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# Fatal Facts

## A Publication of the National Coroners Information System

**Edition 21 (March 2011)**

This edition of Fatal Facts features 46 coronial cases where recommendations have been made. These cases were closed by a Coroner between 01/03/09 and 31/05/2009. As a number of recommendations involved quad bikes or SIDS, these are the focus for the case studies.

If you wish to seek further information regarding any of the cases contained in this edition (and you are an authorised NCIS user), log into the NCIS website with your authorised user name and password, and find the particular case by clicking on the “NCIS Search” tab and selecting “Find Case”.

If you have forgotten your user name and password, or require advice regarding access to the NCIS database, please do not hesitate to contact our Access Liaison Officer, Jo Cotsonis, at [joannac@vifm.org](mailto:joannac@vifm.org) or on (03) 9684 4323.

Should you not currently have access to the NCIS, or wish to enquire about an information search, please contact the NCIS team at [ncis@vifm.org](mailto:ncis@vifm.org).

Jessica Pearse  
Manager, NCIS.

### NCIS at a glance

- Number of cases on the NCIS (cases closed by a Coroner between 01/03/2009 and 31/05/2009): 2744
- Number of findings on the NCIS (cases closed by a Coroner between 01/03/2009 and 31/05/2009): 2019
- Number of cases with recommendations (closed by a Coroner between 01/03/2009 and 31/05/2009): 46

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

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

*Many of the recommendations made in these findings were similar in nature, and have accordingly been reproduced once after the case summaries.*

**Case No:** TAS.2002.554

**Date of Finding:** 17 April 2009

**Coroner:** John Olle

**Case Summary:**

The deceased, a young child, died as a result of neck and spinal injuries when the quad bike he was riding struck a rock and rolled. The deceased lived on a farm with his parents and was performing his daily task of collecting and carting rocks using the quad bike which he had been doing for the last 18 months. Although the coroner found in this particular case the age of the rider was not a contributing factor, he noted that the finding "in no way derogates from the embargo, prohibiting children less than 16 years from riding the baseline quad bikes".

**Case No:** VIC.2002.1455

**Date of Finding:** 17 April 2009

**Coroner:** John Olle

**Case Summary:**

The deceased, a teenager, died from blunt force trauma to the head when the quad bike he was riding struck a tree stump. The deceased lived on a farm and had previously ridden the quad bike under supervision and instruction yet on the day of the incident, the deceased took the bike to ride with friends.

**Case No:** VIC.2002.3126

**Date of Finding:** 17 April 2009

**Coroner:** John Olle

**Case Summary:**

The deceased, a teenager, died from head injuries when the quad bike he was riding collided with a culvert. The deceased had received half an hour instruction on riding the bikes from an adult earlier in the day after visiting the farm at which the quad bike was kept.

**Case No:** VIC.2002.3822 & 3823

**Date of Finding:** 17 April 2009

**Coroner:** John Olle

**Case Summary:**

Two deceased, a middle aged adult and young child died when the quad bike they were on reversed at speed, pinning the passengers under a camper tray. The quad bike was reported to have developed gear selection problems previously.

**Case No:** VIC.2002.218

**Date of Finding:** 17 April 2009

**Coroner:** John Olle

**Case Summary:**

The deceased, a farmer, was riding a quad bike while conducting work on his property (weed spraying), when the quad bike appears to have rolled. The deceased was found to have died of myocardial infarction and multiple injuries.

**Case No:** TAS.2002.114

**Date of Finding:** 17 April 2009

**Coroner:** John Olle

**Case Summary:**

The deceased, aged in his seventies, died of mechanical asphyxia following a four wheel bike roll-over while towing a trailer and using a weed spraying system on his farm. Two months prior to his death, the deceased had purchased the quad bike, primarily for weed spraying purposes.

Case No: VIC.2002.471

Date of Finding: 17 April 2009

Coroner: John Olle

### Case Summary:

The deceased, aged in his fifties, died of traumatic asphyxia when the quad bike he was riding while weed spraying rolled on his farm (which was notably hilly). Several months prior to death the deceased had purchased a Suzuki 500cc quad bike and had affixed a spray tank and hose to the vehicle. It was surmised that while riding the quad bike the front left wheel encountered an embankment of two foot in depth, and rolled. It was noted that early owner's manuals identified the danger of carrying or towing a load on terrain that was not level and flat. The deceased's manual did not stipulate that cargo must not be carried on terrain other than level and flat, nor made reference to the requirement for proper instruction.

### Comments

Extensive comments were made by the coroner regarding the safety of, operation of and instruction in quad bike riding:

- quad bikes must never be operated without proper instruction.
- proper instruction requires the operator to complete a certified training program which encompasses every facet of quad bike operation.
- beginners are particularly at risk.
- the capacity to carry or tow load is extremely limited; quad bikes must never be used to carry or tow load on any terrain that is not level and flat.
- quad bikes are terrain sensitive machines. They are extremely unstable on a variety of terrains, common to farms.
- quad bikes must not be described or marketed as All Terrain Vehicles or ATVs. So described, a false impression is created, which warnings are unable to erase.
- children must never ride baseline quad bikes.
- helmets are compulsory quad bike apparel.
- the campaign 'Stupid Hurts' is counter productive.

### Recommendations

The above comments concluded with the following recommendations:

1. WorkSafe Authorities in Victoria and Tasmania work with the Victorian and Tasmanian Consumer Affairs Authorities to ensure that quad bikes are not sold to or operated by persons who have not completed a Certified Training Program.
  2. The above Authorities investigate, in conjunction with quad bike Distributors and FarmSafe to develop a Certified Training Program along the lines of H.A.R.T. or Stephen Gall Ride Smart Ride Safe programs.
  3. These recommendations were distributed to Consumer Affairs Tasmania, Consumer Affairs Victoria, WorkSafe (Victoria), Workplace Standards (Tasmania).
- \* See Transport Section for description of one other ATV related death which occurred on a road.

*Many of the recommendations made in these findings were similar in nature, and have accordingly been reproduced once after the case summaries.*

**Case No:** TAS.2005.332

**Date of Finding:** 25 May 2009

**Coroner:** Tim Hill

**Case Summary:**

The deceased, an infant, was left to sleep with a bottle in his mouth while co-sleeping with adult parents in their bed after parents had consumed alcohol and cannabis. The deceased was discovered dead in the morning. The medical cause of death assigned was "Sudden Unexpected Death in Infants".

