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

**Reportable Deaths**

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

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

**Fatal Facts Search**

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

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

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

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

Fatal Facts Edition 25 includes cases that were investigated at inquest and where the Coronal Finding contains recommendations. Edition 25 includes cases that were closed between 1 April and 30 June 2010. Fatal Facts contains a précis of case circumstances and of the coronial recommendations and is produced by the staff at the NCIS. Every effort has been made to accurately summarise the case circumstances and findings. Despite this, it should be noted the summaries are not authorised or exact replications of the coronial finding. The original finding should be accessed for formal reference.

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

Fatal Facts Edition 25 contains summaries of 127 cases where recommendations were made as part of the formal coronial finding. Of these cases, 78 are Australian and 49 are from New Zealand.

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

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

What is a Coronial Inquest?

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

The cover photo for Edition 25 comes from the recently published NCIS Fact Sheet: Intentional Self-Harm among Emergency Services Personnel.

To access this Fact Sheet please go to

www.ncis.org.au
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ACT.2006.62 – Adverse Medical Effects
Whilst in hospital, the deceased passed away from heart failure connected to a large blood clot as a result of deep vein thrombosis.

Recommendations:
I recommend that the Hospital review its practices with regard to keeping records of drugs prescribed and administered to patients so as to minimise the possibility that drugs may be administered and not recorded, and consider implementing a requirement that two responsible persons must sign the records of the hospital to confirm that prescribed medication has been administered.

NSW.2007.5911 – Adverse Medical Effects/ Child & Infant Deaths
A child died in hospital from bacterial meningitis. It had not been diagnosed by a number of clinicians who had examined the patient.

Recommendations:
To the Minister for Health:
• I recommend that the Hospital for Children and the Area Health Service review their guidelines to provide for the assessment by senior staff of children presenting with any signs of toxicity before such children are discharged;
• I recommend that the Children’s Hospital and Area Health Service review their guidelines to provide for annual training of clinical staff in Emergency Departments in relation to the detection of meningitis, including the possibility of children presenting without signs of meningism and with normal vital signs, and in relation to the appropriate tests to be conducted;
• I recommend that the Children’s Hospital and Area Health Service review the efficacy of CRP and other tests, whether alone or in combination, in improving the diagnosis of serious bacterial infection;
• I recommend that the Children’s Hospital and Area Health Service review the literature concerning meningitis they distribute to parents (or carers) on discharge of children with any sign of toxicity. The document given to parents ought include clear, succinct instructions on what to look out for and the importance of returning immediately to a doctor if signs or symptoms are seen.
• I recommend that the Children’s Hospital and Area Health Service consider amending their triage questionnaires to include an inquiry as to the number of recent attendances made by children at hospitals or on General Practitioners in relation to the same illness.
• I recommend that the Children’s Hospital and Area Health Service consider amending their triage questionnaires to include an inquiry seeking to measure the degree of parental concern.
• I recommend that the Children’s Hospital consider whether a measure of “parental concern” can and should be built into its computerised diagnostic tool for serious bacterial infection.
• I recommend that NSW Health consider rolling out the Children’s Hospital’s computerised diagnostic tool to all NSW hospital Emergency Departments.
• I recommend that NSW Health consider ways in which the Children’s Hospital’s computerised diagnostic tool (or a suitable version of it) may be made available to primary carers.
• I recommend that, if it has not already done so, the Children’s Hospital consider developing a training module in which clinicians not only discuss but practice the diagnosis and treatment of rare but serious bacterial infections in simulated settings.
• I recommend that, if it has not already done so, the Children's Hospital consider formally integrating the study of cognitive bias and error into its teaching and training syllabus concerning differential diagnosis.

NZ.2008.1821 Adverse Medical Effects/ Natural Causes/ Child & Infant Death
A ten year old died from an undiagnosed cardiac condition Long QT Syndrome despite seeking medical attention.

Recommendations
To the Royal New Zealand College of General Practitioners (RNZCGP):
**NZ.2008.1821 continued**

- that the RNZCGP promulgates information to Fellows of the College to raise awareness of the issues raised in this case, particularly in relation to sudden cardiac deaths in young people; and

- Considers whether the minimum level of resuscitation skill for a general practitioner should be increased from Resuscitation Council Level 5.

To [location] Health Centre:

[6]I recommend that [location] Health Centre:

- ensures that it has a Significant Event Management System to address serious, or potentially serious practice problems; and

- All members of its staff are trained to use its Advisory External Defibrillator.

**NZ.2008.2377 Adverse Medical Effects/ Natural Causes**

Person suffering from epilepsy died after being trapped behind a toilet door in hospital during an epileptic seizure and resuscitation efforts were delayed.

**Recommendations**

I recommend that a copy of these Findings be forwarded to the Minister of Building and Construction in order that his officials investigate further the Building Code as same applies to toilet doors, specifically those installed in areas used by vulnerable persons. It may be considered appropriate that the Building Code be enhanced in order that toilets, particularly in places where they are more likely to be used by persons prone to collapse, to have doors opening outwards, sliding doors, quick lift release external hinges, or an insert door of the type now adopted at [location] Hospital.

I recommend that a copy of this Finding be sent to the Minister of Health in order that the Minister’s officials investigate the possibility of enhancement to hospital Emergency Plans, which could learn from the lessons tragically learned at [location] Hospital.

I recommend that [location] District Health Services Limited review its Emergency Plans Manual to ensure that all possible events are planned for and that the Manual include an appropriate Index.

**NZ.2009.3152 Adverse Medical Effects/ Older Person**

Elderly woman died of peritonitis after a bowel infarction was operated on. The deceased’s condition was not diagnosed originally, and she had been sent home before again calling the ambulance.

**Recommendations**

That the ED Unit at [location] Hospital undergo further education with consideration as to the possibility that a patient may have an ischemic bowel as the earliest surgical intervention increases the chances of a full recovery.

Consideration of the production of ambulance service notes taken on initial contact with a patient or the patient’s medical advisor be made available as soon as possible to the Emergency Department may assist the practitioners involved with diagnosis.

**SA.2004.3916 Adverse Medical Effects/ Transport & Traffic Related**

A 55 year old male died of acute coronary syndrome while driving after presenting with symptoms at hospital in which effective diagnosis and treatment were not provided.

**Recommendations:**

1) That the Minister for Health, in conjunction with other stakeholders and interested entities, cause training programs to be directed towards the education of general practitioners, and in particular those general practitioners who are practising or who aspire to practise in country areas, as to the following:

- The importance of informing oneself of and examining a patient’s risk factors for heart disease when considering, determining and identifying presentations of acute coronary syndrome;

- The importance of conducting a global risk assessment when endeavouring to identify an acute coronary syndrome that takes into account, on a global in-the-round basis, the patient’s risk factors for heart disease and the patient’s symptomatology;
SA.2004.3916 continued

- The importance of general practitioners having regard to observations made by paramedics of patients presenting with suspected acute coronary syndrome;
- The importance of obtaining, if possible, records of previous presentations of the patient that might be relevant to the identification of an acute coronary syndrome, for example, previous ECGs taken in respect of the patient;
- The need to study and understand the relevant protocols, guidelines and clinical pathways that are available to general practitioners such as the ‘Management of Chest Pain / Suspected Acute Coronary Syndrome’ protocol promulgated by ICCNet; as well as the ‘National Heart Foundation of Australia, Cardiac Society of Australia and New Zealand Guidelines for the management of acute coronary syndromes’;
- The need to rigorously follow the acute coronary syndrome diagnostic pathways to their conclusion, with particular emphasis in respect of cases where the Low Risk Protocol has been embarked upon;
- The importance of general practitioners considering what might be the worst case scenario when a patient presents with chest pain and/or other symptoms of an acute coronary syndrome; and the importance of identifying with some certainty an explanation for those symptoms before dismissing them as not being due to an acute coronary syndrome;
- To promote amongst general practitioners, especially those who practice in country areas, and especially those who have been trained overseas, greater knowledge, skill and confidence in interpreting ECGs;
- To promote a greater understanding amongst general practitioners of the need to compare ECGs within a series so as to more readily identify the presence of, and significance of, ECG changes within that series;
- To promote a greater understanding amongst general practitioners of the need to identify occasions upon which there is a need to refer ECGs for expert specialist interpretation such as that provided by ICCNet; and to promote a greater awareness of the availability of such specialist services;
- The importance of providing patients with sufficient information to enable them to make fully informed decisions as to whether they should receive further diagnostic measures and treatment in respect of a suspected acute coronary syndrome;
- The importance of general practitioners understanding the pathophysiology involved in an acute coronary syndrome.

2) That the Clinical Director of ICCNet give consideration to amending the ‘Management of Chest Pain / Suspected Acute Coronary Syndrome’ protocol so as to include within it specific reference to:
- The need to keep in mind that single ECG and Troponin test results that are negative do not exclude the presence of an acute coronary syndrome;
- The importance of examining, within a series of ECG tests, the presence of, and significance of, ECG changes within that series;
- To identify appropriate occasions for referral of ECGs for expert specialist opinion.

3) That the Royal Australian College of General Practitioners and the Royal Australian College of Rural and Remote Medicine, as overseen by the South Australian Medical Board, include as part of their curricula more rigorous training of prospective admittees to the Colleges with respect to the identification of acute coronary syndrome with particular emphasis upon:
- interpretation of ECG results and the need to look for and identify the presence of and significance of changes in a series of ECG results; and
- the utility of, the necessity of proper timing for and the significance of Troponin levels; and that the Colleges include these topics as part of their examination material.

4) That the Minister for Health cause advice to be promulgated to general practitioners relating to the need for general practitioners to highlight within their individual patient records the presence of risk factors for heart disease in respect of those patients.

5) That the Minister for Health cause careful scrutiny to be maintained of the expertise and knowledge of overseas trained medical practitioners in respect of the identification of symptoms of acute coronary syndrome, and in particular as to their level of skill and expertise in the interpretation of ECGs.

SA.2005.288      Adverse Medical Effects/ Transport & Traffic Related
A pedestrian was hit by a car and sustained head injuries which lead to an acute and fatal episode of deprivation of oxygen from his brain and cardiac arrest two weeks later.
SA.2005.288 continued

**Recommendations**
- That the Minister for Health draw this case to the attention of the Chief Executive Officers, or equivalent, of all public hospitals in South Australia with a view to the promulgation and establishment of a culture among medical practitioners that involves cross-checking, by way of laryngoscopy, of the positioning of endotracheal tubes in situations that involve clinical uncertainty as to their correct positioning.
- That the Minister for Health cause steps to be taken within all public hospitals in South Australia to institute capnography on a continuous basis in respect of all intubated patients, and especially in situations involving the administration of a paralytic agent to those patients.
- That the Minister for Health cause steps to be taken within all public hospitals in South Australia to ensure that in all situations that involve clinical uncertainty as to the correct positioning of an endotracheal tube, capnography is utilised to check whether the tube is correctly positioned.
- That the Minister for Health cause steps to be taken within all public hospitals in South Australia to encourage the use of laryngoscopy to check the positioning of an endotracheal tube immediately following the administration of a paralytic agent to the intubated patient.
- That the Minister for Health draw these findings and recommendations to the attention of the Chief Executive Officers, or equivalent, of all private hospitals in South Australia with a view to their giving consideration to the subject matter of the within recommendations.
- That these findings and recommendations be drawn to the attention of the Joint Faculty of Intensive Care Medicine (Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Physicians) for its consideration and necessary action.

SA.2006.156  Adverse Medical Effects

A patient died from complications of surgery to relieve a lack of blood supply to a sore foot. This was due to a lack of senior staff rostered at the hospital, resulting in junior staff not monitoring the patient’s haemoglobin levels while on anticoagulants.

**Recommendations**
- That the Minister for Health draw these findings to the attention of the Chief Executive Officers of all public hospitals in South Australia with a view to appropriate consideration being given to the observations made by Professor Cade as discussed in paragraphs 7.2, 7.3 and 7.4 herein as to the need to amend the hospitals’ Heparin Protocols and as to the desirability of the practice of including a copy of the protocol in the patient’s infusion chart;
- That the Minister for Health draw to the attention of the Chief Executive Officers of all public hospitals the desirability of identifying in advance of the commencement of anticoagulation therapy, the relevant blood grouping of the patient so as to facilitate the more timely delivery of a blood transfusion should the necessity for the same arise;
- That the Minister for Health draw my findings in respect of the necessity to monitor haemoglobin levels in circumstances such as those that pertained to [the deceased], to the attention of the relevant person at all medical schools in South Australia;
- That the Minister for Health take the necessary steps to ensure that wards in all public hospitals are at all times appropriately staffed.

SA.2006.1858  Adverse Medical Effects

A chiropractic patient died from a lack of oxygen to the brain and cardiac arrest resulting from an unknown cause. A lack of timely response by the chiropractor to alert emergency medical assistance was found to be a factor.

