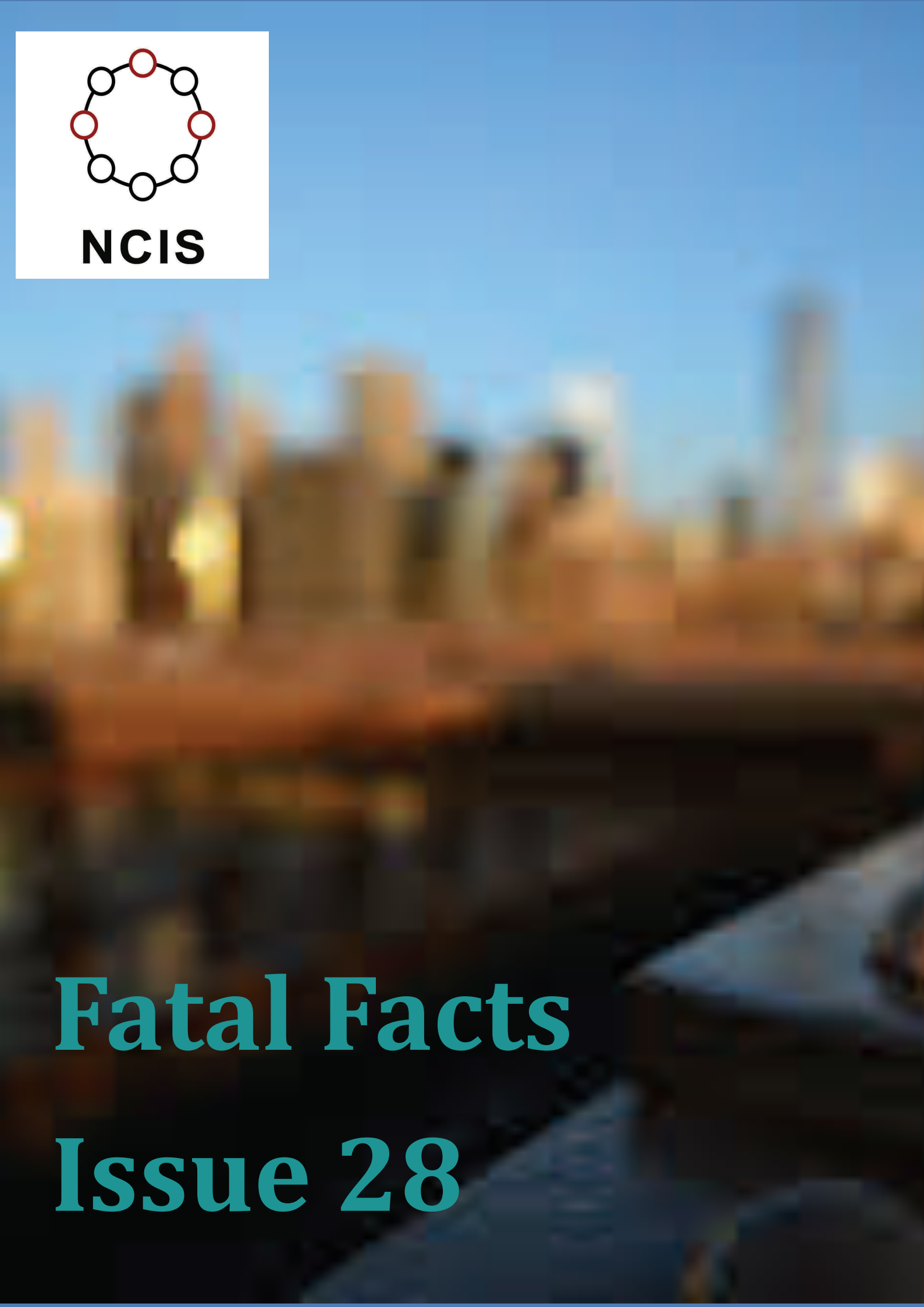

NCIS

Fatal Facts

Issue 28

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 March 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.

VICTORIA State Government | 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 28 February 2016

In this Edition

Fatal Facts Edition 28 includes cases where the investigation is complete and where the Coronial Finding contains recommendations. Edition 28 includes cases that were closed between 1 January and 31 March 2011. *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 28 contains summaries of cases where recommendations were made as part of the formal coronial finding. Of these cases, 45 are Australian cases and 40 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.

All case summaries in this edition are available on Fatal Facts Search, accessible via the NCIS website.

What is a Coronial Inquest?

An inquest is a 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.2009.6095 Adverse Medical Effects/ Child & Infant Death

A baby died two days after delivery from a subgaleal haemorrhage caused to position of forceps, and traction and by compression force used during delivery.

Recommendations:

I recommend that all women when admitted to a birthing centre have discussed with them the pros and cons of having a vaginal examination to evaluate and provide a baseline for the progress of their labour.

NZ.2009.3601 Adverse Medical Effects/ Natural Causes

The deceased had presented at hospital with chest pain. This was diagnosed as muscular-skeletal pain and she was discharged. The deceased died a week later from a heart attack in her home.

Recommendations:

I recommend that [location] Hospital:

- Review its troponin testing protocols to ensure that clinical errors such as that identified in the review do not recur and to ensure that samples taken are forwarded to an appropriate laboratory for further testing as required
- Review the operation of its ECG machine to ensure that it operates to an appropriate standard in future.
- Give consideration be given to ensuring that patients presenting with pain which could be of cardiac origin undergo a stress test within 72 hours and the hospital investigate methods of ensuring such a service is available.

TAS.2008.370 Adverse Medical Effects

The deceased had undergone a stent placement and an angioplasty at hospital, but was discharged the next day. Once home, the deceased complained about pain in the abdomen. The deceased was found dead a day later from a laceration in the left external iliac artery that was sustained during surgery and caused a haematoma.

Recommendation

One recommendation that I do make concerns the information that may or may not have been given to the deceased and her carer upon discharge. I am unaware of what information may have been provided but I believe it is of fundamental importance that following medical procedures, in particular, surgical procedures, that patients and those to whom care they are discharged are advised what to do and who to contact when there is a deterioration in their health subsequent to discharge. This is especially the case where the procedure has not proceeded in the range of normal expectation with some form of complication as in this case. I am unaware of whether the deceased was given such advice but if she had and had heeded that advice when she first exhibited signs of distress during the afternoon on [date] it is possible that the outcome for her may have been different.

TAS.2009.57 Adverse Medical Effects/ Drugs & Alcohol

The deceased died of mixed drug toxicity after receiving pain relief in hospital after undergoing simultaneous knee joint replacements.

Recommendation

It is noted that this investigation has identified an instance occurring on [date] where hospital staff have not fully completed the entry in the drug charts to show the dosage administered to the deceased. Further, it is not clear from the records whether the dose of morphine prescribed for the deceased in the morning of [date] was delivered in the manner directed. Although these matters did not play any role in the deceased's death, they nevertheless lead me, particularly coupled with the nursing staff's failure to promptly cease the administration of the ropivacaine, to recommend that [the hospital] undertake a comprehensive review of its drug administration processes with a view to eliminating errors of this nature.

NSW.2009.376 Child & Infant Death/ Water Related

A six year old child drowned in the family's inflatable backyard swimming pool.

Recommendations

To: The Minister for Fair Trading
That all retailers of inflatable or portable pools that can be set up at home for personal use and which are capable of holding water over 300mm deep be required by law to inform the purchaser thereof that the safety provisions of the Swimming Pools Act 1992 apply to such pools and that, in particular, such pools must be fenced.

To: The Minister for Human Services
That an understanding of the safety provisions of the Swimming Pools Act 1992 be included as part of the training of community service officers who undertake client home visits as part of their duties.

NSW.2010.303 Child & Infant Death/ Transport & Traffic Related/ Leisure Activity

A child died while fishing after a car rolled back on to him, causing crush injuries. The car was unmanned at the time, and the driver had been assisting a friend with maintenance on a crane when the car rolled back.

Recommendations

Given [the deceased's] family's experience of frustration and lack of information, I recommend that any review of the protocol consider a formal notification process to the deceased's or victim's family or the Coroner setting out the reasons for such determination.

This leads me to the final issue for which I make a recommendation. The act of leaving a vehicle unsecured is an offence under the Road Rules. It only has a (minor) financial penalty. Specifically:

ROAD RULES 2008 - REG 213
Making a motor vehicle secure
213 Making a motor vehicle secure
(1) This rule applies to the driver of a motor vehicle who stops and leaves the vehicle on a road, except so far as the driver is exempt from this rule by an exemption order under rule 213-1.
Note: "Motor vehicle" is defined in the Dictionary.
Note: Sub rule (1) is not uniform with the corresponding sub rule in rule 213 of the *Australian Road Rules.* However, the corresponding sub rule in the *Australian Road Rules* allows another law of this jurisdiction to provide for drivers to be exempted from this rule. Different rules may apply in other Australian jurisdictions.
(2) Before leaving the vehicle, the driver must apply the parking brake effectively or, if weather conditions (for example, snow) would prevent the effective operation of the parking brake, effectively restrain the motor vehicle's movement in another way.
Maximum penalty: 20 penalty units.
(3) If the driver will be over 3 metres from the closest part of the vehicle, the driver must switch off the engine before leaving the vehicle.
Maximum penalty: 20 penalty units.
(4) If the driver will be over 3 metres from the closest part of the vehicle, and:
(i) There is no-one left in the vehicle, or
(ii) There is only a child or children under 16 years old left in the vehicle, the driver must remove the ignition key before leaving the vehicle.
Maximum penalty: 20 penalty units.
(5) If the driver will be over 3 metres from the closest part of the vehicle and there is no-one left in the vehicle, the driver must:
(a) If the windows of the vehicle can be secured-secure the windows immediately before leaving the vehicle, and
(b) If the doors of the vehicle can be locked-lock the doors immediately after leaving the vehicle.
Maximum penalty: 20 penalty units.
Note: "Window" is defined in the Dictionary.
(6) For the purposes of sub rule (5), a window is secure even if it is open by up to 2 centimetres.

NSW.2010.303 continued

Section 42 of the Road Transport (Safety and Traffic Management) Act 1999 provides for the offence of negligent driving occasioning death. It is a criminal offence carrying a sentence of imprisonment and or financial penalty. The section would not apply to this incident because the vehicle was not being driven nor was [name] at the time, the driver.

I recommend the Attorney General give consideration to creating a criminal offence where an act of failing to secure a vehicle occasions death or grievous bodily harm.

NZ.2008.2378 Child & Infant Death/ Transport & Traffic Related

The deceased child had been dropped off in a church car park with other siblings, and they have all ran towards the church. The deceased then returned to the car for unknown reasons, and without anyone noticing. The deceased's father moved the car forward, not noticing the deceased who was struck by the vehicle, causing death

Recommendations

That the Board of Management and Congregational Members of the [name] Church [address], immediately:

- Obtain a consulting engineers report to implement a safely designed and constructed car park area between the church frontage and recreation building - that car park to have marked designated parking bays.
- That unless commercial deliveries are being made, that particular area of car park to be restricted for usage only when full congregational meetings are being held and that at that time a warden be instructed to monitor the safe parking of vehicles.

NZ.2009.4001 Child & Infant Death

The infant deceased was found not breathing at home, after co-sleeping with an adult between two pillows on a bed.

Recommendations

I consider it important to reiterate the message that bed sharing by adults with infants exposes the infant to the risk of death and should be avoided for every sleep. Recent coronial decisions have made recommendations to the Ministry of Health aimed at ensuring that public health advice in relation to safe infant care practices and safe sleeping environments are strengthened, broadened and consistent among public health educators and health professionals so as to make it clear that bed sharing with infants should be avoided. Accordingly, a copy of these Findings will be sent to the Ministry of Health to consider in the context of these previous recommendations regarding bed sharing.

