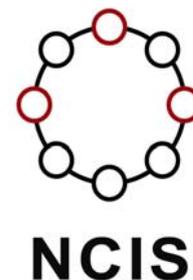


NCIS

Fatal Facts

Edition 33

NCIS Fatal Facts



Fatal Facts is produced by the National Coronial Information System (NCIS) for public circulation. It contains case summaries and coronial recommendations for 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 database 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 (three 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 30th June 2012. The NCIS have populated the tool with all past issues of *Fatal Facts* as well as including all recent issues and cases.

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

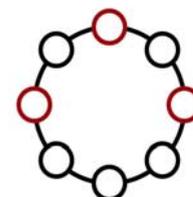
Despite this, it should be noted that they are not authorised summaries or exact replications of coronial findings. The original finding should always be accessed for formal reference.



Justice
and Regulation

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

NCIS Fatal Facts



NCIS

Edition 33 January 2017

In this Edition

Fatal Facts Edition 33 includes cases where the coronial investigation is complete and where the Coronial Finding contains recommendations. Edition 33 includes cases that were closed between 1st April and 30th June 2012. *Fatal Facts* contains a précis of case circumstances and of the coronial recommendations. It 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 33 contains summaries of cases where recommendations were made as part of the formal coronial finding. Of these cases, 62 are Australian cases and 44 are New Zealand cases.

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

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

What is a Coronial Inquest?

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

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NSW.2007.6287 Adverse Medical Effects

A woman died after being administered adrenaline during a day procedure and suffering an anaphylactic reaction.

Recommendations

- To the Australian and New Zealand College of Anaesthetists, that the guidelines on sedation and/or analgesia for diagnostic and interventional medical or surgical procedures PS 9 (2010) be amended so as to require 'non-Anaesthetist Medical Practitioners' to undertake, at not less than twelve monthly intervals, comprehensive and practical training in advanced cardiac and life support at not less than twelve monthly intervals.
- To the Royal Australian College of General Practitioners and the Australian and New Zealand College of Anaesthetists, that appropriate and effective steps be taken to publicise to 'non-Anaesthetist Medical Practitioners' providing sedation and/or analgesia the Guidelines entitled 'Medical management of Severe Anaphylactoid and Anaphylactic Reactions.

NSW.2008.1842 Adverse Medical Effects/ Older Persons

An elderly person died after complications with abdominal surgery, including compromised airflow through a tracheostomy tube that was positioned incorrectly, while being turned in bed.

Recommendations

I recommend that the Royal College of Surgeons and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists consider introducing a mandatory training requirement for postgraduate certification in Gynaecological Oncology that there be a participation in the work of a general surgical unit, particularly in the areas of gastrointestinal and urological surgery, for a period of not less than twelve months.

NZ.2010.2944 Adverse Medical Effects/ Natural Causes/ Physical Health

A person suffering from Duchenne Muscular Dystrophy and reliant on a machine to breathe, died after a power outage caused his Bilevel Positive Airway Pressure (BiPAP) machine to stop working.

Recommendations

- I adopt the recommendation in the Summary of the [location] District Health Board event review summary.
- I recommend that the availability of non-invasive ventilation machines, with a battery backup, be provided for patients such as the deceased who require mechanical assistance to breathe when clinical circumstances dictates that this is appropriate for such patients.
- I direct that this Finding be forwarded to the Ministry of Health to ensure that the Recommendation is considered by all Health Boards.

SA.2008.649 Adverse Medical Effects/ Natural Causes

A person with a history of polio died of pneumonia. The hospital that the deceased attended did not transfer the deceased to a larger hospital when his condition began to deteriorate.

Recommendations

I recommend that the Department of Health support the continuation of the work of the Deteriorating Patients Steering Group with a view to the implementation of systems for the detection and subsequent management of deteriorating patients.

NOTE: Due to five cases of similar circumstances, where the deceased had cancer and was using an alternative treatment involving caesium from a particular medical facility, the WA Coroner made the same recommendations for all cases.

WA.2005.540 Adverse Medical Effects/ Drugs & Alcohol/ Physical Health

A person with cancer died of a caesium induced heart arrhythmia after seeking alternative treatment in a particular treatment centre.

WA.2005.541 Adverse Medical Effects/ Drugs & Alcohol/ Physical Health

A person with cancer died of gastro intestinal haemorrhage and metabolic derangement arising out of a treatment including caesium in a particular treatment centre.

WA.2005.547 Adverse Medical Effects/ Drugs & Alcohol/ Physical Health

A person with cancer died of gastro intestinal haemorrhage and metabolic derangement arising out of a treatment including caesium in a particular treatment centre.

WA.2005.548 Adverse Medical Effects/ Drugs & Alcohol/ Physical Health

A person with cancer died of sepsis arising out of the administration of a treatment including caesium at a particular treatment centre.

WA.2005.706 Adverse Medical Effects/ Drugs & Alcohol/ Physical Health

A person with cancer died after taking caesium from a particular treatment centre.

Combined recommendations

- I recommend a form of restricted access for caesium chloride and other caesium salts in the same way as has been provided for Laetrile (B17).
- I recommend any Visa application for entry into Australia by [name] be closely scrutinised by the Department of Immigration & Citizenship (DIAC).
- I recommend the data available from the operation of [name] in [location] be comprehensively evaluated by relevant experts to provide education and information to medical health practitioner as to the effects of administration of these substances.

WA.2007.929 Adverse Medical Effects/ Indigenous/Mental Illness & Health/ Drugs & Alcohol

An Indigenous person suffering from mental health issues and alcohol addiction died of respiratory arrest in association with medication drug effect and alcohol intoxication. The deceased had been taken to hospital after he had threatened family members with an axe, and whilst in a state of agitation, he was heavily sedated which is believed to have attributed to his death.

Recommendations

- The WA Country Health Service (WACHS) [location] should take immediate steps to employ permanent and/or ad hoc security staff to help medical staff care for and treat agitated mental health patients, so as to minimise the need for prolonged and deep sedation.
- The WACHS [location] should take immediate steps to ensure that when a patient is cared for or treated, without informed consent first having been obtained, then the treating doctor should contemporaneously, or as soon as practicable thereafter, record the fact that the treatment or care has been given without consent and explain the basis upon which the treatment or care was provided.
- The WACHS [location] should take immediate steps to ensure that in the case of patient who is unable to provide informed consent and who needs to be sedated or restrained; then,
 - ◇ The most limited form off sedation/restraint should be applied.
 - ◇ Any period where a person is sedated/restrained needs to limited to the shortest possible period of time.
- The WACHS [location] and the Department of Health should consider providing greater funding for the Royal Flying Doctor Service, so that transfer times for severely mentally ill patients can be minimised.

WA.2010.1311 Adverse Medical Effects/ Youth

A sixteen year old youth died as a result of Pneumonia Complicating Influenza A (Swine Flu) infection. The deceased has contracted the flu and due to a staphylococcus infection already in his blood, contracted pneumonia. The hospital that he attended sent him home stating that he had gastroenteritis, through a nurse who needed to be helped on triage. The deceased died the next day.

Recommendations

- Western Australia Country Health Service (WACHS) develop a standardised online e-learning package for preceptors.
- Nursing rosters make it plain who is a preceptor on any given shift.
- Introduction of a requirement all new nursing staff sign to acknowledge receipt of orientation documentation and that the document they sign contains an index of the documents they receive.
- Mandatory provision of verbal and written advice to all new nursing staff detailing the differences between working in a tertiary hospital in the metropolitan area and a regional hospital such as [name].
- Mandatory provision of verbal and written advice to all new nursing staff detailing the role of receptors and the area/s in which it is believed the new nurse requires support over and above that of adapting to a new regime/facility.
- Mandatory completion of the MR1 (or equivalent) patient name and basic observations at/for every presentation to triage unless impossible due to the patient's state of consciousness and/or required immediacy of treatment.
- The Department of Health continue the roll-out of the new patient system to ensure improved access to clinical information to country hospitals and real time access to patient information.
- Provision of on-site educational workshops to assist in competency compliance in key areas which must include triage. This will require roster support.

TAS.2011.219 Aged Care/ Physical Health

A nursing home patient who suffered from significant mental and physical conditions died after choking on food. The deceased was deemed a 'choking risk' and all food had to be cut up however this was not done on this occasion.

Recommendations

I recommend that all Nursing Homes review their procedures to ensure that patients who are considered as posing a 'choking risk' when eating are adequately supervised at this time, and that all staff having contact with that patient are made aware of all risks associated with that person and that ongoing training is provided to staff members on the appropriate response to patients presenting with choking-like symptoms.

VIC.2007.1357, 1384, 1386 & 1410 Aged Care/ Older Persons

Four residents of an aged care facility died after a salmonella outbreak within the facility.

Recommendations

To ensure appropriate preparation for and management of an infectious outbreak in an aged care facility

- To ensure the Department of Health (in consultation with the Department of Health & Ageing (Commonwealth)) introduce a clear regime which mandate aged care facilities to report infectious disease outbreaks in the facility to the Department of Health. An infectious disease outbreak for this purpose is unexplained vomiting and diarrhoea in two or more residents and/or staff within 72 hours of each other.
- In consultation with the Department of Health and Ageing (Commonwealth), I recommend that the Victorian Department of Health require aged care facilities to have a designated Infection Control Manager. The role of the infection control manager should include (i) outbreak prevention measures; (ii) ensuring readiness for infectious outbreak via documented procedures that are disseminated to and are accessible to all staff; compulsory training regimes for all staff; availability of all necessary equipment and manuals and (iii) coordinating the management of any outbreak including appropriate communication of all notifications and advice to all relevant entities, staff, treating doctors and affected families; identification of the cause; liaising as between all relevant agencies and persons as to the results of any faecal (or other testing for infectious disease) and notifications to the Department of Health.

VIC.2007.1357,1384, 1386 & 1410 continued

- The Department of Health amend its 2010 Guidelines by inserting a requirement that aged care facilities develop a comprehensive document for the facility which sets out in detail what must be done in the event of an outbreak. To this end, the Department of Health may be assisted by the Critical Resources Manual and Outbreak Management Kit developed by Benetas as a model to assist other facilities.
- To assist in the overall daily management of an infectious outbreak, consistent with paragraphs 20 to 23 of the Joint Statement to the Coroner, when an outbreak is assessed as possibly food or waterborne, the Victorian Department of Health Communicable Diseases and Prevention Control Unit should establish an Incident Management Team (IMT). This is to ensure that one lead agency has overall control over the outbreak to manage (i) the timely investigation of the outbreak and (ii) to oversee the infection control measures and (iii) communication and provide guidance and expertise.
- To ensure state wide understanding and consistency in reporting back test results including faecal test results during an infectious outbreak the regime set out in paragraphs 23 to 29 in the Comments section of this Finding be incorporated into the 2010 Guide.

To ensure the appropriate level of knowledge and understanding amongst the medical profession with respect to their responsibilities for mandatory notification of infectious disease and the role of the Department of Health during any infectious outbreak

- In conjunction with the appropriate Colleges and Associations, the Department of Health review the knowledge of general practitioners of the notification requirements as set out in the Regulations and within Departmental Guidelines. This review should be used to inform the nature of measures to be undertaken to improve general awareness of notification obligations upon general practitioners and their knowledge of the role of the Department of Health in an infectious disease outbreak including the limits of the Department's involvement

To enhance communication between locum doctors and treating doctors outbreak

- That operators of locum services make clear to their agency doctors that it is the locum doctor's responsibility to ensure that if in their view a patient in an aged care facility during an infectious outbreak should be reviewed within 24 hours, that such an opinion be conveyed to the nursing staff, the locum service and the treating doctor in the most practical and effective way possible.