**Recommendations**
- That the Chiropractic and Osteopathy Board of SA consider implementing and enforcing a requirement that chiropractors have at their disposal the necessary measures, skills and equipment to deliver effective first aid and resuscitation in the event of a cardio respiratory arrest of a patient including the following:
  * CPR skills, with regular recertification
  * The employment of a personal assistant with CPR skills, especially in cases of sight impaired practitioners
  * The installation of automatic defibrillating equipment within a chiropractic clinic
  * The installation of oxygen delivery equipment within a chiropractic clinic
  * The implementation of a crisis management plan that would describe the necessary action to be taken in an emergency including the cardio respiratory arrest of a patient.
- That the Chiropractic and Osteopathy Board of SA instruct registered and practising chiropractors immediately to call for the assistance of the South Australian Ambulance Service in the event of a patient losing consciousness and responsiveness while undergoing chiropractic treatment.
NOTE: Due to a number of cases where the deceased had died of heart disease after presenting at hospital and released without effective treatment in SA, the Coroner held a joint inquest with combined recommendations

SA.2005.2948  Adverse Medical Effects/ Natural Cause
A 51 year old person died from ischaemic heart disease due to coronary atherosclerosis, collapsing at home after presenting with symptoms at hospital in which effective diagnosis and treatment were not entered into.

SA.2006.386  Adverse Medical Effects/ Natural Cause
A 42 year old person died from ischaemic heart disease at home after presenting with symptoms at hospital in which effective diagnosis and treatment were not entered into.

SA.2006.965  Adverse Medical Effects/ Natural Cause
A 76 year old person died at home from ischaemic and hypertensive heart disease after presenting with symptoms at hospital in which effective diagnosis and treatment were not entered into.

Combined recommendations
• That the Minister for Health, in conjunction with other stakeholders and interested entities, cause training programs to be directed towards the education of general practitioners, and in particular those general practitioners who are practising or who aspire to practise in country areas, as to the following:
  • The importance of informing oneself of and examining a patient’s risk factors for heart disease when considering, determining and identifying presentations of acute coronary syndrome;
  • The importance of conducting a global risk assessment when endeavouring to identify an acute coronary syndrome that takes into account, on a global in-the-round basis, the patient’s risk factors for heart disease and the patient’s symptomatology;
  • The importance of general practitioners having regard to observations made by paramedics of patients presenting with suspected acute coronary syndrome;
  • The importance of obtaining, if possible, records of previous presentations of the patient that might be relevant to the identification of an acute coronary syndrome, for example, previous ECGs taken in respect of the patient;
  • The need to study and understand the relevant protocols, guidelines and clinical pathways that are available to general practitioners such as the ‘Management of Chest Pain / Suspected Acute Coronary Syndrome’ protocol promulgated by iCCNet; as well as the ‘National Heart Foundation of Australia, Cardiac Society of Australia and New Zealand Guidelines for the management of acute coronary syndromes’;
  • The need to rigorously follow the acute coronary syndrome diagnostic pathways to their conclusion, with particular emphasis in respect of cases where the Low Risk Protocol has been embarked upon;
  • The importance of general practitioners considering what might be the worst case scenario when a patient presents with chest pain and/or other symptoms of an acute coronary syndrome; and the importance of identifying with some certainty an explanation for those symptoms before dismissing them as not being due to an acute coronary syndrome;
  • To promote amongst general practitioners, especially those who practice in country areas, and especially those who have been trained overseas, greater knowledge, skill and confidence in interpreting ECGs;
  • To promote a greater understanding amongst general practitioners of the need to compare ECGs within a series so as to more readily identify the presence of, and significance of, ECG changes within that series;
  • To promote a greater understanding amongst general practitioners of the need to identify occasions upon which there is a need to refer ECGs for expert specialist interpretation such as that provided by iCCNet; and to promote a greater awareness of the availability of such specialist services;
  • The importance of providing patients with sufficient information to enable them to make fully informed decisions as to whether they should receive further diagnostic measures and treatment in respect of a suspected acute coronary syndrome;
  • The importance of general practitioners understanding the pathophysiology involved in an acute coronary syndrome.

That the Clinical Director of iCCNet give consideration to amending the ‘Management of Chest Pain / Suspected Acute Coronary Syndrome’ protocol so as to include within it specific reference to:
• The need to keep in mind that single ECG and Troponin test results that are negative do not exclude the presence of an acute coronary syndrome;

- The importance of examining, within a series of ECG tests, the presence of, and significance of, ECG changes within that series;
- To identify appropriate occasions for referral of ECGs for expert specialist opinion.

That the Royal Australian College of General Practitioners and the Royal Australian College of Rural and Remote Medicine, as overseen by the South Australian Medical Board, include as part of their curricula more rigorous training of prospective admittees to the Colleges with respect to the identification of acute coronary syndrome with particular emphasis upon (a) interpretation of ECG results and the need to look for and identify the presence of and significance of changes in a series of ECG results; and (b) the utility of, the necessity of proper timing for and the significance of Troponin levels; and that the Colleges include these topics as part of their examination material.

That the Minister for Health cause advice to be promulgated to general practitioners relating to the need for general practitioners to highlight within their individual patient records the presence of risk factors for heart disease in respect of those patients.

That the Minister for Health cause careful scrutiny to be maintained of the expertise and knowledge of overseas trained medical practitioners in respect of the identification of symptoms of acute coronary syndrome, and in particular as to their level of skill and expertise in the interpretation of ECGs.

TAS.2007.529  Adverse Medical Effects
A 43 year old person suffered from pulmonary thrombo-embolism due to complications of abdominal surgery.

Recommendations:
This finding leads me to recommend that the [location] Regional Hospital and those other non-tertiary hospitals in Tasmania review their practices for the transfer of seriously ill patients.

TAS.2008.157  Adverse Medical Effects/ Physical Health
A person died suddenly from asthma while taking medication for hypertension.

Recommendations
- A focussed effort (if it was necessary) to persuade [the deceased] that further investigation of her condition was essential.
- A more comprehensive investigation of [the deceased’s] asthma including lung function tests to determine if it was either not present or sufficiently mild so to make the use of a selective beta-blocker a relatively safe option. The probability is that such investigation would have established the presence of her chronic lung damage revealed at post mortem and thus made inadvisable the use of Atenolol.
- A more comprehensive investigation of hyperaldosteronism as the cause of [the deceased] hypertension. Had such testing proceeded it is possible that this diagnosis would have been made (both Associate Professor Greenaway and Professor Bell are confident it would have been) and treatments specifically tailored to that condition would have been put in place. This in all probability would not have included Atenolol.
- Pending the outcome of further investigations resort should have been had to alternate drug therapies other than a beta-blocker. I note that Professor Bell has identified a range of other drugs available to treat hypertension which are not contraindicated for asthma sufferers and which apparently have an excellent safety record.

TAS.2009.462  Adverse Medical Effects/ Physical Health
A 39 year old person suffering from epilepsy died from lack of oxygen to the brain as a result of cardio respiratory arrest. It was found after the death that the deceased suffered from an undiagnosed heart condition which may have been aggravated by the medications prescribed.

Recommendations
This tragic death serves as a reminder to medical practitioners of the need to take particular care in prescribing multiple medications for persons with a history of seizures, particularly the possibility of their combination lowering the seizure threshold and/or having a toxic effect upon the heart. This leads me to recommend that medical associations and colleges remind their members firstly of the need to be particularly cautious when prescribing medications such as tricyclic anti-depressants and tramadol to patients with a history of epilepsy and/or seizures and secondly, to carefully and regularly monitor the drug levels of patients taking sodium valproate in combination with other drugs (tricyclic anti-depressants) because of the risk of an adverse interaction.
NSW.2010.707 Aged Care
A resident of a boarding house facility for the disabled and homeless died from the effects of asphyxiatiion caused by choking on a sandwich.

**Recommendations**

**To the Minister for Ageing & Disability Services:**
- I recommend that that in light of the NSW Governments stated intentions to implement Boarding House reform within this State that any such reform incorporates the requirement for the mandatory registration of all current and future operators of Boarding Houses who have the capacity to accommodate two or more persons.
- I also recommend that in the implementation of Boarding House Reform that any Legislation enacted addresses in it accommodation standards, service standards and greater occupancy protection for all Boarding House tenants.
- I recommend that a regulatory body separate from the Department of Ageing, Disability and Home Care (DADHC) is enacted with powers to monitor, prosecute and arbitrate disputes between Boarding House (BH) operators and Tenants in a similar manner to a Residency Tribunal. I would also further include in this recommendation a provision for the mandatory notification and reporting by employees of Boarding Houses or service providers of any suspected or identified breaches committed under any relevant Legislation governing Boarding House reform.
- I recommend that included in any Boarding House reform, consideration be given to developing strategies for the provision of financial assistance by Government and Incentives to encourage investment and compliance by Boarding House operators with any Legislative requirements in order to comply with Recommendations 1-3.

**To the Minister of Health:**
I recommend a review also be conducted by NSW Health to consider the establishment of protocols for health service providers addressing annual mandatory reviews for residents living in Boarding Houses suffering from mental illnesses or conditions.

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

NZ.2009.510 Aged Care/ Water Related/ Intentional Self-Harm/ Older Persons
Person in a care home went missing after an argument with his wife. The deceased was then found in a pond. The deceased suffered a stroke and regularly talked about self-harm.

**Recommendations**

**To New Zealand Aged Care Association**
That NZACA highlights to its members:
- The obligation to provide complete and accurate handover information about the physical and mental health of a client being transferred from one healthcare facility or rest home to another; and
- ii. The need for rest homes to have in place policies and procedures to follow if a client is found to be missing, including the need for prompt and effective reporting to the Police.

**To the New Zealand Police**
A copy of this finding will also be sent to the New Zealand Police with the following recommendation:
- That the New Zealand Police continue with ongoing training of staff about the correct procedure for responding to receipt of a report about a missing person.

NZ.2009.3524 Aged Care/ Mental Illness and Health
The deceased died at the rest home at which he had been living for over 21 years. He had become increasingly unwell and in the week before his death had had a cough and fever - which developed into bronchopneumonia on the day before his death. The deceased was subject to a Community Treatment Order under the Mental Health (Compulsory Assessment and Treatment) Act 1992 at the time of his death.

**Recommendations**
NZ.2009.3524 continued
To [location] Rest Home
I recommend that [location] Rest Home:
• Ensures that it has a current policy that sets out the obligations its staff have under the Coroners Act 2006 for reporting deaths of rest home residents to the police;
• Ensures that the staff are aware of, and comply with, the policy.
To Dr [name]
I recommend that Dr [name] reviews his obligations under the Coroners Act 2006 in relation to reporting to the police deaths of his patients who are in official custody or care.

VIC.2007.2151 Aged Care/ Older Persons
An 80 year old person died from choking on food at an aged care facility.

Recommendations
I recommend the audit process undertaken by [organisation] and the measures set out in the attached Action Plan be distributed by the relevant Minister to all Aged Care Facilities in Victoria.

SA.2008.66 Aged Care/ Older Persons
An elderly person died from asphyxia in an aged care facility, when the deceased fell out of bed. The deceased trapped their head between the bed and a bed stick (instrument used to help the mobility of patients).

Recommendations
• That the manufacturers, suppliers and distributors of the KA524 bedpole apparatus ensure that consumers of the product are provided with written instructions as to the correct installation of the product that deal with the following:
  * The desirability of ensuring that sufficient weight is placed upon the apparatus to ensure minimal movement of the apparatus while the user is in bed;
  * That in respect of reclining beds, that the apparatus should be placed beneath the mattress at the foot end of the bed with the U shaped section of the frame pointing towards the foot of the bed and should not be placed beneath the raised section of a bed;
  * That any gap between the bedpole vertical component and the mattress be eliminated;
  * The desirability of frequent checking of the position and stability of the apparatus as installed in the bed.
  * The need for any person or organisation that utilises bedpoles to ensure that the deployment of the bedpole is risk assessed in each application;
  * That the product should not be utilised in respect of persons who have a history of falling from bed;
  * That the device should not be used by persons who have a cognitive impairment;
  * That the device should not be used by persons who have no access to immediate assistance;
  * The fact that a gap created between the vertical bedpole and the side of the bed has resulted in a fatality by way of head and neck entrapment.
• That the Australian Government Department of Health and Ageing draw these findings and recommendations to the attention of all Australian aged care services and approved providers.
• That, if it has not done so already, that SafeWork SA promulgate and distribute a Hazard Alert in relation to the use of bedpoles and the dangers associated with their use.
• That the Office of Consumer and Business Affairs promulgate and distribute a hazard alert or similar publication in relation to the use of bedpoles and the dangers associated with their use.

By directing the above recommendations to the manufacturers, suppliers and distributors of the KA524 bedpole I do not mean to imply that any of those entities have been neglectful or are otherwise at fault.
NOTE: Due to a spate of child & Infant drownings in NSW, there was a combined inquest into the below deaths

**NSW.2006.2565**  
Child & Infant Deaths/ Water Related  
An infant drowned in a residential above-ground pool. The pool was enclosed by a home-made fence. Council approval for the installation of the pool had never been sought and as such the pool and the fence had never been inspected for compliance with relevant building and safety standards.

**NSW.2008.6309 & 6315**  
Child & Infant Deaths/ Water Related  
An infant died as a result of drowning after falling into a residential swimming pool. The pool fence was found to have a number of gaps and a missing gate.

**NSW.2008.6331**  
Child & Infant Deaths/ Water Related  
An infant drowned in a residential swimming pool. Temporary fencing had been installed around the pool however the pool was not completely fenced and access could be gained from the backyard. No approval had been sought for construction of the pool from the relevant authority.

**NSW.2008.5722 & 5731**  
Child & Infant Deaths/ Water Related  
Two children died in the same incident after falling into a fenced in-ground residential swimming pool. The deceased had gained access from the house to the outdoors where the pool fence was pegged open.