TAS.2009.334 Child & Infant Deaths/ Physical Health/ Adverse Medical Effects

The deceased child, who had been born with mild autism, short neck and congenital fusion of the vertebrae, contracted swine flu (viral pneumonia) and died. The child had been tested for viral pneumonia in hospital but it was a negative result, so she was discharged from hospital. An ambulance was then called when the deceased began to deteriorate, however it did not arrive within 40 minutes, and a further ambulance had to be called. The deceased was taken to hospital but was unable to recover.

Recommendations

The following recommendations followed the completion of the Serious Incident investigation.

- All communications staff should be required to obtain and maintain currency in Advanced Medical Priority Dispatch Service (AMPDS) or other dispatch program's accreditation.
- AMPDS to be utilised as a mandatory patient prioritisation system for all ambulance response service. Variation of an AMPDS classification should only be made by an approved clinician. Operational policies should be updated to ensure that clear direction is provided to staff in prioritisation of cases.
- Appoint a Quality Support Coordinator to undertake audit, training and mentoring for communications staff in the use of AMPDS. Tasmanian Ambulance Service (TAS) should review its current case classification and consideration be given to aligning the classification to the 4 classifications set by AMPDS.
- TAS should adopt an accredited communications officer training program. This program should be offered to all current communications staff and become a mandatory requirement for all new staff.
- The position of senior communications officer needs to be reviewed to ensure that the role provides support, coaching and mentoring to all communications staff.
- All staff, when acting in senior roles should be given sufficient orientation and training to enable them to undertake all aspects of that role.

TAS.2009.334 *continued*

I find that in this case the response by the Tasmanian Ambulance Service was not in accord with acceptable guidelines. I am satisfied that the Serious Incident investigation carried out by [name] National Academies of Emergency Dispatch has adequately addressed the identifiable shortcomings in this response. I accept and adopt the recommendations which flowed from this investigation and urge the prompt implementation of all of those recommendations.

WA.2007.77 Child & Infant Death/ Adverse Medical Effects

The deceased infant was born with a congenital heart defect that was corrected via surgery. The infant was sent home from a large hospital, to be monitored at a smaller hospital. The parents presented the infant to the local hospital with a high temperature, and was sent home by a nurse without seeing a doctor, or told to take the baby to another hospital. The 3 month old infant later died of a cardiac arrhythmia.

Recommendations

I recommend that if operation circular 1485/01 is altered, the guidelines contain a similar attached list which, like the existing list, is very clear and easy to understand.

I further recommend that any list of patients to be notified to a doctor by accident and emergency triage nursing staff continue to include infants up to the age of 6 months and children up to the age of 5 years with pyrexia.

NZ.2010.1497 Drugs & Alcohol

The deceased had gone to watch the V8 Supercar race and consumed alcohol while at the event. She had also taken herbal party pills. Once the deceased and a friend have arrived home, they have consumed more alcohol and the deceased has smoked a small amount of cannabis. The deceased then complained of a headache and went to lie down. Throughout the night, the deceased vomited, and commented that she felt better by doing so. However she was found struggling for breath, body rigid. The ambulance was called and the deceased was rushed to hospital but it was found she was brain dead. Care was withdrawn and the deceased died shortly after.

Recommendations

[The deceased's] death highlights the dangers of people ingesting herbal party pills, smoking an illicit drug, consuming alcohol and taking medication when the combined effects of these substances is unknown. Since completing this inquest, I have become aware of a news article, dated 22 December 2010, referring to two other people suffering adverse side effects after ingesting legal party pills. A twenty-one-year-old man suffered a large brain haemorrhage, and is still recovering. Another man of unknown age was reported to have also suffered a brain haemorrhage after taking a particular pill. The article suggests that people who took these party pills were playing 'Russian roulette', because of the unknown effects they can have. I endorse the sentiment expressed in this article, and voice my great concern that these party pills can be legally acquired without adequate warning to the public of potentially serious side effects.

I make the following recommendation:

- That the appropriate regulatory agency review the safety of all party pills with a view to either banning the sale of such party pills or at least requiring the packaging of such party pills to contain a warning of potentially serious side effects.

This recommendation is directed to all government agencies having involvement in the approval for sale of substances within New Zealand.

TAS.2009.346 Drugs & Alcohol

The deceased was a methadone user and had a history of self-harm. The deceased died as a result of combined drug intoxication (including fluoxetine, methadone, oxycodone and diazepam).

Recommendations

This is another unfortunate case where a person has combined the use of prescribed drugs with illicit drugs and the combination has proved fatal.

TAS.2009.346 *continued*

Although the outcome in this case may not have been affected it is of concern that the new Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards first proposed some years ago has apparently not been implemented. This policy was to replace the present Tasmanian Methadone Policy 2000 and address many of the shortfalls of that earlier Policy. It is surely in the interests of public health that any improved revised model be implemented as soon as possible.

The continued ready illicit access to prescribed Schedule 8 medications such as Oxycontin has been highlighted in a number of coronial findings over the last 5 years. I encourage those involved in the roll-out of the real time reporting capability of the supply of prescribed Schedule 8 drugs and the improvement of clinical decision making by medical practitioners in relation to opioid prescribing to bring those projects to the desired conclusion as soon as possible.

VIC.2008.5210 Drugs & Alcohol/ Adverse Medical Effects

The deceased was discovered unresponsive on the floor of the bedroom, along with drug paraphernalia and empty bottles of methadone. The deceased was on a methadone program and had been given takeaway doses for 28 days, as the deceased worked interstate.

Recommendations

- That the responsible regulatory authorities, The Department of Human Services (Victoria) and the Department of Health (Victoria), establish a clear mechanism of supervision of the safety arrangements for take away dosage of methadone.
- That there be a prohibition upon take away methadone dosage unless responsible regulatory authorities, the Department of Human Services (Victoria) and the Department of Health (Victoria), are satisfied that safe storage arrangements are in place in the premises in which the drug is to be stored.
- That the responsible Minister/s give consideration to legislative amendment if necessary to enable the implementation of appropriate levels of supervision and safety arrangements.
- That the responsible Minister/s give consideration to legislative amendment if necessary to enable the provision of health information, such as overdose events or drug related arrests, to the General Practitioner supervising a patient's pharmacotherapy program such as the methadone maintenance program.
- I direct that a copy of these findings be provided to: The Honourable Nicola Roxon MP, Minister For Health (Commonwealth); The Honourable Mr David Davis MLC Minister for Health (Victoria); The Honourable Ms Mary Wooldridge MP, Minister for Community Services Victoria; The Secretary, Department of Human Services (Victoria); The Secretary, Department of Health (Victoria); The Health Practitioner's Board of Australia (Victoria); The Pharmacy Board of Australia (Victorian Branch); The Medical Practitioners Board of Victoria; The Pharmacy Guild of Australia (Victorian Branch) and The Australian Medical Association (Victorian Branch).

VIC.2010.802 Electrocution/ Older Persons

An elderly person had gone through a manhole into a roof cavity to connect a TV antenna. The wiring in the house was extremely old and the power had not been turned off prior to the deceased going into the roof, and the deceased was electrocuted.

Recommendations

Energy Safe Victoria (ESV) have an opportunity not only via its own publications, but also via influence or involvement in apprentice education for review of educational material at trade school, in respect of the risks and corrective procedures identified in these findings.

- I would recommend that ESV take every opportunity to increase emphasis upon safety risks with ageing and old electrical connections and fittings so the prospect of avoiding this sort of risk and death may be reduced by involvement in trade education and its own publications, online and in print.
- ESV should also review its website and publication strategies, with a view to placing further emphasis upon risks to public health and safety, especially to the ordinary home owner or occupier which arise in circumstances illustrated by [deceased's] death. Also review its presentation of, and commitment to, the Home Safety Inspection Program.
- It is a prudent and sensible step for any person who may be considering the purchase of a home, either constructed before the 1960 s, or at all, to consider a pre-purchase electrical inspection. Such steps are not uncommon with retention of builders or engineers to advise of structural risks and maintenance or repair costs which may come with a property. Similar identification of safety and costs risks with respect to electrical safety should be considered by purchasers and those who advise them.

VIC.2010.802 continued

- To the extent solicitors are involved in advising purchasers of homes and buildings, regarding proper enquiries upon, or disclosure by Vendors, any practice, either undertaken informally within the legal profession, or otherwise by additional formal legal procedure, should be considered. In this context, I recommend that any Conveyancing Committee or Property Law Group within the Law Institute of Victoria, and ESV, give consideration to the merits of Vendor Certificates of electrical safety, and/or regular procedures for enquiry or investigation of electrical safety by purchasers of specific (or all) buildings and/or for other review strategies upon sale and purchase of relevant buildings. To minimize or avoid risks to health and safety as occurred here.
- Community awareness of the existence and type of risks to safety identified in respect of the death of [the deceased] by any means, may well assist others in avoiding such risks, and/or in the appreciation of them resulting in remedial action at an earlier date.
- Accordingly, magazines or other publications, also home renovation publications, as well as weekend or daily magazine or newspaper publication of these findings regarding the avoidable circumstances of this death may well also assist in wider public awareness of risks.

WA.2009.1222 Electrocution/ Child & Infant Death/ Indigenous

A two year old child died of electrocution after crawling through a hole in the wall in a Department of Housing home and touching an exposed steel frame and an electrical cord. The child received a fatal 240 volt electric shock.

Recommendations

- I recommend that the limitation period for offences contrary to regulation 52(3) of the Electricity (Licensing) Regulations 1991 be amended so that the period of limitation commences to run from the time when the regulator becomes aware of a suspected breach rather than from the date on which the offence is alleged to have been committed
- I recommend that consideration be given as to whether there is proper cause for disciplinary action in respect of [name] in accordance with regulation 30 of the Electricity (Licensing) Regulations 1991.
- I recommend that consideration be given as to whether there is proper cause for disciplinary action in respect of [name] in accordance with regulation 30 of the electricity (licensing) regulations 1991
- I recommend that the Department of Housing complete regular electrical audits of its properties to ensure that electrical safety is being provided to its tenants
- I recommend that the Department of Housing ensure that its officers inspecting properties are able to identify Residual-Current Devices (RCDs) and can ensure RCDs are in place and appear to be in operating condition. Those officers should also be able to identify obviously unsafe electrical fixtures or fittings.
- I recommend that in future when the Department of Housing engages electrical contractors to carry out electrical works on its tenanted properties the terms of engagement require those electrical contractors to report any absences of RCDs or other issues bearing an electrical safety which come to their attention.

NSW.2009.3657 Falls/ Law Enforcement

While being chased by police for trespassing, the deceased fell from a stone wall into a concrete car park below, suffering blunt force trauma.

Recommendations

I recommend that the [location] Hotel investigate modifying its Northern Boundary Wall, subject to any heritage restrictions, to minimise the risk of that wall being climbed in future, and implement such a scheme.

NZ.2009.3770 Falls/ Older Persons

The elderly deceased was standing outside on a flat surface, when she fell, hitting her head on cobblestone ground. The deceased started vomiting, and had instant swelling and significant blood loss. An ambulance was called and took the deceased to hospital, and despite being treated for the injuries to her head and hip, her condition deteriorated and she passed away.

NZ.2009.3770 continued

Recommendations

This case highlights the need for clinicians to make thorough enquiries regarding a patient's history upon presentation. It also demonstrates the need for enquiries to go beyond the patient alone, in situations where the circumstances indicate the possibility of confusion. It may also suggest the need for tightening up the handover procedures from St John ambulance personnel to emergency department personnel, although in this case there was a comprehensive patient report form provided by St John ambulance crew to the ED. It may be that the triage nurse should have drawn [doctor's] attention to the reference to vomiting contained in that patient report form.