VIC.2009.3288 Aged Care/ Adverse Medical Effects

A nursing home patient died of aspiration pneumonia.

Recommendations

That the [location] General Medical Centre review its processes, procedures and documentation in relation to the obtaining of and recording of consent from or on behalf of patients for 'not for resuscitation' status.

WA.2006.1043 Aged Care/ Falls/ Adverse Medical Effects/ Mental Illness & Health

An elderly woman with dementia died after a number of falls in the nursing home she was residing in, causing terminal bronchopneumonia. The deceased had fractured her femur in one of these falls however this was left undiscovered for three months.

Recommendations

- Nursing homes which request doctors to attend in order to review residents consider implementing methods of ensuring that the relevant doctor receives the request, including methods using internet and SMS technology.
- Nursing homes consider implementing a system of providing visiting doctors with documentary notification of all information likely to be particularly relevant to the respective resident's condition. I have in mind as potential systems the 'doctor's folder' system discussed above and, though not discussed in evidence, the use of electronic folders sent to the relevant doctor as part of emailed requests to attend.
- Nursing homes consider adopting the system of patients' notes in which nurses' notes are integrated with doctors' notes so as to render them more accessible by visiting doctors.

NZ.2009.62 Child & Infant Death/ Adverse Medical Effects

An infant died of intrapartum asphyxia during birth. There was a prolonged second stage of labour, foetal malposition and uterine rupture, causing the death of the infant.

Recommendations

- The Ministry of Health should reconvene the consultative group that reviewed the referral guidelines and consider amendments to the Referral Guidelines 2012 which:
 - ◇ Clarify the definition of the commencement of second stage of labour in the light of the findings in this case to remove any ambiguity;
 - ◇ Provide a process for the transfer of clinical responsibility for midwifery care from the Lead Maternity Carer (LMC) to secondary midwife care that involves a conversation between the LMC, the secondary midwife, the woman concerned and any specialist involved, to determine that the transfer of midwifery care is appropriate and acceptable, and determine the respective roles and responsibilities.
 - ◇ Reword paragraphs 1 and 2 'Purpose' and 'Guiding Principles' to:
 - State that the Referral Guidelines were formulated following extensive consultation with Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and New Zealand College Of Midwives (NZCOM), is evidence based and is considered good and safe practice;
 - Emphasise that the Referral Guidelines should be followed in most cases.
- The [location] District Health Board require that its obstetrics registrars consult with their respective supervising specialist in respect of every woman that has transferred from primary care.
- The Midwifery Council of NZ:
 - ◇ Review midwifery training to ensure that training is consistent with the Referral Guidelines;
 - ◇ Encourage midwives within their first years of practice, to practice within the safe harbour of the Referral Guidelines;
 - ◇ Consult with the NZCOM and Health Workforce New Zealand, with a view to reviewing the Midwifery First Year of Practice Programme, with particular emphasis on the mentoring aspect of the programme, with a view to changing the mentor to a supervisor;
 - ◇ Work with the Ministry of Health to make the Midwifery First Year of Practice Programme compulsory;
 - ◇ Review the roles and descriptions of midwives who provide collegial support, supervision and oversight to colleagues.

NZ.2009.4037 Child & Infant Death

A six month old infant died from a sudden unexplained death in infancy (SUDI) after being put on his stomach to sleep.

Recommendations

It is recommended that Well Child Providers such as Plunket, Tamariki Ora and others be engaged with expectant mothers from about week 36 of their pregnancy so that these carers are able to engage with the family at the earliest opportunity to educate and develop safe sleeping practices and other best practices for the newly born.

NZ.2009.4049 Child & Infant Death

A one month old baby died after co-sleeping with his parents, who had consumed alcohol the previous evening.

Recommendations

The Court refers to the recent Findings into the Inquest into the death of Baby I released by the Coroner's Court on [date]. Those Findings were referred to in discussion with the family and the grandmother was urged to explain the risks to her daughter and not have the new baby sleep with the parents. The risks of unsafe sleeping arrangements, tiredness and alcohol were fully explained.

NZ.2009.4049 continued

In the Baby I decision, all of this was fully examined and the Court refers and relies on those Findings as being directly applicable in the facts before it. The obvious inference here is that the deceased may well be alive today had he not been sleeping in the same bed as his parents who were tired and affected by alcohol.

The recommendations referred to in paragraph 38 and 39 of Baby I Findings are again adopted in these Findings and they are set out below.

- That the public health advice in relation to safe infant care practices and safe sleeping environments be strengthened and broadened to as to make it clear that:
 - ◊ Bed-sharing by adults and siblings with infants under six months exposes the infant to the risk of death and should be avoided.
 - ◊ The safest place for babies to sleep for the first six months of life is in a cot beside the parental bed.
- That steps be taken by the Ministry to ensure that the same advice is given by public health educators and health professionals in those public health sectors over which the Ministry has influence.
- That the Moe Ora scheme, referred to in para 45, and similar schemes, be encouraged by government and lent every possible support, with a view to ensuring that every new mother and mother-to-be is provided with a cost if she is unable to afford the cost of purchase.

Further Recommendations

- I recommend that the Ministry of Health Website be far more explicit in terms of the risks associated with unsafe sleeping practices and set out a guideline as to safe sleeping practices and unsafe sleeping practices with a graphic warning that if unsafe sleeping practices are followed there is a very real risk that the baby will die.

NZ.2010.3040 Child & Infant Death

A nine month old infant died of septicaemia, possibly through eczematous skin, and consequent fever that was further compounded by the overheating of the room that he was placed in.

Recommendations

I recommend that a copy of this Finding be forwarded to Child and Youth Mortality Review Committee (CYMRC) in order that the circumstances of the death of the deceased can be further explored and identified, to enable appropriate publicity to be given to the circumstances of his death in order that such circumstances do not recur.

NZ.2010.3049 Child & Infant Death

A four month old infant died from acute bronchopneumonia associated with unsafe sleeping conditions.

Recommendations

The issue of unsafe sleeping arrangements for babies has been highlighted in a number of Coronial decisions over the past few years. There have been calls upon the Government agencies and child focus agencies to provide better education and monitoring around safe sleeping practices.

I can only reiterate the principles around safe sleeping. These principles are not new as they have been advocated for some years by Coroners. Nevertheless, they remain important and appropriate:

- To always ensure baby is in their own bed.
- To place baby on their back and appropriately wrapped.
- To ensure baby's face is clear from soft toys, blankets, sheets, clothes or anything that will compromise their ability to breathe unencumbered.
- Place baby where they can't wriggle under blankets or become wedged between mattress and cot.
- Don't use a pillow.

NZ.2010.3049 continued

- Don't sleep baby next to you; other adults; or other siblings of the baby.
- If baby needs to sleep with you they should have their own independent bed whether it be a crib, wahakura or a plain old cardboard box made into a comfortable bed if necessary.

QLD.2009.1266 Child & Infant Death/ Transport & Traffic Related

A child died after running away from her residential care home and being struck by a car.

Recommendations

- The Department review its processes in placing a child in residential care outside of a service agreement, including that a management plan be developed between the Department and residential care facility to closely monitor the child's progress especially during the period before the first Developmental review of the placement and that be put in place prior to the placement of the child.
- The Department develop a field in the Integrated Client Management System (ICMS) which records any past conflict/relationship issues between other children and/or past carers which is easily accessible by Child Safety Officers (CSOs) and Placement Services Units (PSUs) for reasons including placement decisions.
- The Department review its processes concerning seeking feedback from carers following a placement and implement a mechanism of feedback by providing carers with a feedback sheet which is stored in a place easily accessible for staff to relay information to future carers and in order to take that information into account for future placements of the child.
- The Department review its processes concerning reporting requirements by both home based carers and care facilities as to events occurring throughout the placement and reporting processes be streamlined in both instances.
- In particular for care facilities, in addition to the initial phase of operations there should be regular audits by the Department of the existence of appropriate policies and procedures and compliance with best practice models for internal communications, communications with the Department and staff training to deal with complex behaviours and critical incidents.
- The Department ensure that as part of their supervision of CSOs, team leaders or other appropriate personnel must review investigations undertaken of kinship care options and the timeframes set for renewed enquiries in that regard.
- [Company] ensure that it has in place monitoring and internal review processes to ensure the existence of appropriate policies and procedures in all its centres, and compliance with best practice models for internal communications, communications with the Department and staff training to deal with complex behaviours and critical incidents.
- The Queensland Police Service (QPS) ensure all officers acting as District Duty Officer (DDO) or equivalent have completed Incident Command Training prior to acting in such positions if possible but at least that officers have completed the SAP module preparatory to such training.
- The QPS revise OPM sections 12.5 and 17.5 (including the Risk Assessment Guidelines) and map the [location] Search and Rescue SOP against it to ensure
 - ◇ The management of medium risk incidents are more clearly articulated, including when an incident should be escalated to a high risk;
 - ◇ The relevant procedures consistent with each other (SOPs with the OPMs); and
 - ◇ The relevant QPS officers responsible for managing patrols to locate a missing person rather than a full scale search, have the necessary training to coordinate the patrols and manage the incident in an efficient and effective manner.
- QPS consider obtaining a facility to permit 000 calls to be monitored, and, if appropriate, be joined by persons other than the call taker.
- The QPS revise its communication procedures between the DDO and Comco to ensure each know the status of the job, including the areas being patrolled and the areas to be patrolled, and requiring the Comco to consult with the DDO before re-allocating resources from an incident managed by the DDO to another job.
- QPS increase the frequency of the broadcasts of BOLF's (All points bulletin) in searches for missing persons who are classed as 'known vulnerability' such that broadcasts are sufficient in the circumstances to inform the greatest possible number of officers of the information.

QLD.2009.1266 continued

- The Department consider developing an audit tool for examining policies and procedures, internal communication, communication with the Department and staff training of a start up organisation which could be used by the Clinical Trial Management System (CTMS) in the initial phases of the commencement of a residential facility (e.g. monthly site visits to conduct an audit by CTMS until review of the license application is undertaken by the independent assessor).

TAS.2007.289 Child & Infant Death/ Adverse Medical Effects

An infant died of hypoxic brain damage due to birth asphyxia nine days after delivery. The deceased was originally planned to be delivered at home, but the midwife became concerned and they went to hospital. However, there was a delay in the delivery of the infant at the hospital.

Recommendations

I acknowledge that the [Hospital] has investigated the circumstances surrounding this death and taken some steps to address some identified shortcomings. However, it is my recommendation that those steps taken by the hospital be supplemented by a requirement that it adopt a policy requiring each woman who presents, following a failed home delivery, to be immediately reviewed by a consultant obstetrician upon arrival at the hospital. It is hoped that these steps together will go some way to reducing the likelihood of a similar preventable death occurring in the future.

VIC.2011.1452 Child & Infant Death/ Fire Related

A four year old child died after inadvertently lighting a fire while playing with matches. The child suffered burns to 80% of his body and was unable to recover.

Recommendations

- That fire and child safety authorities give consideration to a public safety campaign reminding parents and householders of the need to review the safety of their household if young children are likely to attend the premises.
- That fire and child safety authorities give consideration to a public safety campaign reminding parents and householders that matches and other fire lighting implements should be stored safely and out of reach of young children.
- I direct a copy of these findings be provided to: The family, the Interested Parties; the Minister for Police and Emergency Services; the Minister for Community Services; The Child Safety Unit, Royal Children's Hospital; The Child Safety Commissioner; the investigating member, [name]; Senior Station Officer [name], Country Fire Authority [location]; [name]; The chief Fire Officer, Country Fire Authority and the Chief Fire Officer, Metropolitan Fire Brigade.

VIC.2011.3607 Child & Infant Death/ Transport & Traffic Related

A five year old child died after being struck by a truck whilst out on a walk. The deceased had run across the road and the truck driver was unable to avoid the collision.