**Case No:** TAS.2008.305

**Date of Finding:** 8 May 2009

**Coroner:** Donald Jones

**Case Summary:**

The deceased, a two month old baby, was given a bottle at night then put into bed with his parents where he slept in the bed between the wall and his father. On waking the next morning his father found the deceased unresponsive. The medical cause of death stated "interstitial pneumonia, picornavirus and co-sleeping with adults".

**Case No:** TAS.2008.330

**Date of Finding:** 5 May 2009

**Coroner:** Donald Jones

**Case Summary:**

The deceased, a two month old baby, died as a result of Sudden Unexpected Death in Infancy while co-sleeping with an adult. The deceased had been taken into bed with the mother and father after failing to settle in her own bed, and given a bottle. On awaking the next morning the deceased was unresponsive. An ambulance was called however the deceased had died.

**Case No:** TAS.2008.109

**Date of Finding:** 19 May 2009

**Coroner:** Stephen Carey

**Case Summary:**

The deceased, an eleven month old baby, died as a result of sudden unexpected death in infancy whilst co-sleeping in a single bed with an adult who had consumed alcohol. The deceased had suffered numerous ongoing physical and neurological complaints since birth and was subject to ongoing medical treatment and supervision. There were documented previous concerns as to the welfare of the child.

### *Comments*

Coronial recommendations were that public education programs stress that sharing a sleep surface with a baby increases the risk of Sudden Unexplained Death in Infancy, Sudden Infant Death Syndrome and fatal sleep accidents. These risks are further heightened in circumstances where the person sharing the bed is a smoker, or is affected by alcohol or drugs that cause sedation.

The coroner noted the continual need to educate and inform the community on practices that may assist in the prevention of similar tragic deaths, and has reiterated that eliminating known risk factors can reduce or prevent deaths associated with parents co-sleeping with their babies.

### *Recommendations*

The investigating coroners of the various cases noted that (as per the Nationals SIDS Council of Australia Safe Sleeping Campaign Guidelines) to provide a safe sleeping environment for babies, the following safety and preventative measures should be adopted by parents to reduce or eliminate risk factors:

- Put baby on his/her back to sleep from birth. Do not sleep baby on its tummy or its side.
- Parents should not smoke before or after the birth of the baby.
- Sleep baby with face uncovered.
- Alternatively, use a sleeping bag without bedding.
- Have a safe cot, safe mattress, safe bedding and safe sleeping environment for baby day and night.
- Prevent the baby overheating by ensuring that his/her head and face is always uncovered and by avoiding over heated rooms. Always dress baby appropriately for the room temperature.
- Do not sleep with the baby on any sleep surface (bed or sofa).

### *Recommendations, cont...*

- As indicated, the risks of sharing a sleep surface include overlaying of the baby by another person, entrapment or wedging and suffocation from pillows and blankets.
- It is preferable to sleep baby in its own cot next to the parent's bed for the first six to twelve months of life as this has been shown to be protective.

## Adverse Effects / Reactions to Medical, Surgical Care

TAS.2004.  
438

The deceased previously underwent a gastric stapling procedure which initially led to some weight reduction, however after regaining weight was admitted for laparoscopic stomach banding. During the laparoscopy, extensive adhesions were encountered and the laparoscopy was abandoned and the procedure converted to open surgery. A complicated post operative course followed and the patient displayed adverse symptoms on the day following surgery. She was attended by her surgeon on the second day following surgery. On the third day the surgeon did not attend the patient and was not informed of nursing observations that adverse symptoms continued until the fourth post-operative day. A review by an emergency doctor led to a readmission to the operating theatre where a hole in the small bowel was located. Despite further medical intervention and multiple readmissions to theatre, the patient's condition continued to deteriorate and they died approximately 3 weeks after initial surgery. It was determined that the deceased died from multiple organ failure and disseminated Aspergillus infection following perforation of the small intestine after laparoscopic and open gastric banding.

**Recommendations**

That preferred practice is for surgical patients to be reviewed on a daily basis by the treating surgeon whilst they are in hospital. If the demands on a surgeons skills are such that daily reviews are not possible, as happened in the case of the deceased, these circumstances obligate the Hospital to have in place a system which ensures firstly that nursing staff are adequately trained and experienced to recognize signs or symptoms indicating a patients deteriorating condition and secondly that those patients receive immediate medical attention either by the surgeon or, if he is unavailable, by other suitable medical practitioner. It is recommended that the Hospital review its practices to ensure that such a system is in place and operating effectively.

NT.2007.  
81

The deceased, an infant, died shortly after birth from organ failure (caused by not receiving enough oxygen). In this case deficiencies in the care provided were found to have contributed to the death. The death was not reported to the coroner until more than 6 months later.

**Recommendations**

- That the policy regarding the reporting of neonatal deaths to the Coroner needs to be clarified. All staff (obstetric, midwifery and neonatal) need to be aware of the policy regarding reports to the Coroner.
- That regular senior medical input should occur in the management of high risk labours in the obstetric ward. As a minimum the registrar should be performing labour ward rounds every 4 hours, and in some cases visiting individual patients with high-risk characteristics more frequently.
- That there be mandatory education for all staff involved in application and interpretation of electronic fetal monitoring. This must be more than a "unit expectation" and include all midwives and doctors, not only senior staff. Orientation programs for midwives and doctors must include interpretation of electronic fetal monitoring.
- That staffing on the Birth Suite ensure that the team leader/senior midwife is available to support other staff, midwives and doctors. The nurse fulfilling this role cannot also be expected to take a primary clinical load and be responsible for the care of individual women as well.