I mention these matters in the hope that both St John and the [location] District Health Board will undertake a review of their procedures for the handover of patients to determine whether such procedures are sufficient to prevent any gaps in knowledge of a patient's history for the ED clinicians. I have stopped short of making a recommendation with regard to the matters stated above as I suspect that such procedures are currently adequate and appropriate, although I do not have any direct evidence on the issue. I am confident that my comments alone will initiate a consideration by the respective organisations as to whether or not a formal review is required.

With regards to the procedures related to requesting a CT scan for patients presenting with a head injury, I make the following recommendations:

- That all clinicians should adopt a very low threshold in deciding whether to request a CT scan for elderly patients presenting with a head injury.

This recommendation is directed to all District Health Boards and to the Medical Council of New Zealand, for dissemination to all hospitals and doctors in private practice.

NZ.2010.2714 Falls/ Leisure Activity

The deceased suffered a fall on an ice skating rink while assisting as a parent helper. The deceased hit her head solidly on the ice. Medical attention was sought the next day and she was admitted to hospital, where multiple scans and hourly observations were conducted. However the deceased's condition deteriorated, and she was unable to be resuscitated.

Recommendations

The case highlights the importance of wearing protective helmets in an ice skating situation, not only for beginner or inexperienced skaters, but for all skaters.

ii. As highlighted by the Department of Labour, accident data relating to ice skating injuries is not held or reviewed by any independent or central body, so the true incidence of accidents may not be recognised within the industry.

iii. The initiative taken by the skating rink operator in providing protective helmets free of charge is commendable and such action by other skating rink operators is to be encouraged.

The comments in [i] above are directed to persons undertaking ice-skating activities.

The comments in [ii] and [iii] above are directed to skating rink operators and organisations involved in injury prevention.

TAS.2009.399 Falls/ Older Persons

The elderly deceased had climbed up a ladder to fix the roof of a gazebo that had become loose in strong wind. The deceased fell from the ladder, striking his head on the concrete ground.

Recommendations

[The deceased's] unfortunate death is a further example of deaths occurring to individuals having arisen from working in and around the home undertaking general maintenance. I must again warn home owners and others undertaking tasks not in the work/employment environment of the inherent risks attached, especially when working at height when lack of experience, lack of provision of proper safety equipment, lack of planned risk assessment, age or medical condition may give rise to dangers and risk to life.

It is again timely to warn members of our community about the risks and I again adopt the comments of Coroner McTaggart in 2007 in a not dissimilar death when she said –

TAS.2009.399 *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.

"Coronial files, particularly in other Australian jurisdictions, disclose numerous examples of how such deaths occur in a variety of risk areas such as working on ladders or the roof, electrical work, garden maintenance and motor vehicle repairs. As with the deceased, many of these cases involve what would, by reference to applicable Australian Standards, be considered unsafe systems of work or the use of unsafe equipment.
An Australian Standard is a set of guidelines produced as a result of deliberations by a committee of stakeholders in industry. In the context of particular equipment used in the workplace, an Australian Standard gives practical guidance for training and certification, and its safe selection, supply, erection and maintenance. A significant objective of an Australian Standard is the health and safety of persons engaged in industry.
Although Australian Standards have been primarily developed for the workplace, they represent best practice in safety generally. People involved in working on home maintenance should aim to follow these standards as closely as possible in order to minimise the risk of injury.
A high proportion of these deaths have occurred to males over the age of 60 years.
This older group of persons have not, for much of their working lives, been exposed to the pro-active culture of safety or risk management as it exists today. Instead the emphasis was more upon the "good sense" of the individual to take care. Since the Workplace Health and Safety Act 1995 was enacted the emphasis in the workplace and in training focuses upon assessment of risks and the elimination of those risks using all reasonably practicable measures. Workplace Standards Tasmania, a division of the Department of Justice, is charged with administering the Act and promoting health and safety in the workplace.
The deceased's accident and other Coronial cases demonstrate that familiarity with a particular task is not necessarily good protection against the possibility of injury. In many situations the inadvertence triggering the injury or death is in itself borne out of familiarity and complacency."
Coronial statistics indicate deaths in the area of home maintenance in Tasmania have been uncommon in recent years. However, this death should serve as a caution to those considering domestic maintenance work.
Based upon advice received from officers of Workplace Standards Tasmania in the course of this investigation, I would recommend that the following safety precautions are taken before embarking on domestic maintenance work:

- Take care to comply as far as possible with any Australian Standard applicable to the task at hand so as to reduce the risk of injury or death. Members of the public are encouraged to seek advice by telephoning the Workplace Standards Helpline on 1300 366 322. Copies of publications to assist with safety, such as use of ladders and working at heights, are available by request through the helpline or via the Workplace Standards website at www.wst.tas.gov.au.
- Take regular breaks from the work. As a general rule a break of approximately 10 minutes every hour is advisable. This could vary depending on many factors such as age and physical make up. Many persons working on or around their homes are prone to work for long periods to achieve their desired objective. Regular breaks reduce the fatigue that may cause a loss of concentration. This precaution becomes more important for persons in the older age group.
- Realistically assess physical capability to perform the work. Consider whether any particular physical or mental limitations or disabilities may give rise to safety concerns or risk of injury in any given task. Review carefully whether the work can or should proceed safely in light of any such limitations.
- Conduct a risk assessment. That is, take time before commencing to identify potential safety hazards in the proposed work. It is important to also consider in this assessment the "worst case scenario" in respect of potential for injury. Steps should then be taken to minimise the risks of the occurrence of those events. In the event of uncertainty as to the best response to the risk, members of the public are welcome to contact Workplace Standards for assistance."

NZ.2008.422 Fire Related/ Drugs & Alcohol

The deceased died in a house fire that started from a lit candle in the hands of a young person. The deceased was sleeping in a 'sleep out annexe' and was heavily intoxicated, which may have contributed to the failure to notice the fire.

Recommendations

To the Mayor and Councillors of the [location] City Council:

- That the council expand the identification of properties such as the [location] Street address by utilising the aerial photography available to the staff so that any properties that may have sleep-outs or other residential annexes be inspected to ensure that they are safe (this is not intended in anyway to be seen as an effort to prosecute or require demolition of any such buildings but to ensure that the properties comply with the general residential safety and construction obligations).

NZ.2010.648 Fire Related/ Older Persons

The elderly deceased died from ischaemic heart disease and thermal burns after his clothing caught fire from a stove element in the kitchen of his residence. He suffered thermal burns to 60% of his body and died the next day in hospital.

Recommendations

It appears important that there be appropriate education of the public as to clothing material flammability, and precautions that should be taken to avoid clothing fires.

While I appreciate that the New Zealand Fire Service has a comprehensive education programme in place, and that the Fire Service is currently updating its publications for persons aged 65 and over, I recommend the Fire Service undertake a public education programme as to the facts about clothing fabric flammability.

I note that while there are Australian/New Zealand Standards for Textile products Fibre content labelling, and while in New Zealand children's clothing labelling in terms of fire-resistance only focuses on night-wear, there is no requirement in New Zealand for flammability rules governing wearing apparel. I understand that New Zealand Standards and the Ministry of Consumer Affairs are currently looking into the issue of clothing and flammability.

I direct that this finding relating to the death of [the deceased], and the U.S. publication referred to in this finding, be referred to the Standards Authority and the Ministry of Consumer Affairs and I recommend that Authority and the Ministry consider the implementation of rules requiring flammability labelling of clothing.

SA.2008.1542 Fire Related/ Older Persons/ Aged Care

The elderly deceased lived in a nursing home suffering from dementia and significant issues using both hands. The deceased dropped a lit cigarette on herself and sustained full thickness burns, 4th degree burns and airway burns. The deceased was not able to survive these injuries and passed away.

Recommendations

Accordingly, I make the following recommendations:

- I repeat the recommendation that I made at the conclusion of the Inquest, namely, that any facility that chooses to permit its residents to smoke on the premises should ensure that in the case of each individual smoker the risk of harm to the resident, having regard to the level of dementia, the loss of manual dexterity of the resident and other matters relevant to the ability of the resident to smoke safely, and thus the need for and level of supervision, is properly assessed. Such an assessment should take place on an ongoing basis having regard to the possibility of deterioration in the level of cognitive ability and dexterity of the individual over time. All staff responsible for care and their supervisor should be made aware of such an assessment
- That in any circumstance in which the safety of the smoking activity of a resident in an aged care facility becomes problematic, that procedures be put in place within the facility to ensure that any decision made or practice that is maintained within the facility regarding that resident's habit of smoking, is made known to, discussed with and approved by the resident's representatives and/or family
- That in formulating or altering any resident's care plan, the involvement of the resident him or herself and/or their respective representatives and/or family members should be secured;
- That aged care facilities create procedures whereby concerns about the wellbeing of residents, as raised by visiting family members, are properly documented at the time and that the concerned family member is given the opportunity to read and acknowledge what is in fact documented;
- That within aged care facilities, carers, including agency staff, be required to attend handovers of shifts of staff, or participate in other briefings, in order to familiarise themselves with any adverse issues concerning the current wellbeing of a resident in their care;
- That within aged care facilities it be a mandatory practice for all carers to acknowledge in writing the fact that they have read changes to the care plan of a resident, especially changes that may be relevant to the safety of a resident.

I direct that a copy of these findings and recommendations be furnished to the relevant Commonwealth and State aged care authorities for dissemination to all aged care facilities.

NZ.2010.361 Geographic/ Leisure Activity

The deceased was tramping in rugged and wet conditions, and became stranded without adequate food and shelter. The deceased has succumbed to the combined effects of starvation and exposure.

Recommendations

- I recommend that it be brought to public attention the fact that the [location] bush and mountains are unforgiving. [The location] is not a tramping destination for the unprepared, for the poorly equipped and for the inexperienced.
- Before entering into the bush or back country, the most important message for a tramper to observe is to tell someone where they are going. Department of Conservation have a sign-in/sign-out system, which, if utilised, may have brought to the attention of the appropriate authorities any delay in the return of [the deceased] to civilisation.
- I recommend that all persons venturing into the bush, particularly those who travel unaccompanied, take with them a personal locator beacon (PLB), which can summons assistance promptly and with little risk to those who are called upon to assist

NSW.2009.5414 & 5415 Homicide & Assault/ Weapon/ Domestic Incident

Two people died of stab wounds inflicted by family member.

Recommendations

To the Minister for Health:

That the NSW Government considers amending the Mental Health Act 2007 in order to:

- Expressly state that in determining whether to schedule a mentally ill patient pursuant to s.14 (1)(a), the term *'for the person's own protection from serious harm,* should be understood to include the harm caused by the mental illness itself.
- Expressly state that in determining to schedule a mentally ill patient pursuant to s. 14(1)(a), the term *for the protection of others from serious harm* should be understood to include *for the protection of others from serious emotional harm.*
- Delete reference to *physical harm* in s. 15(a) and (b) and to specify that the term *for the persons own protection from serious harm*, should be taken to include the harm caused by the mental illness itself, and the term *for the protection of others form serious harm* should be understood to include *for the protection of others from serious emotional harm.*
- Ensure that there is no ambiguity in Part 1(1) of Schedule 1 as to the test that must be met before a patient is scheduled in accordance with the Act.
- That NSW Health design and distribute an information booklet setting out advice (that includes an emphasis on the availability of community treatment orders) for families, carers and friends seeking to support persons suffering from a mental illness/disorder, who have been threatened by or are fearful of a person who may be suffering a mental illness/ disorder.

NZ.2009.890 & 891 Homicide & Assault/ Domestic Incident/ Drugs & Alcohol/ Intentional Self-Harm

The deceased persons were a couple, where deceased one was killed by deceased two who shot her in the head and then took his own life. There were instances of domestic violence within the relationship. Deceased One had been drinking prior to the attack and this may have reduced her defences.

Recommendations

The case highlights the ongoing patterns of violent behaviour on the part of [deceased 2] following previous convictions. The evidence indicates that the Police were not alerted to incidents of domestic violence on the part of [deceased 2] against [deceased 1].

