the word TRUCK is inadequate for the purpose.

Pooling:

- Attention should be given to the northern edge of the bitumen road surface adjacent to the area where cars park at [business] to prevent the pooling of water falling heavy rainfall. The particular area referred to is clearly depicted in photos.

VIC.2010.87 **Transport & Traffic Related**

A motorcyclist died in a collision with an electric bicycle rider.

Recommendations

After the impact the bicycle helmet worn by the second deceased person was found some distance from the body and was severely damaged. It is clear that it was not adequately secured. Ironically [deceased] sustained the more serious head injuries, despite wearing a proper motorcycle helmet, which remained in situ throughout the collision and subsequent impacts.

The increasing availability and use of electric cycles of the scooter type may deceive some users as to the real dangers of riding them on the road. I recommend that an examination and analysis of injuries sustained by people using non-registrable electric or pedal-assisted electric cycles be undertaken to establish if there is an evidence based case for reviewing the laws with respect to their use.

WA.2008.1535 Transport & Traffic Related/ Drugs & Alcohol/Youth

A young person suffered from multiple injuries and incineration in a single vehicle car crash when their vehicle veered off the road and into a tree. The deceased was a night shift nurse who was experiencing sleeping problems and hay fever. The deceased was taking Doxylamine to alleviate both problems which may have caused drowsiness.

Recommendations

- I recommend that the Shire of [location] replace the existing warning sign on [location] Road advising of the end of the sealed section of road with a sign that is compliant with Australian Standards and is of the specified minimum size and constructed of the specified material.
- I recommend that WA Country Health Service take the following action –
 - ◇ Put in place appropriate policies to address the safety of staff who work shift work;
 - ◇ Monitor fatigue related crashes involving staff working shift work;
 - ◇ Put in place training and education to address fatigue related issues; and
 - ◇ Review accommodation throughout the state for staff working shifts with a view to ensuring, where possible, accommodation is available for staff who need to sleep prior to driving home.

NZ.2007.1553 Water Related/ Leisure Activity/ Physical Health

A qualified diver drowned after diving with a group to collect scallops from the sea bed. All four divers left the sea bed as a group, but the deceased and another diver experienced difficulties when resurfacing. It appears that the deceased may have suffered from asthma and was carrying a larger than normal amount of weight in the dive belt, which would have attributed to the deceased failing to resurface.

Recommendation

When considering the issues raised by [deceased's] death, I have looked at whether or not I should make a recommendation to tighten the regulation of recreational divers in an effort to reduce the number of deaths occurring. The New Zealand Underwater Association (NZUA) is strongly opposed to any tightening of regulations, particularly in relation to the current medical surveillance system, for a number of reasons. NZUA does recognise that an issue exists where divers may be medically cleared to begin their dive training but may then develop medical conditions subsequent to obtaining a course qualification. In my view this is exactly what has happened in [the deceased's] case. NZUA believes that this issue is best addressed by educating divers of the need for medical review at any time there are significant health changes.

I have also elicited the view of the Police National Dive Squad on the matter of the regulations governing recreational diving. The view expressed to me is that any regulatory imposition on recreational diving would be very difficult to police, and would be seen as restricting individuals rights to undertake an internationally recognised recreational activity. I have accepted that it would be very difficult to regulate recreational diving to the extent necessary to prevent further deaths occurring in similar circumstances to those in this case.

I do, however, endorse the proposal suggested by NZUA, and make the following recommendations in the hope that this will lend weight to the proposal:

- That all organisations involved in the training or operation of recreational underwater divers increase their efforts to educate all divers of the need to monitor their medical conditions and to seek medical advice concerning any medical conditions that arise to determine whether they should still continue to dive.
- That all such organisations referred to above make greater efforts to educate divers of the particular dangers applicable to divers who have breathing related medical conditions such as asthma.

These recommendations are directed to NZUA, and I hope that this organisation will disseminate these recommendations to all other organisations involved in recreational diving.

NZ.2009.1400 Water Related/ Leisure Activity/ Physical Health

The deceased had been fishing with family off rocks when they suddenly had a seizure and fell into the water. Despite the efforts of other fishermen and family members, the deceased drowned. The deceased had epilepsy but refused to take medication to treat this.