**Adverse Effects / Reactions to Medical, Surgical Care—Continued**

<p>NT.2007. 81</p>	<p><b>Recommendations, cont...</b></p> <ul style="list-style-type: none"> <li>• That improved lines of communication between junior medical staff, senior medical staff and midwives in relation to consultation, referral and supervision need to be developed. The lines of accountability and responsibility need to be formalised and an escalation policy developed and implemented.</li> <li>• That hospital staff be reminded, once again, about the importance of note-taking both in relation to medical treatment, and in the documentation of requests made by patients in relation to their care.</li> </ul>
<p>TAS.2007. 549</p>	<p>The deceased had been receiving treatment for pain management following a back injury and depression. His treatment regime included the medications Tramadol (for pain relief) and Doxepin (for depression), however when the deceased began experiencing epileptic fits and convulsions the Tramadol (which can lower seizure threshold and result in generalised convulsions) was ceased. When the seizures continued a month later an anticonvulsant was commenced and an EEG performed, the results of the EEG investigation not having been concluded at the time of death. The deceased, who suffered Hepatitis C, also underwent a liver biopsy to determine the amount of damage suffered to his liver. A specialist gastroenterologist was of the opinion that the dose of Doxepin prescribed to the deceased was unlikely to lead to toxicity if taken as prescribed. Two months later the deceased collapsed in an apparent fit and did not recover.</p> <p>The Forensic Pathologist noted that Doxepin is an anti-depressant that is toxic to the heart in overdose. Individuals with chronic liver disease may be at increased risk of Doxepin toxicity because they are unable to adequately metabolise Doxepin from their blood resulting in inadvertent overdose. Individuals with chronic heart disease are at increased risk of cardiac-toxic effects of Doxepin. The death of the deceased was a result of a combination and inter-relationship of his chronic heart disease, Hepatitis C and the use of anti-depressant medication Doxepin.</p> <p><b>Recommendation</b></p> <p>That medical practitioners be reminded of the possible fatal consequences in the use of Doxepin where there exists liver and/or heart disease.</p>
<p>VIC.2007. 4443</p>	<p>Following elective surgery of a right shoulder arthroscopy for a rotator cuff repair, the deceased suffered a cardio-pulmonary arrest. She was resuscitated and transferred to ICU where an echocardiogram performed suggested a pulmonary embolism and a CT scan of the brain demonstrated a large left middle cerebral artery deficit. A decision was made to provide palliative care only and the patient subsequently died. It was noted that a form exists at this hospital for doctors to complete about the prevention of developing venous thromboembolism but it is apparently not considered necessary for this type of surgery.</p> <p><b>Recommendation</b></p> <p>That the Hospital review with its medical officers the use of the <i>prevention of developing venous thromboembolism</i> form with a view to mandating its completion for all surgical patients.</p>

**Adverse Effects / Reactions to Medical, Surgical Care—Continued**

WA.2007.  
258

The deceased had been unwell for the past week suffering from headaches and stomach pain. She sought medical attention on three occasions, firstly attending a doctor twice on the day prior to her death, secondly by a locum doctor on the evening prior to her death, who both diagnosed her as suffering from gastroenteritis. She remained unwell and the deceased was found by her mother the next morning, unresponsive, and was taken to hospital and placed in ICU. She was diagnosed as suffering Type 1 diabetic keto acidosis. The deceased remained unresponsive and life support was turned off. The deceased was found to have died as a result of multi system failure following acute onset (Acute Diabetic Ketoacidosis) Diabetes Mellitus in a person with known Lipoatrophic Panniculitis.

**Recommendations**

1. The finding be sent to The Royal Australian College of General Practitioners, in an effort to elevate general practice awareness of differential diagnosis of sudden onset DKA in young people.
2. In view of the reportedly rising incidence of diabetes in young people, GPs not overlook the fact the ability to pass urine may mask developing dehydration due to the onset of DKA and use of a urine sugar test may be a useful tool in diagnosis.
3. GPs explain the unpredictability of ED admission times as a necessary factor in prioritisation of medical care while explaining the benefits of access to specialist support in undiagnosed illness.
4. GPs consider that when a patient has suffered an autoimmune condition in the past it may indicate a propensity to other autoimmune conditions.

WA.2007.  
263

The deceased had been diagnosed with breast cancer in 1992 and remained in remission until December 2005 when she was diagnosed with secondary metastatic metastases. She underwent treatment by way of chemotherapy and radiation-therapy and as part of the treatment was issued with a "Red Card" for presentation at an Emergency Department in case of becoming unwell (in particular, showing signs of febrile neutropenia, which results from a lowering of white cells which fight infection in the patient's system and result in fever and uncontrolled infection unless treated). In February 2006 the deceased complained of pain in her shoulder and had a temperature of 38 degrees, and was taken to the Health Facility by her husband where her Red Card was presented at triage. At 6:53 she was given a triage score of 3 (meaning she should have been seen within thirty minutes). The Emergency Department was particularly busy that evening, and the deceased was eventually seen at 8:20 that evening, and her antibiotic treatment was commenced at 10:20 that evening, however, she continued to deteriorate and died three days later.

**Comments and Recommendations**

The coroner noted that in view of the activity in the EDD that night it would have benefited, certainly the deceased and the family, if the deceased's blood could have been taken earlier so antibiotic treatment could be commenced by 8:30pm at the time she saw the doctor.

Although the prognosis of the deceased was not good, it is not clear she would have died when she did if treatment had been started earlier, however the coroner accepted that the deceased was in a very vulnerable position and the prognosis for her survival appeared bleak.



## Adverse Effects / Reactions to Medical, Surgical Care—Continued

WA.2007. 263 Cont...	<p><b>Comments and Recommendations, cont...</b></p> <p>Following a review of this incident, the hospital adopted several changes. The following recommendations made by the coroner are similar to the changes made by the hospital.</p> <ol style="list-style-type: none"> <li>1. The hospital include in its training and protocols a requirement that triage nurses type the fact the possession of a Red Card on the information available to the ED computer screen at triage along with the relevant clinical information. This would allow physicians within the ED to consider whether or not early taking of bloods may avoid delays later.</li> <li>2. Where ATS2 are unlikely to be met consideration be given to obtaining a full blood count in preparation for the patient being seen by the doctor in the ED.</li> <li>3. The Hospital consider the issues of communication where treating and admitting consultants differ. It is known people suffering distress have difficulty processing information and it is often necessary to provide relevant information on an ongoing basis.</li> </ol>
NT.2007. 210	The deceased, a newborn, died shortly after a difficult birth where medical intervention was required. See 'child deaths'.
VIC.2007. 3393	The deceased, an asthmatic child, died following an asthma attack where emergency medical assistance was requested. See 'child deaths'.

