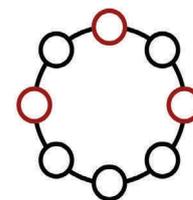


NCIS

Fatal Facts

Issue 26

NCIS Fatal Facts



NCIS

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

Reportable Deaths

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

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

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*.

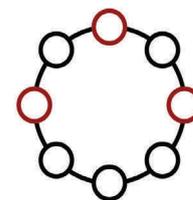
Fatal Facts Search works by users selecting categories using tick boxes for cases of relevance. A broad search (one category) will return many relevant cases. A narrow search (3 categories) will return relevant cases with the most matches at the top of the results. Cases currently included in the search tool are cases closed between 15th March 2002 and 30th September 2010. The NCIS has now uploaded all past issues of *Fatal Facts* and will include all upcoming issues once released.

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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.

NCIS Fatal Facts



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Edition 26 September 2015

In this Edition

Fatal Facts Edition 26 includes cases that were investigated at inquest and where the Coronial Findings contain recommendations. Edition 26 includes cases that were closed between 1 July and 30 September 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 26 contains summaries of 107 cases where recommendations were made as part of the formal coronial finding. Of these cases, 47 are Australian and 60 are from New Zealand.

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

New Zealand cases are included from Edition 25 only.

What is a Coronial Inquest?

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

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TABLE OF CONTENTS

Category	Pages
Adverse Medical Effects	5-9
Child & Infant deaths	9-13
Drugs & Alcohol	13-14
Falls	15
Fire Related	16-17
Homicide & Assault	17
Intentional Self-Harm	17-19
Law Enforcement	20-21
Leisure Activity	22-24
Mental illness & Health	24-25
Natural cause deaths	25-26
Physical Health	26-27
Sports related	27-28
Transport & Traffic Related	28-33
Water Related	33-36
Work-related	37
Youth	37

NSW.2006.6046– Adverse Medical Effects/ Physical Health

The deceased experienced heart attack symptoms and was admitted to the Cardiac Care Unit where an exercise stress test was administered by two junior doctors. This led to an Aortic Dissection and the deceased passed away.

Recommendations (To the Executive Officer, Sydney West Area Health Service)

- The [location] Area Health Service Acute Chest Pain Protocol should be reviewed and amended as appropriate to emphasise the necessity to consider and exclude life-threatening conditions other than cardiac ischaemia, specifically aortic dissection, coronary artery occlusion and pulmonary embolism, in all presentations of acute chest pain.
- The [location] Acute Chest Pain Protocol should be reviewed and amended as appropriate to incorporate diagnostic guidelines for aortic dissection, coronary artery occlusion and pulmonary embolism. The diagnostic guidelines should be based on current evidence-based criteria and include relevant clinical history, findings and signs as well as appropriate diagnostic investigations. Where life threatening conditions other than cardiac ischaemia are excluded, the reasons for such exclusion should be noted.
- The [location] Acute Chest Pain Protocol should be reviewed and amended as appropriate to emphasise that all sections of the Chest Pain Evaluation Emergency Department (ED) Management Form (Exhibit 2, page 93) are to be completed and that the basis of any “Action” taken (i.e. to admit under a cardiologist or to discharge with follow up) be clearly indicated. Specifically, the person filling in the form must note the likelihood of ischaemic heart disease, the risk stratification, the preliminary diagnosis and the action to be taken.
- Any electronic version of the Chest Pain Evaluation ED Management Form referred to above should be designed in such a way that completion of every section is required before the final section on “Action” taken can be filled.
- The [location] Chest Pain Emergency Management Guideline (Exhibit 2 page 92) should be amended:
 - ◇ To clarify the meaning of the term “recurrent pain” to include any chest pain (typical or atypical) that has resolved and then recurred or never fully resolved.
 - ◇ To replace the words “differential diagnosis” with “preliminary diagnosis”.
 - ◇ To provide that an exercise stress test is not to be carried out in any case where the patient is experiencing any form of chest pain at the time of the proposed test. Where a patient is managed in accordance with the [location] Acute Chest Pain Protocol the patient’s clinical progress notes should make this clear and the relevant sections of the protocol should be easily identifiable and accessible for reference by all health care professionals managing the patient. Cardiac technicians and doctors who may be supervising an exercise stress test should be specifically directed to ensure that no test be administered if the patient has any degree of chest pain at the time of the proposed test or has had any chest pain between the time the test was ordered and the time of the proposed test. The document headed “[location] Hospital Division of Medicine – Improving after hours assessment and hand-over by resident medical staff” (Exhibit 7) be reviewed and amended as appropriate to:
 - ◇ Clarify the meaning of “recurrent chest pain” in paragraph 1 consistent with recommendation 6(a) above – “recurrent pain” to include any chest pain (typical or atypical) that has resolved and then recurred or never fully resolved
 - ◇ Clarify the meaning of the word “resolve” in paragraph 3.
 - ◇ Incorporate the need for early escalation to senior medical staff in the case of a change in the patient’s condition including any clinical sign or symptom not previously noted.
 - ◇ Clarify the meaning of “instability” in paragraph 6.
 - ◇ Include hand-over by night interns as well as night registrars in paragraph 7.
- Following the amendments to the document referred to in recommendation 9 above, consideration should be given to elevating this to the status of a Sydney West Area Health Service protocol.

