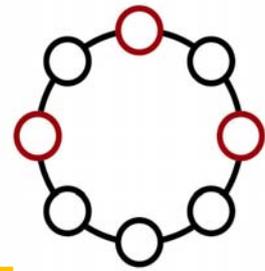


# NCIS Fatal Facts

Edition 22 - May 2012



**NCIS**

This edition of Fatal Facts features 51 coronial cases where recommendations have been made. These cases were closed between 1 June 2009 and 30 September 2009.

As a number of recommendations involved deaths in custody or during police pursuit, these are the focus for the case studies.

In this edition, we are introducing a new topic area. A *Procedural* category has been created to identify recommendations relevant to the coronial investigation process.

If you seek further information regarding any of the cases contained in this edition and you are an authorised NCIS user, log into the NCIS website and find particular cases by clicking on the 'NCIS Search' tab and selecting 'Find case'.

Should you require advice regarding NCIS access, please contact our NCIS Access Officer, Jo Cotsonis at [joanna.cotsonis@vifm.org](mailto:joanna.cotsonis@vifm.org) or on (03) 9684 4323.

If you do not currently have access to the NCIS and would like to enquire about an information search, please contact the NCIS team on [ncis@vifm.org](mailto:ncis@vifm.org).

## NCIS AT A GLANCE

- \* Number of cases on the NCIS (cases closed by a Coroner between 1 June 2009 and 30 September 2009): 4158
- \* Number of findings on the NCIS (cases closed by a Coroner between 1 June 2009 and 30 September 2009): 3358
- \* Number of cases with recommendations (cases closed by a Coroner between 1 June 2009 and 30 September 2009): 51

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

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



The NCIS is managed by the Victorian Institute of Forensic Medicine on behalf of the State/Federal funding agencies. The NCIS is funded by each State/Territory Justice Department around Australia, and the Australian Departments of Health & Ageing, SafeWork Australia, the ACCC, the Australian Department of Infrastructure and the Australian Institute

## CASE STUDY— DEATHS IN CUSTODY OR WHILE IN POLICE PURSUIT

### Case No.: NT.2008.2

The deceased attended a party which degenerated during the afternoon as people become progressively more aggressive and intoxicated. As a result Police were called to attend.

The deceased was asked by police to leave the premises to which the deceased agreed. As they were walking outside, a comment was made to the deceased causing an aggressive reaction. While Police were trying to force the deceased's arms behind their back, the deceased struggled and the entire group, including the deceased, fell to ground. The struggle continued whilst the deceased was on the ground. After handcuffs were put on, the deceased was placed in the police van. While doing this, police noted the deceased was unable to bear their own weight and was very quiet.

After the deceased was placed on the van bench and slipped over, police checked for the deceased's pulse but could not find any. An ambulance was called and the deceased was transported to hospital where the deceased was declared dead.

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### Case No.: SA.2007.822

The deceased died as a result of a high-speed pursuit in which police followed a stolen vehicle in which the deceased was the passenger. After an initial termination call, which was not heard by all participants, there were two additional calls to terminate the pursuit.

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### Case No.: WA.2008.162

The deceased died as a result of a heat stroke while in custody, having been arrested by police in relation to traffic offences while driving. The deceased was transported a distance of approximately 360 kilometres in the back section of a van which had been modified to carry prisoners and had two security cells or pods. The temperature on that day was over 40°C.

At a point during the journey the deceased collapsed and was taken to hospital where it was noted the presence of a laceration on the forehead and a large burn on the abdomen. Evidence revealed that the burn had been caused by contact between the deceased's skin on the metal steel pod in which they had been held in custody.

## CASE STUDY— DEATHS IN CUSTODY OR WHILE IN POLICE PURSUIT

Many of the recommendations made in these findings emphasise the need for more training, improvement of communication strategies, amendments of proceeding manuals, and the use of new technologies.

### Recommendations:

1. Amendment of custody manuals advising police members to take any apparently mentally ill or disturbed person by the most direct practical route and as quickly as possible to a hospital or doctor for the purpose of an assessment.
2. Offer clear guidance to operational police in relation to the handover of patients to hospital.
3. Ensure operational police are trained to ensure a proper understanding of the dangers of sudden cardiac arrest and positional restraint asphyxia, and in strategies to deal with mentally ill persons both in custody and generally in the course of their duties, specially in relation to communication strategies, control tactics and identification of symptoms and changes in behaviour.
4. Give police members step-by-step instructions on exercising the power of immediate apprehension for the purpose of a mental health assessment.
6. Clarify police powers and responsibilities.
7. Use of technological aids when tracking a police chase and speeds involved, perhaps by the use of Global Positioning Satellite technology.
8. Having a dedicated transmission network to deal with high speed pursuits to assist incident controllers to obtain information relevant to the risk assessment process.
9. Review of training procedures.
10. Regular monitoring of Justice of the Peace to ensure that they are performing their duties appropriately.
11. Review procedures to extend the availability of video conferencing and, in the absence of video conferencing, consider to increase the use of telephone conferencing so decisions, specially those relating to the liberty of subjects, can be wherever possible made by qualified magistrates.
12. Review of court procedures with a view to limiting unnecessary transportation of accused persons over long distances.
13. Replace the fleet of prisoner transportation vehicles with vehicles which are both safe and humane.
14. Review policies and procedures relating to welfare of detainees and duty of care to ensure that procedures in place are sufficiently comprehensive and address the known risks.

## CASE STUDY— DEATHS IN CUSTODY OR WHILE IN POLICE PURSUIT

15. Ensure that there are sufficient contract monitors to regularly review operations in regional locations so as to ensure that the prisoner transportation fleet is maintained in a safe manner.