**NSW.2008.5722 & 5731**  
Child & Infant Deaths/ Water Related  
Two children died in the same incident after falling into a fenced in-ground residential swimming pool. The deceased had gained access from the house to the outdoors where the pool fence was pegged open.

**NSW.2008.6350**  
Child & Infant Deaths/ Water Related  
An infant died after drowning in a residential in-ground swimming pool. The fence was later found to be non-compliant.

**NSW.2009.248**  
Child & Infant Deaths/ Water Related  
An infant died from drowning in a swimming pool. The coroner believed the pool gate had likely been propped open at the time of incident. The gate was found to be neither self-closing or self-latching.

**NSW.2007.6309**  
Child & Infant Deaths/ Water Related  
An infant drowned after falling into an in-ground swimming pool that was located on the family’s property. The pool was unfenced however fencing was not a legal requirement due to the size of the property.

**Combined recommendations for infant drowning cases delivered by Magistrate McMahon, April 2010**


- That a continuing media campaign be developed by the relevant NSW Government Department in conjunction with the Royal Life Saving Society and other appropriate non-government bodies to emphasise the need for constant supervision of young children who are, or reside, in the vicinity of home swimming pools.
- That a media campaign be developed by the relevant NSW Government Department, in conjunction with local government authorities within NSW, to emphasise the need for:
  * The obtaining of approval for the construction and installation of all home swimming pools whether they be in or above ground, and
  * The need for the regular maintenance of fencing and gates surrounding such pools.
  * The need to ensure that pool gates are never propped open.
- That consideration be given by the relevant NSW Government Department, in conjunction with local government authorities within NSW to:
Combined recommendations continued

* Developing a centralised register of private swimming pools,
* Developing a systematic plan for the regular review of all private swimming pools in NSW so as to ensure compliance of such pools with the safety provisions of the Swimming Pools Act 1992.

- Consideration is given to an amendment of the Swimming Pools Act 1992 so as to remove all exemptions from the application of that Act.

To: The Minister responsible for the administration of the Residential Tenancies Act 1987.
That consideration be given to providing by law that:
- Owners of residential properties that contain a private swimming pool and is the subject of a residential tenancy agreement are obliged to take all reasonable action to ensure that the pool is and remains compliant with the safety provisions of the Swimming Pools Act 1992, and;
- That the owner of a property containing a private swimming pool, that is the subject of a residential tenancy agreement, should warrant at the commencement of each such agreement that the pool and the surrounding fencing and gates comply with the safety provisions of the Swimming Pools Act 1992.

To: The Minister responsible for the administration of the Fair trading Act 1987.
- That the relevant NSW Government Department in conjunction with industry associations develop systems:
- To ensure that purchasers of aboveground swimming pools are advised at the point of sale of their obligations under the Swimming Pools Act 1992, and
- Sellers advise the relevant local government authority of the delivery of an aboveground swimming pool to a property within the boundaries of that authority.

To: The Attorney General.
- That consideration be given to the enactment of a criminal offence, analogous to that of negligent driving causing death, to apply in circumstances where a person dies as a result of the negligence of a third party with respect to the maintenance or use of a private swimming pool.

NT.2009.57 **Child & Infant Death/ Animal/ Water Related**
A child was taken by a crocodile while playing and swimming with other children in a local creek.

**Recommendations**
I recommend that the increased public safety measures which are set out in detail at sections 4.4-4.6 of the Management Program for the Saltwater Crocodile in the Northern Territory of Australia 2009 -2014 are resourced and implemented in accordance with that Program.

NZ.2008.1515 **Child & Infant Death**
An infant died after falling off a double bed and becoming wedged between a bed and a wall.

**Recommendations**
Pursuant to section 57 of the Coroners Act 2006 I make the following recommendations or comments (if any): The lives of young infants are best protected if they are put down to sleep, in their own secure sleeping space.

NZ.2008.2371 **Child & Infant Death**
An infant died after co-sleeping with father.

**Recommendations**
I endorse the repeated messages made by Coroners and other health professionals that promote safe sleeping arrangements for babies and infants. The risk of accidental asphyxiation is increased when the baby or infant sleeps with an adult or adults. However the risk of death increases and becomes far more serious if the sleeping adult or adults are intoxicated.

I refer to the basic principles of the "Safe Sleep Programme" and the SUDI Prevention work promoted by the Ministry of Health. The principles of safety include "face up, face clear, smoke free and in their own bed".
NZ.2008.3175  Child & Infant Death
One month old infant died as a result of SIDS due to being placed face down on a double bed shared with other siblings.

Recommendations
I can only endorse safe practices in sleeping arrangements for babies. Irrespective of where a baby may sleep the potential cause of death as in SIDS can happen in any sleeping arrangement even in a cot. I can only encourage parents to use safe sleeping arrangements with their babies. Do not compromise safety for convenience.

NZ.2009.2427  Child & Infant Death/ Transport & Traffic Related
Child died after running behind school bus onto the road and being hit by a car that did not see the child.

Recommendations
(a). That the appropriate regulatory agencies require all buses used for transporting school pupils on school bus runs ("school buses") to be fitted with a system of flashing warning lights to indicate to other road users that the school bus is slowing, stopped, or moving off from a stop, in the carrying out of its function.
(b). That these flashing lights be automatically activated whenever a school bus on its run slows below a certain speed, and remain active until the bus speeds up again beyond a certain speed, having either picked up or dropped off passengers.
(c). That all school buses have their rear windows sign-written, reminding motorists of the legal requirement to reduce their speed to 20 km/h while passing a school bus which has stopped for picking up or dropping off children.
These recommendations are directed to the Ministry of Education and the Ministry of Transport, and the New Zealand Transport Agency. They are also to be distributed to all operators of school bus runs in the Waikato in the hope that the industry will adopt these recommendations without the need to amend current legislation.

NZ.2009.2522  Child & Infant Death
An infant died from dehydration after a virus infection

Recommendations
[Doctor] has provided a submission in which he indicates that [the deceased] could have been vaccinated against rotavirus if the government funded such vaccinations in New Zealand. No doubt [doctor’s] submission is predicated on the basis that if [the deceased] had not contracted rotavirus he would not have eventually died from hypernatremia dehydration. I therefore make the following recommendation:
That the New Zealand government consider prioritising the funding of vaccine for rotavirus. This recommendation is directed to the Ministry of Health and any other government department involved in funding vaccines.

NZ.2009.2680  Child & Infant Death
Infant died from Sudden Infant Death Syndrome as a result of co-sleeping with his family

Recommendation
I feel compelled to draw attention to the fact that [the deceased] was in an unsafe sleeping environment at the time of his death. I make this comment in the hope that other parents will acknowledge the risk of co-sleeping with their infants and refrain from this practice.

NZ.2009.2714  Child & Infant Death/ Adverse Medical Effects
Infant died of dehydration leading to hypernatremia after contracting gastroenteritis.

Recommendations
I endorse all of the actions proposed by the [location] Health Board to address the failures identified in the Serious Event Review. I note the evidence provided by [doctor] that there has been a significant improvement in the adherence by staff to the existing policy of daily weighing of infants suffering from gastroenteritis.
[Doctor] has audited this policy over a significant period of time, and no doubt this has contributed to the improvement.
Given the facts of this particular case, I consider that a similar audit should be undertaken to ascertain whether the concerns of parents of infants are being adequately recorded in nursing notes.
NZ.2009.2714 continued

- I also consider that the recognition of re-presentation of an infant within a short time frame should not depend solely on staff noting this and passing on this information.
- I make therefore make the following recommendations:
  - (a). That an audit be taken on a regular basis to ensure that the concerns of parents of infants are accurately recorded in the nursing notes during an admission.
  - (b). That the [location] Hospital Board consider including in its computer system the automatic generation of an alert when a patient re-presents within a short time frame, and that this alert be printed on the patient labels or in some other manner which will attract the attention of anyone perusing the clinical notes.
- These recommendations are directed to the [location] Health Board.

NZ.2009.2778 Child & Infant Death

Infant died of sudden infant death syndrome as a result of co-sleeping.

**Recommendations**

- I can only endorse the numerous comments that Coroners and others concerned for the safety of infants have made for many years: that parents must refrain from placing infants to sleep in inherently dangerous environments.
- I can understand why parents like to have the infants close to them while they are sleeping. But the risks posed by co-sleeping far outweigh, in my view, the benefits of such parental bonding. I recommend that parents, if feeling the need to have infants close to them while sleeping, adopt the recommended practice of the infant having his or her cot in the parents' bedroom. This enables the parents to keep close observation of the sleeping Infant, while maintaining a safe, separate, space for the infant to occupy.
- Parents also need to ensure that infants are placed on their backs to sleep and not on their stomachs. If an infant is wrapped in a blanket and then placed on a mattress on its stomach, there is a significant risk of the infant suffocating by having its mouth and nose buried in the bed clothes covering the mattress.

NZ.2009.2988 Child & Infant Death

Six week old infant died in his mother's bed from sudden infant death syndrome while co-sleeping with his mother.

**Recommendations**

Parents have a responsibility to protect their baby from foreseeable harm. A baby is totally reliant on their parents for protection. A sleeping mother cannot account for her movements while asleep and bed-sharing is potentially unsafe for a newborn infant, especially when other factors are combined.

There has been considerable publicity given to the warning that bed-sharing is particularly hazardous when the baby's mother has smoked during pregnancy. [Deceased's] mother smoked during pregnancy and continued to smoke after [deceased's] birth. Considerable publicity has also been given to the warning that reduced awareness of the baby can occur when the mother is excessively tired. [Deceased's] mother acknowledged that she was very tired, having worked at a laborious job in the two weeks preceding [deceased's] death.

There is the opportunity to co-sleep within arms-length of baby without the heightened risk of asphyxiation that bed sharing presents. A crib, bassinet or wahakura placed up against the parent's bed provides all the benefits of co-sleeping (including monitoring, bonding, and promoting breastfeeding by making night feeds easier) while considerably reducing the risks of mechanical asphyxia.

NZ.2010.1474 Child & Infant Death

Infant died in hospital after presentation in a shocked state attributable to haemorrhagic disease of the newborn.

**Recommendations**

The Royal New Zealand College of General Practitioners, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the New Zealand College of Midwives, the New Zealand Nurses Organisation and the Foetus and Newborn Committee of the Paediatric Society of New Zealand support the use of vitamin K for all babies to prevent Vitamin K Deficiency Bleeding.

The risk of Vitamin K deficiency bleeding without Vitamin K injection is 8.6/100,000. With Vitamin K injection the risk is reduced nearly 90 times to 0.1/100,000.

- It is the parents' choice whether to have Vitamin K administered to their baby, and if the decision is made to administer Vitamin K, whether to do so by injection or orally.
NZ.2010.1474 continued

- Parents must be provided in a timely manner with information to enable them to make an informed decision.
- In accordance with Right 6 of the Code of Health and Disability Services Consumers’ Rights, health providers are obliged to provide accurate, timely and balanced information to consumers, including the risks, side effects, benefits and alternatives, and the risks of alternative treatments or non-treatment.
- The risks of non-treatment were explained to [deceased’s] parents while in the Special Care Baby Unit at [location] hospital.
- In accordance with Right 7 of the Code of Health and Disability Services Consumers’ Rights, consumers have the right to refuse consent even when the evidence for treatment is strong and a clear recommendation to give a treatment has been given. Annabel’s parents refused the offer of Vitamin K administration based on discussions with health providers at [location] hospital after baby [deceased’s] birth, and in particular based on research undertaken by baby [deceased’s] father and information provided at ante natal classes attended by both of deceased’s parents.
- The midwife assisting baby deceased’s mother did not provide relevant information to the parents when requested, as the timing of the provision of that information apparently did not meet the midwife’s scheduled plan. While I am satisfied that adequate information was provided to baby [deceased’s] parents at [location] hospital to meet the requirements of Right 6 of the Code of Health and Disability Services Consumers’ Rights, I recommend that if a baby is born before a midwife can impart information scheduled to be provided, the midwife should ensure that the relevant information is provided as soon as is practicable after the midwife becomes aware of the birth.

My comments are to be conveyed to the Royal New Zealand College of General Practitioners, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the New Zealand College of Midwives, the New Zealand Nurses Organisation and the Foetus and Newborn Committee of the Paediatric Society of New Zealand.

TAS.2009.288  Child & Infant Deaths/ Leisure Activity
A five year old child died from asphyxia after a trampoline accident in which the child’s bike helmet became entangled with a clothesline while using the trampoline.

Recommendations
At some point the trampoline had been moved underneath the clothes line to fully utilise the space in the backyard. After being on the trampoline, [deceased] became entangled in the clothes line by the strap of the helmet which resulted in the deceased’s tragic death.

It is therefore my recommendation that trampolines are not positioned underneath clothes lines, trees, or any similar obstruction where a child might hit themselves or become entangled.

NZ.2007.1521  Drugs & Alcohol
Person died as a result of a drug induced cardiac arrhythmia. He was injected with a solution of the drug BZP which acted in conjunction with alcohol, cannabis and the prescription drug Haloperidol.

Recommendations
- I recommend that a copy of this Finding be forwarded to the Police Drug Intelligence Agency and to the National Addiction Centre as further examples of the fatal consequences taking of legal and illegal drugs in a cocktail.
- I recommend that a copy of this Finding be forwarded to the Minister of Health so further publicity be given to the dangers of persons taking drugs which are not prescribed for them, and are not procured through legitimate sources, there always being the potential for additional harm from contaminants.