NSW.2006.6046 continued

- The SWAHS should develop an induction program presented by a senior cardiologist to ensure that all residents and interns caring for cardiac patients are familiar with relevant protocols. Emphasis should be placed on circumstances where consultants or other senior doctors need to be contacted and to any contra-indications to testing procedures such as exercise stress testing.
- A copy of these Recommendations and Findings should be forwarded to the Director, Health Services Performance Improvement Branch, NSW Department of Health, for consideration in the review of a standardised Chest Pain Protocol

NZ.2008.3161 Adverse Medical Effects

The elderly deceased was admitted to hospital following a fall in the home. The deceased had a long history of medical conditions including Hypertension, heart failure and pneumonia.

While being fed, the deceased began choking on food. This resulted in the deceased coughing mucous and oxygen saturation levels dropping. The deceased later died after family decided not to resuscitate if the deceased's condition deteriorated.

Recommendations

I recommend to both the Canterbury District Health Board and Medirest that that the Red Tray Project is implemented in [location] Hospital.

NZ.2008.3375 Adverse Medical Effects

The deceased was admitted to hospital due to poor nutrition, as the deceased wasn't eating or coping well at home. The deceased underwent a procedure where a feeding tube was placed in the stomach to get the nutritional levels back to normal. After the surgery, the deceased complained of increased abdominal pain and subsequently the deceased passed away from complications (peritonitis) arising from leakage from the gastropexy.

Recommendations

Accordingly, I recommend to [location] District Health Board that they consider the issues raised by [deceased's] case to assess what steps can be taken to improve clarity and communication of feeding instructions for patients who have undergone tube insertions. In particular, the question of what constitutes "feeding" needs to be considered (that is, nasogastric, gastrostomy or oral), together with what process will enable the adequate communication of these instructions.

NZ.2008.3484 Adverse Medical Effects

The elderly deceased was admitted to hospital for an inflamed finger caused by gout. Due to unavailable beds, the deceased was administered intravenous flucloxacillin in the outpatient department, where they suffered a cardiovascular collapse and arrest due to an anaphylaxis reaction and passed away.

Recommendations

Recommendations related to organisation wide actions and are recommended to the Capital & Coast District Health Board (C&C DHB) Clinical Governance Executive for consideration and action.

- C&C DHB review the risks highlighted by this event related to providing consistent current accessible medication alert information in hand and electronic clinical patient records to inform the risk mitigation plan and medication alert strategy and consideration be given to consistency with GP clinical records.
- The Chief Medical Officer write to all Senior Medical Officers highlighting the learning from this event, in particular requiring the discussion of this learning with all junior medical staff within their teams related to the importance of reviewing medication history and documenting a current evaluation of the patient medications and alert/sensitivities in the clinical records and on the medication chart.

Directorate recommendations

- The Clinical Nurse Specialist (CNS) Resuscitation and the Service Leader Emergency Management be advised of the finding regarding non completion of telephonist 777 form and follow up to ensure such failure does not recur.
- That the CNS Orthopaedic Clinic reminds staff of the processes following an unexpected death including reporting the event, notifying senior staff, review and debriefing.
- The CNS Orthopaedic Clinic ensure the blood glucose monitor is correctly calibrated as per existing requirements, and consider replacing this with a portable battery powered unit that can be located near the resuscitation equipment."