16. Provision of detailed practical training in respect of duty of care obligations and that such training be refreshed on a regular basis for all staff.

## ADDITIONAL CASES — DEATHS IN CUSTODY OR WHILE IN POLICE PURSUIT

### NSW.2006.2894

The deceased was arrested and handcuffed by police. During the arrest, the deceased became unconscious so the police officers began CPR without success. Post mortem reports established that the deceased suffered a cardiac arrhythmia.

#### Recommendation:

- Consideration be given to implementing on a State wide basis an appropriate protocol that deals with issues associated with the release of a Mental Health patient on escorted leave or the discharge of a Mental Health Patient.

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### NSW.2007.6188 (& Intentional Self Harm, & Procedural)

The deceased was a prison inmate who disconnected the phone cord from the communal phone and used it to hang themselves in their cell.

#### Recommendations:

- The Department of Corrective Services review the systems and protocols in place for inmates known to be at-risk, to determine whether these presently provide for a coordinated and proactive management plan for such inmates.
- The Department of Corrective Services review its Investigative Services Branch and the requirements of reports made by its investigators to ensure that full information is gathered, systemic issues are identified, and, if necessary any recommendations are made, by the Investigators both for the use of the Coroner, and for full consideration by the Department.
- The Department of Corrective Services provide all investigation reports undertaken by or on behalf of the said Department into deaths in custody to the Office of the State Coroner immediately upon finalisation (subject to any legal claims made).

## ADDITIONAL CASES — DEATHS IN CUSTODY OR WHILE IN POLICE PURSUIT

### **VIC.2006.2940 (& Intentional Self Harm)**

The deceased had learned that a close family member had died suddenly and unexpectedly. On the same day and after police intervention due to a domestic dispute, the deceased was offered a ride by attending police officers. While on route to the chosen destination, the deceased requested to be taken out as the deceased preferred to walk. The deceased intentionally walked into the path of a truck causing their death.

#### **Recommendations:**

- The Victoria Police considers using the facts of this case as a teaching resource to assist in developing an understanding in all members being inducted into Victoria Police, the expectations placed upon them for responsible policing.
- The Victoria Police review what is being taught to recruits and disseminated throughout Victoria Police as to obligations to members of the public being transported by Victoria police when not under arrest or in custody.
- The Victoria Police ensure that great caution is exercised in the immediate wake of any death and that every attempt is made to ensure that only accurate information is communicated to any other person.
- That Victoria Police consider requesting members directly involved in a death in police custody, care or control to participate in an electronically recorded interview as soon as practicable after the death.

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### **WA.2007.1393**

The deceased died as a result of ligature compression of the neck while in prison.

#### **Recommendations:**

- The Department of Corrective Services investigate the desirability of a Special Purpose Unit somewhere in the Northwest of the State which can be adapted to accommodate prisoners requiring different care regimes to ensure their safety.
- The Department of Corrective Services ensure appropriate transfer from regional lockups or prisons to and from that facility.
- Funding be provide to ensure adequate CCTV monitoring of all special and general use areas of the prison.

## ADDITIONAL CASES — DEATHS IN CUSTODY OR WHILE IN POLICE PURSUIT

### VIC.2007.4786

The deceased died from hanging. The deceased was serving an Intensive Corrections Order (ICO).

#### Recommendations:

- Corrections Victoria to identify appropriate staff to offender ratios to adequately supervise and support offenders in accordance with policies and procedures. Contingency plans should be developed in advance of staff levels dropping below identified levels.
- Review and establish protocols between Community Correctional Services (CCS) and agencies delivering programs (e.g. drug and alcohol counselling) to ensure timely feedback to CCS regarding attendance of offenders. If offenders are not attending appropriate action needs to be taken at the earliest opportunity.
- Temporary transfer or liaison with other regions when offenders are temporarily out of the supervising region to ensure offenders can be supervised and/ or linked with necessary supports during this time.
- There needs to be continued vigilance to ensure that the CCS Standard D6.1 (Risk of Suicide and Self Harm) is fully implemented at a local level. Ongoing training and auditing is required.

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### TAS.2009.29

See 'Intentional self-harm'.

## SUMMARY OF INCIDENT & RECOMMENDATIONS

### CHILD DEATHS

#### ACT.2005.258

The deceased was less than 3 months old, and was discovered deceased face down in the cot one morning. The child had been put to bed approximately 5 hours before.

#### Recommendation:

- Every mother of a child born in the Australian Capital Territory be provided with information relating to safe sleeping practice for infants including a brochure "Sids & Kids - Safe Sleeping" published in September 2007 (as it may be updated).

#### NSW.2008.521

The deceased child was admitted to hospital after prolonged vomiting. After tests and treatment, it was discovered that the deceased was suffering from a brain tumour. The child's health continued to deteriorate and they passed away. The official cause of death was determined to be Cerebellar medulloblastoma, a highly malignant tumour known to occur in the cerebellum (a portion of the brain located in the posterior fossa), particularly in children.

#### Recommendation:

- That the circumstances in which the deceased was diagnosed as suffering from a *cerebellar medulloblastoma* be the subject of an article in the *Australian Family Physician* in order to ensure that the need for early diagnosis and treatment of such condition is highlighted to medical practitioners and others who may be required to treat patients with such conditions.

#### SA.2006.1548

The deceased died of Group B streptococcus infection which was undoubtedly contracted while the deceased was still in the womb and very likely during labour. The deceased's mother underwent a GBS screening test with the result reported as negative.