A Police Officer who carried out a Family Violence Death and Child Homicide Review and reported to the Coroner made the following general recommendation which I endorse:

- That anti-violence campaigns such as "It's Not OK" continue to raise awareness and to encourage the reporting of domestic violence, by family members, friends, associates and neighbours.

I direct that the Ministry of Justice provide a copy of these Findings to Associate Social Development Minister, Hon [name] with particular reference to the above.

NSW.2008.2513 Intentional Self-Harm/ Mental Illness & Health

A mentally ill person, who had been taken to hospital by police due to threatening self-harm, was discharged the same day. The deceased returned home and jumped from the 15th storey balcony of an apartment building two hours later.

Recommendations

I recommend that the [location] Local Health Network review its training Programmes and materials concerning the Mental Health Act 2007 so as to ensure compliance with the provisions of the Act and in particular, to ensure where practical, that all staff exercising power or functions under the said Act are conversant with its procedures and requirements.

NZ.2008.2454 Intentional Self-Harm/ Mental Illness & Health

The deceased, who suffered from schizophrenia, took their own life by hanging.

Recommendations

I recommend that a copy of this Finding be sent to SDHB for the Mental Health Team to consider and learn from the death of [deceased].

NZ.2008.2751 Intentional Self Harm/ Mental Illness & Health

The deceased, who suffered from mental illness, took their own life by hanging. The deceased's relationship had broken down and they were suffering from stress and in need of respite care.

Recommendations

That the [location] District Health Board review its provision for Respite Care Facilities to ensure that there is an adequate availability of such facility on a needs basis.

NZ.2009.701 Intentional Self-Harm/ Mental Illness & Health/ Transport & Traffic Related

The deceased suffered from depression and a mood anxiety disorder and was struggling due to work and family issues. The deceased projected their vehicle at high speeds deliberately off a road through bushland, where the car rolled onto its roof. The deceased was located some 50 days after the crash.

Recommendations

- That the Police Search and Rescue Team establish a portfolio of private equipment and operators who may be able to provide a skill set that can assist with Search and Rescue operations, such portfolio to meet the criteria and standards that is required by the requisite legislation.

NZ.2009.2677 Intentional Self Harm/ Mental Illness & Health

The deceased had previously tried to take her own life by drug overdose and by self -harming. She was discharged and was released back into family's care. She then hung herself. She had been suffering from mental illness, and her mother had taken her own life a year before.

Recommendations

To: The Chief Executive, [location] District Health Board

- That the risk management plans developed by CAT Team members following serious acts of self-harm or attempted suicide by patients be reduced to writing and a copy thereof made available to those family members/friends into whose care the patient is to be placed, with clear and explicit advice as to the nature and extent of ongoing risk and the need for monitoring.

NZ.2009.2848 Intentional Self-Harm/ Law Enforcement

The deceased was a prisoner at [location] Men's Prison. He had a previous history of self-harm and had recently been moved to the At Risk Unit, pending transfer to another prison. While in the At Risk Unit, the deceased hung himself.

Recommendations

[The deceased] used the air circulation vent, a grill above his cell door, as the hanging point to enable him to end his life. The recommendation to eliminate such hanging points had previously been made. [Name], Manager at [location] Prison, has advised the Court that changes to the door grills have now been made in J Block and the Remand Unit at [location] Prison (in total 190 cells), with the installation of grills with holes approximately 3mm in diameter, preventing them being readily used as hanging points. Had such grills been in place [the deceased's] death on [date] may possibly have been prevented.
I also consider it appropriate that any triggers to self-harm identified by Psychiatrists, Psychologists and other medical officers should be entered as an alert on IOMS, to assist persons observing and assessing an inmate, and I make a recommendation accordingly.

While I appreciate that there are fiscal implications and operational risks with electronic locks (such as erroneous remote opening/closing by staff, system errors and the ability for prisoners to jam them), in the interests of prisoner safety I recommend that the Department of Corrections explore a means of more immediate ability to open cells at [location] Men's Prison where a prisoner is in imminent danger, including considering facilities for the remote unlocking of individual cells and reviewing the availability of keys to Corrections personnel.

NZ.2009.2874 Intentional Self-Harm/ Drugs & Alcohol

The deceased was unemployed and his relationship had broken down. The deceased took his own life by hanging.

Recommendations

I recommend that a copy of this finding be forwarded to CYMRC. I have investigated a number of deaths of young male adults in which cannabis use in conjunction with suicide is a common theme. The issue is worthy of further research.

NZ.2010.1505 Intentional Self-Harm/ Mental Illness & Health

The deceased was suffering from depression and had been referred to Mental Health Services within the two areas that the deceased was travelling between. The deceased was contacted and made several calls to mental health services in the lead up to his death, but no face to face meeting was held. The deceased took his own life by hanging.

Recommendations

I recommend that the [location] District Health Board Community Mental Health Service reviews its policies and processes for managing calls to the crisis team to assess whether they are sufficiently robust to ensure that sufficient information is obtained (including recent contact with the crisis team and whether the caller is registered with the service) to enable decision making to be informed by relevant information.

TAS.2009.498 Intentional Self-Harm/ Drugs & Alcohol/ Weapon

The deceased had been taking Champix, a prescription drug to help stop smoking. The deceased's family noticed he had become more irritable, aggressive and difficult to get along with since taking the medication. The deceased used a shotgun to take his own life.

Recommendations

It is clear that medical practitioners who prescribe Varenicline must take particular note of any neuropsychiatric indicators in patients and provide clear advice with careful follow-up. There is nothing to suggest [the deceased's] general practitioner did not do so in his case.
What is clear is that [the deceased] did not adequately disclose important indicators and while it is impossible to say whether any such disclosures would have made a difference in his case and it is also impossible to say that his ingestion of Varenicline was a direct causal link in his death, there is sufficient connection for me to place warnings before the community to be generally aware of the side-effects and any contra-indicators when taking or considering the taking of medication such as Varenicline and to disclose to their medical practitioners any relevant background information.

TAS.2009.498 *continued*

It is also important for patients to stop taking Champix and contact their healthcare professional immediately if changes in behaviour or thinking, agitation or depressed mood that are not typical for the patient are observed, or if the patient develops suicidal ideation or suicidal behaviour.

TAS.2010.158 Intentional Self-Harm/ Mental Illness & Health

The deceased suffered from bipolar and also had a history of suicide attempts. The deceased was found hanging from an open manhole.

Recommendations

I recommend that Tasmania Police, in consultation with medical and ambulance services, reconsider the guidelines to be used in similar circumstances, especially as to the initiation of CPR until the arrival of paramedics who are trained and experienced in making the determination of when the initiation or cessation of CPR is appropriate.

SA.2009.539 Law Enforcement/ Transport & Traffic Related/ Drugs & Alcohol

The deceased was a passenger in a car that was being pursued by police. Both the driver and the deceased were affected by alcohol and drugs. The vehicle was speeding, lost control and hit a brick wall.

Recommendations

In making the following recommendations I have had regard, as I have in previous inquests, to the need to avoid creating an impression that motorists will not be pursued if they fail to stop to remain stationary or that they can ignore legitimate police directions with impunity.
I make the following recommendations:

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

WA.2008.832 Law Enforcement/ Physical Health/ Sports Related/ Indigenous

A prisoner with obesity, diabetes and previous complaints of chest pain died while playing football in the exercise yard of a prison. The deceased was not able to be revived.

Recommendations

- At this early stage in the implementation of the patient management system for prison clinicians (called EcHO) I am anxious the progress notes aspect of the system ensures recording of contemporaneous medical investigations in an obvious manner. This will allow a proper updated and relevant history to be provided to external consultants and advise in-house doctors of the investigations which are currently being conducted with respect to individual prisoners.

WA.2008.832 *continued*

- The initiative by Geraldton Regional Aboriginal Medical Service (GRAMS) to use indigenous health workers in [prison] be supported while accepting prison security is an issue which will always provide some tension with welfare issues. These need to be addressed.
- I understand there is funding available for indigenous health workers via the Mar Mooditj Foundation. This is based on submissions from Aboriginal Legal Service (ALS) on behalf of [the deceased's] family. Unfortunately I did not have the opportunity to hear from the Foundation in person. If a mechanism can be developed whereby security concerns are protected, I strongly urge prison authorities to work cooperatively with external sources of funding where possible. The use of indigenous health workers where prisoners need to attend consultant reviews and ongoing investigations could be invaluable. This will ultimately contribute to the community as a whole by using the window of opportunity provided for input to indigenous health issues while indigenous prisoners are in custody.
- Training with respect to calling a Code Red where there is a medical emergency which has not yet been defined be impressed upon prison officers.
- Appropriate, adequate and ongoing CPR training be provided to prison officers and appropriate prisoners.
- There be a clear direction to nurses attending medical emergencies they are to provide leadership in the welfare arena, which will allow attending prison officers to appropriately concern themselves with security issues.

NZ.2010.356 Leisure Activity/ Water Related

The deceased, an experienced kayaker was on a kayak trip with some friends. The deceased owned an inflatable canoe but an older canoe was going to be used by one of the group, a plastic older style canoe. While on a trial run to see if the canoe was able to be used, the deceased fell out and was quickly swept up into rapids. Despite attempts to save the deceased, he drowned.

Recommendations

One month ago I sat an Inquest where another person had drowned. I said then, and will say again, **"WEAR A LIFE JACKET. NOT WHEN YOU THINK IT NECESSARY, NOT WHEN YOU FEEL UNCOMFORTABLE CONCERNING CONDITIONS, BUT ALL OF THE TIME."** It cannot be stated with certainty that had [the deceased] been wearing a life jacket then he would have survived, but he could have survived, and for his death to have a continuing meaning, we must take lessons from it.

NT.2009.211 Mental Illness & Health/ Youth/ Intentional Self-Harm

The deceased youth had been admitted as a voluntary patient in a psychiatric ward. The deceased had been refused overnight leave due to suicidal thoughts, but was allowed to go out on day leave. The deceased returned to her home residence and hung herself.

Recommendations

Given these significant changes I do not consider it necessary to say anything further other than to RECOMMEND that what is set out in the materials included in the statements of [name] and [name] at exhibits 14 and 15 as being promised to occur, actually occur. This is an important service and it is not the first time that I have had cause to consider during the course of an inquest that additional funding should be provided to the On Call Team. As I stated during the course of proceedings, Government must be accountable for properly funding and resourcing these teams so that they can properly undertake their duties and responsibilities in taking care of the mentally ill.

The death of this young woman is a tragic reminder of the significant needs of the mentally ill in our community and the continued responsibility of Government and the wider community to maintain efforts to improve services in the hope that this kind of death can be avoided in the future.

NZ.2008.2164 Mental Illness & Health/ Fire related/ Intentional Self-Harm

The mentally unwell deceased started a fire deliberately in the home to take their own life. The deceased had been in contact with Mental Health Services before the death but was not admitted to a mental health facility.

NZ.2008.2164 continued

The incident review carries the following recommendations:
"Involvement of family and caregivers is a critical part of psychiatric care, mandated by the Mental Health Act. We recommend the Service ensures the requirements of Section 7(A) of the Act are met and where decisions not to involve the family are made, that these are documented and reviewed. The Ministry of Health guidelines to the Mental Health Act of April 1, 2000 provide clear guidance in this area. This direction should also include involvement of family/caregivers and discharge planning with similar requirements for documentation where this is not deemed clinically appropriate. "

The Court endorses the recommendation made by the incident reviewers, as recorded above.

NZ.2009.2693 Mental Illness & Health / Intentional Self-Harm/ Weapon

The deceased was mentally ill and suffering from a relationship breakdown. The deceased died from a self-inflicted rifle wound.

Recommendation

I recommend that a copy of this Finding be forwarded to SDHB for the attention of the Southern Mental Health team, with my thanks for their help, my support for their work and my endorsement of their report and recommendations.