Recommendations

When embarking on a fishing expedition off the rocks on any beach in New Zealand, fishermen should be wearing a floatation device of some sort in the event that they are washed into the sea they have the ability to survive until proper assistance can be offered.

NZ.2009.2983 Water Related/ Leisure Activity/ Drugs & Alcohol/ Youth

The deceased youth had gone out with friends collecting seafood and scuba diving. The deceased did not have their own gear and hired some gear, but borrowed the rest, including the dive belt, from friends. The deceased began to have trouble with the mask, so surfaced. The deceased was then observed to be lying face down in the water and was unable to be revived. The deceased had consumed alcohol and cannabis prior to diving.

Recommendations

The issue was also raised about the obtaining of medical certificate as to fitness for persons undertaking recreational diving courses. As a result of [the deceased's] death, it is the recommendation of Constable [name] to the Department of Labour and Dive training establishments within New Zealand to ensure persons obtain a diving medical with input/comments from their family General Practitioner prior to completing every course (an individual's national history must be checked for contradictions to diving). The only exemption would be for courses completed within one calendar year of the last dive medical so long as no significant change in health has taken place.

I endorse the recommendation made by Constable [name] directed to the Department of Labour and dive training establishments within New Zealand.

NZ.2010.64 Water Related/ Leisure Activity

The deceased tourist drowned on the {location} river after the raft in which family were rafting on flipped and the deceased was pinned underneath the water by a large rock.

Recommendations

I have no specific recommendations to make. Recreational users on moving water must be aware of their capabilities, the capabilities of their equipment and the dangers presented by moving water. Despite all reasonable precautions being taken, tragedies can and do occur.

NZ.2010.275 Water Related/Leisure Activity/ Weather Related

The deceased was a regular diver, and had completed around thirty-seven dives in a two year period. The conditions involved heavy seas, dirty water and not much light, yet the divers continued with their dive to source paua. The deceased was located about thirty minutes later face down in the water and was not able to be revived.

Recommendation

[The deceased's] equipment was tested and a report was completed by Constable [name] of the Police National Dive Squad, [location]. In his report Constable [name] referred to ten points following examinations of [the deceased's] diving equipment. Constable [name] makes the following recommendations for recreational divers:

NZ.2010.275 continued

- Ensure that divers plan to be on the surface at 50 Bar.
 - That all dives should be conducted with a dive buddy.
 - Divers should monitor their gauges throughout the dive.
 - Divers should ensure they have the correct amount of weight at the start of the dive.
 - Divers regularly service their dive equipment to ensure the performance.
 - Complete pre-dive equipment function tests.
 - All divers are to carry a dive knife.
 - All dive stores are to have current air purity certificates.
 - Divers must check and monitor weather/sea conditions and if in doubt not go out
- I endorse those recommendations.

NZ.2010.353 **Water Related/ Leisure Activity**

The deceased was fishing from rocks and was swept from the rocks by a large wave into the sea, where they subsequently drowned.

Recommendations

I recommend that appropriate publicity be given to the dangers of rock fishing, specifically in and around Cape [location], recognising the dangerous weather and sea conditions likely to prevail there.

Before any attempt is made to venture on to the rocks at the foot of Cape [location], any person proposing to fish ought first to investigate, thoroughly, the prevailing weather conditions, as well as the future weather conditions, and sea conditions, and ought also to take the time to observe sea and swell conditions for a period from a position well above sea level prior to exposing themselves to danger on the rocks.

I recommend that the [location] Peninsula Coastguard continue with their efforts in erecting appropriate warning signage and installing safety equipment at Cape [location] in the hope that this may prevent a further tragedy.

TAS.2010.152 **Water Related/ Leisure Activity**

A person died from saltwater drowning after a dinghy in poor condition capsized. The deceased was not wearing a lifejacket at the time.

Recommendations

The dinghy was in poor condition and assessed by the Manager Vessel Standards and Survey, Marine and Safety Tasmania, as being unseaworthy. Of particular relevance was the fact that both forward and after buoyancy compartments were damaged so as to render them ineffective resulting in the boat not being able to float if it were swamped. If this buoyancy had been in proper condition the boat would have been able to support [deceased and friend] until help arrived. Persons using any form of boat or persons providing such craft to others to use ought to ensure that the craft is seaworthy and safe for its intended use.