### Child Deaths

NT.2007. 210	<p>The deceased died 8 days after birth following a difficult labour where medical intervention was required. During the mother's labour vacuum extraction was used to deliver the deceased's head, however he then became stuck; his shoulders failed to deliver after his head emerged (a medical emergency called dystocia). There is only a very short window of time to overcome dystocia before the baby will start to suffer from irreversible brain damage, and ultimately death. The deceased was delivered 15 minutes after he became stuck and lack of oxygen during that time damaged his organs. He was extremely unwell when he was born and died at 8 days old.</p> <p>The inquest examined the care provided to his mother antenatally and during labour. The Coroner found that some management decisions could have been made differently, and had this occurred, it is possible that this death may have been prevented, the most important being that the attempt to deliver this baby by vacuum extraction should have been done in the operating theatre rather than the birthing suite.</p> <p><b>Recommendations</b></p> <ol style="list-style-type: none"> <li>1. The Hospital should ensure that all trials of instrumental deliveries occur in theatre and that a consultant is called for advice in all such cases. This needs to be clear in the guidelines. The guidelines already recommended that consideration be given to performing such deliveries in theatre, and need to be strengthened. Urgent attention needs to be given to removing these barriers that currently prevent this occurring and ensuring that such deliveries are in fact taking place in theatre.</li> <li>2. The Hospital needs to institute improved quality and safety procedures. There needs to be senior support and allocated time for such reviews and the review should occur soon after the event, be multidisciplinary, involve all of the people who had a role, occur in a non threatening atmosphere and have recorded outcomes. Consideration should be given to sourcing external assistance depending on the seriousness of the matter.</li> <li>3. When a foetus is thought to be clinically "large" and has a fundal height above the mean in a woman who is post-dates (that is who is beyond the due date for the baby) then consideration should be given to performing an ultrasound element of foetal weight as a guide to actual foetal size.</li> </ol>
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## Child Deaths

VIC.2007. 3933	<p><b>Comments and Recommendations</b></p> <p>After reviewing the evidence, the coroner concluded that the following factors that could have influenced the death:</p> <ul style="list-style-type: none"> <li>• management of the deceased's chronic asthma syndrome,</li> <li>• management of the deceased's acute asthma attacks,</li> <li>• the period of time the deceased's brain was without oxygen, and</li> <li>• the time taken for the Metropolitan Ambulance Service to respond to the "000" call that was made after the football game.</li> </ul> <p>The following recommendations were made:</p> <ul style="list-style-type: none"> <li>• The Royal Australian College of General Practitioners update their web-site and documentation to encourage members to develop a practical formal Asthma Action Plan with their patients as advocated by The Royal Children's Hospital and Asthma Foundation Victoria.</li> <li>• The Department of Education and the Victorian Teachers Union form a Working party to review the prohibition on teachers providing medication under their Schools Asthma First Aid Policy.</li> <li>• The Royal Australian College of General Practitioners encourage members to reinforce the importance of complete implementation of their patients' formal Asthma Action Plans including transport to hospital if so advised by ambulance officers who attend.</li> <li>• The Royal Australian College of General Practitioners encourage members to reinforce the importance of complete implementation of their patients' formal Asthma Action Plans including transport to hospital if so advised by ambulance officers who attend.</li> <li>• Ambulance Victoria review despatch arrangements for Mobile Intensive Care ambulance crews stationed in public hospitals to ensure their rapid and timely deployment when required.</li> </ul>
QLD.2006 .2118	The deceased, a youth with a history of mental health issues, committed suicide after attending (but not being admitted to) an Emergency Department of a hospital. See 'intentional self harm'.
NT.2007. 81	The deceased, an infant, died shortly after birth from organ failure. See 'adverse effects/ reactions to medical/surgical care'.
WA.2007. 258	The deceased, a youth, died of Diabetes Mellitus in a situation where medical intervention/ treatment was sought on several occasions. See 'adverse effects/ reactions to medical/surgical care'.
TAS.2008. 534	The deceased, a young child, died in a single vehicle motor accident. See 'transport related'.
TAS.2002. 554	The deceased, a young child, died in a quad bike accident. See 'Highlighted Issue: quad bikes'.
VIC.2002. 1455	The deceased, a youth, died in a quad bike accident. See 'Highlighted Issue: quad bikes'.
VIC.2002. 3126	The deceased, a youth, died in a quad bike accident. See 'Highlighted Issue: quad bikes'.

## Child Deaths—Continued

VIC.2002. 3822	The deceased, a young child, died in a quad bike accident. See 'Highlighted Issue: quad bikes'.
ACT.2003 .15	The deceased, a newborn, died shortly after birth via emergency caesarean following a car crash in which his mother was fatally injured. See 'transport related'.

## Diving, Scuba Diving and Snorkelling

QLD.2005 .721	<p>The deceased had been undertaking a technical deep diving course over the preceding months. Having just completed the final dive of his course he emerged from the ocean and climbed onto a charter boat and almost immediately complained of burning pain in his chest and severe shortness of breath. Despite assistance from people on the boat, the deceased lapsed into unconsciousness and died a few minutes later, the cause of death fulminate cardio-pulmonary decompression sickness incidental to deep water technical diving.</p> <p><b>Recommendations</b></p> <p>A number of detailed recommendations were made by the coroner with regards to better coordination of agencies responsible for investigating dive deaths and more timely notification to coroner, availability of CT scanning of deceased divers, methods for technical divers to reboard the dive platform and responsibilities of practitioners regarding conducting dive medicals.</p>
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## Domestic/Leisure Incidents

VIC.2002. 1455	The deceased, a youth, died in a quad bike accident. See 'Highlighted Issue: quad bikes'.
VIC.2002. 3126	The deceased, a youth, died in a quad bike accident. See 'Highlighted Issue: quad bikes'.
QLD.2005 .721	The deceased died following a deep sea diving activity. See 'diving, scuba diving and snorkelling'.
TAS.2008. 417	The deceased, an elderly male, fell while walking home from a local shopping complex. See 'falls'.
VIC.2006. 1982	The deceased was assaulted during night out to pub and died as a result of injuries received during the assault. See 'homicide/interpersonal violence'.