#### Recommendations:

- Recommendations made to the South Australian Minister of Health, the South Australian Department of Health and the Medical Board of South Australia, draw attention to the incidence of false negative GBS screening test results and to the possible adverse consequences of implicit reliance upon reported negative screening test results in determining whether to administer antibiotic prophylactic cover after pre-labour rupture of the membranes (PROM). Specifically, an amendment of the guidelines in respect of the "Management of intrapartum antibiotic prophylaxis and treatment" was recommended by a South Australian Coroner.

#### TAS.2006.204

The deceased's mother failed to seek medical assistance after the deceased suffered a head injury in the two weeks preceding the death.

#### Recommendation:

- The Coroner emphasised the importance of supervision of young children and early treatment of injuries and/or illnesses.

#### NSW.2007.3323

See also 'Transport related deaths'.

## CHILD DEATHS

### NSW.2008.4640

See 'Water related'.

### QLD.2006.3339

See 'Water related'.

### NSW.2008.3396

See 'Water related'.

## TRANSPORT RELATED DEATHS

### NSW.2007.1343

A tug plane towing a glider experienced difficulty shortly after take off. The deceased was a trainee passenger in the front seat of the glider being towed during an initial training flight. The training instructor was in the back of the glider. The pilot of the tug plane had issued a pre flight briefing where weather conditions were discussed. Due to the presence of a grader on the preferred runway, a different runway was used. At the time of take off, the pilot noticed that there was a cross wind and attempted to navigate the plane accordingly. Shortly after, the pilot observed that the aircraft was not gaining suitable altitude and eventually made the decision to release the glider, with the intention of 'bouncing' it over a fence. Due to the aircraft's reduced velocity, the glider collided with the fence and the trainee / passenger was killed. The instructor and pilot suffered minor injuries.

#### **Recommendation:**

- That consideration be given to issuing a direction to all soaring clubs and or other organisations that conduct or provide facilities for the towing of gliders. Such direction should state that in the event that maintenance operations are being conducted, on or near a runway, which may involve the use of equipment, machinery or personnel that all gliding operations are to cease irrespective of whether the pilot of the tug aircraft or the pilot of the glider, feel that it is safe.

### NSW.2007.3323 (& Child Death)

Whilst crossing the road at traffic lights, a pedestrian and the child being carried were struck by a garbage truck. The vehicle driver was turning left into the road as the lights changed and did not see the pedestrians whilst rounding the corner. The parent suffered serious injuries and the child passed away as a result of the incident.

#### **Recommendations:**

- Position in relation to the question whether transparent doors ought be fitted to heavy vehicles to be reconsidered.
- Address issue of blind spots on heavy vehicles obscuring pedestrians and other smaller road users by amendment of the Australian Design Rules for Motor Vehicles and trailers.
- Introduction of a change to phasing of traffic lights so as to provide pedestrians with a 10-15 second head start at intersections controlled by manually triggered pedestrian control signals at which left-turning traffic and pedestrians are sharing the same road space.
- Installation of left-turn arrow control lights at any intersection identified as a common thoroughfare for heavy vehicles turning left in built-up areas where such intersections are also commonly used by pedestrians.

## TRANSPORT RELATED DEATHS

### NSW.2007.6180 (& work related)

The deceased was an experienced pilot who was testing an experimental water extraction process to be used in bush fire assistance operations. The aircraft crashed into the lake.

#### Recommendations:

- Applicants for a special Certificate of Airworthiness (Experimental Certificate) to provide a comprehensive risk identification and mitigation analysis of the proposed experimental use of the aircraft.
- A record to be maintained of the decision making process (including matters considered) leading to the issue of such certificates.
- That policies and procedures be developed to assist officers to identify issues for consideration, especially matters relating to safety.

### QLD.2007.181 (& Procedural)

The deceased died after losing control of their 4WD while traversing a drive track located in a motorbike and 4WD park. The deceased was thrown from the vehicle and sustained fatal injuries.

#### Recommendations:

- Local authorities dealing with development applications concerning outdoor recreation facilities be required to refer the application for assessment by the Department of Local Government, Sport and Recreation.
- The Department of Local Government, Sport and Recreation stipulate continuing membership of the appropriate outdoor sports or recreation body as a condition of the application's approval.
- The Division of Workplace Health and Safety review its determination that the injury to members of the public at worksites are beyond its investigative jurisdiction.
- The chief forensic pathologist develop a guideline to assist pathologists undertaking coronial autopsies identify those cases in which vitreous humour should be collected for toxicological analysis.

### QLD.2007.2267 (& work-related)

The deceased died as a result of a single motor vehicle crash. Tyre marking at the scene indicated that the vehicle moved to the left of the roadway onto the eastern dirt shoulder and then continued across the on-coming traffic lane leaving the roadway, striking a large tree.

#### Recommendations:

- Queensland Transport promote or continue to promote the risk of fatigue and speeding in motor vehicle crashes.
- The office of Workplace Health and Safety promote healthy practices about courier drivers to try to prevent similar deaths in the future by trying to encourage employers not to have unrealistic expectations of employees travelling such long distances after a full day work.

### TAS.2008.505

The deceased died from multiple injuries sustained in a motor vehicle crash after removing the key from the ignition while their car was still in motion. As a consequence, the engine disengaged and the steering wheel locked as soon as an attempt was made to steer the vehicle. It was unable to be diverted from its course thus moving from its lane into the opposite lane and into the path of a truck.

#### Recommendation:

- All people involved in driver training, such as parents and driving instructors, remember the need to incorporate in learner driver education advice concerning fundamental motor vehicle mechanics, including direction about the danger of driving when a vehicle's engine has been

## TRANSPORT RELATED DEATHS

disengaged.