NZ.2009.2583  Drugs & Alcohol/ Weather Related
Person died from hypothermia due to exposure after she lay in water in a drain at the side of a highway for five hours in adverse weather conditions and after consuming alcohol and Diazepam.

Recommendations
That both Ambulance Communications and Police Communications review their procedures to ensure that all relevant information is provided to enable proper assessment to be made of the urgency status of a situation and the location of an event.
NZ.2009.2993 & 2994 Drugs & Alcohol/ Transport & Traffic Related
The deceased and three passengers were driving to purchase more alcohol after drinking at a private residence, when the driver overcorrected the vehicle and rolled over, crashing into a concrete power pole. The deceased and one of the passengers were not wearing seatbelts and were ejected from the car and subsequently died.

Recommendations
I recommend that Transit New Zealand review the signage at the bend at which the crash occurred with a view to placing speed advisory signs at both north and south approaches to the bend, together with updated and approved chevron boards.

NZ.2009.3038 Drugs & Alcohol/ Falls
The deceased had been drinking heavily and fell while making his way up stairs in his home. He then collapsed on the toilet and fell backwards against the wall and window to the toilet. He died from acute alcohol intoxication and positional asphyxia.

Recommendation
The Court makes the following recommendations;
To: The Director General of Health, Ministry of Health, [location]
- That the public health advice in relation to consuming alcohol and safe practices and the risks associated with alcohol intoxication be strengthened and broadened so as to make it clear that:
  - Alcohol is a central nervous depressant and exerts its effects in a manner similar to that of a general anaesthetic.
  - There is a fine line between anaesthesia from alcohol and death.
  - If a person drinks to the point that they become unconscious and/or “flake out” then there is a risk that the person will die.
  - That death can result from inhalation of vomit with subsequent asphyxia or by inhibition of the nerves controlling breathing causing respiratory depression and death.
  - That the levels of alcohol an individual person can tolerate vary widely depending on their age, height, weight, experience and tolerance of alcohol and food consumption.
  - To especially stress that falling asleep as a result of consuming too much alcohol can result in positional asphyxia. That it be explained in clear language that this simply means that a person asleep from alcohol can get themselves into a position that restricts their breathing in terms of their head and neck position and they can die.
  - That putting a person who is severely affected from alcohol consumption in the recovery position and monitoring them may not be sufficient to prevent their death from the central nervous system depressant and general anaesthetic effect of alcohol and that despite the best intentions of those caring for that person, death can still result. An ambulance should be called for and the person should be taken to hospital where steps can be taken to ensure the person survives the effects of acute alcohol intoxication.

- That steps be taken by the Ministry to ensure that the same advice is given to Public Health educators and health professionals and other educators to ensure that this information is widely disseminated.
- That this recommendation be sent to the Secretary for Education and Chief Executive of the Ministry of Education so that they can draw this information to the attention of educators to ensure that it is widely disseminated.
- It is directed that a copy of these Findings be sent to:
The Director-General of Health, Ministry of Health [location]; Secretary for Education and Chief Executive of the Ministry of Education; The Minister of Health parliament building [location]; The Minister of Education parliament building [location]; The Children's Commissioner; New Zealand Media.

QLD.2008.6673– Drugs & Alcohol/ Adverse Medical Effects
A 45 year old person died from an overdose of Quetiapine (Seroquel) augmented by alcohol despite seeking medical assistance from hospital.

Recommendations:
- the drug Seroquel be packaged, marketed and supplied in packets of 30 to protect against lethal doses of the medication being dispensed to vulnerable members of society.
- That Queensland Health urgently provide full training in emergency and mental health to health professionals staffing regional/rural hospitals after hours;
- A policy for dealing with mental health patients presenting to regional/rural hospitals after hours.
QLD.2008.6673 continued

- That a national database containing dispensing histories for all patients be developed to enable pharmacists to identify over-dispensing of prescription medication. Such a database should have a facility to raise an alert if the same prescription medication has been dispensed by any pharmacist to the same patient within a short period of time.
- To enable this to take place, I further recommend that the Federal privacy laws to be amended to enable PBS information about a patient to be disclosed to the approved supplier of medication to that patient.

TAS.2009.32 Drugs & Alcohol/ Physical Health

A 45 year old person died from mixed drug toxicity (methadone and Diazepam) and obesity.

Recommendations

This tragic death presents me with another opportunity to remind medical practitioners and the public at large that both methadone and diazepam are central nervous system depressants. As such their use increases the risk of drowsiness, sedation and respiratory depression. Their combined use increases those risks, particularly for persons who are significantly overweight. Medical practitioners need to be alert to these risks when prescribing benzodiazepine medications (eg diazepam) particularly when the patient is either taking prescribed methadone or is at risk of using it illicitly.

NT.2009.131 Fire Related/ Child & Infant Deaths

An infant died after receiving severe burns from a house fire.

Recommendations

I recommend that the planning and construction of further dwelling houses in the area and other similar remote communities, without access to professional fire fighting services, include consideration of practical designs and materials which may lessen the risk of rapid auto ignition.

TAS.2009.487 Fire Related/ Drugs & Alcohol

A 38 year old person died from smoke inhalation from a fire. It was found that the fire was most likely started from a cigarette or match that caught the furniture on fire. The deceased was under the influence of alcohol and marijuana.

Recommendations

It is timely to remind people of the dangers of smoking when in a bed or laying on a couch, particularly after consuming alcohol. A further recommendation is that greater consideration be given to the placement of smoke detectors. The evidence suggests that the smoke detector was in the hallway and the door between the loungeroom and the hallway was closed which may have prevented activation of the smoke alarm. Persons should be reminded to ensure that their residence is sufficiently fitted with smoke detectors to cover more than one area, for example kitchens, loungerooms and hallways. They should also ensure they are properly fitted.

VIC.2005.1376 Homicide/Assault

A 37 year old police officer died from a gunshot to the head. The gun shot was fired by a person that the police officer had apprehended for speeding. The gun was taken from the officer in question by the person who fired the shot.

Recommendations

- I recommend that the practice of working one up be abolished in circumstances involving high risk activities such as drink driver, late night and remote area intercepts and that a risk assessment tool be developed to assist supervisors to determine whether one or two up manning is appropriate in other circumstances.
- I am satisfied that the equipment failure issues associated with the 925 Holster have been addressed by the withdrawal of the holster in September 2009 and therefore make no recommendation as to this matter.
VIC.2005.1376 continued

I recommend that Victoria Police review its processes and procedures for reporting equipment failure, so as to ensure that in future any reported equipment faults are properly and fully analysed and responded to by senior force command in a timely manner.

I recommended that consideration be given to adopting a tendering process which provides sufficient flexibility consistent with the special requirements of Victoria Police when tendering for operational safety equipment.

NSW.2006.2333 Intentional Self-Harm/ Mental illness & Health

The deceased, who suffered from schizophrenia, sustained multiple injuries and died after entering onto railway tracks where the individual was struck by a train. It appears the individual had intended to end their own life. The deceased had a lengthy history of mental health illness and had made multiple presentations to mental health and emergency facilities in the month prior to death.

Recommendations:
In situations where a multidisciplinary team is engaged in a patient’s care, consideration ought be given to the recording and reading of information on handover being made mandatory.

There appears to be no systems of briefing or internal investigation when a patient dies within the care of the acute care team. Given that inquests often take place many months and sometimes years after the relevant events, the family of the deceased, investigating bodies and those involved in the care of the deceased person would benefit from consideration of the surrounding events at or around the time and some record, similar to a critical incident report, ought be kept.

A copy of the findings together with the comments will be sent to the relevant Minister and Department of Health.

NSW.2008.3554 Intentional Self-Harm/ Youth/ Mental Illness & Health

A teenager died from asphyxiation after hanging themselves with the intention of taking their own life. It appears the deceased had a history of self-harm and was also a victim of bullying.

Recommendations
To the Minister for Education and Training I recommend:

• The NSW Department of Education and Training should revise its policies as to the placement of sufficient school counsellors at high schools. This revision should start from the proposition that schools of the size of this High School (500+ students) should have a full time counsellor.

• The NSW Department of Education and Training should ensure that every high school in NSW creates and maintains a dedicated email address; text message and/or chat room account or number where students and their parents can report incidents of bullying or harassment. The existence of that facility should be widely publicised in the school community and advertised in every newsletter sent home to parents and guardians.

• In relation to students transferring from one high school to another who have not previously seen a school counsellor, the NSW Department of Education and Training should instigate a procedure whereby there is a compulsory meeting between the Deputy Principal (or Principal), the School Counsellor, the Head Teacher (Student Welfare) and the Year Advisor to discuss whether anything in the general student file (including issues of past bullying or incidents of self-harm) suggests that the student may benefit from counselling at the new school.

• The NSW Department of Education and Training should instigate a system whereby, if the information discussed in the compulsory meeting referred to in (3) or (4) suggests that the student may benefit from counselling, there should be a compulsory meeting between the student and the school counsellor.

• The NSW Department of Education and Training should revise its policies so as to provide practical and clear guidance to senior school staff as to the circumstances in which police should be called to deal with (i) incidents of physical assaults involving students which either occur on school grounds or which come to the notice of the senior staff and (ii) threats, intimidation or harassment by students over telephones or via the internet (‘cyber bulling’).
NSW.2008.3554 continued

Those policies should provide clear guidelines as to when contacting the police is mandatory (such as serious physical harm or serious cases of online bullying). Those policies should clearly inform senior staff that police officers are best placed to investigate the origin of online and telephone threats and that police officers will not automatically charge the student but will consider formal warnings, cautions or merely making a record of the incident.

To the NSW Parliament I recommend:
- The NSW Parliament should consider introducing legislation in similar terms to regulations 39-46 of the South Australian Education Regulations 1997 to ensure that a school’s responsibility to deal with bullying issues encompasses cyber bullying and extends beyond school hours and beyond incidents that take place physically on school grounds. The South Australian Department of Education has received advice that these Regulations are written broadly enough to enable their application to events that occur out of hours or off site.

To the Minister for Police I recommend:
- The NSW Police Force should engage one of the counsellors or psychologists employed by the State Coroner of NSW to instruct and/or lecture police trainees on issues surrounding the attendance by police at scenes involving fatalities and the availability of resources which provide support and grief counselling for the bereaved.
- The NSW Police Force should consider the employment of additional officers to work in the School Liaison Police program.

NZ.2007.140 Intentional Self Harm/ Mental Illness & Health/ Law Enforcement

Person who was arrested after a psychotic episode jumped from a bridge after being released on bail.

Recommendations

Implementation of recommendations of the SER by the CDHB has been carried out. I endorse both the recommendations and the changes that have been put in place pursuant to these. They should decrease the risk for other people in similar circumstances to those in which [deceased] had contact with the Mental Health Services.

The changes made to the Duty Solicitor Scheme were not consequent on [deceased’s] death, but having more Duty Solicitors rostered on for a full day instead of half a day will ensure continuity for their clients. I would have recommended this change, had it not already been implemented.

I endorse the change made at the Watch House that means that prescribed medications go to Court with the accused. At paragraph 15 of this Finding I stated that I find that [deceased’s] suicide was preventable (in the short term at least) and I identified a number of contributing factors which, had any one of these had been absent, would have made it much less likely that [deceased] would have killed themselves on [date]. I make the following recommendations to try to eliminate the contributing factors that have not already been eliminated by changes already made:-

- The Minister of Police, and to
- The Minister of Health

I strongly recommend that the Watch House Psychiatric Nurse scheme is continued and expanded it to other busy Police stations in New Zealand. It began in 2008 as a pilot in [location] and [location]. Currently it is being reviewed by the New Zealand Government. [Deceased] was put before the Court at a time when he had psychiatric needs and was thus particularly vulnerable. [Doctor] recommended that [deceased] be seen by the Psychiatric Court Liaison Nurse the next morning at court. If the scheme been in place at the time of [deceased’s] arrest he would have been able to seen by a Psychiatric Nurse at the Watch House. This nurse would have had the power to keep the deceased back from Court to be examined by a Psychiatrist. [Doctor’s] evidence is that he has no doubt that if [deceased] had been seen by Psychiatrist on the Friday morning, hospitalisation would have been recommended and this would have likely meant that the outcome for the deceased, at least in the short term, would have been very different. I thus consider it an invaluable service in preventing deaths occurring in circumstances similar to those in which [deceased’s] occurred.

- The [location] Branch of the New Zealand Law Society
- Superintendent [name], District Commander, [location] District Police

I recommend that where a bail address is proposed, which is not the address of the victim, that the Duty Solicitor and Police Prosecutors together to request Court escort staff to check this proposed bail address and I recommend that education is provided for Duty Solicitors and for Police Prosecutors, in the light of this death, as to the importance of such a bail check.
NZ.2007.140 continued
To: The Chief District Court Judge
The Presiding Judge in the No 1 District Court on [date] has a reputation for having an extremely sound knowledge of the Mental Health legislation and the processes under the Mental Health Act, but was unaware that [deceased] would not be able to attend an appointment with a PES psychiatrist if he was remanded in custody.