## Drugs/ Alcohol

WA.2007. 13	<p>The deceased was a female in her early twenties who had a history of recreational drug use. The deceased attended a party where she consumed alcohol and half an ecstasy tablet, followed by three more tablets later that evening. After lapsing into incoherence an ambulance was called and the deceased was transferred to hospital where she died in the early hours the following morning.</p> <p><b>Recommendations</b></p> <ul style="list-style-type: none"> <li>• That where there has been a fatal drug overdose police ensure any remnants of drug are analysed to the maximum capacity in order to assist with both medical understanding of the death and police intelligence with respect to sourcing of the drugs.</li> <li>• That where there has been a fatal drug overdose with hospital attendance the police seize any hospital admission blood which may have been taken for screening to assist with medical intelligence with respect to drug fatalities and police intelligence with respect to drug sourcing.</li> </ul>
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TAS.2008. 372	<p>The deceased, in her early thirties, was a user of both illicit and licit drugs. The deceased had attended a Pharmacy and took a dose of her prescribed Methadone and also collected (as prescribed) two additional take-away doses on that day. Four days later the deceased was found by police dead in her home. In the past twelve months the deceased had been prescribed Methadone, Diazepam, Citalopram, Ventalin inhaler and Panamax. An excess of Citalopramin was found on the premises over and above the prescribed entitlement. Alprazolam was also found in the blood analysis of the deceased, that drug having not been prescribed to her on any occasion. It is commonly accepted practice that such a drug is mixed with Methadone and injected. The coroner concluded that the cause of death was due to continued misusing and overusing both prescribed and non prescribed medication and in particular administering Methadone to a level within the reported fatal range and Citalopram at a greater than therapeutic level.</p> <p><b>Comments &amp; Recommendations</b></p> <p>The Coroner described the outcome as “yet another example of the misuse of Methadone obtained via the Tasmanian Opioid Pharmacotherapy Programme and also the use of Methadone in conjunction with other licit and illicit drugs, in particular Alprazolam. There have been previous detailed observations and recommendations made by Coroners in relation to the prevalence of this misuse within Tasmania. I adopt again those comments and recommendations and urge all those who have a part to play to pursue the recommended revision of the Tasmania Opioid Pharmacotherapy Programme as well as steps to diminish the very high (by National standards) prescription levels of Alprazolam within this State”.</p>
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## Falls

TAS.2008. 417	<p>The deceased, a male in his late 70s, fell while walking home from the local shopping complex. He was transferred to hospital where a CT scan established that the deceased had suffered severe brain injuries. The deceased passed away the following day however his death was not reported to a coroner until three days later.</p> <p><b>Comments and Recommendations</b></p> <p>It was found that the deceased died in hospital as a result of complications of a closed head injury sustained during a fall from standing height at his home. The Coroner expressed concern that this death was not reported to a Coroner as soon as possible after it occurred; <i>“It is clear the death occurred as a direct consequence of a fall, and therefore it constituted a reportable death pursuant to the Coroners Act 2005. The delay in reporting this death necessitated the postponing of the deceased’s funeral, and caused much stress and anxiety for his family. Although it was not evident in this case, any delay in reporting a death to a Coroner also has the potential to result in the loss or destruction of evidence, or to compromise the outcome of a coronial inquiry”.</i></p>
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**Falls—Continued**

<p>TAS.2008. 417 Cont...</p>	<p><b>Comments and Recommendations, Cont....</b></p> <p><i>“I am told by the medico-legal advisor at the Hospital that a review of the circumstances has identified a ‘miscommunication between treating clinical units’ as the reason for the delay in reporting his death. As a response, the Hospital has specifically reminded the clinicians involved and all medical practitioners of their reporting obligations under the Coroners Act. Additionally, I am advised that a copy of the Hospital policy concerning reportable deaths was sent to all medical staff, and included an amendment stating that ‘all Coroner’s cases must be reviewed/ reported by senior registrars or consultants, to ensure that all cases are being reported correctly.’ I commend the response by the Hospital and encourage continued education within the Hospital as to reporting deaths to the Coroner”.</i></p>
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**Homicide/ Interpersonal Violence**

<p>VIC.2006. 1982</p>	<p>The deceased was a man in his early thirties who died of respiratory obstruction after being assaulted during an altercation outside a hotel. The deceased was hit in the face by another man, and fell backwards without any apparent attempt to brace his fall and the deceased hit his head on the pavement. An ambulance was called. Five minutes later a police foot patrol of four officers attended. A short time later, the deceased stopped breathing. No resuscitation mask was available and when a police divisional van arrived, the police issue “Personal Protection Kit” (PPK) was missing the one-way valve attachment necessary to enable resuscitation to be undertaken without the risk of infection. Ambulance officers arrived and commenced CPR. This was continued on route to the hospital but the deceased was pronounced dead shortly after arrival.</p> <p><b>Recommendations</b></p> <ol style="list-style-type: none"> <li>1. That the Chief Commissioner of Police ensures that CPR training is delivered to police officers on the same equipment as is mandated in the Personal Protection Kit inventory. If for good reason more than one type of safe resuscitative aid is used in training, then police officers should be familiar with the features and functionality of each aid, and above all, with the aid which will be available to them in the field, whether in the PPK or otherwise.</li> <li>2. That consideration be given to legislation requiring licensed premises to keep a comprehensive first aid kit, including safe resuscitative equipment in particular, and a regime for enforcing this requirement. One possibility would be to attach an appropriate condition to all liquor licences.</li> </ol> <p>Copies of these recommendations provided to:</p> <ul style="list-style-type: none"> <li>• The Attorney-General</li> <li>• Minister for Police and Emergency Services</li> <li>• Minister for Health</li> <li>• Metropolitan Ambulance Service</li> <li>• Rural Ambulance Victoria</li> <li>• Victorian Work Cover Authority</li> </ul>
<p>TAS.2007. 401 &amp; 402</p>	<p>The two deceased, a male and female in their thirties, died in a homicide/suicide incident. The pair had commenced a relationship approximately 18 months before their deaths, with a least two incidents previously involving police. A FVO was served on the male, which was breached about nine months later. On the day of the incident, the male made telephone contact with the female reporting this to police. It was determined due to the female’s brother residing over the road, and the belief the male was a substantial distance away, the female could make arrangements with police the next day. That night, the male arrived at the female’s house with a firearm and subsequently shot the female and then himself.</p>