### TAS.2009.23

The deceased died of blunt trauma as a result of a motor vehicle crash.

When negotiating a right hand bend, the deceased's vehicle ran off the bitumen surface and onto the gravel shoulder. The deceased then lost control of the vehicle whereby it crossed to the opposite side of the roadway and then dropped into a relatively deep culvert. In the course of these uncontrolled movements, the rear of the deceased's head impacted upon a B pillar within the vehicle's cab causing the deceased's fatal injury. The deceased's driving capacity was found by the coroner to be impaired by alcohol. A secondary contributory factor was a 20mm gap between the bitumen edge and the gravel verge.

#### Recommendations:

- Installation of a barricade in the area of the culvert as the Department of Infrastructure, Energy and Resources suggested.
- The gap between the bitumen seal and the gravel verge in the area of the crash be filled following a recommendation made by the police officer responsible for the investigation.

### NT.2007.256

The deceased was intoxicated and walked in front of a car at night time. The driver had been previously involved in a similar incident. The driver's vision was in excess of the motor vehicle requirement for a minimum of 6/12 vision binocularly, although glasses were required when driving.

#### Recommendation:

- The Registrar of Motor Vehicles consider introducing requirements for an increased frequency of vision testing above a particular age, which would at a minimum require annual testing for drivers over 80 years of age.

## ADVERSE EFFECTS OR REACTIONS TO MEDICAL/ SURGICAL CARE

### NSW.2006.4385 (& Aged Care)

The deceased suffered from a number of medical conditions including heart problems and diabetes, and was cared for regularly at home by a relative and a visiting nurse. The deceased was admitted to hospital for a chest infection, and it was agreed that they would be moved to a nursing home for more complete care.

The family doctor was in attendance during the move and completed a medication chart to assist nursing staff. The medication dosages and markings provided by the doctor on the deceased's chart were interpreted differently by various nursing staff members and eventually the deceased was administered a dosage significantly higher than required. After displaying symptoms of acute illness, the deceased was hospitalised and later died.

#### Recommendations:

- All detected incidents must immediately be brought to the attention of the Director of Nursing, the Deputy Director of Nursing or the Registered Nurse in charge. The Director of Nursing, the Deputy Director of Nursing or the Registered Nurse in charge is then to notify the pharmacist, or the treating doctor, or an after hours doctor or is to call an ambulance, whichever is the appropriate course of action.
- That the staff record the medication administered to residents in the period between the admission of a resident and the drawing up of a medication charge by a doctor in the Progress

## ADVERSE EFFECTS OR REACTIONS TO MEDICAL/ SURGICAL CARE

Notes for each patient each time the medication is administered.

### TAS.2006.304

The deceased died from ischaemic/ hypoxic encephalopathy following an unexplained cardio-respiratory arrest following laminectomy.

#### Recommendations:

- The Hospital take steps to ensure that it is fully acquainted with the data retrieval features of all patient monitors used upon its wards and
- The Hospital ensure that all nursing staff required to use monitors are also aware of those features.

### TAS.2008.233

The deceased died as a result of a bleeding arteriovenous fistula pseudo-aneurysm due to haemodialysis for chronic renal failure.

#### Recommendations:

- World Health Organisation grant to improve handover, which is directed mainly at handover between staff at the change of shifts, be expanded to all other wards as a mean of improving the standard of this critical aspect of patient care.
- A nursing position be established for a dialysis vascular access coordinator, based in the departments of Vascular Surgery and Nephrology.
- Creation of early identification of patients for arterio-venous fistula (AVF).
- Communication between patient, dialysis nurses, nephrologists and the vascular surgery team.
- Documentation of AVF problems, investigations, options and management plan.
- Ongoing surveillance of AVF to optimise outcomes.
- Protection of veins and hospital wide education.

### TAS.2009.92

The deceased died from a pulmonary thrombo-embolus complicating prolonged immobilisation during recovery from subarachnoid haemorrhage resultant from a saccular aneurysm of the right middle cerebral artery.

#### Recommendation:

- The Hospital undertake an investigation of pneumatic calf compressors usage as standard pre-operative treatment for risk patients and make whatever adjustments to its pre-operative procedures, if any, that may be indicated.

### TAS.2009.141

The deceased died as a result of caecal torsion due to adhesions due to a peri-appendiceal abscess.

#### Recommendation:

- The Hospital take steps to ensure that unless exceptional circumstances exist that consultants in charge of patients physically see their patients as soon as possible on admission and in any event within 24 hours of such admission.

### NSW.2007.2910

Whilst in hospital giving birth, the deceased was required to have an emergency caesarean

## ADVERSE EFFECTS OR REACTIONS TO MEDICAL / SURGICAL CARE

operation. The newborn was delivered healthy and the deceased began to bleed from the uterus and failed to clot. The deceased was transferred to another hospital where treatment was continued. After several heart attacks the deceased was unable to be revived.

### **Recommendation:**

- That consideration be given to implementing a uniform policy in all New South Wales hospitals that provides that a full blood count and group and hold be undertaken for all elective and emergency caesarean sections.

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### **NT.2007.199 (Sports-related)**

The deceased developed chest pain and shortness of breath during football training and presented to the hospital emergency department. The deceased died inside the Emergency Department while waiting to be attended to by a nurse.

### **Recommendation:**

- The Hospital should give consideration to making provision for backfilling the second triage nurse position (there are two nurses except from midnight to 7am) when a nurse takes a meal break or is otherwise absent.