NZ.2008.4135 Adverse Medical Effects/ Mental Illness & Health

The deceased lived in supported accommodation due to schizophrenia. The deceased was being treated with clozapine. The deceased was experiencing dizziness and subsequently fell at the accommodation, resulting in being taken to hospital. At hospital, the deceased suffered a heart attack. Cause of death was cardiac arrhythmia.

Recommendations

To the Clinical Director, [location] District Health Board Mental Health Services:

- That the report provided to this inquiry by the cardiologist [name], be considered as part of the review of the Clozapine Guidelines being undertaken by the Clinical Directors of the three [location] District Health Boards; and
- That particular consideration should be given to incorporating into the Clozapine Guidelines (or other relevant guidelines or policy) a requirement that any patient on clozapine or other atypical antipsychotic who has a history of syncope or dizziness whilst taking this medication should be referred for a comprehensive cardiological assessment.

I will send a copy of this finding to the Centre for Adverse Reactions Monitoring (the New Zealand centre for reporting adverse reactions to medications) for its consideration.

NZ.2009.1302 Adverse Medical Effects/ Physical Health

The deceased had been taking medication for cancer for about a week when they suddenly collapsed at home and passed away. Despite the cancer, the deceased was in good health. The cause of death was a reaction to the Capecitabine that the deceased had been taking.

Recommendations

I recommend that a copy of this Finding be sent to the Centre for Adverse Reactions Monitoring (CARM) and Intensive Medicines Monitory Programme (IMMP) of the Pharmacovigilance Centre, Otago University, to ensure that the rare risk factor of arrhythmia from Capecitabine is given publicity.

NZ.2009.3025 Adverse Medical Effects

The deceased felt unwell while getting prescription medication after seeing the doctor, so has returned to the doctor's surgery and was sent immediately to hospital. The deceased suffered a cardiac arrest in the ambulance. The original ambulance could not get the defibrillator to work and as such a second ambulance was sent. Unfortunately, they could not revive the deceased.

Recommendations

I fully endorse the recommendations contained in the St John report.

I make the following recommendations:

- I recommend that all of the recommendations contained in the St John report be implemented as soon as practicable. This recommendation is directed to the Medical Director, St John.
- I recommend that all rural-based general practitioners ensure that they are sufficiently familiar with all models of defibrillators used in their areas, as to their different functions and in troubleshooting any apparent malfunctions. This recommendation is directed to the Medical Council

NZ.2010.411 Adverse Medical Effects

The deceased suffered from a long-standing lumbar spine problem and had previously taken large amounts of codeine. The deceased's doctor was concerned at the amount of codeine being taken and suggested paracetamol as an alternative. The deceased was then admitted to hospital with general unwellness, shortness of breath and mild confusion. It was discovered that the continued use of paracetamol had caused acute liver failure, with the deceased passing away from encephalopathy.

Recommendations

The public should be made aware that paracetamol, codeine and ibuprofen, which are available as over the counter medication, have the potential to cause death if not taken in accordance with the recommended dosage.

TAS.2008.257 **Adverse Medical Effects/ Older Persons**

An elderly patient died from acute myocardial heart disease while waiting to be admitted to a cardiac ward.

Recommendations

It is clear from reading the hospital records that the Cardiology Unit's unwillingness to admit [deceased] in the face of all of the evidence indicating this to be the proper course was a source of real frustration and irritation for Department of Emergency Medicine (DEM)'s medical staff and Dr [name], the medical registrar. It is likely that it was also the cause of real distress for [deceased] and his family. These were consequences which should not have occurred. They lead me to **recommend** that the [hospital] review its guidelines and criteria for the admission of patients from DEM to the in-patient wards, most particularly the Cardiology Unit, and that its medical staff is fully appraised of those guidelines and criteria.

WA.2007.848 **Adverse Medical Effects/ Physical Health**

A person died as a result of metastatic cancer and was treated by a homeopath who advised that they could treat the cancer and the deceased did not seek surgical options.

Recommendations

- I recommend that the Commonwealth and State Departments of Health review the legislative framework relating to complementary and alternative medicine practitioners and practices with a view to ensuring that there are no mixed messages provided to vulnerable patients and that science based medicine and alternative medicine are treated differently.
- I recommend that the Medical Board of Western Australia finalise its document Complementary Alternative and Unconventional Medicine if it has not already done so and take steps to ensure that the document is promulgated to the profession and complied with.