NZ.2009.2451 Natural Cause Death/ Older Persons

An older person was discovered deceased at his home after suffering from a heart attack.

Recommendation

I recommend that a copy of this Finding be forwarded to [doctor] and to [location] Medical Centre Limited, and to [company] Health Limited for the attention of [doctor] and other clinicians.

NZ.2010.262 Natural Cause Death

The deceased suffered a large ruptured abdominal aortic aneurysm, and had emergency surgery at [location] hospital. The deceased was given antibiotics and heparin while in ICU. He was given a variety of exercises from the physiotherapy service and was discharged 2 weeks later.

Seven days following his discharge, the deceased became short of breath and despite resuscitation efforts, the deceased passed away. He had seen his GP within that seven day period but did not mention pain to him, despite mentioning it to his partner.

Recommendation

While I endorse the actions of the Vascular Service regarding the brochure review, I propose to make specific recommendations about the review of patient information as follows.

- I recommend to [location] District Health Board's Vascular Services, and the Royal Australasian College of Surgeons, that they review their patient information literature on Abdominal Aortic Aneurysm, to consider whether adequate and clear information is given regarding the risk of Deep Vein Thrombosis/pulmonary thromboembolism, and the steps that need to be taken to manage that risk. The literature review should also consider whether to outline within the brochures, the specific signs and symptoms of deep vein thrombosis/pulmonary thromboembolism and what steps (for example, medical review) should be taken in the event that such symptoms are experienced.

I am also of the view that [location] District Health Board Vascular Services should give consideration to ensuring that the relevant brochures are available (or have been given) to patients at the point of discharge - noting that the Charge Nurse Manager indicated such information is usually given "on admission" (which for some patients may be some considerable time earlier). The brochures obviously contain relevant post-discharge information (for example, about situations in which to seek further medical help following discharge) which would be helpful to highlight to patients at the time they leave the hospital. Moreover, I note that the Discharge Checklist has specific sections titled "Education Given" and "Discharge Instructions" in which reference could and should be made to any written information provided to the patient as part of the discharge process.

NZ.2010.1013 Older Persons/ Transport & Traffic Related

The elderly deceased, who suffered from impaired eyesight, was driving his vehicle in fog when he missed a hairpin bend on the road and rolled down an embankment. The deceased was thrown from the vehicle and was unable to be revived.

Recommendations

With a view to preventing deaths in similar circumstances in the future, and because of the narrowness of the road on [location] and the restricted visibility on the corner, I recommend to the landowners and to [location] District Council as the Road Authority that appropriate road side barriers be placed on the relevant corner to both indicate the bend and prevent vehicles leaving the road at the bend.

TAS.2010.84 Older Persons/ Natural Cause Death

An elderly person died in hospital from a stroke following digitalis toxicity due to chronic renal failure. The deceased had elevated levels of digoxin (secreted by the kidney) on admission and had been treated with Digibind, but the digoxin levels did not decrease.

Recommendations

[Name] has identified multiple deficiencies in [the deceased's] care and management when she attended the Emergency Department at the [location] on [date], particularly in identifying the root cause of her illness and her medication management. These deficiencies did not directly contribute to [the deceased's] death. Nevertheless, they are a cause for real concern and lead me to **recommend** that the [hospital] undertake a review of its Emergency Department's management of elderly patients who present with a complex medical history. Consideration should be given to the adoption of a multi-disciplinary approach to the treatment and care of these patients wherever practicable.

The action taken by [name] to identify other patients in her practice who have been taking digoxin and putting in place a protocol for the ongoing assessment of their renal function is a most responsible and heartening response to the circumstances of [the deceased's] death. It is my **recommendation** that similar steps be taken by all general medical practices within the State.

NZ.2009.1883 Physical Health/ Adverse Medical Effects

The deceased was confined to a wheelchair, having had a brain haemorrhage twenty years prior. The deceased had a MediAlert alarm which was activated twice while the deceased was home alone. Due to issues with gaining access to the house, and delays with ambulance, the deceased was not able to be resuscitated once found, and it appears the deceased suffered another brain haemorrhage.

Recommendations

In an effort to avoid such failings occurring in the future when time may have an effect on the outcome, I make the following recommendations:

- That Tunstall revises its protocol concerning disconnecting the communication link following activation of an alarm so that the link is maintained until such time as the person can communicate with the operator, or assistance reaches the person in need.
- That Tunstall addresses the failings identified in its systems with regard to contacting the appropriate emergency contact persons, in order of their ranking, as its highest priority immediately after contacting the emergency services, following activation of an alarm.
- That Tunstall provides emergency services with the precise and complete information for gaining access to a house where someone has activated an alarm.
- That Tunstall contacts St John Ambulance Service for an update within a relatively short time following the initial request for an ambulance to be dispatched after an alarm activation, and if St John advises of a significant delay in being able to respond, Tunstall should consider other options.

The above recommendations are directed to Tunstall Healthcare NZ Limited.

- That St John reviews its system of assigning priority to a job to ensure that all of the circumstances are taken into account, and the appropriate urgency ascribed to a particular job.
- That St John gives ambulance dispatchers more training in judging when the Fire Service should be contacted and requested to respond to an unanswered medical alarm, and to be more proactive in requesting assistance from the Fire Service in appropriate circumstances.

NZ.2009.1883 continued

- That St John urgently considers deploying more ambulances within [location] and the [location] district to ensure that the service provided is not hindered by a lack of such resources.

The above recommendations are directed to St John Ambulance Service.

NZ.2010.467 Physical Health/ Transport & Traffic Related/ Water Related

The deceased suffered from diabetes and while running errands, appeared to be suffering from low blood sugar after a call to his partner stating that he was irritable and becoming confused.
The deceased then attempted to drive home but went into a hyperglycaemic coma. This forced the car off the road into the lake, and the deceased drowned.

Recommendations

I recommend that a copy of this Finding be forwarded to Diabetes New Zealand for the information of the organisation and for distribution to members in a manner Diabetes New Zealand thinks fit.

VIC.2007.3458 Physical Health

The deceased had numerous health issues including complex cardiac disease (including myocardial infarction, coronary artery bypass graft surgeries and atrial fibrillation), hypercholesterolemia, chronic obstructive airways disease and dialysis dependent renal failure. After collapsing at work, the deceased was taken to hospital where there was a wait of 24 hours for a cardiac bed in a larger hospital. Once transferred, the deceased seemed stable, but had headaches. The deceased then deteriorated rapidly and an intracranial haemorrhage was diagnosed. Despite an emergency craniotomy, the deceased never regained consciousness.

Recommendations

- That [location] enhances the electronic medical records in use in the Emergency Department so as to reinforce the 'Adult Head Injury Request' protocol by requiring mandatory consideration of the protocol where key factors are present. In the alternative, that the enhancement is premised on the presence of any head strike or injury and anticoagulation therapy.
- That [location] considers expanding the electronic records to all departments so as to facilitate accessibility and encourage treating clinicians to access patient's medical records to inform treatment
- That [location] takes steps to encourage specialist medical staff to make as holistic an assessment of the patient as possible, and at a minimum requires a full re-assessment of the patient upon admission to a specialist unit.

NZ.2010.198 Sports Related/ Transport & Traffic Related

The deceased was competing in a motorcycle racing event with his daughter, involving a motorbike with a sidecar. As the deceased was negotiating a corner, another bike collided with the deceased's bike. Both the deceased and his daughter were thrown from the vehicle, with the other bike landing on top of the deceased. Despite being airlifted to hospital, the deceased suffered a heart attack and was unable to be revived.

Recommendations

I note that Motorcycling New Zealand (MNZ), following this crash, gave notice that no future races would allow such a mismatch of motorbikes in the same race pending the outcome of the investigation into the crash.
I therefore make the following recommendation:
That MNZ review its policy on allowing motorbikes with different power and braking abilities to participate in the same race, and specifically to consider whether it is safe for riders if this practice is to continue.
This recommendation is directed to Motorcycle New Zealand Incorporated for dissemination to all motorcycle clubs and event organisers as appropriate.

NZ.2010.267 Sports Related/ Transport & Traffic Related

The deceased was taking part in an organised two day motorcycle rally. The deceased was riding with a cousin in a rural area when he clipped the back of his cousin's motorcycle and was thrown off, hitting his head on the road. He was discovered by motorists not long after the crash but was unable to be revived.

NZ.2010.267 continued

Recommendations

Event organisers have a duty to ensure that all reasonable steps are taken to minimise the chances of serious injury or death. This requires a proper assessment of the likelihood of serious injury or death and how it could occur. It requires identification of causal elements such as excess fatigue. It requires a management plan to minimise or eliminate these causal elements.
Before embarking on the [the event] races, [the organiser] spent considerable time researching other events, both motorcycling and bicycling to understand what guidelines and standards are in place governing the organisation of such events. He found no standards or formal guidelines to assist him.
In previous inquiries by Coroners, including myself, where a death has occurred in an organised recreational biking event, comment has been made about the lack of such guidelines and standards and I have previously made recommendations to The New Zealand Association of Event Professionals, The Department of Labour, and Bike NZ, and SPARC to set up meetings and talk with each other and with event organisers to establish an industry safety standard or code of practice or protocol for in that case, off road bicycling events.
It seems to me that this recommendation can be made in relation to many other events including those on the motorcycle calendar.
[The organiser] has expressed willingness to be part of a working party to look at the current gaps in event organising in the motorcycle calendar.
I thus recommend to The New Zealand Association of Event Professionals, The Department of Labour, the organisers of events on the motorcycling calendar, and SPARC to set up meetings and talk with each other to establish a safety standard or code of practice or protocol for motorcycling events.

VIC.2009.2300 Sports Related/ Work Related

A boxer on a tourist visa died after taking a hit to the head during a sparring session, despite wearing headgear. The deceased suffered a subdural haemorrhage and did not regain consciousness.

Recommendations

That there be a system of regulation implemented which requires:

- Mandatory application for professional registration of boxers proposing to participate in professional training or who are participating in sparring at a level directed towards professional contest or with a professional boxer; and
- Mandatory medical certification as to fitness to compete, including blood testing, before a boxer participates in training or sparring at a level directed towards professional contest or with a professional boxer and that such blood testing be undertaken each 6 months.
- Mandatory reporting of hospitalisation of any boxer of any status whether professional or amateur, for injuries sustained whilst participating in training, or sparring or competition.
- That the Boxing and Contact Sports Board implement a level of supervision upon gymnasiums, when the training of boxers is occurring at a level directed towards professional participation to ensure compliance.

I direct that a copy of this finding and recommendations be provided to the family of the deceased; other interested parties; The Honourable MP Minister for Sport and Recreation; the Secretary, Department of Planning and Community Development; The Registrar, Professional Boxing and Combat Sports Board (Victoria) for the attention of the Board.

NSW.2010.106 Transport & Traffic Related

A person died after the vehicle in which they were driving impacted with a prime mover.

Recommendations

To the Director General of Transport

- The current legislation requires wide load escorts for any load wider than 3.5 metres require an overmass/oversize permit, flashing warning lights, flags and signs, but does not require a pilot/ escort vehicle. The current legislation does not appear to take into account wide loads which are required to travel on narrow country roads.
- A review of the wide load escort requirements should be undertaken to address amendments to the legislation. The relevant legislation should be amended to reflect travel performed on narrow roads. The maximum width without pilot vehicles, on country roads, particularly on narrow roads should be altered to 3 metres.

NSW.2010.106 continued

- Furthermore additional escort vehicles should be required where the total road width at any point is less than 6 metres in width.
- If these recommended amendments to the pilot/escort vehicle requirements had been in place then this collision may not have occurred as the pilot/escort vehicle would have provided sufficient warning of the oversize vehicle to oncoming vehicles.
- An amendment to the legislation may avert any similar collisions occurring in the future.
- It is recommended that a formal review of the legislation, particularly in relations to pilot/escort vehicle requirement for oversize vehicles on narrow roads, be undertaken with a view of implementing the recommendations as detailed above.