Recommendations

In recent days announcements have appeared in the media of an intention to construct a footbridge across [name] to the east of and separate from the road bridge to avoid similar tragedies. I recommend that this project be given the highest priority by those who are responsible for such works.

WA.2008.419 Child & Infant Death/ Adverse Medical Effects/ Indigenous

An Indigenous infant born at a small hospital died after inhaling meconium during the birth process and contracting perinatal pneumonia. Despite being born seemingly healthy, her condition deteriorated and she was not monitored regularly. She was taken by ambulance to a larger hospital, however there were no nurses or doctors sent with the ambulance to treat her in transit.

WA.2008.419 continued**Recommendations**

- I recommend that Western Australian Country Health Service put in place a system whereby the taking of observations by nursing staff in appropriate cases is audited.
- I recommend that Western Australia Country Area Health Service put in place a system whereby note taking of staff is audited on a regular basis.
- I recommend that all medical staff in regional areas of Western Australia be informed about the existence and function of Newborn Emergency Transport Service (NETS).
- I further recommend that information about the existence and function of NETS be provided to visiting medical practitioners as part of their orientation.
- I recommend that the WA Department of Health review the process of induction for visiting medical officers from overseas with a view to ensuring that those practitioners are better equipped to deal with emergencies which may occur in country hospitals.
- Further, I recommend that the WA Department of Health put in place a system whereby visiting medical officers have improved access to advice and assistance from suitably qualified medical experts in a supportive environment.

WA.2008.882 Child & Infant Death/ Indigenous

A six month old Indigenous infant died after co-sleeping with parents. The infant had been removed from her parents due to concerns for her safety after her mother was hospitalised with mental health issues, and her father was incarcerated. Her parents were not informed of the risks of sudden infant death upon the deceased's return to their care.

Recommendations

- I recommend that the Department for Child Protection (DCP), the [location], offer the Best Beginnings Program (or any subsequent and similar program) to all new parents with whom the DCP has dealings so that the program draws the widest participation from the broadest range of the population, particularly those parents whose circumstances are challenging.
- I recommend that WA Health work with other stakeholders (Community Health Nurses, the DCP, Aboriginal Medical Health Providers, SIDS and Kids and other interested groups) to work towards developing and transmitting a coherent message relating to the known risks that can cause unexpected infant mortality. In providing that information to Aboriginal parents it should be developed and delivered in a culturally appropriate and relevant way.
- I recommend that the Department of Health develop a tab in its purple book (or subsequent iteration), that gives parents advice about the fact of sudden infant deaths, the factors that are reasonably thought to be associated with those deaths and practical advice as to how to reduce the risks to a child. For example, Parents should be provided with appropriate information about their child's safe sleeping arrangements, the risks associated with a child being exposed to second-hand smoke and a child being kept in an environment that is too warm.

NZ.2009.4022 Drugs & Alcohol/ Youth

A fifteen year old girl died following an overdose of heart medication. The deceased had received a number of abusive text messages from the wife of her former boyfriend before she ingested the tablets.

Recommendations

The Court recommends that these findings be forwarded to the Law Commission, to the Attorney General and to the Minister of Justice.

The Court recommends that there be a new law enacted to adequately provide culpability and a penalty provision which has a deterrent effect that covers the new forms of cyber communication (including texts, computers, Facebook, Twitter, and other forms of social media) and is particularly hard on abusive and malicious content. That new law should particularly note the vulnerability of young people as an aggravating factor.

NZ.2010.2562 Drugs & Alcohol

A person suffering from alcoholism died after drinking cleaning fluid to become intoxicated.

Recommendations

It is the essential function of a Coroner to draw to public attention the causes of a death and the circumstances of a death in order that the circumstances, if drawn to public attention, may reduce the chance of further deaths in similar circumstances. The deceased was an alcoholic. He, whilst likely affected by alcohol, chose to ingest an inherently dangerous substance, careless of its effects on him. In particular, the advice of Environmental Science and Research (ESR) in relation to the cumulative central nervous system depressant effects of the various substances taken by the deceased needs to have its dangers publicised. Those drinking to excess and consuming products not designed to be consumed do so at their peril.

In addition to calling for appropriate publicity to be given to this Finding by the media, I direct that same be forwarded to the Drug and Alcohol Addiction Centre, Otago University, Christchurch for the attention of [name].

NZ.2010.3072 Drugs & Alcohol

A woman who suffered from a number of health issues for which she was prescribed medication, died of cardiac arrhythmia following an overdose of prescription medication.

Recommendations

I will ensure this Finding is reported in the media with the message that the public need to be made aware that prescribed medications are to be taken exactly as recommended by the doctor who prescribed them. It is inappropriate for a patient to vary a prescription as a patient is likely to lack the appropriate knowledge of the consequences.

TAS.2008.323 Drugs & Alcohol

A drug user who sold her take-away methadone for other drugs, died of a drug overdose.

Recommendations

From information available to me during my investigation, it would seem that the prescribing of take-away doses of methadone contrary to advice or without close assessment of each patient; or a lack of understanding of the risks to the patient; or the prescribing of two or more incompatible drugs; or the failure to recognise optional treatment; or a lack of understanding of addictive behaviour and possible associated mental health issues- is not an uncommon systems failure within Australia. I would recommend and urge medical schools to ensure appropriate training of new medical practitioners in those areas and the continuing and regular education/professional development of all such practitioners engaged in these complex areas, including skills in the objective assessment of subjective information provided by patients.

As I understand it, accreditation of medical practitioners to prescribe opioids can be removed by Alcohol and Drug Services (ADS) and/or Pharmaceutical Services (PSB) or under the provisions of the Poisons Act for non-compliance with best practice or if the prescribing of pharmaceuticals is placing patients at risk. I recommend a firmer system of enforcement of those obligations in appropriate cases.

It is not the first time similar issues to those raised by me in and about the cause of this death have been commented upon by Tasmanian Coroners. I adopt and repeat the following recommendations of Coroner Chandler in the inquest into the death of [name] which occurred on [date]:

The foregoing leads me to recommend that prescribing clinicians, when considering whether a patient should be authorised to use 'takeaways' as part of a methadone or buprenorphine programme, should have regard to the patient's personal and domestic circumstances and in particular whether the patient resides with a person who is mentally unstable and at risk with respect to drug misuse. In these circumstances the patient should not be authorised to use 'takeaways' unless the clinician can be satisfied that the drugs will be safely and securely stored so that the co-resident is unable to gain access to it. An esky is not a suitably secure place. It is my further recommendation that any decision made to authorise the use of 'takeaways' be continuously reviewed by clinical assessment and by consideration of information provided by the patient and by other health professionals regarding the patient's living and social circumstances.

TAS.2008.323 continued

Assessment of clinical stability and of any patient and public safety issues should form a routine part of clinical assessment each time the patient is reviewed by his/her prescriber. Such review will enable the prescribing physician to consider his/her assessment of the patient's need for 'takeaway' doses in the light of any change in the patient's circumstances including his/her domestic arrangements.

For all of the above reasons and my concerns, I propose forwarding a copy of my findings to the Chief Pharmacist; the Medical Council; the Australian Health Practitioner Registration Agency and the Dean of the Medical School at University of Tasmania (UTAS) for their consideration and further investigation, if considered necessary.

It is also important to bring to the attention of the community that in 2010, of the 14,679 medical registrars under tuition in Australia for entry into differing specialities, only 11 of them were being trained in the speciality of addiction medicine. In this ever burgeoning problem area, that must be of considerable concern to our community.

My investigations also lead me to a strong conclusion that experienced long-term users of prescribed opioids are adept at so-called 'doctor shopping' to obtain multiple prescriptions and then selling part or all of their 'takeaway' methadone doses to illicitly fund their preferred drug such as benzodiazepines. They can also be adept at demanding the prescription of a particular drug and I can accept that from time to time with the constraints of the Medicare system and the lack of time available to medical practitioner in some cases, they may prescribe according to the wish of the patient rather than by full objective assessment of needs. However, in my view that does not absolve them from their responsibility of ensuring proper treatment and prescription in the best interests of the patient.

In April 2010 when handing down a finding of a death of a person who was clearly 'doctor shopping' for multiple drugs, I recommended the acceleration of a proposal for a national and centralised register accessible by medical practitioners and pharmacists, to provide data which would undoubtedly minimise this practice to the benefit of the patient and the community.

So it is on a more positive note and very pleasing to discover that Tasmania is now leading the country in the implementation of real-time notification of the prescription of all Schedule 8 drugs in Tasmania. This innovative system has been developed over the past two years or so and has now captured about 95% of pharmacies dispensing reportable drugs such as Schedule 8 drugs including opioids and the benzodiazepine alprazolam. A new system is now being rolled out to community GPs which will allow them to be able to connect to a special database. This database will give them access to appropriate information to support their decision to prescribe opioids. This information will relate only to the patient being treated and not third party information.

In my view, such prescribers need this support at the time of prescribing drugs of dependence especially if the patient is not known to them. Access to this data will be available in real time once GPs are connected via their desktop computers. It is my recommendation that any medical practitioner prescribing opioids and in particular any practitioner accredited as a prescriber of opioid pharmacotherapy must follow standard good clinical practice and check that database before prescribing. Alternatively, if they are unable to access the database they will have the option of contacting PSB direct.

VIC.2009.2117 Drugs & Alcohol/ Mental Illness & Health

A man with a long history of polysubstance abuse died following a drug overdose. The deceased had been admitted to hospital due to his mental state and risk of self-harm, but had been discharged back to a residential accommodation facility.

Recommendations

I recommend that the [name] Hospital Psychiatric Unit and [name] Welfare Services review the Referral Form/ Discharge Plan with the view to including an additional space for 'Issues of concern to the patient/client' and 'action Taken'. The inclusion of the patient's subjective concerns and the action initiated, if any, will assist the case workers in communicating with the client on their arrival at [name and location] and empower the case worker to address, as far as possible, the client's concerns.

VIC.2010.3766 Drugs & Alcohol/ Transport & Traffic Related

An intoxicated person had an argument with friends and died when they were struck by a train after they had walked away from the group.

VIC.2010.3766 continued**Recommendations**

- That the responsible rail authorities erect a fence along the boundary between the maintenance access road and the rail reserve between [name of streets] to restrict pedestrian access to the rail track.
- That an assessment be made of the need to reinforce the existing fence at the site where the western side of the rail reserve meets [name of street].

NZ.2010.3127 Falls/ Older Person

An elderly woman visiting friends fell one and a half metres down a flight of stairs, resulting in fatal injuries to her head.

Recommendations

The Court recommends that these Findings be forwarded to the Minister of Housing and that the Minister considers the most appropriate way to ensure that relevant Council Building Codes for properties that take members of the public in to stay, whether or not formally run as a business, must comply with reasonable safety standards and that they be regularly inspected to ensure that they continue to comply.

NZ.2011.2784 Falls/ Older Person/ Physical Health

An elderly person with an intellectual disability who lived in a residential home, fell down a set of stairs, resulting in head injuries. The deceased was able to return to his room, however later died of cardiac arrhythmia due to the head injury.

Recommendations

I recommend to [organisation] that:

- To the extent that it has not already done so, it implements the recommendations in the Final Internal Investigation Report into the death of [deceased] completed by [name] and dated [date].

VIC.2008.3635 Fire Related/ Drugs & Alcohol

An intoxicated person died of burns after his clothing became after sitting on the brick hearth of an open fireplace at a pub.