WA.2007.1481 **Adverse Medical Effects**

A 20 year old died of anaphylaxis after consuming a product that had nuts in it.

Recommendations

Those at risk of life-threatening anaphylaxis should carry an Epipen with them at all times, and particularly when eating out and when travelling to remote places.

The Department of Health should develop a Western Australian 'model of care' for anaphylaxis. This should incorporate service provision by immunology/ allergy specialists, other specialists, general practitioners, pharmacists and other health professionals to provide care and evidence based information in a timely manner. Adequate resources including a project officer should be provided. Minimum standards of care and service provision should be defined and must be adequately funded.

The Department of Health should improve the education of health professionals about –

- ◇ acute management of anaphylaxis; and
- ◇ Appropriate follow up of the patient at risk of future anaphylaxis. As part of this, there needs to be the development of best practice guidelines in the diagnosis and management of anaphylaxis which is regularly updated. There should be easy access to the Australasian Society of Clinical Immunology and Allergy (ASCI) action plan for anaphylaxis, access to adrenaline auto injector trainers and patient educator resources and access to adrenaline auto injectors at the point of primary care after the initial episode of anaphylaxis.

Education of the food industry in regard to allergens and allergic customers' needs to be improved. This should include training staff about allergens, allergic customers, accurate labelling, full and complete disclosure of food ingredients and possible routes of cross-contamination with allergens. This could be done by Environmental Health Officers who would need further training for this purpose.

WA.2007.1481 continued

Path West Laboratory Medicine WA should retain blood samples, stomach contents and food samples in all cases of suspected anaphylaxis until after the Coroner has made findings.

The Department of Health should provide video link facilities and hands free phone facilities (preferably with a head set) for remote nursing posts, such as Coral Bay, where a doctor is not resident and medical supplies in an emergency had to be provided by electronic means.

Medicare Australia, or other relevant body, revise the PBS prescription criteria for the prescription of Epipens (or other adrenaline auto injectors) to allow for

- ◇ prescription of more than one Epipen (or other adrenaline auto injector) at a time, and
- ◇ for prescription of an Epipen (or other adrenaline auto injector) following any anaphylactic reaction (and not only, as now, where adrenaline has been administered for that reaction or with the approval of an allergy specialist).

NOTE: Due to a number of cases where the deceased had died of co-sleeping with an adult, or died after a ventouse delivery extraction the SA Coroner held a joint inquest with combined recommendations

SA.2007.982, 1130; SA.2008.1357, 1728, 1761**Child & Infant Deaths**

Five cases in SA where an infant died after co-sleeping with an adult

Combined recommendations

The message to be drawn from these five tragic deaths is that the risk of sudden, unexplained death in infancy is greatly increased where a child sleeps in the same bed with one or more parents or other adults, whether the mechanism of death is asphyxia due to overlaying, bedding or otherwise. On the other hand, there are benefits to parents sharing a room with an infant where the infant is sleeping in a safe cot expressly designed for that purpose.

I recommend that the Minister for Health consider these findings and consider the promulgation of a pamphlet such as Exhibit C71c with an appropriate adjustment of the age referred to therein from 6 months to 12 months.

SA.2006.1763; SA.2007.493**Child & Infant Deaths/ Adverse Medical Effects**

Two SA infants died after separate ventouse extraction deliveries, causing subgaleal haemorrhages.

Combined Recommendations

I make the following recommendations:

- That the Minister for Health and the Medical Board of South Australia draw these findings and recommendations, and in particular those relating to the circumstances surrounding the death of [deceased] the attention of the wider medical community;
- That the Royal Australasian College of Physicians draw these findings and recommendations to the attention of its members and in particular those members who are neonatologists;
- That the Royal Australasian College of Physicians promulgate and circulate for the benefit of its members a College Statement that replicates that of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists document dated July 2009 and entitled 'Prevention Detection and Management of Subgaleal Haemorrhage in the Newborn';

That the Royal Australasian College of Physicians draws to the attention of its members, and in particular neonatologists, the following matters:

SA.2006.1763 & SA.2007.493 combined recommendations continued

- ◇ That practitioners should recognise that subgaleal haemorrhages can behave in unpredictable ways and can have devastating consequences;
- ◇ That undue reliance should not be placed upon a clinical picture of haemodynamic stability alone as the clinical picture may be falsely reassuring;
- ◇ that regular monitoring of acidosis and haemoglobin levels, among other parameters, is essential;
- ◇ That upon a diagnosis of a subgaleal haemorrhage in a neonate, practitioners should have regard to the potential need for cross matched blood transfusion and transfusion of fresh frozen plasma and that they should immediately take the necessary steps to ensure that cross matched blood and fresh frozen plasma is available to be administered at short notice;
- ◇ That if a decision is made to administer a blood transfusion or a transfusion of fresh frozen plasma that practitioners should ensure that it is administered without delay.