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### **NT.2008.303**

The deceased suffered pancreatic cancer. After several cycles of chemotherapy, they were treated with palliative care. To control pain the deceased was administered high level medication via a Graseby Syringe Driver Pump at even times throughout a 24 hour period. While in hospital, the deceased expressed the desire to return home to pass away. The deceased was discharged with two Graseby Syringe Driver Pumps attached. Syringe one administered 160mg of Hydromorphone and 4mg of Dexamethasone. Syringe driver two contained 60mg of Hydromorphone and 4mg of Dexamethasone. The deceased's treating doctors were of the opinion that the deceased would not survive the weekend.

Upon checking of the syringe drivers it was noted that the first syringe driver had administered the 24 hour dose of medication in less than 9 hours. Treating doctors were not concerned due to the deceased's level of tolerance and their advice was to disconnect the syringe driver and take it away to be replaced. Another syringe driver was later provided. The deceased passed away the following day.

The investigation did not identify any evidence that the syringe driver was interfered with by another person or by the deceased. The machine was found to be faulty despite having been serviced in accordance with the technical manual.

### **Recommendation:**

- The Department of Health and Families investigate the use of the Graseby Syringe Driver Pumps as a matter of public health and safety.

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### **SA.2005.2906**

The deceased died of an acute right subdural haematoma. The deceased had a history of ankylosing spondylitis which is a condition of the spine that can generate pain from time to time, had stents placed in each of the iliac arteries to encourage better leg circulation, had a transient ischaemic attack (TIA), and was diagnosed as from suffering atrial fibrillation (AF) which is a condition of the heart that involves arrhythmia. The deceased was placed on a Warfarin regime in order to prevent or minimise the rapidity of clotting.

### **Recommendations:**

- The Department of Health, in conjunction with the Medical Board of South Australia, conduct an investigation in relation to the level of knowledge, expertise and experience of overseas trained

## ADVERSE EFFECTS OR REACTIONS TO MEDICAL / SURGICAL CARE

medical practitioners in respect of the prescription of Warfarin and the need to maintain adequate monitoring of anticoagulation levels in the patient so prescribed; and if necessary implement appropriate measures to ensure that overseas trained practitioners are not permitted to practice until they have demonstrated a satisfactory level of such knowledge, expertise and experience.

- The Department of Health, in conjunction with the Pharmacy Board of South Australia, give consideration to whether it is necessary for pharmacists who fill prescriptions for the drug Warfarin to impart oral or written information to the person so prescribed in respect of the need for monitoring of anticoagulation levels.
- The Department of Health promulgate a brochure containing information as to the need for patients who are prescribed Warfarin to be monitored and that such brochure be made available for distribution by general practitioners to their patients.
- The management of the hospital review the efficiency of its after-hours radio graphical and radiological services, undertake the training of a medical practitioner or practitioners to enable them to perform emergency parietal burr hole procedures, and ensure that upon the presentation of patients who are on warfarin or other anticoagulant therapy that this fact is displayed prominently in the patient's clinical record and that in any event the same is specifically drawn to the attention of the examining medical practitioner.

### NT.2007.135

See 'Drugs or Alcohol'.

## WATER RELATED

### NSW.2008.310 & NSW.2008.311

Three young people entered a storm water tunnel to produce spray paint art after consuming alcohol. Whilst inside the tunnel, a heavy downpour of rain occurred, causing flash flooding in the drain. Two of the people drowned and one sustained serious injuries.

#### Recommendations:

- Sydney Water seek to encourage the reporting of intruders in the water sewerage systems to police and its own 24-hour hotline by inserting notices on its website, by providing notices with water bills or by any other appropriate means.
- Sydney Water publicise the dangers of flash flooding in storm water tunnels, drains and canals by the same means.
- The NSW Police investigate the activities of the group and take appropriate action to close down the group's website.
- The Local Area Command in its regular patrols pay close attention to the manhole entrances to the Lurline Bay storm water tunnel system with a view to early detection of intrusion and the deterrence of graffiti artists and others unlawfully entering the system.
- A well known graffiti artist to post a notice on their website warning graffiti artists against using storm water tunnels, drains and canals because of the dangers of flash-flooding.

### NSW.2008.4640 (& Child deaths)

The deceased was under 2 years old and entered a water retention pond and drowned during an excursion to a park organised by a day carer.

#### Recommendations:

- Isolating fencing be erected around the playground equipment at the park.
- The safety signage erected at the park be reviewed with a view to installing signs of such design

## WATER RELATED

that would highlight the presence of the water hazard and the need for close supervision of small children.

### QLD.2006.3339 (& Child deaths)

The deceased's family lived adjacent to a school ground and pool. The deceased's father created a gate in the dividing boundary fence so as to provide ease of access between the home and the school grounds. The deceased was found face down in the school pool, unable to be revived.

The cause of death was identified as asphyxia due to drowning.