Recommendations

- That the Australian Hotels Association- Victoria use the circumstances of the deceased's death to encourage their members to consider open fireplaces as a hazard that requires appropriate controls, such as the installation of guarding that cannot readily be removed by patrons.
- That the Director of Liquor Licensing Victoria provides information to all new and existing licensees regarding the management of patron risks associated with open fireplaces. This information could be incorporated into existing publications provided to licensees, such as the Design Guidelines for Licensed Venues and the revised Venue Safety Audit. Licensees should be encouraged to guard open fireplaces, and have a process to prevent the removal of fireguards by patrons in order to prevent fire related injuries.

WA.2007.759 Fire Related/ Physical Health

A legally blind person died of smoke inhalation and incineration after falling asleep whilst smoking a cigarette. The cigarette fell onto a mattress which then ignited.

WA.2007.759 continued**Recommendations**

I recommend the Department of Housing, in the course of conducting annual property inspections, endeavour to test Residual Current Devices (RCDs) and smoke alarms at the same time to allow proper testing of smoke alarm batteries and so minimise disruption to the household's power supply.

NSW.2010.4792 Homicide & Assault/ Youth

A fifteen year old is missing and presumed deceased.

Recommendations

To the Commissioner for Police

That the death of [name] be referred to the Unsolved Homicide Unit of the NSW Police for further investigation in accordance with the procedures and protocols of that Unit.

NT.2010.162 Homicide & Assault

A person was fatally stabbed in the neck by a person that he had an intimate relationship with, who then stole items from the deceased's home.

Recommendations

In the past, I have accepted police assurances with respect to their internal recommendations. However, I note that pursuant to s46B of the Act the Commissioner is only required to report on compliance with recommendations that are made by me. I am concerned to ensure that the internal changes identified as necessary by the police are in fact implemented, so that a recurrence of the failings in this investigation might be avoided in the future. Accordingly, I make the following recommendations:

- That compliance with the Investigation Management Guidelines be strictly enforced such that all serious cases are investigated by the Major Crime Division. That Crime Command provides detectives for all major investigations.
- That Orders be issued to ensure that the Forensic Science Branch uploads all reports onto PROMIS (Patient Management).
- That case conferences between Forensic Services, prosecutions and the investigation team be made mandatory and be conducted in a timely manner, that is at least one month before committal and trial listings.
- That case conferences between Forensic Services, prosecutions and the investigation team be made mandatory and be conducted in a timely manner, that is at least one month before committal and trial listings.
- That the Detective Development Program be re-written to ensure training in and implementation of contemporary investigative practices.
- That any outstanding fingerprint analysis in connection with this death be completed.
- That blood pattern analysis in connection with this death be completed.
- That any outstanding biological forensic analysis of seized exhibits in connection with this death be completed.
- That all outstanding PROMIS tasks in connection with this death be completed.

NOTE: Due to a case where an individual killed 3 people and then himself, the QLD Coroner made the same recommendations for all cases.

QLD.2011.1640 Homicide & Assault

A woman was killed by her ex-partner.

QLD.2011.1641 Homicide & Assault

A man was killed by his girlfriend's ex-partner.

QLD.2011.1662 Homicide & Assault/ Child & Infant Death

A five year old was killed by her father.

QLD.2011.1663 Intentional Self-Harm

A man took his own life after killing three other people, including his own child.

Combined recommendations continued

Recommendations

Continuation of the Domestic Family Violence Death Review Unit (DFVDRU)

- Having regard to the number and proportion of homicides associated with domestic and family violence and the limitations of current policing and intervention models to prevent them, I recommend the Departments of Communities, Justice and Attorney General and Police continue to fund the DFVDRU so that intensive, expert scrutiny of all aspects of these deaths can better inform the responses of the relevant agencies.

I have earlier described the Queensland Police Service (QPS) Domestic Violence Protective Assessment Framework. It is a very worthy initiative but the evidence presented to this inquest suggests some of its categorisation of risk factors should be reviewed. I have also drawn attention to doubts about its effectiveness as a screening tool.

Domestic Violence Protective Assessment Framework

- I recommend that officers of the QPS Domestic Family Violence Unit (DFVU) liaise with the officers of the Office of the State Coroner (OSC) DFVDRU to review the categorisation of some of the risk factors contained in the protective risk assessment framework and that they apply the assessment tool to the circumstances of the domestic and family fatalities reviewed by the DFRU to ascertain whether it is likely to have prompted first response officers to have effectively intervened.

I am of the view the evidence presented to this inquest could be utilised by officers engaged in the Act as 1 program administered by the Department of Communities to raise public awareness of the perniciousness of non-violent domestic violence.

Don't wait for physical violence

- I recommend the officers of the OSC DFVDRU liaise with the Department of Communities to consider whether the evidence presented to this inquest should inform public awareness campaigns about the risks posed by non-violent domestic and family violence.

WA.2009.56

Homicide & Assault/ Indigenous

An Indigenous woman was murdered by her husband. The deceased had experienced domestic violence for a number of years and he had threatened to kill her. The deceased's husband was on parole for threatening to kill when he fatally stabbed the deceased.

Recommendations

- I recommend that the Department for Child Protection, the Department of Corrective Services and WA Police work together with a view to putting in place procedures which would involve ensuring that there is a plan in place to protect victims of crime prior to the release on parole of offenders believed to have threatened harm or to be intending harm to those victims.
- I recommend that the Department for Child Protection review the accommodation available to victims of domestic and family violence to ensure that in the case of women with children who are the subject of threats of extreme violence secure accommodation can be provided for those women and for their young children. In cases where it is likely that without such accommodation being provided, the women or children may be murdered, procedures should be in place to ensure that there can be immediate provision of a place of safety.
- I recommend that the Department of Corrective Services review its process of assessing the risk offenders on parole pose to victims and use a common sense approach based on the facts of a particular case rather than any form of actuarial risk assessment or use of statistics which do not reflect the gravity of threatened violence or the true circumstances of the case.
- In addition, every effort should be made to obtain all of the available information relating to the risk prior to conducting any such risk assessment.
- I recommend that where it is suggested by the Department of Corrective Services that a condition relating to the geographical location of a parolee could provide a protection to a victim, the advice should provide a practical means for monitoring the whereabouts of the parolee so that breaches can be readily identified.
- I recommend that the monitoring of parolees by telephone contacts should be kept to a minimum and that wherever possible, parolees should be required to report in person.

WA.2009.56 continued

- I recommend that if a parolee is to reside in a regional setting, local police should be informed of that fact and of the terms of any conditions of the parole.
- I recommend that the Department of Corrective Services and WA police work together to ensure that there is sufficient information sharing so that police can have an effective role in monitoring the conditions of persons released on parole and there are efficient mechanisms in place to ensure that parolees who breach parole conditions can be apprehended and, in appropriate cases, the parole revoked.

NZ.2011.2892 Law Enforcement/ Adverse Medical Effects/ Natural Causes/Physical Health

A prisoner with heart disease died in his cell. Due to a number of public holidays, his appointment with the medical team to assess his condition had not occurred.

Recommendations

- I recommend that Corrections, to whom a copy of this Finding is being sent, consider and adopt, insofar as is possible, the recommendation included in the report of [name], Inspector of Prisons, with specific reference to the recommendation in paragraph 18 of the Executive summary.
- I recommend that Corrections consider further the methods to address the continuing taking of illegal drugs by prisoners whilst they are in custody.
- I recommend that Corrections consider alternative strategies to ensure that prisoners, who ask to see a medical practitioner, are not frustrated in this request by issues such as statutory holidays, the need to attend Court or similar. In saying this, I acknowledge that evidence given at the Inquest Hearing said that changes in the existing policy to address this issue have been instituted.

NZ.2011.2930 Law Enforcement/ Intentional Self-Harm

A prisoner took their own life in their low security cell and was located deceased the following day.

Recommendations

- That the prisoner cell and location check policy be reviewed to better ensure the welfare of the prisoners.
- That taking into account of the Department's facilities standards, the design of new cell facilities should avoid exposed piping.
- That consideration be given to only prisoners considered at low risk of self-harm and who are 'towards the pathway of being released' be placed in low security units with design features such as exposed piping.
- That policy concerning a prisoner's at-risk status in New Zealand prisons is reviewed as regards the weight to be placed on historical at-risk information relating to the prisoner.
- That [location] Men's Prison reviews its procedures to ensure prisoner cell and location checks are carried out at irregular intervals.

The above recommendations are directed to the Chief Executive, Department of Corrections as to the first four recommendations, and the Manager, [location] Men's Prison as to the last recommendation.

WA.2000.758 Law Enforcement/ Drugs & Alcohol

A prisoner died of a heroin overdose in his cell. The prisoner had procured the drug off someone while attending a prisoner cricket match.

Recommendations

- The Department for Corrective Services should consider introducing a policy directive aimed at informing prison officers charged with escort duty as to:

WA.2000.758 continued

- ◇ What contact prisoners should have with visitors who have not pre-booked a visit with the prisoner at an event outside the prison; and
- ◇ What to do in the event a prisoner has unauthorised contact with members of the general public, who are at an event.
- The Policy should inform prison officers as to the appropriate sanctions available to them, such as the early termination of an event.
- The Department for Corrective Services should reconsider whether it introduces a policy that sets a staff/inmate ratio for events allowed pursuant to section 95 of the Prisons Act 1981, so as to ensure that prisoners are unable to receive contraband whilst outside prison.
- Or it should take effective steps to search prisoners returning from section 95 events, so as to minimise the risk of contraband entering the prison.
- The Department for Corrective services should take immediate steps to amend policy directive 30 relating to the death of a prisoner. Section 3 of the policy directive should be amended so that it directs the senior officer to immediately call for an ambulance when a prisoner is found in an unresponsive state of collapse, even if the prisoner is without apparent signs of life.
- The Department for Corrective Services should consider the reintroduction of a trained canine unit, or appropriate technology, at [location], with the intention of reducing the flow of illicit drugs into the prison, deterring prisoners from having drugs and detecting drugs in the prison environment before they can be used by prisoners.

WA.2010.1393 Law Enforcement/ Natural Causes

A prisoner died in hospital as a result of a HIV infection complicated by cancer. The deceased had refused all treatment for his diseases while incarcerated.

Recommendations

I support and recommend Department of Corrective Services (DCS) Health Services:

- Develop Not for Resuscitation protocols consistent with those used by Health Department for use in a custodial setting;
- Explore procedures to facilitate easy access to patients for observations and care while placed in the prison infirmary at the end stage of their illness;
- Obtain or facilitate the consent of prisoners/patients for appropriate placement at the end stage of their illness, including their expressed wish to die in a prison setting;
- Develop appropriate protocols to ensure the timely and relevant flow of medical information between agencies in relation to prisoner/patients;
- Develop appropriate protocols around removal restraints consistent with relevant considerations;
- Develop relevant legislative change if necessary for early or urgent review in exceptional circumstances; and
- The Department of Health engage in this process to assist DCS in achieving an outcome consistent with current medical practices.

NSW.2010.3814 Leisure Activity/ Youth

A fifteen year old died of exposure and hypothermia after going beyond boundaries while skiing and getting lost.

Recommendations

To [location] Ski Resort

- I recommend that [location] Ski Resort undertake a review of the signage, ropes and boundary markers, which define the ski area boundary. The purpose of this review must be to minimise the risk of a skier inadvertently skiing past the resort boundary.
- I recommend that [location] Ski Resort implement a policy that all boundary ropes and signage are checked and maintained daily during the ski season. Boundary ropes must be at a height which acts as both a physical and visual boundary.

NSW.2010.3814 continued

- I recommend that [location] Ski Resort develop and implement clear and appropriate guidelines or protocols for how they deal with reports of missing persons. The guidelines or protocols implemented must include a requirement that 000 be immediately contacted.

To the Minister for Police

- I recommend that all staff at [location] Police Station be trained that when they receive any calls relating to concern for welfare or missing persons in the [location] National Park, they must immediately notify and brief the [location] Supervisor.
- I recommend that induction procedures for extra staff and police who perform duties as part of the [location] Sector of the [Location] Local area command during winter be reviewed and improved, particularly for procedures in relation to calls or jobs received relating to concern for welfare or missing persons in the [location] National Park.