Although there was no obligation at law for [deceased] or [friend] to wear life jackets, this tragedy highlights that accidents can happen in light weather conditions in close proximity to shore. Legislative requirements ought be treated as the minimum safety requirements and persons taking part in water based activities should take all reasonable steps that they assess as being necessary to ensure their safety.

NSW.2009.2165**Work Related**

A person died from traumatic asphyxia while doing excavation as part of the deceased's occupation.

Recommendations:

To prevent this type of incident reoccurring, Workcover NSW recommends that:

- That persons undertaking excavation work follow the Code of Practice for Excavation Work which provides guidance to prevent injury to persons engaged in excavation work. In particular section 3.1 "Prevention of collapse or failure of trenches and excavations" outlines that incidents have occurred in the past as a result of the inability of the soil to stand by itself for the duration of the work and as a result of decisions taken by persons with insufficient expertise in the area of soil stability. The Code outlines the importance of seeking advice from qualified engineers, undertaking a geotechnical analysis and the engagement of a competent person to supervise the progress of the excavation work where the pre work assessment identifies the risk of an unstable condition.
- That persons undertaking excavation work ensure that there is an adequate system of shoring, benching or battering to control the risks arising from:
 - ◇ The fall or dislodgement of earth and rock,
 - ◇ The instability of the excavation or any adjoining structure,
 - ◇ The inrush of water
 - ◇ The placement of excavated material,
 - ◇ Instability due to persons or plant working adjacent to the excavation.
- That persons undertaking excavation work ensure that adequate measures are taken in the immediate vicinity of excavation work so as to prevent the collapse of the work. In particular, an employer must ensure that no materials are placed, stacked or moved near the edge of excavation work so as to cause the collapse of the work.
- That persons undertaking excavation work control unauthorised access to the excavation by ensuring that perimeter fencing is provided.

NZ.2009.1456**Work Related/ Water Related**

The deceased was undertaking installation work on a wharf structure, below the level of the platform and over the water. The deceased was attached by a harness to a ladder that needed to be repositioned as the work continued. The ladder became detached from the wharf and fell into the water. The deceased was attached to the ladder and was unable to get free and drowned, despite efforts from his work colleague to find them in the murky water.

Recommendations

From the evidence presented at the inquest, it was apparent that [company] and [company] lacked comprehensive formal guidelines or standard operating procedures with regards to safety issues for employees and contractors engaged in performing work over water at heights. Both organisations appear to have delegated to the employees or contractors the responsibility for their own safety while performing such work, although whatever safety equipment was considered appropriate was made available to such employees or contractors. I accept that ultimately it is up to such employees or contractors to ensure their own safety, but in my view their employers and principals should provide a very strong and effective process for identifying hazards and for mitigating the risks posed by such hazards. To be robust, such a process should be documented in a site-specific safety plan, and should incorporate (inter alia) appropriate safety equipment, training in the use of such equipment, and a requirement for another worker to check the integrity of safety equipment being relied on by any person to prevent them falling into the water.

I note comments made by [company] management that [the deceased's] death has prompted a review of [company's] policies and procedures relating to engaging contractors and to safety issues. I commend [company] on this initiative, but feel that it is appropriate to make some recommendations in the hope that such recommendations may reduce the risk of further deaths occur in similar circumstances.

NZ.2009.1456 continued

I therefore make the following recommendations:

- That [company] and [company] draw up guidelines for the appropriate identification of hazards for employees or contractors carrying out work over water;
- That [company] and [company] draw up guidelines for employees and contractors working over water, and consider requiring such employees or contractors:
 - ◇ To be secured to an appropriate structure by an appropriate primary and secondary securing system; and
 - ◇ To wear a lifejacket; and
 - ◇ To have another worker check the integrity of safety equipment being relied on by any person to save them from falling into the water.

These recommendations are directed to [company] and to [company].

NSW.2006.6017 Youth/ Water Related/ Misadventure/ Homicide & Assault

A young person was found dead in a dam on a property, where a party was held in which drugs and alcohol was consumed. It is not apparent at this time what caused the deceased's death and whether they were the victim of suspicious circumstances or misadventure.