#### Recommendations:

- As recommended by Coroner Spencer in 2005 the Parliament proclaim a single piece of legislation containing a uniform set of rules and regulations relating to the construction of pool fencing, irrespective of the date of construction of the pool. The legislation ought to make provision for safety inspection of all recorded swimming pools on a regular basis and, at least, on every occasion where the integrity of the pool fence has been compromised by any alteration.
- All common fences between contiguous properties, one of which contains a swimming pool, must be a 'pool fence' as defined by the prevailing legislation and not merely a 'boundary fence'. Further, any gate that intersects the pool/boundary fence must be self-closing and self-latching. The onus of ensuring compliance with the legislation ought to be that of the owner of the land on which the pool is sited. This death resulted from a boundary fence, as distinct from a pool fence, being modified.
- The Parliament ought to consider, in drafting legislation, enacting a provision that required owners of properties adjoining a pool to keep the boundary fence clear of objects that would assist a young child to gain access to the pool (e.g. the planting of trees or the building a barbecue within about 1 metre of the boundary fence.)
- The legislation enacted should also provide that where a boundary fence of adjoining properties forms part of a pool fence, any inspection of the swimming pool fence should also entail an inspection of the property owner's boundary fence.
- The legislation might also provide that where an owner rents or leases a property where a boundary fence forms part of a pool fence any rental, tenancy or lease agreement include a provision that the renter or lessee be provided with information about pool fencing requirements and an acknowledgment as to a responsibility to ensure such fencing is kept in a good, safe state of repair.
- An advertising campaign emphasising the dangers swimming pools (any other water impoundments) pose to young children should be commenced/ continued. The material ought to be directed not only at owners whose properties have had pools installed but also at persons, whether owners, renters or lessees, who reside in properties where the boundary fence adjoins a pool.
- The community ought to be encouraged to be proactive and report to the appropriate authority situations in which, as a breach of pool fence safety, the life of a child is placed at risk.
- Legislation must provide for substantial penalties where pool owners refuse or neglect to maintain pool fencing to the requisite standard.

### NT.2008.6

The deceased drowned while trying to cross a raising river.

#### Recommendation:

- A water height marker to be erected at an appropriate point at the Victoria river to assist road users to determine the level of water in the causeway.

## WATER RELATED

### NSW.2008.3396 (& Procedural)

The deceased entered a dam to retrieve a ball. Whilst swimming back to shore, the deceased sank beneath the surface. The deceased's body was recovered some 15 minutes later and transported to hospital where they eventually died.

#### Recommendations:

- In case where a death or serious accident occurs on land or sites managed by any government authorities, organisations or agencies which are attended by Police, the relevant government body be notified by Police of the incident in question as soon as is reasonable practicable.
- Prevent the presence of lifebuoys being obscured from view.
- Installation of advisory signs at the swimming areas in the park notifying of the presence and location of lifebuoys.
- A fence should be erected around the children's playground located near the swimming area.

## INTENTIONAL SELF-HARM

### NT.2006.295 (& Procedural)

The deceased committed intentional self-harm by hanging following an argument with their mother. The deceased had previously attempted self-harm by the same means and made several statements to that effect.

The elapsed time between the death and the submission of a final coronial investigation brief was more than 2 years.

#### Recommendations:

- The Coronial Investigation Unit is appropriately staffed and resourced in order that the members of that Unit are able to, and do, exercise investigative, oversight and liaison functions in relation to deaths reported to the coroner.
- Specific strategies to be put in place to ensure that reportable deaths are investigated by police officers in a timely way, with the expectation being that a coronial investigation file of satisfactory quality will be submitted to the Coroner within 6 months from death to death.
- The Director General for the Department of Health introduce an Adolescent Health Service within NT Department of Health.

### TAS.2009.29 (& death in custody)

The deceased was diagnosed to be suffering from a situational crisis upon a background of alcohol dependence. The deceased was taken into protective custody and transported to hospital for mental health assessment due to the deceased's making threats of self-harm while intoxicated.

After being assessed, the attending doctor agreed to release the deceased into police custody under the public drunkenness provisions of the Police Offences Act 1935. Police was advised that the deceased should be returned to hospital if once sober there were expressions of self-harm. The deceased was sufficiently sober to be released from police custody and returned home where they died as a result of asphyxia due to hanging.

#### Recommendations:

- Police to liaise with the hospital authorities with view to putting in place protocols for the detention, care and assessment/ treatment of mentally disturbed persons whose management is complicated by alcohol and/ or drug intoxication.
- The creation of a place of safety within the Hospital precinct where an individual could remain until sufficiently unaffected by alcohol/drugs to permit psychiatric assessment.

## INTENTIONAL SELF-HARM

### NSW.2007.6188

See 'Additional cases—Deaths in custody or while in police pursuit'.

### VIC.2006.2940

See 'Additional cases—Deaths in custody or while in police pursuit'.

## DRUGS OR ALCOHOL

### NT.2007.135 (& Adverse effects or reactions to medical/surgical care)

The deceased was found dead at the residence of a friend. The deceased had a history of chronic use of therapeutic drugs, with some of these drugs and syringes being found adjacent to the body.

The cause of death was acute multiple drug toxicity.

#### Recommendations:

- That the Medical Board of the Northern Territory investigate:
  - the deceased's ability to obtain Schedule 4 medication (Xanax) at the same time as the deceased received Schedule 8 medication (MS Cotin) from a medical practitioner.
  - the level of prescribing Xanax medication by another medical practitioner to the deceased between the relevant period.

## AGED CARE

### TAS.2007.38 (& Procedural)

The deceased had previously suffered a stroke, causing paralysis of the vocal chords and difficulty in swallowing food and drink and was recommended to maintain a diet of thickened fluids and pureed foods. However, the deceased had been non-compliant at times.

It was the deceased's practice to eat meals alone in their room. The night of the incident, the deceased requested chicken nuggets and chips for dinner. In the interest of the deceased's quality of life, the requested meal was served.

The deceased choked while having dinner and died due to aspiration pneumonia.

#### Recommendations:

Recommendations made by the Department of Health and Human Services and endorsed by the coroner:

- to establish a standard multidisciplinary assessment process for in-patients to include but not limited to :
  - admission criteria for rural facilities
  - multidisciplinary admission check list
  - patient risk profile plus ancillary tools and plan.
- all rural hospital staff to attend "mock after hours emergency response" scenario based training (a component of CPR Core Training) including but not limited to:
  - emergency pager system
  - ancillary staff
  - roles of emergency response team including team leaders and team members.
- to provide practical (hands on) training on the checking, maintenance and correct use of emergency equipment including but not limited to:
  - policy and procedures ensuring readiness and resources of emergency equipment.