I direct that a copy of this decision and recommendations also be sent to [list of other resorts] for them to review and, if appropriate, improve their own policies, procedures and guidelines for ski area boundary signs and ropes, and what procedures they adopt and carry out when they receive reports of missing persons.

NZ.2010.2947 Leisure Activity/ Falls

A tourist died after slipping while mountain climbing and falling 500m metres into a crevasse.

Recommendations

- I recommend that mountaineers consider very carefully their nutrition and hydration requirements for what is clearly a very strenuous and energy intensive sport. Publicity should be given by mountaineering clubs and tramping clubs to their members, and others, and, if appropriate, advice should be sought from expert nutritionists.
- Mountaineers should consider carefully their experience and ability and should adjust their ambitions appropriately. Climbing solo is acceptable but carries grave dangers. Novice climbers should learn appropriate rope handling and belaying techniques and compromise their objectives if their techniques are unsound. Mountain users ought always to conduct appropriate research on their objectives, take local advice when given and be prepared to adjust their destination according to the advice given.
- Mountaineers ought to carefully consider appropriate methods to affix crampons to their boots in the most appropriate, secure manner. It is necessary to adopt, not only the manufacturers recommendations on sale, but also such enhancements as have been established by subsequent usage.

NZ.2011.2297 Leisure Activity/ Transport & Traffic Related/ Drugs & Alcohol

A fisherman died after driving his boat at high speed into rocks at night. The deceased was intoxicated and there was poor visibility at the time of the incident.

Recommendations

I recommend that the text of this Finding be referred to by Maritime New Zealand (MNZ) in its future publications as a further example of the dangers of operating boats whilst intoxicated and I ask that MNZ continue to give publicity to the dangers.

NZ.2011.2761 Leisure Activity/ Falls

A tourist died after slipping and falling over a bluff while tramping. There was a possibility that the ground was still frozen or had light snow on it, and the deceased's footwear was not appropriate for such conditions.

Recommendations

I recommend that a copy of this Finding be forwarded to Federated Mountain Clubs for a synopsis to be published in the Bulletin of the organisation to draw to public attention, and specifically the attention of mountain users, the dangers associated with tramping, whilst alone, with inappropriate footwear and without appropriate experience in our mountain regions.

NZ.2011.2928**Leisure Activity/ Youth/ Transport & Traffic Related**

A seventeen year old youth fell off a jet ski while riding with friends and was struck by another jet ski. The deceased suffered a head injury and drowned.

Recommendations

Accordingly I recommend and reinforce the Lewis recommendations as follows:

- All powered recreational vessels or Maritime products be registered and issued with an identification number. It must be highly visible.
- All operators of powered recreational vessels or Maritime products be required to hold a license before operating the vessel or Maritime product.
- All candidates for licenses be required to know the basic safe boating rules and their legal responsibilities.
- The laws relating to Maritime activity be reformed to incorporate the above recommendations and in addition provide for a graduated form of penalty similar to the Land Transport Legislation.

That Consideration be given to the introduction of an 0800 number like 0800 Crime Stoppers to make it easier for people to report hoonish and other behaviour on the water.

I further recommend that consideration be given to requiring all operators and passengers on jet skis to be required to wear life jackets and helmets at all times.

ACT.2011.44**Mental Illness & Health/ Law Enforcement**

A mentally ill person was killed by a gunshot to the chest after a stand-off with police. The deceased had advanced on an officer with a meat cleaver and a knife.

Recommendations

- The Australian Federal Police (AFP), in consultation with ACT Mental Health, develop a protocol for the exchange of information in respect to ACT Mental Health consumers.
- That ACT Ops (Specialist response group) and ACT Mental Health staff be trained in this protocol.
- That the embedded ACT mental health worker in ACT Ops continue.
- That consideration be given to increasing the periods during which an ACT mental health worker is embedded in ACT Ops.

NSW.2009.1786**Mental Illness & Health/Intentional Self-Harm**

A mentally ill person with psychosis died of ligature strangulation after absconding from the family home whilst on day leave from the mental health unit of a hospital. The deceased was under a Mental Health Review Hearing determination at the time of his death.

Recommendations

I recommend:

To the New South Wales Minister for Health

- That consideration is given to the introduction of a leave form for involuntary patients with first episode psychosis.
- That consideration is given to the creation and distribution of an information package for patients and their families/carer relating to first episode psychosis.

NOTE: Due to five (only two currently available as below) cases of similar circumstances, where the deceased was living in a facility set up for the disabled and homeless, the NSW Coroner made the same recommendations for all cases.

NSW.2009.4049 Mental Illness & Health/ Natural Causes

A woman with mental illness who lived in a facility set up for the disabled and homeless, died of heart complications.

NSW.2010.707 Mental Illness & Health

A woman with schizophrenia who lived in a facility set up for the disabled and homeless, died after choking on a sandwich.

Combined recommendations

To the Minister for Ageing & Disability Services:

- I recommend that that in light of the NSW Governments stated intentions to implement Boarding House reform within this State that any such reform incorporates the requirement for the mandatory registration of all current and future operators of Boarding Houses who have the capacity to accommodate two or more persons.
- I also recommend that in the implementation of Boarding House Reform that any Legislation enacted addresses in it accommodation standards, service standards and greater occupancy protection for all Boarding House tenants.
- I recommend that a regulatory body separate from the Department of Ageing, Disability and Home Care (DADHC) is enacted with powers to monitor, prosecute and arbitrate disputes between Boarding House (BH) operators and Tenants in a similar manner to a Residency Tribunal. I would also further include in this recommendation a provision for the mandatory notification and reporting by employees of Boarding Houses or service providers of any suspected or identified breaches committed under any relevant Legislation governing BH reform.
- I recommend that included in any BH reform, consideration be given to developing strategies for the provision of financial assistance by Government and Incentives to encourage investment and compliance by BH operators with any Legislative requirements in order to comply with the above recommendations.

To the Minister of Health

- I recommend a review also be conducted by NSW Health to consider the establishment of protocols for health service providers addressing annual mandatory reviews for residents living in BH's suffering from mental illnesses or conditions.

To the President of the Royal Australian & New Zealand College of Psychiatrists

- I recommend a review be conducted by the Governing Council of your organisation into the circumstances of all 6 deaths with a view to establishing clearer protocols for all psychiatrists in addressing the requirements for monitoring the prescription and usage of multiple anti-psychotic medications by longer term mental health patients.

NZ.2010.2587 Mental Illness & Health/ Intentional Self-Harm

A mentally ill person died after taking their own life. The deceased's family and friends had tried to seek mental health support for the deceased with no success.

Recommendations

I recommend that:

- The [location] District Health Board adopt the telephone triage documentation process for telephone referrals and calls during working hours as recommended in the [name] report.
- A formal process be developed by [location] District Health Board and adopted by the Mental Health Team to document the outcome of Team meetings and discussions.
- The management of the [location] District Health Board Mental Health Service endeavour to formulate an agreement with agencies in [location] (and elsewhere) which will foster collaboration with the [location] Mental Health Team and clarify roles and responsibilities and establish clear paths of communication.

NZ.2010.3051**Mental Illness & Health/ Intentional Self-Harm**

A mentally ill person took their own life. The deceased had attended hospital to get help, however left before he could see the doctor due to waiting times.

Recommendations

- I recommend that the [location] District Health Board take into account what could be considered to be issues of some suboptimal care offered to the deceased, specifically [location] District Health Board should make it easier for afterhours visitors to find Emergency Psychiatric Services (EPS) and contacts, ensuring patients are attended to as soon as practicable in a secure and private setting and ensuring appropriate follow up of all persons who have attended the Service.

VIC.2006.4296**Mental Illness & Health/ Fire Related/ Law Enforcement**

A mentally ill person died after igniting himself following threats to set himself on fire. The deceased had doused himself in an accelerant and was flicking a cigarette lighter when police sprayed him with capsicum spray in an attempt to distract him. The spray then caught a spark and ignited. The deceased did not survive his injuries.

Recommendations

- That the Minister for Mental Health extend the policy of providing triage and integrated services to patients with dual diagnoses to small regional hospitals like [location] Hospital.
- That the Department of Health and Victoria Police review their protocols relating to mental health telephone triage in [location] to improve flexibility of communication between mental health service providers including local service agencies, Ambulance Victoria, Victoria Police, Accident & Emergency Department at [location] regional Health Service, [location] Community Mental Health Service, and the Mental Health Triage Service at [location].
- That the [location] Health Service ensure that Accident & Emergency Department staff report to police all patients who present in police custody and discharge themselves without assessment by a mental health practitioner.
- That the Chief Psychiatrist ensure that the changes recommended by the Mental Health Triage Scale Advisory Committee are consistent with other triage scales used concurrently in Accident & Emergency Departments of regional health services.
- That Victoria Police and Ambulance Victoria establish a protocol and practical guidelines for transport of patients suspected to have a mental illness under section 10 of the Mental Health Act 1986.
- That the Minister for Mental Health and the Minister for Police and Emergency Services cooperate to establish an inter-ministerial commission or agency with access to direct service delivery for people with a mental illness and dual diagnosis across the justice and health sectors as recommended by [name].
- That Victoria Police arrange copies of the Mental Disorder Transfer Forms (VP Form L42) to be forwarded to the Centre for Operational Effectiveness for analysis and consideration in developing the next six months curriculum for Operational Safety Tactics Training (OSTT).
- That Victoria Police review the specifications for the labelling of Beacon oleoresin capsicum (O/C) spray to ensure that its flammability is well-communicated and the label does not rub off.
- That Victoria Police include examples of the flammability of O/C spray including the distance required to reduce the likelihood of igniting the solvent in all six monthly Operational Safety & Tactics Training programmes.
- That Victoria Police review the uptake of Operational Safety & Tactics Training to evaluate recall of safety information, including flammability relating to use of O/C spray, in operational circumstances.
- That Victoria Police authorise an independent specialist review of the solvent and propellant systems for oleoresin capsicum to identify an appropriate non-flammable solvent that requires a less flammable propellant with characteristics that are consistent with operational requirements.

VIC.2007.784**Mental Illness & Health/ Intentional Self-Harm**

A person suffering from depression who had experienced a relationship breakdown and financial troubles, died following an act of intentional self-harm. He had been discharged from the mental health ward of a hospital the previous day. The deceased's family believed that the deceased was still at high risk of self-harm, but he was discharged by the consulting psychiatrist.

VIC.2007.784 continued

Recommendations

- That clinicians remain attentive to the contribution able to be made by the patient's family and carers, and incorporate into their decision making process their knowledge of his or her behaviour and thinking.
- That the Chief Psychiatrist facilitate development of a tailored information package to all patients, their family members and carers on first admission to an approved mental health service.
- That the Chief Psychiatrist inform herself about the preferences of clients, families and carers before she determines how best to communicate with them about what they can expect to experience during and after their first admission to an approved mental health service.
- That the Chief Psychiatrist publish clinical practice guidelines to assist approved mental health services concerning practice in relation to case management and discharge planning for all first admissions to acute adult mental health services.
- That the [location] Hospital adult psychiatry unit ensure that discharge plans for first admission patients always include appropriate short to medium term accommodation arrangements and that cohabitants agree to these arrangements before discharge.
- The [location] Hospital adult psychiatry unit ensure that discharge plans for first admissions always include immediate transfer back to and communication with their known general practitioner.
- That the [location] Hospital amends its new discharge arrangements to include daily contact by North East Crisis Assessment Treatment Team (NECATT) until patients have consulted their general practitioner and their management has been transferred back to them.
- That the Chief Psychiatrist amend clinical practice guidelines to advise that the same or similar practices apply to discharge of voluntary patients as already apply to involuntary patients.
- In the alternative, that the [location] Hospital acute adult psychiatry unit appoints case manager for voluntary first admission patients to help them manage their discharge arrangements and follow them into the immediate post discharge phase of their therapy.
- That the designated case managers take responsibility for ensuring that the clinical team maintains contact with first admissions in the early post discharge period until patients have consulted their general practitioner and their management has been transferred back to them and coordinate post discharge supports.