NZ.2008.273 Transport & Traffic Related/ Older Person

An older person died after crossing railway tracks at a pedestrian rail crossing and being hit by a train. The deceased failed to notice the train sounding its horn in the first instance and continued to cross, only hesitating when the horn was sounded again, but continued to move forward.

Recommendations

- That KiwiRail review its approach as to dealing with scenarios when a Locomotive Engineer notices people within the Rail Corridor in that it provide staff training for the Locomotive Engineers to enable them to access situations where not only is it applicable to sound the train's horn but also to take emergency action to brake the train. (In this instance this is no criticism of the actions of the Locomotive Engineer in this particular instance.) I accept that it is not practicable to stop trains in all instances where the public have trespassed into the Train Corridor; I simply suggest that training for operators faced with this type of situation be implemented.
- As to Corridor Maintenance; it has been commented on that the corridor in this location was showing signs of overgrowth and poor fence maintenance but that this had improved subsequent to this fatality. The recommendation is that within the vicinity of crossing points and stations that overgrowth should be attended to on a regular basis so not to impair the Engineer's vision and that fencing be regularly inspected and maintained in those areas.

NZ.2008.2065 Transport & Traffic Related

The deceased died after crashing a Quad bike (ATV) and sustaining massive skull fractures. The deceased contracted terminal bronchopneumonia and was not able to recover.

Recommendations

To the Honourable Minister of Transport & to the Honourable Minister of Labour
The Court endorses the new educational and enforcement programme being proposed by the Department of Labour, but considers that both Ministries undertake an immediate investigation to consider the mandatory installation of:

- The compulsory wearing of helmets when operating A TVs in any circumstances; and
- The installation of a roll bar on all A TVs/quad bikes; and
- The installation of lap belts on all ATVs/quad bikes.

NZ.2008.2194 & 2196 Transport & Traffic Related

The deceased persons were passengers in a vehicle being driven to work when the driver lost control, and the vehicle crashed and overturned. The deceased persons sustained extensive injuries and were not able to recover.

Recommendations

I recommend that a copy of this Finding be forwarded to the New Zealand Shearing Industry Health and Safety committee, the Department of Labour and to the Minister of Labour with my request that the safety of vehicles transporting employees to and from their place of work be the subject of a review taking into account these Findings.

Employers must be encouraged to utilise the safest possible vehicles and to ensure that drivers are trained appropriately.

NZ.2009.2463 Transport & Traffic Related/ Youth

The deceased was crossing a street with a group of friends when a vehicle struck the deceased. The deceased was in hospital for several weeks but never regained consciousness.

Recommendations

I consider it is appropriate in this instance to make some comments concerning the attitude of the group of young people who were with [the deceased] on the night of the crash, in the hope that my comments may prevent further deaths occurring in the future in similar circumstances. As indicated above, I am very concerned that these young people showed very little concern for their own safety when crossing a suburban street. The fact that they were intoxicated may well have contributed to this poor attitude.

I would like to think that [the deceased's] death will serve as a very strong warning that it is dangerous to consume large amounts of alcohol and then walk across public roads with a disregard for traffic. It is well accepted in society that driving a motor vehicle while affected by alcohol is inherently dangerous; it should also be well accepted that walking across a suburban road in a similar state also carries a significant risk. If any good is to come out of [the deceased's] death, it should be that young people appreciate the dangers posed by alcohol intoxication for pedestrians that this group appears to have been ignorant of.

As stated above, I consider that the environment was a contributing factor to the crash which resulted in [the deceased's] death. I therefore make the following recommendation:

- That the relevant territorial authority either remove all of the trees from the median strip in the centre of Street, or else ensure that the branches of those trees are maintained at a suitable height so that drivers of vehicles on that street do not have their vision of pedestrians standing on the median strip restricted by the foliage on those trees.

This recommendation is directed to the territorial authority responsible for the roads within the city of [location].

NZ.2010.161 Transport & Traffic Related/ Work Related

The deceased was operating a bulldozer and clearing trees on a property. The deceased was trying to remove a stump when the blade of the bulldozer slipped and the bulldozer tracks crashed to the ground. The deceased was not wearing a seatbelt and was thrown from the bulldozer, which then rolled over the deceased.

Recommendations

It is clear from the evidence that if [the deceased] had been wearing the seatbelt while operating the bulldozer, he would have survived this incident. The Department of Labour speaker who investigated this incident noted that the seatbelt fitted on the bulldozer had the appearance of having been used regularly. There is no indication of the reason why [the deceased] had not put his seatbelt on at the time of this incident.

- I note that there is no legal requirement for an operator of a bulldozer to wear a seatbelt. I have considered whether it might be appropriate to make a recommendation that operators of bulldozers where a seatbelt at all times, but I have no evidence as to whether this is practicable or even desirable. There may be situations where operators of bulldozers put themselves at greater risk by wearing a seat belt.
- In the absence of evidence on this point, I simply make the above comments in the hope that the relevant safety organisations will consider whether it should be made compulsory for seat belts to be worn while bulldozers are being operated.

NZ.2010.1501 Transport & Traffic Related/ Drugs & Alcohol

The deceased had been drinking alcohol at a party and had slept for a few hours at a friend's place before driving home. He failed to negotiate a T-shape intersection and driven up a bank, becoming airborne before landing in a canal. The deceased suffered severe injuries on impact and passed away.

Recommendations

[The deceased's] death was the result of his driving while still under the influence of alcohol, and also possibly under the influence of cannabis. It demonstrates that having a few hours of sleep does not necessarily mean a person's body has recovered from the effects of consuming alcohol. It also highlights the danger of consuming alcohol with cannabis, due to the fact that cannabis exacerbates the alcoholic effect. It could be that the [deceased] was unaware of this.
I make these comments in the hope that [the deceased's] death will draw attention to the fact that young people in particular must realise the length of time it takes for the human body to divest itself of alcohol, and that consuming cannabis with alcohol is going to increase the effect of the alcohol

NZ.2010.1556 Transport & Traffic Related/ Youth/ Weather Related/ Drugs & Alcohol

The deceased youth was a skilled motorbike rider and owned his own motorcycle. On returning home from visiting a sibling, the deceased failed to negotiate an easy right hand bend in the road. The motorcycle impacted with a concrete power pole. The deceased was thrown from the bike and died from the injuries sustained in the crash. The weather was dry but with patches of dense fog, and that, coupled with the deceased smoking cannabis prior to the accident, was a causative factor in the crash.

Recommendations

This death highlights once again the dangers of smoking cannabis and driving a motor vehicle, especially a motorcycle. I trust that [the deceased's] death will serve as a warning to other young people that they cannot ignore these dangers without running the risk of suffering the ultimate consequence.

NZ.2010.1571 Transport & Traffic Related/ Animal/ Drugs & Alcohol

The deceased had picked up a friend and was driving home when they encountered some cows on the road. The deceased veered to the right to avoid the stock, but collided with a cow. The vehicle impacted with a hedge and a fence on the side of the road. The deceased was discovered in a lifeless state from a passing motorist a short time later. The deceased had methamphetamines in the blood.

Recommendations

Even though there is no evidence to indicate the role (if any) that the methamphetamine consumed by [deceased] played in causing this crash, it is accepted that methamphetamine can adversely affect a driver's ability to control his or her vehicle, and to react appropriately to an emergency situation.
[The deceased's] death highlights again the need for all drivers to refrain from consuming any illicit substance which may affect their ability to drive safely and which potentially impairs their ability to react appropriately to an emergency situation which suddenly presents itself.

NOTE: Due to three cases of similar circumstances, where vehicles being driven by mine workers coming off a night shift collided with other cars in Queensland, the Coroner held a joint inquest with combined recommendations

QLD.2005.2620 Transport & Traffic Related/ Weather Related/ Work Related

The deceased was a police officer driving to work when the vehicle he was driving was hit by another vehicle driven by a mine worker who had just finished an overnight shift. Conditions were extremely poor, with a tropical storm passing through at the time of the collision.

QLD.2005.2621 Transport & Traffic Related/ Weather Related/ Work Related

The deceased was driving home from an overnight shift at a mine when his vehicle collided with another car. Conditions were extremely poor, with a tropical storm passing through at the time of the collision.

QLD.2007.382 Transport & Traffic Related/ Weather Related/ Work Related

The deceased had just finished a night shift in a mine when the vehicle they were driving passed onto the incorrect side of the road and collided with an oncoming vehicle. The deceased died instantly from injuries sustained in the crash.

Combined Recommendations

I thank the parties for the submissions made regarding recommendations which were of significant assistance. I have adopted some of the recommendations proposed in those submissions.

I make the following comments by way of recommendations pursuant to section 46 of the Coroners' Act to assist to prevent similar occurrences in the future and in the interests of public safety on the roads. To the extent that the parties have already taken remedial action, the court expects that those actions are bona fide and implemented long term.

Combined recommendations continued

IT IS RECOMMENDED:

1. That Queensland Police Service conduct a review of the allocation of Traffic Accident Investigation Squad (now Forensic Crash Unit) officers to Regional Queensland. In particular, that a permanent Forensic Crash Unit be established in [location] sufficiently resourced and staffed to ensure timely investigations of fatal and serious road crashes taking into account the issues commented on in this Inquest.
2. That Queensland Transport and Queensland Police Service review:
   - Police traffic accident documentation, training manuals and the First Response Handbook to promote the accurate recognition and recording of fatigue-related crashes; and
   - current basic training and the Forensic Crash Unit specialist training syllabus in order to ensure comprehensive training for traffic and general duties officers who attend crashes. Such a review should include a focus on specific training to assist in identification of fatigue-related crashes and the detection of drivers who are impaired by fatigue;
   - in consultation with appropriate fatigue experts and or road safety experts , the current crash data collection forms (PT51) to consider the development and inclusion of a list of extended categories and enquiries required for classification of crashes by police as being fatigue related for use as an aide memoir in operational field conditions.
3. That an urgent review be undertaken by the Minister for Police, Corrective Services and Sport and the Queensland Police Service of the current police resources and police number allocations in the Central Region. Priority should be considered for the provision of additional police numbers and resources to assist in bolstering policing presence on Central Queensland roads with a view to increasing the effectiveness of current enforcement activities, road surveillance and fatigue monitoring in light of mining activities in the Region.
4. That Queensland Transport in conjunction with the Queensland Police Service undertake a review of current crash data collection procedures, classification of fatigue, the veracity of the surrogate measures, and methodologies for the analysis of crash data by the Queensland Police Service and Queensland Transport in association with appropriate external experts.
5. That Queensland Police Service conduct a trial within a limited geographic area for a set period of time to collect enhanced data on fatigue-related road crashes as discussed in these findings.
6. That a Memorandum of Understanding be negotiated between Queensland Police Service and the Mines Inspectorate to notify the Mines Inspectorate of the road crashes where persons are travelling to and from a mine to enable the Mines Inspectorate to investigate at the mine in relation to the effectiveness and compliance with the health and safety management system and for the sharing of information for the purpose of an investigation by either entity.
7. That Queensland Transport in conjunction with the Queensland Police Service should review and adopt an operational definition of fatigue.
8. That the Queensland Police Service consider retrieval of in-vehicle information recording systems as part of standard investigative procedures for fatal car accidents.
9. That ongoing consideration be given by Queensland Police Service to:
   - creating specific powers for police to stop drivers suspected of being fatigued; and
   - the development of a fatigue-specific driving offence, and, in the meantime;
   - the utilisation of additional investigative techniques to establish fatigue until such time as appropriate fatigue detection methodology is available.
10. That the Queensland Government through Queensland Transport and Queensland Health Commission or other appropriate bodies support/develop further research into a method or mechanism for the detection of fatigue impairment in drivers.
11. That additional effort be committed to improving the quality of data maintained by Queensland Transport and obtained by Queensland Police identifying the location of fatigue hot spots on the roads so that engineering initiatives and other control measures to combat fatigue related crashes might be considered for continuing deployment throughout Queensland in these identified zones.
12. That the Minister for Transport and Main Roads seek the support of all Australian Transport Councils (ATC), Members for the development of a standardised fatigue definition and reporting for road safety purposes
13. That a Fatigue Management Forum be convened to develop best practice fatigue management guidelines for road transport authorities, road users and public and private sector employers across Queensland. The guidelines should address the development of a definition of fatigue, review the extent of fatigue related crashes and the causes for them, the effectiveness of fatigue management standards across the State (including the Qld Resources Council "Fatigue Management Principles") in addressing the causes of fatigue related crashes, development of benchmarks for measuring the effectiveness of the standards and practices, determination of how existing standards and practices can be improved, and review of the most effective ways to reduce the incidence of fatigue related crashes.