## AGED CARE

- to provide education and training in modified dietary management including but not limited to:
  - dysphagia policy and procedure including a decision making framework for non-compliant patients and adoption/ acknowledge of National definitions (speech pathologist and nutrition professional bodies)
  - registered nurse review of completed menus (acute in-patients) daily for appropriateness (policy)
  - catering staff on the preparation of food to ensure compliance with the range of requirements for textured modified diets
  - annual review/ audit of catering by regional hospital catering manager/ dietician.

Additional recommendation made by coroner:

- That those professional bodies and institutions responsible for the initial training and later professional development of doctors and nurses in Tasmania take steps to ensure that these personnel are fully acquainted with the requirements of the Coroner's Act 1995, particularly as it relates to their obligation to report specific deaths.

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### WA.2008.600 (& Falls)

The deceased suffered a fall in the aged care facility where the deceased was residing. The deceased was taken to hospital and diagnosed with fractured femur, displaced fracture of the left humerus and pneumonia in the left lower lobe of the lung. It was decided that the deceased was not fit for surgery and was admitted for palliative care, receiving morphine on a number of occasions.

There were some concerns in respect of the records relating to the morphine prescribed and the morphine dispensed.

#### Recommendations:

- When the Department of Health prints register of drugs books for the purposes of the Poisons Act 1964 (Schedule 8) that consideration be given to including separate columns to record the discarding of Schedule 8 drugs and to allow for a signature to be placed in the book by the person who has discarded the drugs and by a witness to the discard. In the case of the books which have already been printed, that nursing staff specifically record the fact that drugs have been discarded by making a short entry in one of the existing columns.
- The Department of Health adopt a uniform procedure throughout the state that unused Schedule 8 medications which are to be discarded be discarded into a sink, and where this is not practicable due to the layout of the hospital, then into a sharps container.
- That there be a review of the documentation used to record medications given to patients so that any bolus dosed given from a quantity of a medication being provided by way of an infusion can be recorded as such.

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### NT.2008.116 (& Falls)

The deceased was admitted to hospital after being found on the bedroom floor of a low care facility. The deceased was treated for dehydration. Despite treatment the deceased's renal function continued to deteriorate and they died.

The cause of death was identified as pulmonary embolism arising from intracardiac and deep vein thrombosis.

#### Recommendation:

- The Hospital conducts an audit to see whether their guidelines for routine thromboprophylaxis are, in fact, being adhered to and take steps to ensure that they are being implemented if any problems are identified by the audit.

## AGED CARE

### NSW.2006.4385

See 'Adverse effects or reactions to medical/ surgical care'.

## FALLS

### TAS.2008.68

The deceased was attending a hospital as a visitor and fell heavily to the ground after tripping on a low lying cement plinth. This plinth had originally formed part of a direction sign which served the purpose of directing patients to the emergency department.

The cause of death was identified as haemorrhagic stroke complicating a fall from standing height.

#### Recommendations:

- The appropriate person within organisations to take timely and reasonable precautions against obvious risks such as these to the community at large, including by removing the potential risk without delay where possible or by placing appropriate warnings or barriers.

### TAS.2009.82

The deceased was found lying on the floor in a conscious but incoherent state. The ambulance officer's notes indicate that the deceased had been lying on the floor for possibly as long as three days. The deceased's condition deteriorated after being taken to hospital and died as a result of acute renal failure due to a cerebral infarct and dehydration following a fractured neck of the femur sustained in a fall.

#### Recommendation:

- Those elderly who live alone should be reminded of the obvious benefits of permanently wearing a personal alarm device which can be immediately utilised in the event of the wearer becoming incapacitated.

### WA.2008.600

See 'Aged care'.

### NT.2008.116

See 'Aged care'.

### WA.2006.1262

See 'Work-related'.

## FIRE

### VIC.2006.3684 & 3685

The deceased persons died from injuries sustained when a fire broke out in the space between the ceiling of a pizza restaurant and the bedroom of the boarding house where the couple was living.

## FIRE

### Recommendations:

A number of extensive recommendations and comments were made in this case, which included:

- Consumer Affairs Victoria to henceforward play leading role in the administration of the Health Act Prescribed Accommodation Regulations, and related matters.
- Amendments be made to the Prescribed Accommodation Regulations and the Building Regulations designed to facilitate improved oversight of the Boarding House Industry.
- Tenancy Agreements to be established for Building Owners, Rooming House Operators and Rooming House Tenants. Existing arrangements should be publicly identified.
- Administrative and legislative changes designed to make the approvals system more user friendly.

## WORK-RELATED

### SA.2006.128

The deceased died as a result of the consequences of heat exhaustion. The days prior to the deceased's body being found were part of a heatwave with maximum temperatures of over 40°C.

The deceased was last seen alive while working as a charity collector.

### Recommendations:

- That the Minister responsible for the Office of the Liquor and Gambling Commissioner introduce legislation to amend the Collection for Charitable Purposes Act 1939 by making provision for the inclusion within the Code of Practice under the Act specific requirements in relation to the occupational, health, safety and welfare of both paid and unpaid charitable collectors, including but not limited to:
  - requirements governing collectors working in conditions of extreme temperature or in other extreme weather conditions;
  - requirements to ensure the proper supervision of collectors including the means by which the whereabouts and welfare of collectors can be monitored, and identifying circumstances in which it is appropriate or inappropriate for collectors to work alone;
- That in devising the requirements relating to the occupational, health, safety and welfare of collectors to be included within the Code of Practice, that the Office of the Liquor and Gambling Commissioner have regard to the measures that have been implemented by the Spina Bifida and Hydrocephalus Association of South Australia.