Recommendations

Although [deceased's] family contend for a recommendation for a protocol that freshwater deaths ought to be treated as suspicious and other measures to preserve relevant forensic material and improve dialogue between investigators and pathologists, I am unpersuaded of the utility of such a recommendation, given the breath of incidences that would be caught by it, and the number of existing protocols that are currently attached to death related investigations.

The New South Wales Commissioner of Police should give consideration to negotiating a Charter of Agreement between himself and the Queensland Commissioner of Police in relation to the shared use of each Service's police diver resources in the areas close to the New South Wales / Queensland border, similar to the Charter of Agreement apparently in place between the New South Wales Commissioner of Police and the Victorian Commissioner of Police in relation to the shared use of each Service's police diver resources in the areas close to the New South Wales / Victorian border.

The Officer in Charge of this Coronial investigation is to forward a file of the evidence in this matter to the Cold Case Division of the Homicide Squad. I further recommend that these investigators assess the viability of diatom testing of retained physical samples, in consultation with [name], Curtin University, Western Australia.

NZ.2008.3050 Youth/ Transport & Traffic Related

The deceased youth was sitting on a beach with a friend when a motorcycle being ridden on the beach struck them. The deceased was not able to be revived.

Recommendations

The most immediate redress is to have a higher police presence during peak times. This is on top of a stretched police force.

The issue of driving on beaches can only be resolved by the input of the local community and the legislative process is passing laws whether it is locally or nationally. Therefore, I would invite local leaders and MP's to call for public debate. It will not be an easy process.

NCIS - FATAL FACTS WEB TOOL CATEGORY TAGS

CATEGORY TAG	DESCRIPTION
Adverse Medical Effects	Adverse after effects from a recent medical or surgical treatment, failure to comply with medical advice
Aged Care	Incidents that occurred in an Aged Care or assisted living facility or residence including a retirement village
Animal	Incidents where the an animal was involved in the cause of death.
Child & Infant Death	Any case involving a child or infant - 12 years old and under
Domestic Incident	Fatal incident that occurred as a result of domestic injury or event
Drugs & Alcohol	Death where drugs or alcohol or both were a primary or secondary cause of death
Electrocution	Cases where electrocution is the primary cause of death
Falls	Incidents where a fall was involved in the circumstances or cause of death
Fire Related	Incidents where a fire was involved in the circumstances or cause of death
Geographic	Cases where the geographic region is significant to the cause of death eg - remote location
Homicide & Assault	Includes interpersonal violence and family domestic violence
Indigenous	Cases related to a specific demographic group
Intentional Self-Harm	Cases determined ISH by coronial investigation
Law Enforcement	Includes police pursuit, death in custody, parole issues, pending or previous court cases including family court, restraining order and coronial investigation procedures.
Leisure activity	Any leisure actively that directly influence the circumstances including holiday activity or location
Location	Cases where the location of either the incident or the discovery of the body is of significance, does not refer to geographic location
Mental Illness & Health	Incidents where the existence of mental illness issues were involved in the circumstance on death, both diagnosed and anecdotal. Please note mental health is included as a contributing factor to death at the discretion of the Coroner.
Misadventure	Risk taking behaviour such as train-surfing, unintentional drug overdose
Natural Cause Death	Cases where the death is due to natural causes
Older Persons	Cases related to a specific demographic group or where the age of a person was a factor in the death.
Physical Health	Cases where the existing physical health of the person contributed but were not necessarily cause the death
Sports Related	Cases where a sports incident significantly impacted the cause of death.
Transport & Traffic Related	Cases involving road, water and air vehicle incidents, motorised or naturally powered. Also include cases where pedestrians are impacted by transport vehicles.
Water Related	Includes swimming, scuba, snorkelling, boating, fishing and all water related activity in both a recreational or commercial context
Weather related	Cases where the environmental conditions such as heatwave or storm conditions were significant to the cause of death
Work Related	Includes cases where work is related to the death and also where unemployment is significant
Weapon	Cases where the involvement of a weapon is significant
Youth	Cases related to a specific demographic group