- District Court Judges rely on being advised by the Court Psychiatric Liaison Nurses of what options for treatment are available should the Judge grant bail or remand in custody. In [deceased’s] case, the Court Liaison Nurse’s report for the Judge did not make it clear that [deceased] would not be able to attend his PES psychiatric assessment if he was remanded in custody. She has accepted that it was not clear. The Judge thus believed that [deceased] could still have his assessment even though he remanded in custody.

- 113. However, I have found that not being able to see a Psychiatrist that day was a contributing factor to why [deceased] committed suicide. I recommend that to assist in preventing future deaths in circumstances similar to those in which [deceased] died, that the Chief District Court Judge considers whether it would be helpful for District Court Judges to have information provided to them, perhaps in their Bench Book, about the various Mental Health Services in their Districts and what they can and cannot provide. The CDHB has a flow chart it has offered to provide (see below paragraph 116)
The [location] Branch of the New Zealand Law Society
Superintendent [name], District Commander [location] District Police

I recommend that Duty Solicitors (not just those solicitors on the Duty Solicitor course, but also to those already qualified to act as Duty Solicitors), and Police Prosecutors receive education about what mental health services are available for accused persons in Christchurch and what they can and cannot provide, and in particular that:

- PES is a community based service (so is only available for an accused person / defendant who has been granted bail); and that
- It is only the Regional Forensic Service that is available to people in custody and that this service visits the prison on weekdays and accessible for advice at weekends by prison nurses via [location] Unit at [location] Hospital; and that
- Transfer from corrections custody (either from the Courts or prison) to [location] Hospital can only be achieved where an application is made by the Custody Manager of the Prison

NZ.2009.2547 Intentional Self Harm/ Mental Illness & Health
Mentally ill person died from a fall from a motorway structure.

Recommendations
To The Minister of Transport
That consideration be given to the installation of steel barriers to be placed on each end of the round structural tubes to prevent the public gaining access to these tubes.

To the Chief Medical Officer, Capital and Coast District Health Board
That staff of the Mental Health Services ensure that when it is determined that a Client/patient requires General Practitioner follow-up subsequent to mental health intervention, that a more robust reporting and discussion process be implemented between the Mental Health Team and the General Practitioner.

SA.2007.1213 Intentional Self-Harm/ Mental Illness & Health/ Older Persons
A 73 year old person died as result of intentional self harm by tying a garment tightly around their neck. The deceased was in an acute psychiatric ward at the time of death.

Recommendations
- I recommend that the Department of Health continue to develop and implement risk management strategies that, in an assessment of risk of self-harm, take into account the patient’s entire mental health history as it is known at the time of assessment.
- I also recommend that the Chief Executive Officer of the Department of Health instruct clinical staff employed in acute and chronic mental health facilities that concerns expressed by members of a patient’s family or by a patient’s associates should be communicated to, and be properly evaluated by, the patient’s treating psychiatrist or psychiatric registrar.
**NCIS Fatal Facts**

**Edition 25 - June 2015**

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**TAS.2008.427  Intentional Self-Harm/ Mental illness & Health**
A 42 year old person suffering from depression overdosed on venlafaxine and diazepam while out with companions. The deceased’s companions failed to give medical assistance when they discovered the deceased had taken a large quantity of drugs.

**Recommendations**
In this matter the evidence does not allow me to find that [the deceased] would necessarily have been saved if timely assistance was provided. However, I find in accordance with [the doctor's] opinion that such failure was a significant contributing factor in his death. There were various medical measures that may have been successful to prevent the deceased's death. Each witness, apart from one witness, could have helped [the deceased] by taking the small step of alerting police or ambulance. I wish to comment on the reasons why no action was taken to help by [three witnesses]. I would categorise all three as independent witnesses, or 'bystanders'.
The bystander effect is a social psychological phenomenon that refers to cases where individuals do not offer help in an emergency situation when other people are present.

It is disappointing that [the three witnesses] failed to alert police or ambulance services as to their observations. It does indeed appear that some of the factors described in the research were operating upon their minds. I would however urge members of the community generally who witness someone in a serious predicament to make an effort, if they safely can, to contact police or ambulance. It cannot be assumed that someone else has already taken such steps.

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**VIC.2007.194  Intentional Self– Harm/ Mental Illness & Health**
A 32 year old person died of suicide by means of an overdose of Cholpromazine, Mirtazapine, Olanzapine.

**Recommendations**
That consideration be given to a [location] Prevention & Recovery Care Service (PARCS) being constructed at [location]. The deceased in this case clearly needed admission to a step down unit which is less clinical than an inpatient facility but could provide a psychiatric nurse 24 hours a day and monitoring of medication. Whilst it is accepted that progress in getting well from psychiatric illness is sometimes better achieved at home than in a hospital, the move from hospital to home in this case, like in many others, needed a more supported bridge than relying on loving and well-meaning family members.

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**TAS.2008.376  Intentional Self-Harm/ Physical Health**
A 53 year old person died of intentional self harm by insulin-induced hypoglycaemia.

**Recommendations**
Due to the many difficulties involved in attempting to determine the cause of [the deceased's] death, I recommend in all cases where syringes or like administering devices are located at the scene of a death that they be taken possession of by the investigating police officers for possible analysis.

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**NSW.2008.2905  Law Enforcement/ Intentional Self– Harm**
A prisoner died after hanging themselves in their cell. The prisoner had a prior history of self harm in custody and was recently diagnosed with bowel cancer.

**Recommendations**
To the Minister for Corrective Services I recommend:

- I recommend that the Minister direct that committees overseeing the installation of security systems in NSW prisons include senior representatives from all affected facilities and from senior management at regional area or above.
- I recommend that the Commissioner for Corrective Services direct that all decisions concerning significant alteration to security systems affecting more than one Correctional facility be authorised only by senior management at regional level or above.
**NSW.2008.2905 continued**

- I recommend that the Commissioner direct that all such decisions be fully documented.
- I recommend that security systems not be "commissioned" (in the sense of being made technically operational) until all relevant user guides or manuals have been provided or updated and all relevant staff have been appropriately informed and, if necessary, trained in the use of the system.
- If security systems extend beyond one facility to another, I recommend that, if necessary, commissioning take place in clear stages of which all affected parties are kept informed.
- I recommend that if a staged commissioning of security system takes place in NSW Correctional facilities, those parts of the system not in commission are not turned on except for testing or training purposes, are clearly labeled as non-operational until commissioned and staff are kept informed as to the current status of the system are their responsibilities in respect of it.

**SA.2006.1608**  
**Law Enforcement/ Intentional Self-Harm/ Mental Illness & Health**  
A person died from hanging while in custody. The deceased had a history of schizophrenia and expressed suicidal ideation.

**Recommendations**

I would only add to that the Inquest has demonstrated that it is highly desirable, if not a matter of routine requirement, that any expressed suicidal ideation, with or without a plan, should be passed on by nursing staff or junior medical staff to consultant psychiatrists at the clinic for their necessary action. I recommend accordingly. I direct this recommendation to the Minister for Mental Health and Substance Abuse.

**QLD.2006.1757 & 2663**  
**Law Enforcement/ Transport & Traffic Related/ Older Persons/ Youth**

An 82 year old and a young person died from internal injuries sustained in a motor vehicle crash. The crash occurred in the context of a police pursuit of three teenagers whose car collided with the car of the older deceased.

**Recommendations**

The coroner was examining several similar cases and reserved recommendations until all cases were reviewed. The issues examined pertaining to this case were:

- QPS pursuit policy
- Pursuit
- Abandon
- Disengage
- Known circumstances
- Initiating a pursuit
- Continuing a pursuit – on going risk assessment
- Alerting police communications
- Abandoning a pursuit
- Disengaging
- The responsibility of the “pursuit controller”

The coroner concludes: “I have found the QPS pursuit policy was not adhered to by the senior officer in the pursuing vehicle or by the pursuit controller. I readily acknowledge that in neither case was this the result of a wilful disregard of those policies: rather, serious errors of judgement were involved. I also acknowledge no malicious or improper purpose was involved in these errors. They were made by officers attempting to do their jobs. I accept the submissions it can not be proven that had the officers complied with the policies no harm would have come to anybody; but there is in my mind no doubt that by failing to do so they increased the likelihood of a harmful conclusion to the pursuit.

It is obvious the officers involved have suffered as a result of the outcome, as has the person primarily responsible for [the deceased’s] death. However their distress is small compared to the enduring loss of the [the deceased’s] family. I offer them my sincere condolences.”
**NSW.2009.4841**  Law Enforcement/ Intentional Self-Harm

After being stopped by police who were conducting random breath tests in the area, the deceased died from a self-inflicted gunshot wound to the head with the intention of taking their own life.

**Recommendations**

To the Commissioner of Police:

- That the Acting Sergeant be recommended for bravery, compassion and all of his actions.
- That the commissioner give further training so that:
  - Police informants are aware of the desirability detailing information regarding mental health and hospital admissions, when known in the antecedent fact sheets.
  - Any negotiation team give the priority to the early notification of next of kin in involving high risk incidents and in particular before release of any information to the media.

**WA.2006.578**  Law Enforcement/ Transport & Traffic Related

A 61 year old died from chest injuries resulting from a head on collision when another car who was speeding and evading police collided with the car driven by the deceased.

**Recommendations**

I recommend that consideration be given to amending the instructions for the guidance of police members undertaking emergency driving so that they contain an instruction that the maximum speed obtained by any police vehicle should not exceed a specified speed in excess of the statutory speed limit of the location unless permission to exceed that speed be obtained from a commissioned officer or an acting commissioned office.

**VIC.2008.4392**  Law Enforcement/ Natural Cause Death

A 60 year old died from prostate cancer while in custody.

**Recommendations**

That Justice Health ensure and monitor the implementation of Chronic Health Care Plans, where indicated, by all Justice Health’s contracted care providers.

**WA.2008.1252**  Law Enforcement/ Natural Cause Death/ Adverse Medical Effects

A 30 year old suffering from a heart condition died in custody from a haemorrhage in the brain. This haemorrhage was exacerbated by the deceased’s Warfarin therapy for a heart condition.

**Recommendations**

There be some protocols, or at least discussion, between Department of Corrective Services, SJA and the rural sub-centres establishing policies and procedures for calls for ambulance services from any prison. Correspondingly, it is essential those policies and protocols establish a workable prison check list with which call-takers are satisfied they can suitably prioritise regional ambulances if there are a number of call-outs for areas with limited resources.

**NZ.2008.854**  Leisure Activity/ Water Related

A tourist drowned after falling out of a raft at the bottom of a waterfall while rafting.

**Recommendations**

A Mr [name] has written to the Court from [country]. He is a nephew of [deceased]. Despite the view of Maritime New Zealand I think Mr [name] has made some valuable suggestions in terms of improvements that he thinks would enhance safety for all future tourists. I list those suggestions as follows:

- Warnings of the possible dangers of this sport to be better explained especially to foreign tourists who may never have seen this sport before.
- Warnings to be printed in major foreign languages to ensure that all understand what they are getting into.
NZ.2008.854 continued

- A video showing tourists going through rapids could also be running in the reception area of the railing company.
- First time participants in this sport should not be encouraged to attempt a grade 5 rapid.
- A first aid station should be maintained at the foot of the world’s highest commercially exploited rapids.

I direct that these Findings be sent to Maritime New Zealand and they be asked to consider the improvements suggested by [name]. I asked that they consult widely within the Industry and disclose them to rafting companies.

NZ.2008.1931 Leisure Activity/ Water Related

Person drowned after accidentally falling into a water hole on a track while walking.

Recommendations

To the Minister of Police: This Court recommends that a review be undertaken concerning the notification from COMS to the Police general duties staff and the SAR team to implement what search steps can be undertaken at the very earliest time with respect to urban disappearances, particularly where it is known that the missing person is in some manner handicapped or under care.

NZ.2009.2895 Leisure Activity/ Falls

While delayed and attempting to free abseil lines, the deceased lost balance and put weight onto a tree to which he was tied. The tree broke and the deceased fell.

Recommendations

I recommend that this Finding be forwarded to the editor of the Federated Mountain Clubs Bulletin in order that a synopsis of the facts be published to draw to public attention, and specifically to the attention of climbers, the causes and the circumstances of the death. It is not always safe to rely on existing vegetation for belay purposes and it is always appropriate to select the most secure point to which to attach oneself.

NZ.2009.3066 Leisure Activity/ Falls

Tourist was skiing on an experienced skiers slope when he fell and tumbled, and sliding over 100 metres before coming to a stop. He has died the next day in hospital from the injuries sustained in the fall.

Recommendations

Pursuant to section 57(3) of the Coroners Act 2006 I recommend to the principal funders and contract holders for air responses (ACC and St John) responsible for contracting the primary air response services, that reserve rescue helicopter availability and crewing be reviewed taking account of the circumstances of this case to best ensure response to emergency incidents in a timely manner.

I also recommend to St John that protocols as to notification to Police of serious incidents with life threatening injuries be carefully followed. From [person’s] response referred to above, this is likely to be a matter of staff training.

NZ.2008.1550 Mental Illness & Health/Intentional Self Harm

A person suffering from Asperger syndrome, anxiety and depression was found dead in his car in the garage of the house, with one end of a garden hose secured to the motor vehicle, and the other end inside the drivers window.