Combined recommendations continued

14. That the matter of fatigue be referred to the Ministerial Advisory Council (MAC) for the Council to consider -
    - the appropriateness or otherwise of "competency based" fatigue training for the mining industry; and
    - any other measures considered appropriate by the Council to further enhance the mining industry's contribution to fatigue management.
15. That the Mines Inspectorate investigate:
    - the implementation of a fatigue management Recognised Standard incorporating a workable definition of fatigue including consideration of parameters for maximum number of hours in a day, a week and a shift cycle; and if so then
    - enforcement powers be implemented either within a statutory framework or the employment contact or both to ensure compliance with the fatigue management standard on the shoulders of the employer and the employee.
16. In order to ensure a whole of government response to the occupational health and safety issue of shift work and commuting across all the industrial sectors the Queensland Transport, in conjunction with the Division of Workplace Health and Safety and the Mines Inspectorate, review the current regulatory framework, standards and guidelines to identify risks to workers and the public from shiftwork, commuting and fatigue to ensure the legislative framework manages risk at an acceptable level and make a formal reference of the issue to a joint session of the Coal and Metals Advisory Councils.
17. That mine operators fully explore control measures to reduce or eliminate the risks associated with workers commuting whilst fatigued.
18. That the Mines Inspectorate sponsor, in conjunction with the Queensland Resources Council and the CFMEU, targeted research at both the industry and mine level into shiftwork fatigue risk management and commuting to ensure risk is at an acceptable level.
19. To remove doubt the Department of Industrial Relations and Q-Comp should review the current rules for journey claims to ensure clarity and cover for fatigue-reducing rest breaks before commuting on public roads to make it clear that a worker who is complying with a Fatigue Management Policy which comes under the Health and Safety management system of the mine is covered in the event of a journey claim.
20. That a Central Queensland Road Safety Committee be established to conduct ongoing safety audits of road surfacing to Central Queensland mines, mining towns and regional centres and that consideration be given to funding the Committee through existing mining royalties.
21. That a comprehensive audit be engaged in by the Department of Main Roads and Queensland Transport of Central Queensland roads to consider the appropriateness and risk posed by existing road width, road shoulders, the need or appropriateness of road signage, adequacy and/or need for additional rest areas and identification of fatigue zones where additional fatigue counter-measures might be considered.
22. That the [location] Road be prioritised by Department of Main Roads for road upgrade and road widening between [location] and [location].
23. That Queensland Transport and the Queensland Police Service in conjunction with suitable road safety organisations (such as RAGG and MIRSA) and taking advice from fatigue experts review existing public education campaigns on driver fatigue and develop and implement new public education campaigns on driver fatigue and driver inattention to improve effectiveness of the campaigns.
24. That the Queensland Government prioritise initiatives to address fatigued driving as a critical public safety issue.

VIC.2009.2008, 2009, 2010 Transport & Traffic Related/ Child & Infant Death/ Weather Related

A bus lost control on a bend in wet weather and rolled, ejecting passengers. The three deceased, including a child, were pinned underneath the vehicle and were not able to survive their injuries.

Recommendations

- I recommend that VicRoads review their road maintenance system in light of this finding, and the Comments and Recommendations from [names] and implement a "best practice" system for inspecting, monitoring, auditing, funding and repairing road surfaces to minimise the risk of crashes. This system should also incorporate specific considerations relating to the incidence of extreme climate events and road surface management.
- I recommend that the Victorian Government ensures that VicRoads is adequately resourced to ensure the implementation and sustainability of these Recommendations relating to road maintenance and risk.
- I recommend that the Bus Industry Confederation of Australia in conjunction with Transport Safety Victoria, develop a policy for drivers operating buses with seat belts fitted, to play a recorded audio message or make an announcement at certain intervals, advising bus passengers of their requirements to wear the seat belt provided. Such messages would need to emphasise the importance of seat belts in the event of a crash, and the applicable penalties for failing to comply.

VIC.2009.2008, 2009, 2010 continued

- I recommend that the Bus Industry Confederation of Australia in conjunction with Transport Safety Victoria, introduce a policy for stickers to be provided on all seats of buses fitted with seat belts in order to improve compliance. Such stickers should emphasise the importance of seat belts in reducing the risk of injury, and monetary penalties associated with non-compliance.
- I recommend that Transport Safety Victoria introduce a requirement for child restraints to be made available on all buses operating in Victoria that are subject to ADR68/00.
- I recommend that in the event child restraints are made mandatory for buses subject to ADR68/00 in Victoria, the Department of Transport review the Road Rules 2009 to define the responsibilities for ensuring that a child is suitably restrained in a bus.
- I recommend that Transport Safety Victoria in conjunction with the relevant road safety agencies such as Victoria Police and VicRoads, ensure that a comprehensive strategy is developed to improve seat belt compliance and passenger awareness of the importance of seat belts.
- I recommend that Transport Safety Victoria monitor seatbelt compliance rates on buses operating in Victoria to evaluate the effectiveness of initiatives taken (as recommended above) to improve compliance.
- I recommend that the National Transport Commission work in conjunction with the Bus Industry Confederation of Australia to investigate bus occupant safety measures in addition to seat belts, including retentive window glazing

VIC.2009.3834 Transport & Traffic Related/ Leisure Activity/ Youth

A youth had been riding dirt bikes on a property with other youths on another motorcycle and an unregistered car (paddock basher). The deceased on his bike has collided with the car and the car has driven over the top of the deceased, causing fatal injuries.

Recommendations

- That the Department of Health implement a Victorian Injury Prevention Strategy and place off-road motorcycling safety as a key priority under this Strategy.
- That as part of the Victorian Injury Prevention Strategy, the Department of Health facilitate a targeted awareness campaign to address the safety of children riding motorcycles informally with friends and family.
- That VicRoads establish a sub-committee of the Victorian Motorcycling Advisory Council whose prime responsibility should be examining off-road motorcycling in order to develop evidence-based strategies to reduce the number of injuries. The committee members should extend beyond road safety groups to include appropriate bodies such as the Department of Sustainability and Environment, the Department of Health and off-road riding associations.

VIC.2010.3023 Transport & Traffic Related/ Drugs & Alcohol

The deceased lost control of their vehicle on a curve on a carriageway and impacted a fence and gates at the front of a property. The deceased was intoxicated, speeding and not wearing a seatbelt.

Recommendations

It is my opinion that the current speed limit in the collision area may need to be reviewed. The current posted speed limit is 100 kilometres per hour. I believe that an 80 kilometre per hour speed limit would be more appropriate, taking into account the carriageway width, the curves and the number of intersections and private driveways in the immediate area.

WA.2008.1709 Transport & Traffic Related/ Youth

The deceased youth was hit by a taxi while walking home in the early hours of the morning. The driver of the taxi claimed that the deceased appeared directly in front of him without any time to stop. The deceased died from the injuries sustained in the collision.

Recommendations

- I recommend that the Commissioner of police take steps to ensure that orders and directions relating to evidence capture at scenes of serious and fatal traffic collisions are complied with by attending police

WA.2008.1709 continued

- I recommend that consideration be given to amending the Road Traffic Act 1974 to create an offence similar to that provided for by section 2B of the Road Traffic Act 1988 (UK)
- I recommend that WA police continue to monitor the interaction between the Major Crash Investigation Section and other police units to ensure that there is certainty as to who has ownership and carriage of the investigation of all serious traffic crashes.
- I recommend that the Major Crash Investigation Section's charter of responsibility be reviewed and the criteria which indicate when the section is to investigate be amended to provide greater certainty for police involved and to better reflect in which cases and at what stage of investigations the specialist expertise of the section can be best used.

NSW.2009.1835 & 2119 Water Related/ Leisure Activity

Two people drowned after being washed off a rock ledge by a wave whilst fishing.

Recommendations

To the Minister for Industry and Investment:

- That research be undertaken under the authority of the Department to:
  - ◊ Identify the demographic groups most at risk of drowning related to rock fishing fatalities, and
  - ◊ Identify and assess the effectiveness of all educational, enforcement and engineering safety methods currently used to prevent such fatalities.
- That the results of such research be used to develop a rock fishing safety program for New South Wales.

NZ.2009.1613 Water Related/ Physical Health

The deceased drowned while checking whitebait stands. The deceased was a diabetic, and this may have affected his balance.

Recommendations

Section 32 of the Act requires a Coroner to take into account the existence and extent of any allegations, rumours, suspicions or public concern about the cause of a death. The real cause of the death was *"unusual"* or *"violent"* as defined by the Act, and required my investigation. There is little public speculation as to the circumstances of the death, but it is appropriate when, completing a Finding on deaths in such circumstances for me to ensure that the circumstances of the death are brought to public attention.

NZ.2009.1665 Water Related/ Leisure Activity

The deceased had been fishing with some friends when a line snagged. The deceased entered the water to untangle the line, but got into difficulty when the boat drifted away. The deceased was unable to be rescued and was discovered deceased the next day.

Recommendations

ALL PEOPLE IN SMALL BOATS SHOULD WEAR LIFE JACKETS AT ALL TIMES. That is at all times; not just when the water gets choppy; not just for children; not just when the boat is moving. You do not take your lifejacket off when you are fishing, you wear your lifejacket all of the time.

If [the deceased] had been wearing his lifejacket he may have been able to return to the boat or get instructions to [friend] on how to start the boat to obtain a rescue. If [friend] had been wearing a lifejacket he would have been more confident in his ability to get to [the deceased] and affect a rescue.

I ask that the media give publicity to this recommendation, and a copy of my Finding will be forwarded to Maritime New Zealand (MNZ) to support a call for compulsory use of lifejackets in all boating situations.

I recommend that MNZ consider a publicity programme whereby casual users and passengers in boats can be told the basics of safe boating - how to start, how to steer so that a tragedy such as the death of [the deceased] is not repeated.

TAS.2008.142 & 419 Water Related/ Leisure Activity

The two deceased were an autistic youth and his carer who had taken the youth and another child to the beach for the day. The youth and the carer entered the water on Clifton Beach in adverse water conditions. Both persons were swept away, with human bones found in the following months that positively identified both deceased. The presumed cause of death was drowning.

Recommendations

I recommend that the Secretary when out-sourcing care of young persons with complex and exceptional needs, that he require the potential or actual care providers to address specifically

- staff to client ratios in any such care situations, and
- the training of staff in the particular care needs of each individual child and the assessment of risk to that child in any environment, and
- a developed and documented policy about excursions and the management approval of such excursions, and
- a developed and documented policy whereby management receive in a timely fashion and respond in a timely fashion to incident reports concerning the interactions between carers and children, and
- a developed and documented policy to report to the Secretary relevant incidents involving the care and welfare of a child in care.

WA.2008.1797 Water Related/ Leisure Activity/ Transport & Traffic Related

The deceased was snorkelling and spear fishing in relatively shallow water, used by campers and day trippers who travel to the area, when he was run over by a commercial passenger boat that had 12 passengers on board.