VIC.2008.4049 **Mental Illness & Health/ Intentional Self-Harm/ Transport & Traffic Related**

A mentally ill person with schizophrenia died after being struck intentionally by a train whilst on day leave from the mental health ward of a hospital.

Recommendations

It is recommended that [location] Hospital review its approved client leave procedure/policy to ensure it complies with the Chief Psychiatrist's September 2009 Inpatient Leave and Absence guideline, with particular emphasis on the inclusion of requirements for communicating responsibilities to carers who accompany a patient on leave, and recording crisis information. The aim is to increase the safety of both the patient and the carer.

SA.2009.407 **Mental Illness & Health/ Intentional Self-Harm**

A person suffering from depression and anxiety took their own life. The deceased had presented at hospital with a deliberate overdose, but was deemed not to be at risk of self-harm and discharged.

Recommendations

That the Chief Executive of the Department of Health reinforce with all public hospitals the importance of discharge summaries in mental health cases, particularly where there has been a suicide attempt, and to ensure that notification of such incidents be made to primary health practitioners within 48 hours of discharge.

NZ.2009.3914 Natural Causes/ Leisure Activity/ Water Related

A tourist died of a likely cardiac arrhythmia while swimming with dolphins.

Recommendations

I make the following recommendations pursuant to section 57(3) of the Coroners Act 2006 to Maritime New Zealand and operators of commercial snorkelling activities (including swimming with dolphin activities):

For snorkelling and similar marine charter activities

- Individual waiver forms should be used, not a group form.
- Advice be given to participants that the snorkelling activity can be a strenuous physical activity and may increase the health and safety risk for persons suffering from any medical condition (for example stress from sudden exposure to cold water, panic or strenuous activity can aggravate some medical conditions, and certain medical conditions such as heart disease may result in cardiac arrest and death).
- Vessels should comply with Maritime NZ regulations (e.g. Rule 40A, Appendix 8) and the New Zealand Underwater (NZU) code of practice for dive operators.
- First aid equipment should comply with Maritime NZ requirements and be checked monthly. It should also meet any local or specific needs. An example of this for snorkelling/scuba diving activities might be to not stock a bronchodilator, this being replaced by stocking 'asthma snorkels' and ensuring that an asthma sufferer's own inhaler is immediately at hand.
- An oxygen cylinder of appropriate size (determined by the likely length of time to obtaining emergency services assistance) and an oxygen kit, such as those marketed for the diving environment by the Divers Alert Service Asia- Pacific (DAN, a not-for-profit organisation) is carried. This should be checked daily and kept in good condition. Not all oxygen kits are suitable for the marine environment.
- All employees on board should be trained first aiders including Basic Life Support resuscitation, at least two should be trained Oxygen providers and Automated External Defibrillator (AED) use and all should undertake annual refreshers. Courses specific to diving and snorkelling activities are the most appropriate, such as those of Dan or the Professional Association of Diving Instructors (PADI) or Emergency First Responder, Oxygen Provider Etc. NZU also provides a syllabus for a Dive Activities Supervisor (DAS) programme.
- Maritime NZ regulations be amended to ensure manning levels sufficient to ensure that customers are not essential to providing first aid or resuscitation. This implies an absolute minimum of three people- a skipper, a DAS (1 per 18 snorkelers) and either a deck hand or diving assistant/trainee. Clients should only be involved if they voluntarily bring specific expertise to the situation.
- Rescue and emergency procedures, including man overboard, fire and emergency on board should be documented and practiced regularly.
- An emergency protocol for obtaining assistance should be in place, and practiced/tested at regular intervals. All staff should be trained to operate the vessel's radio on the emergency and local channels.
- Maritime NZ regulations require that, unless it can be shown that an AED cannot be safely stored and used on a particular vessel, an AED be carried on all commercial vessels.
- Adequate floatation devices be available to participants to reduce the likelihood of drowning from swimming failure.

NZ.2010.2642 Older Person/ Natural Causes

An elderly person with advanced cancer died in hospital. The family expressed concerns about the level of care and treatment given to the deceased.

Recommendations

I will arrange a copy of this Finding to be forwarded to the [location] District Health Board for training purposes and for clinicians to take into account the need for more appropriate consultation with family representatives on care and treatment issues.

VIC.2007.4424 Sports Related/ Transport & Traffic Related

A co-driver participating in a motor vehicle rally died after the vehicle he was navigating lost control around a corner and collided with a tree.

Recommendations

- The court received a report from the Confederation of Australian Motor Sport. In that report, it makes a number of recommendations, including:
 - ◇ Open top vehicles and/or vehicles without fill roll cages be excluded from competitions in the type of event that the deceased was competing.
 - ◇ The documentation applicable to such events be more readily identifiable so that individual officials can be held responsible for breach of regulations.
 - ◇ Investigations be made into the improvement of communication, vehicle identification and vehicle separation in similar such events.

I would endorse these recommendations.

NSW.2006.6081 Transport & Traffic Related

A pilot died after his aircraft broke up in flight and impacted with the ground while on an adventure flight.

Recommendations

- That the Civil Aviation Safety Authority (CASA) or the Australian Warbirds Association Limited (AWAL), when issuing Special Certificates of Airworthiness for limited category aircraft make it a mandatory condition of the issuance of that Certificate that aircraft engaged in adventure flights have approved protocols in place to monitor the departure and return of each adventure flight together with Search and Rescue procedures in the event of the non-return of the aircraft from the adventure flight within an appropriately considered timeframe.
- That AWAL amend the Flight Operations Audit Checklist, contained within its current ESAM, to incorporate the auditing of base monitoring of the departure and return of adventure flights together with Search and Rescue and next of kin notification protocols.
- That AWAL amend the Adventure Flights Guidance Material (AF-GM) and exposition for adventure flights by limited category aircraft to incorporate the requirement of base monitoring of departure and return of adventure flights and Search and Rescue notification protocols.
- That CASA, or its delegate, on granting a Special Certificate of Airworthiness for limited category aircraft make it a mandatory condition of the Certificate that the pilot and passenger carry an Emergency Position Indicating Radio Beacon (EPIRB) during any flight.
- That CASA consider making it mandatory for limited category aircraft with a Special Certificate of Airworthiness that engage in adventure style operations have fitted to the aircraft an Emergency Locator Beacon (ELB).
- That CASA instigate such legislative amendments that are necessary to withdraw all exemptions from having an Emergency Locator Beacon fitted to any limited category aircraft engaged in adventure style operations.
- That the Air Ambulance Service of NSW and the NSW Department of Health make provision for the installation of winch facilities for the CareFlight Helicopter operating in conjunction with [location] hospital and/or in the [region] of NSW.
- In conjunction with the above recommendation, that the Air Ambulance Service of NSW and the NSW Department of Health fund and provide proper and appropriate training to those personnel based in [location] and/or in [region] of NSW who are tasked to operate the helicopter winch service.
- That CASA refer to the Maintenance Review Board for consideration, both in general and in particular, amendments to Service Procedure 1137 and NDT/STR/3 that in preparation for Non-Destructive Testing (NDT)- Eddy Current Testing, the area for such testing is to have all coatings removed.

NSW.2006.6081 continued

- That CASA, on a nominated annual date, initiate contact with the existing manufacturers of limited category aircraft, or in the event of the manufacturer no longer existing, the international or national association of the subject type of limited category aircraft, seeking disclosure of any information that has arisen since the last enquiry as it relates to the safe life and safe operation of the subject type or a particular aircraft within the subject type, including any variation of any fatigue measurement factors.

NSW.2010.3236 Transport & Traffic Related/ Physical Health/ Mental Illness & Health

An intellectually disabled patient, who resided at a mental health hospital, was fatally struck by a vehicle that was reversing in the grounds of the hospital.

Recommendations

That Ageing, Disability and Home Care, Department of Family and Community Services will implement, subject to approved funding, all the recommendations from [name] in relation to large residential centres and specialist supported living services in NSW.

NZ.2009.3926 Transport & Traffic Related/ Leisure Activity

While attempting to retrieve his boat from the water, a fisherman became caught between his van and the boat trailer as it jack knifed. The deceased died as a result of mechanical asphyxia.

Recommendations

This unfortunate death serves to remind boat users of ensuring safe practices. In stating the obvious having at least two people involved in the launching and retrieving manoeuvres will always be safer than a single person operation.

The Maritime Safety NZ website has limited instructions around the launching and retrieval process. It is based on a sensible and pragmatic approach. There are 'You Tube' sites that demonstrate launching and retrieving practices that highlight pitfalls and provide safe instruction if you are operating on your own.

The most pragmatic recommendations are to methodically check your equipment and to comply with safe practices in the launching and retrieval process. This includes have a 'pre-launch checklist'. The safest launching recommendation is to have another person assist the driver in guiding the vehicle and boat trailer into the water before releasing the boat safely and leaving the ramp.

The safest retrieval process mirrors the launching process. It also suggests to the driver and supporting team to take into consideration changes in the environment like wind, tides, depths of water and slime on the ramp that may impact on the retrieval process since launching.

In summary, having more than one person involved in the process is a far safer prospect than a single operator. The launching and retrieval process is about good practices that include thorough safety checks and safe practices in the releasing and retrieving the boat from the trailer. It is consideration of the ever changing elements of wind, tides and the environment.

NZ.2009.3934 & 3989 Transport & Traffic Related

A pilot and his passenger died after the microlight aircraft they were travelling in crashed while on a commercial scenic flight.

Recommendations

make the following recommendations pursuant to 57 (3) of the Coroners Act 2006 to the Minister of Transport, the Ministry of Transport and Civil Aviation Authority (CAA):

- That (other than flight training) consideration be given to permitting only those on microlights that meet the higher standards required for standard category aircraft to be used for the carriage of passengers for hire or reward.
- That consideration be given to whether all microlights carrying a passenger for hire or reward be equipped with a ballistic emergency parachute system.

NZ.2009.3934 & 3989 continued

- That all microlight operators conducting flights for hire or reward publicly display the metrological and wind criteria at which their activities would cease.
- That consideration be given to whether in flex-wing microlight aircraft both lap and shoulder harnesses should be worn at all times during flight by both pilot and passenger, or whether fixed harnesses or inertia reel shoulder harnesses are more appropriate.
- That consideration be given whether for commercial adventure aviation operations the use of active tracking devices and/or impact activated Emergency Locator Transmitters (ELTs) should be mandatory.

NZ.2010.2563 Transport & Traffic Related

A driver died of head injuries after her vehicle slid on a patch of black ice and into the path of a truck.

Recommendations

I recommend that New Zealand Transport Agency:

- Include the roadway in the area where the crash occurred in its list of sites with known ice problems, being a list that is provided in contract documents to maintenance contractors responsible for the monitoring, assessing and treating conditions of the highway network; and
- Consider erecting permanent signage that is available to provide a warning about the hazard of ice on the roadway in the area where the crash occurred.

NZ.2010.2684 Transport & Traffic Related

A person died of crush injuries after being trapped between two trucks when the parking brake on the uphill truck failed and collided with the second truck.