Recommendations

To [location] Health Board

I recommend that the DHB:
- Ensures that mental health staff working with clients with Asperger Syndrome or any other autism spectrum disorder have current and ongoing education on the disorder;
NZ.2008.1550 continued

- Requires that mental health staff seek information from the client and family of a client with an autism spectrum disorder on specifically how the autism spectrum disorder affects the client and incorporates such information into care planning;
- Ensures implementation of the recommendation of the Serious Incident Review Panel that mental health staff working with clients with an autism spectrum disorder utilise the knowledge of the Regional Dual Disability Service and incorporate advice received from this service into intervention plans;
- Ensures implementation of the recommendation of the Serious Incident Review Panel that multi-disciplinary team reviews of clients’ mental health service care are undertaken at regular specified intervals;
- Ensures that the staff involved in the "Alcohol and other Drug and Mental Health Nurses Project" receives specific education and have access to information about autism spectrum disorders and the potential vulnerabilities of people with this condition when taken into custody;
- Assesses how best to strengthen links with Court Liaison Nurses so that they become part of the multi-disciplinary team response for mental health services’ clients with complex needs who have frequent contacts with the justice system.

To [location] Health Board and the New Zealand Police
I recommend that [location] Health Board and the New Zealand Police:

- Consider whether as part of the "Alcohol and other Drug and Mental Health Nurses Project" a system can be introduced so that clients of the DHB’s mental health services with complex issues who have frequent contact with the justice system (including those with an autism spectrum disorder as well as a mental illness) can be formally flagged in the Police system to ensure that their particular needs when taken into custody can be identified quickly;
- Identify ways in which custody officers and Police can best receive education and information on dealing appropriately with people known to have an autism spectrum disorder, including when in custody.

TAS.2008.206 Mental Illness & Health/Adverse Medical Effects
A person suffering from PTSD died from taking a combination of moclobemide, venlafaxine, zopiclone, fluoxetine, oxazepam.

Recommendations
As [the doctor] reported: "This case highlights the difficulties of managing patients that consult multiple practitioners for complex medical problems as well as the dangers of mixing these two classes of medications". Bearing that in mind, I recommend that specialist clinicians and medical practitioners in general continue to use caution when prescribing medications to those with mental illness, especially when their psychiatric history is extensive yet that patient may state they are taking no or have not been prescribed with any such medications. This caution may include communicating with previous specialist clinicians or pharmacists regarding medications previously prescribed and also clearly educating patients about the dangers of combining certain medications. Like other classes of medications, many drugs used to treat psychiatric/psychological conditions are potentially very dangerous at high levels and as this case has shown, there is a potential for a life-threatening situation to occur when certain drugs are used in combination with others.

I am informed that in the UK there is a requirement for patients to register with a single general practice and the entire medical history of the patient is transferred if there is a change of location/practice. While this may well limit patient choice, it is a system that may have some merit and go some way to overcoming the problems identified in [the deceased]’s death. Further and while I am conscious of privacy and other issues, some form of centralised register of prescribed medications available only to medical practitioners or pharmacists treating a patient, especially those with psychiatric/psychological disabilities, may assist in limiting the risks clearly evidenced in this unfortunate death. I am informed the Federal Government is actively considering the implementation of a national and centralised register, but it may be many years before it is achieved. In my view this should be attended to urgently.

WA.2008.676 Mental Illness & Health/ Intentional Self-Harm
A 47 year old intellectually disabled person suffering from depression overdosed on fluvoxamine. The deceased was found in a state of advanced decomposition as a result of failure of community health services organised for the deceased.

Recommendations
WA.2008.676 continued
I recommend that if the Commonwealth wishes to continue to outsource services such as the provision of home respite services, that it puts in place simple procedures which would ensure that providers satisfy basic safety requirements and are aware of and bound by contractual obligations requiring compliance with responsibilities of a service provider and clearly outline the functions and services to be provided. Ideally the Commonwealth should deal directly with service providers to ensure compliance with appropriate requirements. In the event that arrangements with suppliers are to be outsourced or brokered, however, rules need to be in place which would require adequate monitoring of the services actually being provided and the entering into of appropriate agreements, binding on service providers.

VIC.2007.4804 Mental Illness & Health / Intentional Self-Harm
A 32 year old person suffering from Asperger’s Syndrome and schizophrenia committed suicide using a plastic bag and an aerosol can, while on bail.

Recommendations
• The Attorney General and the Minister for Mental Health consider the therapeutic appropriateness and the legal implications of imposing bail conditions which require compliance with a Community Treatment Order.
• The Attorney General refer consideration of appropriate bail conditions for offenders subject to involuntary mental health orders to the Law Reform Commission for their consideration.

NZ.2009.2539 Natural Cause Death / Work Related
Bus driver died of a heart attack after putting snow chains on a bus that was full of passengers.

Recommendations
• There is an issue for consideration namely the adequacy of health screening for drivers of passenger service vehicles. The consequences of the driver’s collapse occurring while the bus was moving on the [location]s road clearly could have been disastrous. The risk is heightened where the route has obvious and frequent hazards, such as often occur on New Zealand high country roads.
• Pursuant to section 54(3) of the Coroners Act 2006 I refer these Findings to the medical review section of New Zealand Transport Agency to consider as a "case study", for possible review of the health screening requirements for a driver of a passenger service vehicle where passengers are carried for hire or reward, and consequently requiring a "P endorsement".

VIC.2008.778 Natural Cause Death / Older Persons
An 84 year old person died from a bowel obstruction caused by a gallstone.

Recommendations
The Department of Human Services and the Australasian College of Emergency Medicine work in conjunction to develop guidelines for the assessment and management of elderly patients with abdominal pain presenting to the emergency department.

That the Department of Human Services and the Australasian College of Emergency Medicine consider including as part of the management guidelines, the automatic escalation to a more senior clinician in circumstances where patients present on a second occasion with the same/similar symptoms such as demonstrated in [the deceased’s] case.

NZ.2007.1242 Older Persons / Fire Related
An elderly person suffering from a number of medical conditions, and being looked after by a caregiver died after a fire in the home. There was a lack of appropriate care and cleanliness of the deceased.
NZ.2007.1242 continued

**Recommendations**
- I recommend that, before she accepts employment as a caregiver in the future, [caregiver] consider the evidence given to the Inquest into the death of [deceased] and her failures in giving him the professional attention he deserved.
- I recommend that Access Home Health Limited review its procedures and processes, addressing, in particular, staff recruitment and training and putting in place a more appropriate audit review system for care being given particularly when concerns about such are communicated.

**NZ.2009.836  Older Persons/ Leisure Activity**
Elderly person died after falling from a climbing wall at an indoor rock climbing gym

**Recommendations**
Pursuant to section 57(3) of the Coroners Act 2006 I make the following comments and recommendations.
- I endorse the initiative of the Department of Labour in its work in developing National Standards/Procedures for the operation of Indoor Climbing Walls.
- I recommend that [Name] amend West Coast Climbing Wall Operations 2007, and The West Coast Climbing Wall Safe Operating Plan 2008 (in addition to changes recommended by the Department of Labour) to include a requirement that all belayers must have a West Coast Climbing Wall belay licence before belaying a climber, for lead climbing.

**NZ.2009.1187  Older Persons/ Transport & Traffic Related/ Water related**
Elderly person died when they accidentally drove their motor scooter off a pier into the sea and drowned.

**Recommendations**
I recommend that [location] City Council take advice from disability providers and consumers with a view to considering whether or not the advantage of having marina access for people using mobility scooters is outweighed by the risk to them of falling off the piers. Even if that balancing exercise falls on the side of continuing to allow access, I recommend that the Council add information and a caution on its signs that the piers are narrow and difficult for mobility scooters to turn around.

**NZ.2009.3703  Older Person/ Transport & Traffic Related**
Elderly person, who lived independently in a retirement village, was walking her dog when she was hit by the wing mirror of a car. She died eight weeks later.

**Recommendation**
To the Chief Executive, [location] City Council
I recommend that [location] City Council reviews the adequacy of the street lighting on the eastern side of [location] in the vicinity of the pedestrian refuge located 450 metres south of [location].

**NZ.2010.2264  Older Person/ Falls/ Natural Cause Death**
Elderly person died as a possible result of a fall & heart attack in her home, however was embalmed by the funeral directors before a post mortem could be carried out.

**Recommendation**
That advice be given to funeral directors in New Zealand that a funeral director should not commence embalming a body until in receipt of documentation that evidences that no examination of the body is required before burial or cremation. That documentation is either a doctor’s certificate (as defined in section 2 of the burial and Cremation Act 1964) or a Coroner’s authorisation in the prescribed form for release of the body.
NSW.2008.1050  Sports Related/ Water Related
The deceased was due to compete in a superboat race. During a pre-race warm-up, the power boat driven by the deceased nose-dived and overturned. The deceased, wearing a racing helmet and lifejacket, was trapped in the hull of the boat and drowned. A companion aboard the boat was thrown from the vessel.

Recommendations
I recommend that the NSW Maritime Authority, with the Australian Power Boat Association and any other person or body the Authority may consider appropriate, conduct a study by a suitable expert or experts into the safety of crew involved in high-speed crashes of recreational and racing power boats with a view to developing practicable measures at reasonable cost for improved standards of safety.
I recommend that, if such a study is conducted particular attention be paid to the question of improving the design and equipment of such vessels to increase the survivability of crews involved in high-speed crashes.

TAS.2008.444  Sports Related/ Leisure Activity/ Transport & Traffic Related
A 21 year old died from head injuries after a trail motorbike accident at a campsite. The deceased was not wearing a helmet or any safety equipment

Recommendations
I recommend that the Government take a lead role in conjunction with stakeholders such as motorcycle clubs and retailers in organising and conducting regular training sessions around the State for off-road motorcyclists and involved parties. Such training should focus upon motorcycle skills, rider safety and legislative requirements.

- I further urge all persons involved in this sport to wear approved safety apparel at all times whilst riding to reduce the risk of death and serious injury. I also urge participants to strongly encourage fellow riders to wear safety apparel.
- I commend the actions of fellow riders and supporters in administering first aid and assistance to [the deceased] at the scene.

A passenger appears to have fallen from the tray of a moving utility vehicle and later died in hospital from injuries received in the fall. It was night time and the vehicle’s headlights were not working. All occupants of the vehicle were intoxicated.

Recommendations
I recommend that Alcohol Management Plans are prepared with reference to the specific needs of individual Aboriginal communities in prescribed areas.

NZ.2008.1706 & 1707  Transport & Traffic Related
Two visiting student pilots died after their plane crashed without an instructor on board.

Recommendations
Survivability/ rescue

- That, as recorded in the incident de-brief, the [location] Aero Club develop a concept for SAR response to meet the specialised requirements for aerial searches, and liaise with the RCCNZ concerning this. This should happen as a matter of priority.
- That the New Zealand Police ensure notification to Police Communications of an SAR incident at the level of Distress phase (DETRESFA) be communicated as soon as practicable to the Police Liaison Officer for the RCCNZ and to the officer in charge of the Police area in which the incident occurred, or is likely to have occurred.
NZ.2008.1706 & 1707 continued

- That the RCCNZ ensure that notification to Police Communications of an SAR incident at the level of Distress phase (DETRESFA) be immediately the distress phase occurs.
- That the IAANZ review its incident control procedures with possible involvement of the CEO as the incident controller and to act as liaison person with outside organisations such as the RCCNZ and the Police.
- That additional to implementing aircraft tracking systems the IAANZ reviews its practices in monitoring aircraft movements not with a view to duplicating the role of Airways but to have a better awareness of the whereabouts of aircraft that exceed their ETAs.
- I recommend that the CAA consider the mandatory inclusion of aircraft tracking systems using GPS technology in all aircraft operated by training organisations to assist general aviation operations and specifically to support SAR operations.

Authorised flight planned route

- By way of observation, it became apparent in the presentation of the IAANZ evidence that rules applicable to the IAANZ students, in addition to Civil Aviation requirements, are the rules and bylaws of the Aero Club as supplemented by such documents as the IAANZ Advanced Navigation CPL. The AC documents are partially outmoded. For example the “timekeeper” referred to in the bylaws is an out dated term and “is essentially the receptionist who, among other things, manages flight bookings”. The documents also cover matters extraneous to the IAANZ such as election of officers. The rules and bylaws were drafted in another era and the language of them particularly as to gender is out-dated. There was one female student in the IAANZ in January 2008.
- This inquest relates to the deaths of two foreign nationals for whom English was not their first language. They had imprecise understanding of expectations as regards flight planned routes and deviations from them, and potential consequences for breaches. They had an imperfect understanding of relevant rules applicable to the IAANZ in addition to requirements of Civil Aviation rules. This may have been a consequence of language. Clear and concise documentation would assist in ensuring misunderstandings of the kind that occurred on [date] will be avoided.
- I recommend that the IAANZ as a matter of priority update its documentation to set out relevant rules applicable to the IAANZ in addition to requirements of Civil Aviation rules and to highlight expectations as regards such matters as flight plan routes and deviations from them, and potential consequences for breaches.

Minimum route operating heights

- I recommend that the IAANZ reviews the training of student pilots at low altitude particularly in mountainous terrain taking account of the CPL cross-country flight test which requires “a low level diversion requiring flight at 500 feet above ground level ...” given that students’ experience in such conditions is generally at a higher altitude - “just below the tops of the hills”.