Recommendations

The boat was travelling at a high speed in an area close to a beach and in a marine life sanctuary. The only restriction on its authorised speed of 30 knots was in the area within 45 metres off shore and in water of a depth of 3 metres or less. The restriction is a speed of 8 knots. This restriction is clearly insufficient to ensure the safety of all users in the [location] Park and I recommend as follows:

- I recommend that the Department of Transport, in consultation with the Department of Environment and Conservation, consider imposing speed restrictions on vessels travelling within the waters of the Shark Bay Marine Park, and in particular imposing a speed restriction requiring that a person shall not drive a boat at a speed exceeding 8 knots within 150 metres of the low water mark.

WA.2010.1946 Water Related/ Transport & Traffic Related/ Law Enforcement

The deceased was one of 50 asylum seekers who died of drowning after their illegal boat that had entered Australian waters, was washed into rocks and sank.

Recommendations

- I recommend that Border Protection command continues to examine ways of improving its surveillance capability around [location] Island so that the risk of Suspected Irregular Entry Vessels (SIEVs) arriving undetected is reduced.
- I recommend that Border Protection Command implement a surveillance strategy, possibly with the assistance of other Commonwealth authorities and organisations on the island such as the AFP, which heightens its coverage at times when the weather and sea conditions are rough.
- I recommend that the Australian Federal Police (AFP) take steps to determine whether access can be obtained to the National Search and Rescue Council endorsed drift modelling program SARMAP covering the Australian search and rescue region as well as adjoining tiles for Indonesia. Steps should be taken to ensure that if possible, coverage would include high traffic areas where SIEVs enter the Australian Search and Rescue Region, allowing timely search and rescue plans to be drawn up for any potential incidents
- I recommend that the AFP takes steps to ensure that there are on [location] Island at all times appropriately trained AFP officers who have completed the National Police Search and Rescue Manager's course and that up skilling should be ongoing to establish a cadre of trained search and rescue personnel.
- I recommend that the AFP be provided with a search and rescue vessel which is suitable to the specific conditions of [location] Island. I further recommend that steps be taken to ensure that if for any reason, the search and rescue vessel is not available; there is a replacement vessel on [location] Island capable of providing an emergency response in difficult sea conditions.

WA.2010.1946 continued

- I recommend that consideration should be given to acquiring two personal water craft for deployment by appropriately trained and equipped staff of the AFP or the Volunteer Marine Rescue Services VMRS) or both on [location] Island.
- I recommend that the Commonwealth and the Shire of [location] Island take steps to ensure that the [location] Beach Boat Ramp is significantly upgraded, that it should be provided with shelter in the form of a rock groyne or similar buffer and that provision should be made so that a person can walk beside the ramp on a stable footing; or
- If this is not considered likely to be effective in providing an appropriate means of deploying a rescue vessel in adverse conditions, such other action be taken as is necessary to ensure that there is a means of deploying a rescue vessel in adverse conditions.
- I recommend that the Commonwealth liaise closely with representatives of the [location] Island VMRS prior to purchasing or replacing any vessels for the VMRS in the future.
- I recommend that the [location] Island VMRS be given autonomy to maintain operational readiness for the VMRS rescue vessel (s) and an appropriate budget be provided to allow this to take place.
- I recommend that arrangements be put in place which would remove the requirements for Masters of Volunteer Marine Rescue vessels to hold a commercial certificate of competency. Operators could then be qualified through the Fire and Emergency Services Authority (FESA) Volunteer Marine Rescue Training Pathway as skippers and crew. This would increase the number of available skippers in the event of a search and rescue incident and would make appropriate training easier to arrange.
- I recommend that Border Protection Command establish an onshore presence as recommended by Lieutenant [name]
- I recommend that the Commonwealth ensure that there is a mooring buoy which will enable the mooring of SIEVs to take place and free up the [location] Island response vessel for ongoing surveillance duties.
- I recommend that the Commonwealth prioritise completion of hydrographic survey of [location] Island and ensure that such a survey is completed in the near future.
- I recommend that the issue of Rigid Hulled Inflatable Boat (RHIB) jet intake protection be allocated a high priority and that there be ongoing investigation of possible solutions to reduce the problem.

WA.2011.289 Water Related/ Leisure Activity

The deceased was collecting crayfish on a reef edge with 3 other people when a surge of water pulled them all into a deep channel. The deceased was swept out of the channel towards the open ocean and was not recovered.

Recommendations

- I recommend that Australian Federal Police give consideration to acquiring a shallow drafted vessel for emergency responses in shallow water in the [location]) Islands
- I recommend that Australian Federal Police urgently review their assets available for response to incidents in the [location] Islands.

NSW.2007.6295 Work Related

An apprentice gas fitter died while installing a gas heater from a high exposure to butane which caused a hypoxic brain injury and cardiac arrhythmia.

Recommendations

To the Minister responsible for the WorkCover Authority of New South Wales and to the Chief Executive Officer of the WorkCover Authority of New South Wales:-

- That the WorkCover Authority of New South Wales issue a Safety Alert advising industry that the presence of butane in liquid petroleum gas ("LPG") products has the capacity to induce a fatal cardiac arrhythmia, ventricular fibrillation or asystole upon exposure to high concentrations of LPG, for example upon the failure, or intentional severing, of an LPG gas supply line.
- That the Coroner recommend that the WorkCover Authority of New South Wales issue a Safety Alert advising industry that Material Safety Data Sheets authored and/ or issued with respect to LPG should include toxicological data and warnings relating to the risk of fatal cardiac arrhythmia associated with the presence of butane in LPG.

NSW.2007.6295 continued

To the Minister for Commerce and the Minister for Fair Trading:-

- I recommend to the Minister for Commerce and the Minister for Fair Trading, in their ministerial capacities relating to the administration of the Home Building Act 1989 (NSW), that as a matter of urgency they notify all holders of contractor licences authorising the holder to contract to perform and/ or perform specialist gas fitting work as defined in the Act that the presence of butane in LPG products has the capacity to induce a fatal cardiac arrhythmia, ventricular fibrillation or asystole upon exposure to high concentrations of LPG, for example upon the failure, or intentional severing, of an LPG gas supply line.

To the Minister for Education and Training:-

- I recommend to the Minister for Education and Training that as a matter of urgency the Minister direct TAFE NSW to incorporate in its learning programme(s) including, but not limited to, the Certificate III Course in Plumbing a warning or Safety Alert that the presence of butane in LPG 16 products has the capacity to induce a fatal cardiac arrhythmia upon exposure to high concentrations of LPG, for example upon the failure or severing of an LPG gas supply line.

To the Proper Office, Australian Liquefied Petroleum Gas Association Limited, trading as LPG Australia:-

- I recommend that the Proper Officer of Australian Liquefied Petroleum Gas Association Limited, trading as LPG Australia, notify its members, and in particular members who manufacture and/ or supply liquid petroleum gas ("LPG") that the presence of butane in LPG products has the capacity to induce a fatal cardiac arrhythmia, ventricular fibrillation or asystole upon exposure to high concentrations of LPG, for example upon the failure or severing of an LPG gas supply line.
- I recommend that the Proper Officer of LPG Australia notify its members, and in particular, members who manufacture and/ or supply LPG, of the view expressed in the course of the inquest touching upon the death of [deceased] by Professors [name] and [name] that Material Safety Data Sheets authored and/ or issued with respect to LPG should include toxicological data and warnings relating to the risk of fatal cardiac arrhythmia, ventricular fibrillation or asystole associated with the presence of butane in LPG.

To the Minister responsible for the WorkCover Authority of New South Wales, the Minister for Energy, Minister for Commerce and the Minister for Fair Trading and to the Chief Executive Officer of the WorkCover Authority of New South Wales:-

- I recommend that the Ministers and the Chief Executive Officer give urgent consideration to referring the regulation of private gas distribution networks, where those distribution networks are contained entirely, and operate solely, within the confines of private property, to the relevant officer and/ or standards committee of Standards Australia with a view to the development of a standard designed to regulate the design, construction, extension and operation of such networks.

To the Commissioner of NSW Fire and Rescue:-

- I recommend that the Commissioner of the Fire and Rescue NSW conduct a review of recording procedures relating to the keeping of records disclosing gas readings, including, but not limited to, gases detected and such other data as may be logged by gas detection units in use from time to time by the Fire and Rescue NSW, with a view to ensuring that all such data obtained with respect to attendances at incidents involving serious personal injury and/ or death are maintained

NZ.2009.2985 Work Related/ Electrocution

The deceased was an electrician who was installing lights in a renovated property. While connecting a junction box in the ceiling, the deceased was electrocuted and was unable to be resuscitated.

Recommendations

- The Department of Labour (DoL) report notes that best practice would have been for the lighting circuit conductor to have been removed from the circuit breaker terminal, and the conductor connected to the earth terminal in the switchboard before work commenced on the circuit. It is also noted that the practice of taping off switches controlling electrical circuits is unfortunately still widely used in the industry.
- The DoL report also recommends that additional training in isolation procedures be carried out for electricians at [company] Electrical Limited, and a copy of the report be sent to that company.

I fully endorse such a recommendation, and trust that the lessons learned from [the deceased's] tragic death will be circulated amongst the entire electrical industry.

SA.2004.1627 Work Related

An apprentice died after becoming caught in a horizontal boring machine. The machine was extremely old and had no guarding or safety devices.

Recommendations

- I recommend pursuant to section 25(2) of the Coroners Act that the SafeWork SA Advisory Committee, established under the Occupational Health, Safety and Welfare Act 1986, examine the practices of SafeWork SA in the period preceding 5 June 2004 in order to consider the adequacy of the inspection regime that was then in place.
- I recommend pursuant to section 25(2) of the Coroners Act that SafeWork SA Advisory Committee examine the practices of SafeWork SA in the period after 5 June 2004 in order to consider the adequacy of the inspection regime that has been in place since then
- As a matter of law reform, I suggest that the Government consider a major reform of the current system of criminal prosecution for fatal industrial accidents. In my opinion it is just wrong that the prosecution of [company] took 5 years to arrive at a plea of guilty. There must be a way to improve that. It seems to me that the family of a person killed in a workplace accident may be better served by seeing an open public inquiry convened within 12 to 18 months of the accident, than a criminal prosecution which might never result in the public hearing of any evidence, and which takes more than three times that long to even start. I suggest that consideration be given to a reform of the law which would enable the following things to happen:
    - ◊ Coroner intimates that where no charges to be laid against any person in connection with the accident, an inquest would be held;
    - ◊ Family elects whether they would prefer that the matter be the subject of an inquest, or the subject of the usual criminal process;
    - ◊ If the family elects that they would prefer that there be an Inquest, the prosecuting authorities (including the DPP) would be empowered to intimate that no person or company would be prosecuted under the Occupational Health, Safety and Welfare Act or any other law. Such intimation would then operate as a bar against future prosecution and, accordingly, no person would be exposed to the risk of self- incrimination in answering questions at the Inquest, with the result that the Court could insist that answers be given, notwithstanding that they might otherwise be refused on that ground.

This is a suggested law reform, not a recommendation under section 25(2) of the Coroners Act. That is because of the way section 25(2) is framed, being limited to recommendations that might prevent or reduce the likelihood of events similar to the event the subject of the Inquest. If section 25(2) permitted recommendations concerning the administration of the law, as the corresponding provision in the Coroners Acts of some other jurisdictions do, I would have made this suggestion a recommendation.

NSW.2009.4294 Youth/ Homicide & Assault

A youth died of a basal subarachnoid haemorrhage suffered after getting into a fight at school.

Recommendations

I recommend to the Ministers for Education and Industrial Relations, and the Workcover Authority, the Occupational Health and Safety guidelines relating to the contents of school First Aid kits be amended to require the inclusion of mouth-to-mouth resuscitation masks.

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 familiy 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