Recommendations

- I recommend that [organisation] Trucks continue with its undertaking to advise all owners and operators of Nissan trucks; Models CW330 and CW380, and to the providers of service to them, of the potential hazard that exists with the inappropriate or premature release of the truck park brake, whether this occurs by reason of poor maintenance, dust or grit ingress, brake wear, or by the failure of an operator to fully apply the brake.
- I recommend that a copy of this Finding be forwarded to Road Transport Association (NZ) Limited, to NZ Contractors Federation and to NZ National Road Carriers (Inc.) to ensure that all members of all organisations are aware of the potential hazard and arrange for vehicles, possibly affected, to be inspected regularly by appropriately trained mechanics.
- I recommend that [company] review its Health, Safety & Environment (HSE) protocols and processes. Whilst I accept that [company] has a Health and Safety Officer and takes advice on matters, the result has been that the company 'talks the talk' but does not 'walk the walk'. The point made by [name] that there was no proof of negligence by [company] and that there was no breach of HSE regulations which directly contributed to the death of the deceased is acknowledged. [Company] was issued with a warning notice.

NZ.2010.2731 Transport & Traffic Related/ Work Related

A visitor on a work trip died of asphyxia after the vehicle he was driving lost control on a frosty road and went over a bank, landing on its roof and trapping the deceased.

Recommendations

- That the road controlling authority maintains a permanent record of the approved location of all permanent warning signs.
- That the maintenance contractor maintains a record of the location of temporary warning signs in particular for ice hazard conditions and regularly keeps the road controlling authority updated as to the location of these signs.

NZ.2010.2731 continued

- In addition to the requirements of the contractor to inspect, replace and maintain existing traffic signs, the road controlling authority carries out at least an annual audit of the location of all approved permanent warning signs throughout the district.
- In addition to the requirements of the contractor to inspect, replace and maintain existing edge marker posts the road controlling authority carries out at least an annual night time audit of the location of edge marker posts throughout the district.
- That the practice of covering-over curve advisory speed signs during hazardous conditions adopted by some road controlling authorities be investigated for icy road conditions.

The above recommendations are directed to:

- The Chief Executive, [location] District Council, for adoption as recommended by their Transport Engineer
- Road Controlling Authorities with responsibility for roads that are prone to winter ice conditions (c/- Road Controlling Authorities Forum New Zealand Inc.), for consideration and, where appropriate, adoption.

NZ.2010.2874 Transport & Traffic Related/ Older Persons

An elderly person died in hospital from injuries sustained when falling asleep at the wheel of their vehicle, which veered from the road before travelling down an embankment and overturning.

Recommendations

I recommend that a copy of this Finding be forwarded to Land Transport New Zealand as a further example of the dangers of driving whilst overtired. I draw to public attention such dangers.

NZ.2011.1972 Transport & Traffic Related/ Drugs & Alcohol

An intoxicated, unlicensed driver died when the vehicle he was driving at excessive speed, failed to negotiate an intersection causing him to lose control and collide with a power pole.

Recommendations

- That an advisory sign be erected on [name] Road to advise motorists that [name] Road is offset to the left
- That 'stop' signs be erected in place of the 'give way' signs currently governing the intersection of [name] Road, [name] Road and [name] Road.
- That a chevron board be erected on the eastern side of [name] Road facing towards [name] Road

NZ.2011.2317 Transport & Traffic Related

A person was driving home from work when a truck travelling in the opposite direction at speed, failed to negotiate a moderate bend and rolled over, colliding with the deceased's vehicle.

Recommendations

That the roading authority responsible for [name] Highway where this crash occurred erect appropriate warning signage indicating the danger of heavy vehicles rolling over at this particular corner.

NZ.2011.2475 Transport & Traffic Related/ Drugs & Alcohol/ Youth

A seventeen year old intoxicated and unlicensed driver crashed his vehicle into a tree at high speed. The deceased had left a party due to a bullying incident.

NZ.2011.2475 continued**Recommendations**

I recommend that a copy of this Finding be forwarded to the New Zealand Contractors Federation for circulation to its members. I ask that all shearing contractors take steps to ensure the safety of their employees outside their normal working hours. Consumption, by members of shearing gangs, of significant amounts of alcohol, ought to receive more supervision. Shearing contractors may be placed in the position of the holders of licenses for liquor outlets and have an element of 'host responsibility' placed upon them.

NZ.2011.2694 Transport & Traffic Related/ Drugs & Alcohol

An intoxicated, speeding driver, whose vehicle was unwarranted and unregistered, died after losing control of the vehicle, which then rolled. The deceased, who was not wearing a seatbelt, was ejected and crushed by the vehicle.

Recommendations

That a raised traffic island be installed at the intersection of [name] Road with [name] Highway to ensure that traffic entering onto the highway do so from a right-angle position.

NZ.2011.2794 Transport & Traffic Related/ Drugs & Alcohol/ Youth

A sixteen year old unlicensed driver who had been smoking cannabis, died after driving erratically onto the wrong side of the road and colliding with a truck.

Recommendations

I recommend that a copy of this Finding be forwarded to New Zealand Transport Authority (NZTA) so that further publicity can be given by that organisation to the dangers of driving whilst affected by cannabis.

NZ.2011.2844 Transport & Traffic Related/ Drugs & Alcohol

An intoxicated and drug affected motorcyclist died after losing control of his motorcycle, crossing to the incorrect side of the road and colliding with an oncoming vehicle.

Recommendations

I intend to circulate this Finding to the media to draw public attention to the tragic consequences of alcohol and cannabis-affected drives in charge of vehicles travelling at high speed.

NZ.2011.2952 Transport & Traffic Related/ Older Person

An elderly person died from injuries sustained when a quad bike he was attempting to reverse moved forward and went over a bank. The deceased was not wearing a helmet.

Recommendations

- I repeat my recommendation that all quad bikes be fitted with an audible alarm that activates when the vehicle is in reverse gear.
- I recommend that all riders of quad bikes wear an approved safety helmet.
- A copy of this finding is to be forwarded to Federated Farmers for publication to its members.

TAS.2010.301 Transport & Traffic Related/ Drugs & Alcohol

An intoxicated person died after being struck by a car while crossing the road. The deceased was not using a pedestrian crossing.

TAS.2010.301 continued

Recommendations

On a daily basis one observes pedestrians crossing roadways not availing themselves of a controlled pedestrian crossing located nearby, I would recommend that road safety awareness programs highlight the safety benefits of using these controlled crossing points.

One matter that was highlighted by this investigation was the lack of Statutory Authority for pedestrians to be tested in relation to blood alcohol readings following a motor vehicle accident. In this case, although an inference can be made as to the involvement of alcohol in respect of the actions of the [deceased] and [friend], formal testing of these persons was unable to be conducted. I would strongly recommend that consideration be given to amending Section 10A of the Road Safety (Alcohol and Drugs) Act 1970 to include a pedestrian. This would ensure a pedestrian involved in a motor vehicle accident, where personal injury has been sustained, would become liable to submit to a blood test. In the circumstances of a motor vehicle accident involving a pedestrian the interests of justice would be best served by both the driver of the motor vehicle and the pedestrian being the subject of a blood test and not just the driver of the motor vehicle as is the present situation.

TAS.2010.397 Transport & Traffic Related/ Youth

A seventeen year old youth died after being struck by a train while riding an All Terrain Vehicle (ATV) bike. The deceased did not check for trains before crossing the tracks.

Recommendations

The independent body [name] engaged by Tas Rail to investigate this matter made several recommendations which I believe are appropriate. The train involved in the crash did not have a recording device which would confirm that the horn had been activated. On the evidence, Tas Rail has addressed this issue.

I would also recommend that Tas Rail negotiate with the owners of the shed adjacent to the crossing to have the shed painted a colour which would contrast with the colour of trains which use this line.

There is evidence to suggest that the train horn may not be audible to drivers if the windows on their vehicles are up and there is other noise (e.g. a radio) inside the vehicle. A similar problem may exist for motorcycle riders wearing helmets. I would recommend that Tas Rail conduct appropriate tests to ascertain whether the decibel level of the existing horn needs to be increased.

TAS.2011.170 Transport & Traffic Related/ Youth

An intoxicated youth died after losing control of the car they were driving while exceeding the speed limit around a bend and colliding with a tree.

Recommendations

As a matter of course, the Department of Infrastructure, Energy and Resources (DIER) conducted a post crash review of the site in an endeavour to reduce the risk of similar type crashes occurring in the future.

The review has determined an appropriate advisory speed for the curve near where the crash occurred, when travelling northbound, is 45km/h albeit the curve can be negotiated at the maximum speed limit of 80km/h. Given the over representation of run-off road crashes in the vicinity of this curve involving northbound traffic, the lower advisory travel speed around this bend would provide additional guidance for motorists negotiating this curve.

As a result of the review, the following recommendations are made:

- The Department of Infrastructure, Energy and Resources (and the [location] Council) introduce the recommendations alluded to in the 'Post Crash Review' as a matter of priority. These recommendations are:
- Traffic and Infrastructure Branch to arrange the installation of 'Winding Road' warning signs (W1-5) and supplementary 45km/h advisory speed signs (W8-2) on each approach to a series of curves that are located on [name] Road.
- Traffic and Infrastructure Branch to arrange the installation of Curve Alignment markers (d4-6) around the curve on [name] Road immediately prior to the crash site for northbound vehicles.

TAS.2011.170 continued

- [name] Council be advised by Traffic Infrastructure Branch to consider the installation of additional guideposts around curves on [name] Road to ensure spacings in accordance with Australian Standards.
- [name] Council be advised by Traffic Infrastructure Branch to consider the installation of additional delineators to the guardrail treatments around curves on [name] Road to ensure spacings in accordance with Australian Standards.
- TIB to arrange for installation of a single continuous barrier line and supplemented with new Raised Reflective Pavement Markers on [name] Road where required.

I fully support these recommendations and trust they will be acted upon as soon as practicable by those agencies given that responsibility.

VIC.2010.3774 Transport & Traffic Related/ Drugs & Alcohol

A motorbike rider under the influence of cannabis died after losing control of his motorbike around a bend and colliding with a tree.

Recommendations

That VicRoads give consideration to the placement of an automated speed activated warning sign at the location of the speed advisory warnings.

WA.2010.889 Transport & Traffic Related/ Law Enforcement

A person being pursued by police died after losing control of their motor vehicle and crashed. The deceased had been pulled over by police earlier in the day and informed that his license was suspended due to unpaid fines. The vehicle was pursued by police after the deceased began driving shortly after being advised of his license suspension.

Recommendations

- I recommend that the Commissioner of Police reconsider the content of the P314 (penalty Enforcement Suspension Form) and ensure that it is drafted so as to correctly advise the recipient of the form how he or she can contact the fines enforcement registry or otherwise pay the outstanding fines in issue.
- I recommend that the Commissioner of Police cause to be published to all officers the content of section 49A Road Traffic Act 1974 together with a practical commentary as to its application.
- I recommend that the Commissioner of Police direct that P314 forms be carried in all police vehicles likely to be used in traffic control duties.

NSW.2010.2444 Water Related/ Leisure Activity

A person drowned after an unintentional fall from rocks into the ocean.

Recommendations

The findings are to be forwarded to the Royal Life Saving NSW to assist with the compilation of information and further research to form the basis of awareness campaigns targeting particular aquatic environments as referred to in the letter of Royal Life Saving addressed to the Coroner's Court and tendered at the inquest.

The findings are to be forwarded to [location] Council with a recommendation that the council give consideration to the carrying out of a coastal risk assessment in cooperation with Royal Surf Life Saving Australia.

NSW.2010.2444 continued

A recommendation that any such coastal risk assessment consider the issue of the adequacy of warning signage installed at the [location] and surrounds and in particular, that consideration be given to enhanced signage incorporating large graphic illustrations of the risks of slipping or falling from rocks in the format adopted at [name of rocks] as referred to the Coroner's Court of South Australia in the finding of the inquest into the deaths of [name and name] handed down on [date].