Students flying together

- Concerning the IAANZ post-crash policy whereby students accruing flight time towards their qualification will rarely be permitted to have other students on board, I comment as follows. I suggest that the risks of having other students on board in such circumstances can be managed by clear rules as to the communications with the pilot-in-command in such circumstances. For example the “giving of some pointers” might be acceptable and the carrying out of certain administrative tasks such as holding a map permitted. Consequently the IAANZ may wish to review its post-crash policy to re-insulate the benefits of allowing student passengers on such flights.

Mandatory Part 141 certification of training organisations

- [person] gave evidence that the CAA has proposed for some time the mandatory Part 141 certification of training organisations. However following consultation on the issue it is now proposed to make certification mandatory for organisations providing flight training for CPL, ATPL, instrument ratings and flight instructor ratings. I endorse this proposal.

NZ.2008.2331 Transport & Traffic Related

Person died after being struck by a car while cycling despite wearing reflective clothing.

Recommendations

The cyclist was wearing clothing with some reflector panels, and her bicycle had appropriate reflector features and a flashing LED tail light (in addition to a 'strobe' white light on the front of her bicycle). The motorist who collided with her did not see her and had had been distracted by the lights of oncoming traffic. Cyclists are increasingly wearing high visibility jackets and this trend has increased since the time of [deceased’s] death.
NZ.2008.2331 continued
Recent evidence of a Serious Crash Unit Investigator at inquest concerning the wearing of high visibility jackets is that the person perceiving the hazard attaches a greater importance to that hazard; "... they see it as a more hazardous situation when confronted with high visibility".
Although in this case the person (the driver of the vehicle) did not perceive the hazard it is self-evident that the greater the visibility features of the clothing/gear worn, the greater the chance of being seen.

ii. Recommend that the Ministry of Transport as a matter of education promote for all cyclists the use of high visibility jackets and clothing with significant fluorescent/reflective features

NZ.2008.2565  Transport & Traffic Related/ Youth
Youth died after overcorrecting while driving and hitting another car.

Recommendations
[Parents] have indicated that they consider further remedial action is necessary on this road to ensure safety of motorists. Adopting their suggestions, I make the following recommendations:
• That the appropriate road controlling authority undertake further remedial work on this corner to the extent of removing part of the bank on the inside edge of the curve, thereby flattening out the severity of the corner
• That the appropriate road controlling authority reconsider the condition of [location] Road in light of the increased traffic flow due to greater development of the farmland serviced by this road, and whether the road in its present condition is adequate to meet the demand of vehicular traffic.

These recommendations are directed to NZTA and to the [location] District Council.

NZ.2008.2575  Transport & Traffic Related/ Water Related
Person died of drowning after they took evasive action to prevent a head on collision and the vehicle skidded across a road, hitting some dead trees and ending up upside down in a pool of water at the bottom of a culvert. The deceased’s seatbelt did not allow him to extricate himself.

Recommendations
Pursuant to section 57 (3) of the Coroner’s Act 2006 I endorse the comments of the Serious Crash Unit Inspector and recommend to the Roading Authority, namely [location] District Council that the section of road in question be improved as a matter of urgency by the provision of centre lines and advisory signs and that consideration be given to the widening of the road.

NZ.2009.807  Transport & Traffic Related/ Work Related
Farm worker died when he lost control of the motorcycle he was riding and crashed, sustaining traumatic head injuries.

Recommendation
That the New Zealand Transport Agency which I understand is the parent organisation responsible for issuing warrants of fitness, alert its various agents. Those are the organisations and the people who actually issue the warrants of fitness. Their attention should be drawn to the potential for engine mount failure in motorcycles. They should be directed where possible to mount a specific inspection as part of the overall structural integrity inspection of the motorcycle. A specific inspection directed to the engine mount area. As indicated I am aware that engine mounts are a difficult item to inspect on motorcycles and it is not my intention in making this recommendation to impose an impossible burden upon inspectors. They should however at the very least be alerted to the potential danger of failure so that they can take a good close look where practically possible at engine mounts.

NZ.2009.1243  Transport & Traffic Related
Person lost control of motor vehicle and impacted with a tree on the driver’s side.

Recommendation
Having due regard to the serious crash report I endorse the recommendations of [police] and recommend that the local authority responsible for the maintenance of the [location] Road review the road signage indicating the speed and curve layout at the vicinity of this accident and also look to install Chevron boards in that area.
NZ.2009.1436  Transport & Traffic Related/ Drugs & Alcohol
Person died after they lost control of the motorbike they were riding and crashed into a paddock. The deceased was over the blood alcohol limit, was not wearing a helmet and was unlicensed to ride a motorcycle.

Recommendation
I recommend that a copy of this Finding be forwarded to Land Transport New Zealand as a further example of a person in charge of a vehicle under the influence of alcohol, losing control with fatal consequences.

NZ.2009.1443  Transport & Traffic Related
Person died when the vehicle they were driving was struck by a large poplar tree which had been blown over during high wind gusts and landed directly on the roof of the vehicle, causing the cab of the vehicle to be crushed, trapping the deceased inside.

Recommendations
I recommend that [location] District Council institute an immediate and comprehensive review of all roadside trees located within the area administered by the Council with a view to ascertaining and confirming their safety. I recommend that, if there is considered to be any danger of such trees falling and causing injury or death to road users, that the trees be removed immediately notwithstanding Council bylaws or policies which may appear to restrict such action. The value of human life is greater than the aesthetic, or historic, value of a roadside tree. I recommend that a copy of this finding be forwarded to Local Government New Zealand for circulation to all local authorities so that the management of each is aware of the hazards presented and that each Council can institute its own programme for ensuring public safety.

NZ.2009.3261  Transport & Traffic Related/ Weather related
Person died while driving a motor vehicle in wet, snowy conditions. The deceased over-corrected and forced the car off the road, through a wooden fence, stopping at a hedge. A piece of fence came through the car and struck the deceased in the head. It appears that the deceased may have been texting shortly before the crash.

Recommendations
- While I am unable to state categorically that this death was due to the use of a mobile phone by the driver of a vehicle, there are indications that this was the distraction that caused [deceased] to lose control of his car. If so, then this is the second finding of this nature that I have made today [see finding into the death of [deceased]. Both of those deaths occurred in the second half of [year].
- This death occurred prior to the change in legislation which now makes it an offence to send texts while driving a car. [Deceased’s] death is further evidence substantiating the need for such a change.

QLD.2009.9036, 9279, 9280  Transport & Traffic Related/ Misadventure
Three passengers were killed in a multiple fatality vehicle accident involving a 4WD being driven at high speed along a beach when the driver lost control of the vehicle.

Recommendations
- Monitor up-take of guide led tours
I consider tagalong tours to have significant safety, social and environmental advantages that will only deliver benefits if those visitors ill-equipped to safely and responsibly undertake independent travel utilise them. Accordingly, I recommend DERM monitor the success of the initiative with a view to encouraging greater participation by island visitors through further restrictions on independent travellers if that appears necessary.
- Check comprehension
With such a significant volume of first time and foreign visitors seeking permits to drive on the island, I am of the view there would be utility in ensuring they have understood the crucial safety measures conveyed in the DERM video and facts sheets. I therefore recommend that DERM consider introducing a set of questions to accompany the application for vehicle permits.
- Review of speed limit
In view of the extensive evidence that in many circumstances driving at 80km per hour on the eastern beach is unsafe and the evidence indicating it can be difficult for first time beach drivers to identify when this is the case, I recommend the Fraser Island Traffic Accident Committee consider recommending to DERM that the speed for hired 4WD vehicles on the island be limited to 60km per hour.
QLD.2009.9036, 9279, 9280 continued

- Age restriction for independent drivers
  In view of the evidence that the risk of drivers crashing reduces with age, and in view of the impending introduction of tag-a-long tours, I recommend DERMTIC consider only issuing vehicle permits to independent travellers hiring 4WD vehicles if they are 25 or older
- Annual vehicle safety inspections
  In view of the failure of self regulation to ensure the Fraser Island 4WD hire fleet is maintained to an acceptable safety standard, I recommend DERM only issue vehicle access permits to hire vehicles that have undergone an annual safety inspection.

TAS.2008.116 Transport & Traffic Related
A 49 year old died from multiple injuries after the deceased’s motorbike was hit by a car that had then driven off.

Recommendation
I note as a result of this tragic crash the investigating Police Officers, in conjunction with DIER and the [location] City Council Engineers have erected a sign prior to the corner recommending a decrease in speed to 45km/h to safely negotiate the corner.

SA.2007.846 Transport & Traffic Related
A 51 year old died in a vehicle collision with a driver that has previously caused a collision on the same intersection.

Recommendations
I recommend that a STOP sign be placed at the intersection of [location] that would compel vehicles entering it or crossing it from [location] to stop before so entering or crossing. I direct this recommendation to the attention of the Minister for Transport, Infrastructure and Energy and the Minister for Road Safety.

TAS.2007.531 & 532 Transport & Traffic Related
A pilot and a passenger died from serious injuries after an ultra-light aircraft crash caused by the pilot’s aircraft inexperience.

Recommendations
I recommend that RA-Australia consider requiring pilots who have not received training/instruction in recently acquired aircraft to undertake recognised and appropriately recorded familiarisation training/instruction in the operation of that particular aircraft, including response to emergencies presented to a pilot of that aircraft, before being permitted to operate that aircraft.

TAS.2009.163 Transport & Traffic Related/ Child & Infant Death
A two year old died from injuries sustained from being ejected from a vehicle during a car accident.

Recommendations
I find that at the time of the crash [the deceased] was not properly restrained in the booster seat. Whilst the booster seat was in the rear of the vehicle being driven by [the driver] it had not been properly secured using the available safety harness. In all likelihood, if the booster seat and [the deceased] had been properly restrained the child would have survived this crash.
The responsibility for properly and safely securing young children in approved safety seats rests with the driver and persons who travel with the child. This again demonstrates the terrible consequences that can flow when these basic safety measures are not followed.

TAS.2009.304, 305, 306 & 307 Transport & Traffic Related
Four people died from multiple injuries sustained from a car accident. The driver was driving in an erratic manner, resulting in the deaths of the driver and three passengers.

Recommendations
I note the measures introduced by Tasmania Police in the Northern Police District to manage reports of poor and dangerous driving. I recommend that Tasmania Police introduce these measures on a State wide basis.
TAS.2009.538  Transport & Traffic Related
A car passenger died from head and chest injuries incurred in a car/bus collision. The car that the deceased was travelling in was being driven by a driver from a country where motorists drive on right hand side of the road.

Recommendations:
I find that the major contributing factor in this crash is inattention on behalf of [the driver], who failed to observe the oncoming bus and then attempted to cross [location]. The intersection clearly displayed a Give Way sign and appropriate road markings are present for north bound vehicles.

There is a restricted sight distance at this intersection for north bound vehicles on [location] when looking west. I do not believe the restricted sight distance was a contributing factor in this crash, as the bus was clearly seen by [the driver following the vehicle the deceased was travelling in] who was following [the driver’s] vehicle at the time of the crash.

I note the [location] Council have subsequently installed safety bar islands and extra signage to make the intersection more conspicuous. The investigating officer states that the [location] Council are also investigating the suitability of a roundabout for the area.

I find that a roundabout at this crash site would be the most comprehensive solution in relation to the crash history of angle collisions at this intersection. A roundabout would slow traffic dramatically which would assist with the limited sight distance at the intersection.

TAS.2009.561  Transport & Traffic Related/ Older Persons
A 68 year old died from multiple blunt force injuries as a result of a car crash. It was found that the deceased was driving on the right hand side of the road.

Recommendations:
From personal experience I am aware that rented motor vehicles in Europe do display prominent signs highlighting that the vehicle is to be driven on the right hand side of the roadway. I have not observed that similar signage is placed in hire vehicles in Australia. Although [the deceased] had some experience in driving in left hand drive countries such as Australia, United Kingdom and New Zealand, [the deceased] still had an apparent lapse of concentration or memory which caused her to revert to her more normal manner of driving. A prominent notation inside the cabin of the motor vehicle may well have prompted a realisation that the deceased was driving upon the incorrect side of the roadway. Given worldwide tourism trends I assume that there is a significant number of persons hiring motor vehicles in Tasmania and driving them upon our roadway to whom driving upon the left hand side of the roadway is abnormal and unnatural. I therefore recommend that consideration be given to the permanent fixing of a warning sign at a prominent point within a motor vehicle cabin, reminding the driver of the need to proceed on the left hand side of the roadway.

TAS.2009.522  Transport & Traffic Related/ Work Related
A 67 year died from injuries to the head resulting from a truck crash while working as a truck driver.

Recommendations:
The observation of [the driver of the car following] strongly suggests the non-genuine retaining bolt or bolts have failed, causing the bouncing movement immediately before the crash.

I would recommend that publicity be given warning of the dangers of fitting after-market parts unless they possess the same or equivalent properties of the part they are replacing.

TAS.2009.565  Transport & Traffic Related/ Youth/ Misadventure
A 13 year old died from head trauma after being crushed between a car and a fence. The deceased had been sitting in a car and released the handbrake and failed to successfully re-engage the parking brake. The deceased then attempted to exit the car but was crushed between the car and a fence. The parking brake was later found to be deficient.

Recommendations:
I find the loss of life was due to misadventure, the deceased would never had anticipated the consequences of her actions on this day. This tragedy highlights the need for all vehicle owners to have their vehicle regularly serviced for potential defects.
NZ.2009.661 & NZ.2009.662 Water Related/ Leisure Activity
Two people died from drowning and hypothermia after their vessel capsized and sank.