## Homicide/ Interpersonal Violence

TAS.2007. 401 & 402 Cont...	<p>The Coroner focused on The Safe at Home strategy (an initiative of the State Government involving Police), the police response, the deceased female's response to police involvement and access to the fire-arm.</p> <p><b>Comments and Recommendations</b></p> <p>The Coroner noted while the procedural failures of the police in this case did not cause or contribute to the deaths of either deceased, it is "my recommendation that in every identified case of family violence that the procedures established under the <i>Safe at Home</i> strategy are observed to the fullest extent possible. It is hoped that this will assist in ensuring, as far as possible, that the very worst outcome as occurred in this case can be avoided in the future".</p>
WA.2001. 959	<p>The deceased, aged in her early twenties, died as a result of manual strangulation and multiple injuries inflicted by her partner who suffered a mental illness. The partner had been admitted as an involuntary patient at a mental health facility numerous times in the years preceding the incident and was diagnosed with paranoid schizophrenia. The deceased suffered auditory hallucinations which commanded him to kill himself, his mother and his girlfriend. Consequentially he was considered to be a serious suicidal and homicidal risk.</p> <p>A period of voluntary admission (after attacking the deceased) involved the partner absconding a number of times with a restraining order taken out against him by a member of the deceased's family. He was later discharged with no reference in the discharge summary to him being a homicidal risk. More recent discharges from the mental health facility also made no indication as to his previously being considered a homicidal risk.</p> <p>The partner was often non-compliant with his medication and used cannabis. At the time of the incident the deceased was being treated at a community clinic as an outpatient.</p> <p>The last practitioner to see the partner was an occupational therapist, when the partner presented to the clinic after missing an appointment with his psychiatrist a few days earlier. The occupational therapist noted that he appeared manic.</p> <p>The coroner noted the significance of the discharge summaries; <i>"Representing a homicidal risk is a very significant statement...No later discharge summary refers to his (the partner's) risk to persons other than himself, even after he had attacked the deceased and threatened her grandmother. I really do find this quite remarkable"</i>.</p> <p>It was noted that there was not an appropriate practitioner available on his final presentation to the community clinic, nor were there adequate warnings to the clinic of his potential for significant relapse. In describing the occupational therapist missing the significance of the assailant's final presentation, the coroner notes "it may have carried much more weight ...if there had been a readily accessible alert on the file of his relapse pattern and his potential for harm" and that "the evidence...suggested better communication about alerts with respect to patients may have provided the clinic staff better awareness of the assailant's potential for serious harm and deteriorating patterns".</p>

## Homicide/ Interpersonal Violence—Continued

WA.2001. 959 Cont...	<p>Another issue was the consistent relapse of psychosis following non-compliance to medication. The psychiatrists were all asked about the use of Compulsory Community Treatment Orders on patients such as the assailant. There was consensus from all psychiatrists the provisions of the <i>Mental Health Act 1996</i>, as amended, with respect to Compulsory Community Treatment Orders did not allow them to make ongoing significant orders unless the patient was floridly psychotic at the time the order was made.</p> <p>The Coroner considered “whether or not it would be reasonable for the Department of Health, Mental Health Division and the Mental Health Review Board to consider whether or not and in which circumstances they would have difficulty with the ordering of on-going depot medication where there was persistent non-compliance with medication which prevented severe relapses of psychotic behaviour in patients such as the assailant; and consequent amendment to the legislation”.</p> <p>Finally, an assessment was made of procedural issues which could lead to an improvement in the community clinic’s ability to identify potential areas of concern for individual patients. The coroner hopes that the obtaining of all discharge summaries to date from authorised facilities for new patients, or freshly re-referred patients, by the duty officer would assist in formulating proper alerts. It was noted these alerts should be clearly identifiable on the file and include presenting patterns of deterioration if applicable and that files should also reference reasons for past involuntary status under the Mental Health Act 1996.</p>
<b>Intentional Self Harm</b>	
TAS.2007. 352	<p>The deceased, aged in his early twenties, died as a result of ingesting a poison. The deceased had variously been diagnosed with Pervasive Development Disorder, Oppositional Defiant Disorder, Asperger’s Syndrome and Autism Spectrum Disorder. Due to difficult behaviour and suicidal ideation it became untenable for the deceased to continue living in the family home and he was moved to ‘supported independent living’, 6 years prior to his death.</p> <p><b>Comments and recommendations</b></p> <p>The coroner noted that is “is of course regrettable that (the deceased’s) condition was not earlier identified to enable earlier and appropriate intervention to occur. While I am unable to state whether this would have had any effect on the most unfortunate outcome for (the deceased), it is considered of high importance that these health, education and community services are made available to others in a similar position in the hope that such tragic outcomes may be avoided in the future”.</p>
NSW.2007 .2041	<p>The deceased, a police officer, suffered multiple injuries after intentionally jumping from a building window.</p> <p><b>Recommendations</b></p> <p>Recommendations were made to the Commissioner of Police, that the Commissioner “give consideration to treating all cases of suicide by serving NSW Police officers as “critical incidents” and to amend the Critical Incidents Guidelines accordingly”.</p>