I request that a copy of the transcript and findings in this matter be forwarded to [name] of [location] Command for his information and for him to consider whether any further action is required in response to the family's letter of complaint.

NZ.2009.3940 Water Related/ Leisure Activity

A person died of drowning and likely cardiac arrhythmia after getting into difficulties while snorkelling in a lagoon in the Cook Islands.

Recommendations

I am unable to make recommendations or comments to persons outside New Zealand to prevent deaths in similar circumstances in the future, however the publication of this finding should assist in making New Zealanders aware of basic precautions to take when snorkelling/swimming (whether in New Zealand or overseas) and may assist in highlighting to operators providing snorkelling activities the practical instructions and procedures that should be in place, and rescue and medical equipment that should be available, in anticipation of emergencies. It would be of comfort to New Zealanders and others undertaking snorkelling activities in the Cook Island if similar standards applicable in Australia and New Zealand were adopted in the Cook Islands.

NZ.2009.4078 Water Related/ Leisure Activity

A person died of drowning due to barotrauma (a physical injury due to the effects of pressure change) while recreational diving.

Recommendations

I endorse the recommendations made by the Police National Dive Squad Report.

These are recommendations that all industry and recreation divers should consider for the future. The recommendations come from what may be described as the shortcomings from this recreational dive.

All those involved in the recreational dive on [date] were experienced divers and may have overlooked some of the basic requirements of safe diving practices. Those recommendations include:

- Ensure that divers discuss a dive plan.
- Divers should remain together during the dive, including during the ascent and descent.
- Divers should be familiar with the dive computer, including reading and understanding the manuals relating to that computer.
- Recognised safe ascent rates should be followed at all times.
- Ensure divers check and maintain their equipment thoroughly.
- Divers should not be afraid to abort the dive if not feeling well.
- Conversely, if the dive buddy thinks their partner is unwell they too should not be afraid to abort the dive.

NZ.2011.2434 & 2435 Water Related/ Leisure Activity

Two tourists died of drowning while trying to cross a river while hiking.

Recommendations

I recommend that the Department of Conservation in considering the revision of the information panel referred to in the third recommendation of the Visitor Incident Investigation Report considers stating that a double fatality occurred due to visitors leaving the track and attempting to cross the [name] River.

NSW.2008.2440 Work Related

A worker died of injuries when using high pressure water jetting equipment to clean a sediment pit. The equipment was not fitted with the correct parts, and while the deceased was holding the lance, he lost control of it and directed a high pressure stream of water into his chest.

Recommendations

To the Director, Safe Work Australia

- A copy of the findings and reports of [name] are forwarded for their information in considering the establishment of a Code of Practice for Water Jetting.

To the Director, Standards Australia

- A copy of the findings and reports of [name] are forwarded for their information in considering the review of the Australian Standard concerning High Pressure Water Jetting.

NSW.2008.4085 Work Related

A worker died while cleaning a boat's hull with acetone and solvent thinners. The deceased was found without his work respirator or any other personal protection equipment.

Recommendations

[Company] has since installed automatic ventilation fans for use on each boat under construction and has introduced training for employees in the use of Personal Protection Equipment (PPE) and in particular, the proper fitting, storage, maintenance and use of masks. There is accordingly no need for specified recommendations on these issues.

To the Minister responsible for the Workcover Authority of New South Wales

- That the WorkCover Authority of New South Wales issue a Safety Alert advising the relevant industries that the effects of inhalation or exposure to high concentrations of the chemicals on Bostik 9913 can include unconsciousness, cardiac arrhythmia and death.
- That the WorkCover Authority of New South Wales issue a Safety Alert to the manufacturer of Bostik Products and the Plastics and Chemicals Industry Association advising that the Material Safety Data Sheets for these products should include, in clear language, that exposure to high concentrations to these chemicals can cause unconsciousness, cardiac arrhythmia and death.

In addition, I direct a copy of these findings, and the reports prepared by [name] and [name] (Name of report) be provided to Bostik Australia Pty Ltd and Plastics and Chemicals Industry Association so that they may consider whether the Safety Data Sheet for Bostik 9913 should be amended to include, in clear language, that exposure to high concentrations to these chemicals can cause unconsciousness, cardiac arrhythmia and death.

To the Minister for Health, being the department responsible for the NSW Ambulance Service and public hospitals:-

- That the Department of Health consider the issuing of information, advice, education and/or training to ambulance officers and other medical professionals on the dangers of administering adrenalin to patients suffering from acute toluene toxicity.

In addition, I direct that a copy of these findings, and the reports prepared by [name] and [name] (Name of report) be provided to the Department of Health to assist in responding to the above recommendation.

NSW.2010.1758 Work Related/Transport & Traffic Related

A rail worker died after the excavator he was working on was hit by a train.

Recommendations

- That consideration be given by the Independent Transport Safety Regulator, the Australian Rail Track Corporation, John Holland Rail Pty Ltd and any other rail infrastructure managers to an amendment to the relevant network rule (s) to ensure that no track occupancy authority is granted whenever a train is within the limits of the track occupancy authority until the protection officer has sighted the lead locomotive number and communicated it to the network control officer.
- That the training in track awareness of rail safety workers (undertaking track maintenance) include the dangers of entering the danger zone before protection is provided, the relevant rules and procedures governing the protection of such workers and the role of the protection officer.

NSW.2010.2719 Work Related/Transport & Traffic Related

A highway construction worker died after being crushed between a reversing front-end loader and a refuelling tanker.

Recommendations

To the Director General of Transport for NSW

That consideration be given to legislative change so that a charge of negligent driving occasioning death can be laid concerning events that occur on private property.

NZ.2010.2607 Work Related/Transport & Traffic Related

A farmer died of haemorrhage and shock complicating multiple severe injuries after being run over by his truck. He had alighted from the truck to muster sheep on the property. The truck had a faulty handbrake.

Recommendations

- I recommend that a copy of this Finding be forwarded to Federated Farmers for publication to its members and to identify the need for vehicles utilised on the farm being regularly inspected and maintained for the purposes of safety.
- I recommend that a copy of this Finding be forwarded to the Department of Labour for its information and with my thanks for their input to the Inquest Hearing.

NZ.2010.2639 Work Related

A fisherman collapsed and died while working on a fishing vessel. The deceased had been pulling in a fishing net some days previously when he was knocked off his feet by a warp wire, rupturing his liver. The deceased did not complain of any injuries or file an incident report.

Recommendations

- A copy of this Finding will be forwarded to [organisation] for the information of the company. I recommend [organisation] consider the information which has been learned and create enhancements to the Trip Injury/Accident Report processes adopted.
- I recommend a copy of this Finding be forwarded to Maritime New Zealand so that consideration can be given to enhancing accident, injury and prevention protocols.

NZ.2010.3166**Work Related/Transport & Traffic Related/ Youth**

A seventeen year old farmhand died after the quad bike she was riding overturned and crushed her.

Recommendations

- I recommend that [organisation], as part of its ongoing focus on worker safety and means of reducing accident rates, take such steps as are available to it to promote the development of a rotational coupling suitable for light trailers being operated in hill terrain by All Terrain Vehicles (ATVs) or similar vehicles.
- I recommend that the Ministry of Business, Innovation and Employment take account of the circumstances of this quad bike rollover, in the ongoing education of the users of ATVs (quad bikes) or similar vehicles.

The above recommendations are directed to [organisation] and the Ministry of Business, Innovation and Employment respectively.

TAS.2010.310**Work Related**

A tree feller died after a large branch fell off the tree that was being cut down and pinned him to the ground.

Recommendations

A recommendation specific to directional tree felling is that where a rope and pulley system are to be used to assist in the felling of a tree, they should be set up no more than 45 degrees past the tree's intended direction of fall. If this cannot be achieved, then the tree should be brought down in sections, working from the top down.

Taking into consideration the report of [names] and industry comments, I make the following recommendations relating to training, accreditation and licensing.

- That the Tasmanian Forest Industry Training Board look at formulating training and accreditation systems to improve the training and safety for arborists in Tasmania.
- That it is a requirement that arborists are to be required to be licensed to do tree felling, as per the Tasmanian Forest Industry (Forest Safety Code Tasmania 2007).
- That part of this training be focused on directional tree felling and the identification of hazards related to tree felling in particular (Forest Safety Code Tasmania 2007).

TAS.2011.178**Work Related/Older Persons**

An elderly farmer was struck by a falling tree limb while felling trees on his farm and died in hospital.

Recommendations

Those engaged in farming and other agricultural activities are often involved in dangerous work. The extent of the danger is often not fully appreciated. Death and injury is all too common. Farms are over represented in work place related deaths in Australia and Tasmania is over represented nationally. I would recommend that government and industry bodies work cooperatively to educate about and increase awareness of farm safety. Some work is already being done. More is to be encouraged.

ACT.2010.181**Youth/ Drugs & Alcohol**

A nineteen year old youth died after ingesting methamphetamine, becoming erratic in their behaviour and entering a creek in the early hours of the morning. This led to the deceased possibly suffering from hypothermia.

Recommendations

I recommend that the Act Government install fencing or barriers leading up to, away from, and along each side of, the footbridge and that some artificial lighting be installed so that persons using the footbridge at night can have a clear view of the footbridge.

NZ.2011.2747 Youth/Transport & Traffic Related

A thirteen year old student ran across the road and was struck by an oncoming car. The deceased was taken to hospital but did not survive his injuries.

Recommendations

That the relevant roading authority consider whether some form of designated pedestrian crossing facility should be established to provide pedestrians with a safer environment for crossing [name] Road in the general vicinity of the entrance to [name] Park/ [name] Centre, or whether pedestrians should be directed to cross this road in another location.

This recommendation is directed to the Chief Executive Officer, [name] City Council.

TAS.2009.512 Youth/Sports Related/ Water Related

A fifteen year old student drowned while on a school sports outing.

Recommendations

It is to the Department's credit that it, having identified some shortcomings in the format of its Guidelines and in their understanding among principals has moved quickly to address these issues. However, it is critical that there be a regular audit of each Departmental school's compliance with the Handbook and it is my recommendation that this be put in place and acted upon.

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 e.g. - remote location
Homicide & Assault	Includes interpersonal violence and family domestic violence
Indigenous	Cases related to a specific demographic group
Intentional Self-Harm	Cases determined ISH by coronial investigation
Law Enforcement	Includes police pursuit, death in custody, parole issues, pending or previous court cases including family court, restraining order and coronial investigation procedures.
Leisure Activity	Any leisure actively that directly influence the circumstances including holiday activity or location
Location	Cases where the location of either the incident or the discovery of the body is of significance, does not refer to geographic location
Mental Illness & Health	Incidents where the existence of mental illness issues were involved in the circumstance on death, both diagnosed and anecdotal. Please note mental health is included as a contributing factor to death at the discretion of the Coroner.
Misadventure	Risk taking behaviour such as train-surfing, unintentional drug overdose
Natural Cause Death	Cases where the death is due to natural causes
Older Persons	Cases related to a specific demographic group or where the age of a person was a factor in the death.
Physical Health	Cases where the existing physical health of the person contributed but were not necessarily cause the death
Sports Related	Cases where a sports incident significantly impacted the cause of death.
Transport & Traffic Related	Cases involving road, water and air vehicle incidents, motorised or naturally powered. Also include cases where pedestrians are impacted by transport vehicles.
Water Related	Includes swimming, scuba, snorkelling, boating, fishing and all water related activity in both a recreational or commercial context
Weather Related	Cases where the environmental conditions such as heatwave or storm conditions were significant to the cause of death
Work Related	Includes cases where work is related to the death and also where unemployment is significant
Weapon	Cases where the involvement of a weapon is significant
Youth	Cases related to a specific demographic group