Recommendations
The Maritime New Zealand Investigation report concluded with the following recommendations:
It is recommended that MNZ, working through the National Pleasure Boat Forum:
• Continue to promote to the recreational boating community the importance of proper vessel maintenance, in particular:
  * The danger of do-it-yourself type repairs or modifications
  * The necessity to regularly check the structural integrity of older aluminium vessels
  * That consistent water ingress is indicative of a leak which should be repaired by a professional before the vessel is used again.
• Continue to promote, in line with the National Recreational Boating Safety Strategy, the carriage of effective emergency equipment by way of a national safety awareness campaign and the introduction of legislation making the carriage of communications equipment in recreational craft compulsory.
• Continue to promote throughout the recreational boating community:
  * The safe use of Life Jackets/PFDs
  * The correct method of in-water survival techniques
  * The effects of hypothermia and the steps that can be taken to reduce its onset
  * The need for trip reporting
  * The need to be prepared for any emergency situation, and the value of assessing risks and implementing contingency plans to mitigate such risks.

I endorse these recommendations, and note that some have already been actioned by Maritime New Zealand by way of articles in Lookout.
The only further recommendation I make is that information about the use of lifejackets should make it clear that inflatable lifejackets are Type 401 lifejackets. I also observe that descriptions of appropriate use of the various types of lifejackets/personal flotation devices might be improved by the inclusion of clarification of terms such as ‘sheltered waters’ and ‘early rescue’, such as were given by [person] in his evidence at the inquest.

NZ.2009.2520 Water Related/ Leisure Activity
Diver experienced difficulties in rough seas while on a dive and died as a result.

Recommendations
[Police officer] concluded his report by making the following recommendations:
"The following are recommendations for recreational divers:
Ensure persons are qualified and medically fit to dive
Ensure persons dive with dive buddies
• All diving should be conducted with well-maintained dive equipment including in date dive cylinders
• Divers need to conduct pre-dive equipment checks such as checking the equipment for leaks
If a fault is found in a piece of dive gear, the dive should be cancelled until the fault is Remedied faulty equipment replaced
Divers need to conduct buoyancy checks to ensure they are neutrally buoyant prior to leaving surface
Divers need to plan their dives, dive in conditions they have been trained in, and which they have experience in."
I fully endorse these recommendations.

VIC.2008.141 Water Related/ Misadventure/ Leisure Activity
A 26 year old person died from diving into shallow water and hitting their head.

Recommendations
• Whilst I recognise that signage can only go so far in protecting people by highlighting dangers, and that its usefulness is limited by people’s preparedness to heed the messages it conveys, the continued absence of signage at the end [location] poses a danger to public safety. I recommend that Parks Victoria considers further upgrades to the signage by additional signs at eye level at the furthest end of [location]
VIC.2008.141 continued
I also recommend that Parks Victoria considers the usefulness of a public education campaign to highlight the dangers posed by shallow water and submerged objects, particularly when jumping and diving from jetties, such campaign to be targeted both as to when it should take place and to those most at risk, which on the basis of the evidence before me is children and young adults.

TAS.2010.99 Water Related/ Leisure Activity
A person died from drowning while on a boating trip due to a crashing wave while retrieving fishing equipment.

Recommendations
This tragic loss of life is a constant reminder to all recreational fishermen of the increased danger they can be exposed to when operating in areas exposed to breaking surf. Although the poor condition of the “Stormy Seas” inflatable life jacket worn by [the deceased] did not contribute to the death it is a reminder to all users of such equipment that it needs to be regularly inspected and serviced to ensure it is capable of inflation when activated.

This tragic event also highlights that this type of personal flotation device may not be suitable for use where there is a possibility by reason of panic, shock or disablement of the wearer that it is not activated. When entering or when operating in an area of increased risk it would be prudent to inflate such a life jacket as a precaution.

NOTE: Due to multiple death fatalities, a joint inquest was held

WA.2007.367, 368, 369, 370 Water Related
Four people died from immersion in water/head injuries/chest injuries when a recreational boat collides with a sea barge. This collision took place due to lack of night visibility of the sea barge.

Recommendations
I recommend that the Department of Transport make appropriate representations with a view to amendments taking place in the International Regulations for Preventing Collisions at Sea 1972 so as to require improved standards of lighting of large vessels at anchor and in particular so that the regulations require some illumination of the hulls of unmanned barges of substantial length.

I recommend that action be taken by the Department of Transport to amend Port By-Laws so that for every port in Western Australia those By-Laws require unmanned barges to be lit in ways which would enable the hulls to be visible or identifiable.

I recommend that the Department of Transport ensure that any certificate of survey provided in respect of an unmanned barge of substantial size require in the special conditions that the barge have the ability to illuminate its hulls while at anchor and have additional lighting to that presently required in accordance with the Prevention of Collisions at Sea Regulations 1983. That suitable anchorages be identified in each port within Western Australia by the relevant Harbour Master for use by large and other vessels.

That the anchorages be identified in consultation with professional and recreational fishers and other users of the port. That the Department of Transport make an appropriate submission to request changes to the Admiralty Sailing Directions which contain the Australian Pilot Documentation to ensure that the anchorages so determined are clearly identified within the Australian Pilot Documentation.

I recommend that the Department of Transport take steps to improve systems available for communication with fishers and users of Western Australian waters in consultation with organisations such as Carnarvon Sea Rescue and the Bureau of Meteorology.

Consideration should be given to means of communicating with recreational fishers in addition to those now available such as in the case of the Carnarvon Boat Ramp placing a sign close to the boat ramp, used by almost all recreational fishers, on which the existence of any identified hazard could be stated.

I recommend that the Department of Transport communicate with and support local water safety organisations like Carnarvon Sea Rescue so that a 24 hour service can be provided which can take calls and relay important information to those on the water or about to go out.

I recommend that the Department of Transport promote the availability of red lights or other lighting which does not detract from night vision for recreational vessels.
NZ.2008.3877  Work Related
Farmer died after being struck in the head by an agricultural irrigator hose end which was being reeled in to a hose drum.

Recommendations
I do not repeat the various recommendations made in the report of the Department of Labour. I have taken account of these in making the following recommendations.
Pursuant to section 57(3) of the Coroners Act 2006 I recommend that:
i. There is strict compliance with industry standards as to a controlled environment for butt welding processes in the field. This is likely to require the temporary erection of a tent with sides sufficient to minimise possible contaminants including draughts.
ii. The Department of Labour provides information to the farming industry as to the hazards of the possibility of butt weld fusion failure and the dangers that this process could entail.

NZ.2008.4171  Work Related
A farmer died after the tractor they were driving rolled end for end and then tipped onto its side, after the forks fitted to the front of the tractor separated from the machine.

Recommendation
That the circumstances of this case and the facts leading to this tragic death be referred to the Ministry of Transport, the Department of Labour and the Police for them to consider whether anything further can be done in terms of bringing to the attention of operators the absolute necessity of wearing seatbelts that are fitted to a vehicle at all times.

TAS.2008.489  Work Related/ Transport & Traffic Related
A 25 year old person died from injuries after a motorcycle accident on a dairy farm. The deceased was not licensed to ride a motorcycle.

Recommendations
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 mended to make such wearing compulsory.
I also recommend that Workplace Standards Tasmania continue 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.

VIC.2006.303  Work Related/ Transport & Traffic Related
A 42 year old person died from head injuries suffered as a passenger in a crash of a CFA vehicle.

Recommendations
- I recommend that the CFA review the Chief Officers SOP 12.03 Driving CFA Vehicles with a view to enabling the endorsement for driving CFA vehicles to suitably identified volunteers, on a temporary/interim basis only until such time as can be arranged for the volunteer to attend a formal accredited driving training course and that such endorsement be performed by accredited personnel outside of the volunteer’s dedicated brigade
- I recommend that the CFA review the ability and use of its briefing systems and, in particular, the use of radio communication, to accommodate and ensure effective communication about track safety/changes even in situations where the issuing of a Red Flag is not warranted.
- I recommend that periodic liaison occur between the CFA, and the Major Collision Investigation Unit (MCIU) and Mechanical Investigation Unit of Victoria Police with a view to identifying, reviewing and improving mechanical and/or engineering features of CFA vehicles for the purposes of improving the safety of the same.
- I recommend that the job description for CFA brigade captains include the responsibility for the endorsement and enforcement of the Chief Officer’s Standard Operating Procedures.
TAS.2009.522  Work Related/ Transport & Traffic Related
A truck driver died from injuries to the head in a truck crash which resulted from aftermarket fitting of non-genuine parts.

Recommendations:
• The observation of [witness] strongly suggests the non genuine retaining bolt or bolts have failed, causing the bouncing movement immediately before the crash.
• I would recommend that the public be given warning of the dangers of fitting after market parts unless they possess the same or equivalent properties of the part they are replacing.

NZ.2007.447  Youth/ Work Related/ Falls
Youth fell from a roof while working as a roof spouting maintenance worker.

Recommendations:
To the Minister of the Health and Safety in Employment Act
That a review be undertaken of the Health and Safety in Employment Act 1992 be implemented particularly with regards to the language in sections 6, 18 (1) (a), 25 (3) (a) to cover situations that involve ‘contractors’ or ‘sub contractors’ placed in a position that [deceased] was. The deceased clearly was under the control of another person who was instrumental in obtaining work and directed that work and it can only be by the action of legislation and consequences of breaching it that may protect people in the position that [deceased] found himself.
<table>
<thead>
<tr>
<th>CATEGORY TAG</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>Adverse Medical Effects</td>
<td>Adverse after effects from a recent medical or surgical treatment, failure to comply with medical advice</td>
</tr>
<tr>
<td>Aged Care</td>
<td>Incidents that occurred in an Aged Care or assisted living facility or residence including a retirement village</td>
</tr>
<tr>
<td>Animal</td>
<td>Incidents where the an animal was involved in the cause of death.</td>
</tr>
<tr>
<td>Child &amp; Infant Death</td>
<td>Any case involving a child or infant - 12 years old and under</td>
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<tr>
<td>Domestic Incident</td>
<td>Fatal incident that occurred as a result of domestic injury or event</td>
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<tr>
<td>Drugs &amp; Alcohol</td>
<td>Death where drugs or alcohol or both were a primary or secondary cause of death</td>
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<tr>
<td>Electrocution</td>
<td>Cases where electrocution is the primary cause of death</td>
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<tr>
<td>Falls</td>
<td>Incidents where a fall was involved in the circumstances or cause of death</td>
</tr>
<tr>
<td>Fire Related</td>
<td>Incidents where a fire was involved in the circumstances or cause of death</td>
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<tr>
<td>Geographic</td>
<td>Cases where the geographic region is significant to the cause of death eg - remote location</td>
</tr>
<tr>
<td>Homicide &amp; Assault</td>
<td>Includes interpersonal violence and family domestic violence</td>
</tr>
<tr>
<td>Indigenous</td>
<td>Cases related to a specific demographic group</td>
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<tr>
<td>Intentional Self-Harm</td>
<td>Cases determined ISH by coronial investigation</td>
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<tr>
<td>Law Enforcement</td>
<td>Includes police pursuit, death in custody, parole issues, pending or previous court cases including family court, restraining order and coronial investigation procedures.</td>
</tr>
<tr>
<td>Leisure activity</td>
<td>Any leisure actively that directly influence the circumstances including holiday activity or location</td>
</tr>
<tr>
<td>Location</td>
<td>Cases where the location of either the incident or the discovery of the body is of significance, does not refer to geographic location</td>
</tr>
<tr>
<td>Mental Illness &amp; Heath</td>
<td>Incidents where the existence of mental illness issues were involved in the circumstance on death, both diagnosed and anecdotal. Please note mental health is included as a contributing factor to death at the discretion of the Coroner.</td>
</tr>
<tr>
<td>Misadventure</td>
<td>Risk taking behaviour such as train-surfing, unintentional drug overdose</td>
</tr>
<tr>
<td>Natural Cause Death</td>
<td>Cases where the death is due to natural causes</td>
</tr>
<tr>
<td>Older Persons</td>
<td>Cases related to a specific demographic group or where the age of a person was a factor in the death.</td>
</tr>
<tr>
<td>Physical Health</td>
<td>Cases where the existing physical health of the person contributed but were not necessarily cause the death</td>
</tr>
<tr>
<td>Sports Related</td>
<td>Cases where a sports incident significantly impacted the cause of death.</td>
</tr>
<tr>
<td>Transport &amp; Traffic Related</td>
<td>Cases involving road, water and air vehicle incidents, motorised or naturally powered. Also include cases where pedestrians are impacted by transport vehicles.</td>
</tr>
<tr>
<td>Water Related</td>
<td>Includes swimming, scuba, snorkelling, boating, fishing and all water related activity in both a recreational or commercial context</td>
</tr>
<tr>
<td>Weather related</td>
<td>Cases where the environmental conditions such as heatwave or storm conditions were significant to the cause of death</td>
</tr>
<tr>
<td>Work Related</td>
<td>Includes cases where work is related to the death and also where unemployment is significant</td>
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<tr>
<td>Weapon</td>
<td>Cases where the involvement of a weapon is significant</td>
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<tr>
<td>Youth</td>
<td>Cases related to a specific demographic group</td>
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