### WA.2006.1262 (& Fall)

The deceased sustained fatal injuries in a rock fall while drilling stripping holes.

### Recommendation:

- When airleg miners are working as contractors underground and are required to install ground support, they be provided by mine management with a short document which clearly identifies the precise extent of ground support required, including the circumstances in which it is appropriate for those miners to exercise their discretion to provide additional support.

### NSW.2006.5117

The deceased was a Police Officer on duty, and was signalling for a vehicle to pull over whilst standing on the edge of the roadway. The vehicle slowed, but the vehicle behind did not, hitting the first vehicle and pushing it forward onto the deceased. The deceased was treated at the

## WORK RELATED

scene but died later in hospital from multiple injuries.

### Recommendations:

- SOPs subjected to a full risk assessment by an independent expert or organization, considering relevant and comparable international practice.
- Prevent police from working on roadways unless protected by police vehicles or other stationary protective barriers placed in suitable positions by police.
- As much warning as possible is to be provided by stopping police to targeted vehicles by using the warning lights on their police vehicles once a speeding vehicle is detected.
- Incorporate in SOPs an express operating assumption that every time an officer attempts to stop an oncoming vehicle, he or she is exposed to a person who may deliberately, negligently or accidentally drive at them.
- That consideration be given to eliminating traffic law enforcement operations by police on foot at multi-lane sites where the speed limit is 80 kph or greater and their replacement with other alternatives such as mobile speed cameras and vehicle-based radars or other instruments.
- Training should be given on dealing with the role of "human factors" in road accidents and in "danger experience" dealing with the police officer's perception of particular dangers which arise in stationary speed enforcement operations.
- Consideration be given to the creation within the Traffic Services Branch of a database recording information about sites used for stationary traffic law enforcement operations, including details such as incidents, accidents and "near-misses" at such sites.
- That, if established, the database be used to review and increase the safety of police methodology, for improvement of training of Highway Patrol officers and for the dissemination of relevant information to Highway Patrols in NSW.
- That the Roads and Traffic Authority (RTA) consider locating fixed speed cameras on freeways and motorways and other high-speed roads in areas identified by the Police Force as being used regularly by motorists travelling at dangerous speeds whether or not they are also identified as accident "black spots".
- That the RTA place on its website detailed information, especially for inexperienced drivers, about the potential hazards of approaching police traffic operations sites and the motorists' responsibilities when doing so.

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### NSW.2007.6180

See 'Transport related deaths'.

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### QLD.2007.2267

See 'Transport related deaths'.

## SPORTS RELATED

### NT.2007.199

See 'Adverse effects or reactions to medical/ surgical care'.

## PROCEDURAL

### TAS.2006.594

The deceased died as a result of multi-system organ failure due to overwhelming sepsis (peritonitis) following a gastric perforation due to an incarcerated paraesophageal hernia.

#### **Recommendation:**

- Provisions about determination of reportable death occurring in a medical setting to be reviewed and amended with a view to providing all persons with greater clarity of the coronial process.

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### TAS.2009.46

The deceased died as a result of cardio respiratory arrest due to congestive cardiac failure due to chest infection. The deceased suffered from schizophrenia and lived in a mental health facility. The deceased's death was reported to the coroner; however, a Medical Certificate of Cause of Death was also issued by treating doctor.

#### **Recommendation:**

- To remind those responsible for the care of persons at approved hospitals that in some cases the apparent natural death of a patient there may require reporting to a coroner under the provision of the Coroner Act 1995. Where this is the case the issuing of a medical certificate should not occur. Advice must be sought from the Coroners' Office in any case where doubt exists as to whether any death is reportable.

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### NT.2007.94

The deceased suffered from dementia. The deceased introduced a foreign object into their body. After being admitted to hospital for surgical removal of the object, the deceased suffered septicaemia and died.

The death was reported to the coroner after a week, therefore the information available for the investigation was limited.

#### **Recommendation:**

- The Hospital institutes a process where there is an internal review of death certificates by a senior staff member chosen for that purpose to ensure that the Coroner's Act is being complied with.

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### NSW.2007.6188

See 'Additional cases—Deaths in custody or while in police pursuit'.

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### NSW.2008.3396

See 'Water related'.

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### NT.2006.295

See 'Intentional self-harm'.

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### QLD.2007.181

See 'Transport related deaths'.

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### TAS.2007.38

See 'Aged care'.

## INDEX

The following is an index of recommendations (by broad topic area) summarised by the NCIS within the 22 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 Andrea Gallo at the NCIS on (03) 9684 4442 or via email: [andrea.gallo@vifm.org](mailto:andrea.gallo@vifm.org)

<b>Topic/ Theme</b>	<b>Edition(s)</b>
<b>Adverse effects or reactions to medical/ surgical care</b> .....	All
<b>Aged care</b> .....	22, 20-13, 11 & 6
<b>Child deaths</b> .....	22-6 & 4
<b>Diving, scuba diving, snorkeling</b> .....	21, 17, 15, 11 & 9
<b>Drugs or alcohol</b> .....	22-11, 9 & 7-2
<b>Electrocution</b> .....	20, 17, 14, 13, 8 & 7
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<b>Fire-related</b> .....	22-10, 7, 5, 3 & 1
<b>Homicide/ interpersonal violence</b> .....	21, 20, 18-11, 9-7 & 5
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<b>Water- related (general)</b> .....	22, 19-1
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