## Intentional Self Harm—Continued

<p>QLD.2006 .2010 &amp; 2118</p>	<p>A joint inquest was held into the death of two males in their late teens who had come separately into contact with the mental services of a specific hospital. In the first instance the deceased had been admitted to a secure ward however was later placed in a general non-secure mental health unit ward. In the second incident a deceased was assessed at the Emergency Department of the same hospital. He was not admitted. In both these cases the deceased took their own lives by jumping in front of a train.</p> <p><b>Comments and Recommendations</b></p> <p>Several issues of concern were identified by the coroner including:</p> <ul style="list-style-type: none"> <li>• Resourcing of mental health services, including number of staff available and number of beds available</li> <li>• Continuity of care of patients</li> <li>• The process of gaining and recording collateral information and the handover of this information</li> <li>• Communication failures between staff, including a hierarchical culture which compromised open lines of communication</li> </ul> <p>It was noted that the limited continuity of care issues have been addressed (by changes to staffing arrangements) at the hospital. Issues about the recording and transferring of important patient information up the chain were referred by the coroner to the Patient Safety Centre. With regards to the resource issues it was noted the State of Queensland has made a commitment for funding for extra mental health clinicians and more particularly a plan to introduce a 25 acute bed ward. The coroner recommended that that this proposal (as set out in the <i>Mental Health Plan 2007-2011</i>) be implemented with priority.</p>
<p>VIC.2006. 652</p>	<p>The deceased, a young man in his twenties, died of severe hypoxic brain injury in the setting of plastic bag asphyxia. The deceased had a history of drug use including cannabis and amphetamines (including Ice). Several days before his death the deceased was arrested by police for an alleged armed robbery. During an attempt by police to interview the deceased the police became concerned about his mental state and the deceased was assessed in a hospital ED and involuntary admitted to a mental health facility. After absconding from the facility (which was an 'open ward') and then being returned, he was found deceased the next day.</p> <p><b>Comments and Recommendations</b></p> <p>It was noted that changes to the plastic bags used in this incident have been made by the facility and observations are now undertaken randomly at the facility so as not to be predicted. The coroner raised several further concerns about the 'open door' unit of the facility and the lack of emphasis placed on the deceased's cannabis habit when considering his treatment plan. The coroner recommended:</p> <ol style="list-style-type: none"> <li>1. The facility continue to implement routine urine drug screens for patients on admission and after leaving the ward without permission.</li> <li>2. The facility implement routine blood drug analyses for patients who present with positive urine drug screens on admission and after leaving the ward without permission.</li> <li>3. The facility routinely implement 1:1 observation levels for patients who return after absconding and test positively to urine analyses for cannabis use until blood tests confirm that they have not used cannabis recently.</li> <li>4. The facility attempt to integrate the available holistic information about their patients into their risk assessments and their management plans.</li> </ol>
<p>TAS.2007. 402</p>	<p>The deceased fatally shot and wounded his ex-partner before turning the gun on himself. See 'homicide/ interpersonal violence'.</p>



## Mental Health Issues

See Intentional Self Harm

## Natural Cause Deaths

See case study profile on SIDS deaths at start of this publication and also refer to 'adverse effects/reactions to medical/surgical care' and 'child deaths' for other relevant natural cause deaths.

**Product Related—Continued** (See case study profile on quad bike deaths at start of this publication)

VIC.2002. 3822	See Highlighted Issue: Quad Bikes
VIC.2002. 3823	See Highlighted Issue: Quad Bikes
VIC.2002. 218	See Highlighted Issue: Quad Bikes
TAS.2002. 114	See Highlighted Issue: Quad Bikes
VIC.2002. 471	See Highlighted Issue: Quad Bikes

**Transport Related**

TAS.2008. 350	<p>The deceased died of a traumatic brain injury received as a result of a motor vehicle crash. The deceased was travelling as a passenger in a motor vehicle when the driver lost control of the vehicle whilst negotiating a bend in icy conditions, spinning in to the wrong side of the road. A vehicle travelling in the other direction collided with the car.</p> <p><b>Comments and Recommendations</b></p> <p>The location of the crash site historically shows a high incidence of loss of control type crashes during wet and icy conditions. The Department of Infrastructure Energy and Resources have conducted a post-crash review of the crash location and have made the following recommendations:</p> <ul style="list-style-type: none"> <li>• The Manager Traffic Projects is requested to install electronic road surface monitoring weather stations at appropriate locations along the area.</li> <li>• DIER commence trials of surface application of Calcium Chloride at selected high risk sites.</li> <li>• DIER Maintenance Services adopt the City Council’s trigger temperature of 4 degrees Celsius, rather than the existing 2 degrees currently used.</li> <li>• DIER’s Asset Management Section to arrange a programme for the removal of large trees along the northern roadside of the area to minimize overshadowing of the travel surface and decrease the duration of ice events.</li> <li>• DIER’s Asset Management section arranges for assessment of skid resistance through the area, identify appropriate treatments and implement those treatments.</li> </ul> <p>The coroner agreed with and endorsed the above recommendations and further, strongly recommended Transfield Services review its current practices to implement a strategy to ensure weather forecasts published by the Bureau of Meteorology after 3pm on any given day, are taken into account for safety and risk prevention work that night or the next day.</p>
TAS.2009. 96	<p>The deceased, a female in her late thirties resided on a farming property. The property was on one side of the highway and the dairy farm on the other side. The deceased was crossing the road on an ATV/quad bike when she was struck by oncoming traffic. At the time of the incident the road was wet and the weather was overcast, the deceased was not wearing any form of protective clothing or helmet. The deceased did not appear to check for traffic before driving onto the highway.</p>

## Transport Related—Continued

<p>TAS.2009. 96 Cont...</p>	<p><b>Comments and Recommendations</b></p> <p>The coroner noted concern that “it is still the case that persons who use and operate motor cycles and ATV’s do not wear approved safety helmets, however I do not believe that in this instance if the deceased had been wearing an approved safety helmet this would have prevented her death”.</p> <p>I therefore make the following recommendations:</p> <ul style="list-style-type: none"> <li>• That Workplace Standards Tasmania continues to work with industry representative bodies and encourage the adoption of safe work practices to deal with risks associated with motorcycle activity including the requirement to wear an approved safety helmet when riding farm bikes.</li> <li>• Given the state of knowledge about the risks and/or severity of head injury that can result from a motorcycle incident I recommend that the wearing of an approved safety helmet be a mandatory requirement when using a motorcycle or ATV and that the Workplace Health and Safety Act 1995 be amended to include this basic safety measure.</li> </ul>
<p>VIC.2008. 2138</p>	<p>The deceased, a pedestrian in his eighties, died of multiple injuries after being struck by a vehicle while attempting to cross the road. At the time the deceased was wearing dark clothing and the roadway was wet and dark following a recent burst of rain. Police attending have noted visibility was poor due to limited street lighting at the intersection. The Coroner has noted that there is ample evidence to suggest that the intersection was poorly lit, and that this was a factor which contributed to the collision...and that “it would be appropriate for the relevant authority to consider whether the lighting of the intersection could be improved to avoid another death in similar circumstances. I accordingly direct the Principal Registrar to provide a copy of this finding to the Council and VicRoads for their information and whatever action they deem appropriate”.</p>
<p>TAS.2008. 534</p>	<p>The deceased, a young child, died of a cervical spinal injury, resulting from a single motor vehicle incident. The deceased was a passenger, sitting in the back middle seat, wearing a lap seat belt which had not been adjusted to fit the child. The driver lost control of the vehicle when rounding a turn and consequently collided with a power pole.</p> <p><b>Recommendations</b></p> <ol style="list-style-type: none"> <li>1. That any person using a motor vehicle fitted with lap seat belts give serious consideration to replacing them with 3 point lap sash style belts.</li> <li>2. That drivers of motor vehicles ensure that their passengers, most particularly children avoid, where possible, occupying seats fitted with a lap seat belt.</li> </ol>
<p>NT.2008. 113</p>	<p>The deceased was an intoxicated pedestrian, aged in his early forties, who died of multiple injuries resulting from a motor vehicle collision. The investigating officer concludes “<i>the major contributing factor...to the cause of this collision is the high level of intoxication (0.158% BAC) and demeanour of the deceased. A secondary factor is the lack of street lighting at the scene of the collision</i>”. The officer in charge suggests a recommendation that street lighting be installed in this section of highway.</p> <p><b>Recommendations</b></p> <p>That the Department of Planning and Infrastructure install street lighting continuously along the relevant area of the Highway.</p>

## Transport Related—Continued

VIC.2007. 196 & 197	<p>The two deceased died when the prime mover they were travelling in failed to negotiate a sweeping left hand turn. The prime mover combination was carrying several hundred sheep at the time and police collision unit investigating the incident noted that a multi level loaded stock transporter is notoriously unstable. Although the driver possessed the minimum qualifications for transporting this livestock weight combination and had some experience transporting cattle, he had no experience transporting sheep. There are acknowledged differences between transporting cattle and sheep.</p> <p><b>Recommendations</b> That VicRoads consider the development of an accredited course and/or information/training materials for drivers who are commencing work in the livestock/transport industry.</p>
ACT.2003 .48 & 15	<p>The deceased was a passenger in a vehicle that was hit from behind while waiting at a red light at an intersection by another vehicle whose driver experienced a hypoglycaemic blackout. The deceased, who was pregnant, was taken to hospital and an emergency caesarean was performed and the child was born that day, but later died along with the mother.</p> <p><b>Recommendations</b> The Coroner drew attention to a previous case of hypoglycaemia that resulted in a road fatality, and the recommendations made by the coroner at the time.</p> <p>The Coroner made a number of recommendations which related to licencing conditions and obligations for insulin dependent drivers and reporting of hypoglycaemic episodes to the road transport authority.</p>
WA.2007. 701 & 702 & 703	<p>The deceased, three men, all died as a result of injuries sustained in impact when the single engine aircraft they were travelling in crashed. The deceased included two passengers and the pilot. Whether or not the impact was as the result of a sudden medical event (the pilot had an unknown heart condition which was discovered post-mortem at autopsy) or distorted perception as to the proximity of the plane to the ground will never be known.</p> <p><b>Comments and Recommendations</b> The ATSB and CASAA may like to consider whether or not the ageing of the general population should be a factor taken into account in private aviation medicals.</p>

## Work Related

VIC.2006. 3043	<p>The deceased was employed as a tool maker and operator, and was performing repairs on a pipe bending machine when another machine operator began to operate the machine. The operator was unaware the deceased was working on the machine at the time, and the deceased was struck in the head and died from head injuries.</p> <p><b>Recommendations</b> The coroner recommended the deceased's employer establish a memorial, which would honour the memory and loss of the deceased, and serve as a legacy that the safety of workers and of the work-place is paramount and that in memory of the deceased, short-cuts in safety will never again be tolerated by the Company.</p>
VIC.2007. 196	<p>The deceased, a truck driver, was killed in a single vehicle collision. See 'transport related'.</p>

## Work Related - Continued

WA.2007. 702	The deceased, a pilot, was killed in a plane crash. See 'transport related'.
VIC.2002. 218	The deceased, a farmer, was spraying weeds on property when their quad bike rolled. See 'Highlighted Issue: quad bikes'.
TAS.2002. 114	The deceased, a farmer, was spraying weeds on property when their quad bike rolled. See 'Highlighted Issue: quad bikes'.
VIC.2002. 471	The deceased, a farmer, was spraying weeds on property when their quad bike rolled. See 'Highlighted Issue: quad bikes'.
TAS.2002. 554	The deceased, a young child, died in a quad bike accident. See 'Highlighted Issue: quad bikes'.
TAS.2009. 96	The deceased, who lived on a farm died in a road traffic accident while riding a quad bike. 'See Highlighted Issue: quad bikes'.

The following is an index of recommendations (by broad topic area) summarised by the NCIS within the 20 editions of Fatal Facts produced thus far.

Please note that cases can often involve multiple topic areas or themes, and therefore may be included in the list below more than once.

Editions 6 - 20 of Fatal Facts can be found on the NCIS website, at:

[http://www.ncis.org.au/web\\_pages/publications.htm#a1](http://www.ncis.org.au/web_pages/publications.htm#a1)

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

<b>Topic/theme</b>	<b>See Fatal Facts Edition(s)...</b>
Adverse effects or reactions to medical/surgical care	All
Aged care	20, 19, 18, 17, 16, 15, 14, 13, 11, 6
Child deaths	21, 20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 7, 6, 4
Diving, scuba diving, snorkeling	21, 17, 15, 11, 9
Domestic/leisure incident	21, 20, 19, 16, 14, 13, 12, 9, 8, 4
Drugs or alcohol	21, 20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 9, 7, 6, 5, 4, 3, 2
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Homicide/interpersonal violence	21, 20, 18, 17, 16, 15, 14, 13, 12, 11, 9, 8, 7, 5
Intentional Self-Harm	21, 20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 5, 4, 3, 2, 1
Mental health issues	21, 19, 18, 17, 16, 15, 13, 12, 11, 10, 9, 8, 4, 3, 2
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Product-related	21, 19, 14, 13, 11, 7, 4, 3
Sports-related	19, 18, 17, 15, 14, 12, 11, 10
Transport-related	All
Water-related (general)	19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 7, 6, 5, 4, 3, 2, 1
Water-related (recreational fishing/boating)	20, 19, 18, 17, 16, 15, 14, 13, 11, 10, 9, 7, 6, 5, 1
Work-related	All