I draw recommendations to the attention of the Minister for Health for transmission to the Chief Executive Officers of all hospitals in South Australia that provide obstetrics services, be they Level 1 or Level 2 hospitals;

- That the Chief Executive Officer of the [location] Hospital take the necessary steps to ensure that in future, assurances given to medical practitioners as to the availability of cross matched blood are met.

NSW.2006.3218 Child & Infant Deaths/ Adverse Medical Effects

The deceased was born premature with a congenital heart disease, and died in hospital 30 days after birth.

Recommendations to the (Minister of Health)

- I recommend that the [location] Area Health Service and the [location hospital] Neo-natal Intensive Care Unit reconsider the Unit's protocol in relation to the use of propofol as an induction agent for infants suffering cyanotic congenital heart disease and settle that protocol in final form as a matter of urgency. The unit ought consider including a direction that propofol not be used in infants with compromised cardiac output and that, in any case, it be used only after senior intensivist or consultant review of the baby.
- I recommend that the Area Health Service amend the Royal Hospital for Women's "Stillbirth, Fetal, Neonatal and Infant Deaths Documentation and Transport Guideline" to insert a requirement that if :(i) a death must be reported to the coroner in accordance with the hospital's coronial checklist and (ii) a pulse oximeter permitting the downloading of data had been attached to the infant at the time of his or her death, subject to any other clinical priorities for the use of that equipment, the data from the pulse oximeter ought be downloaded and retained as part of the infant's medical records.
- I recommend that the Area Health Service consider whether the introduction of functional echo-cardiology training and technology in neonatal intensive care units within its jurisdiction is reasonably practicable, given its budgetary priorities and constraints, within the foreseeable future

NT.2008.104 Child & Infant Death/ Weather

The deceased was a 20 month old infant who died of acute heat stress on a 30 plus degree day.

Recommendations

"I am aware that a draft policy is being developed and I recommend that the Northern Territory Commissioner of Police give attention to finalising this draft policy in conjunction with the Department of Health of Community Services, who is responsible for the Forensic Pathology Unit. I consider that such a policy has the potential to significantly assist members of the NT police to deal with and investigate these types of deaths, particularly in what can only be described as extremely difficult circumstances for all involved".

NZ.2007.542 Child & Infant Death

Infant died at Hospital. Cause of death was severe hypoxic ischemic encephalopathy caused during a compromised home birth earlier that morning.

Recommendations

I recommend that a copy of this Finding be forwarded to the New Zealand College of Midwives, for circulation to its members for their information and education.

- ◇ Midwives ought to carefully assess their patient's intellectual abilities to ensure that advice given is clearly understood and able to be acted upon.
- ◇ Midwives ought to review their communication procedures. A phone call to a pager requiring a phoned response takes more time than would direct telephone to telephone communication.
- ◇ Midwives ought to, when considering a Care Plan for their patients, take into account all of the Family circumstances or Family dynamics including travel arrangements and care arrangements which would need to be made prior to an attendance at a hospital or clinic or admission to hospital.

NZ.2008.2346 Child & Infant Death

Infant died of sepsis from meningococcal disease after presenting at hospital with high temperatures. The infant showed initial improvement with ice blocks and electrolytes and was sent home from the hospital. The infant later died at home.

Recommendations

I recommend that [location] Hospital continue with its development of documentation termed "Meningococcal Disease, Treatment and Contact Training" and, in addition, establish an ongoing training programme for clinicians to ensure its implementation.

I recommend that [location] Hospital adopt and progress the system of doctor and nurse clinical note taking and exchange as identified in the evidence of [doctor].

NZ.2009.2191 Child & Infant Death/ Adverse Medical Effects

The deceased was born with a faint heartbeat but subsequently the heart stopped not long after birth. The deceased was resuscitated but later died, with hypoxic brain injuries. The mother had a prolonged second stage of labour with the deceased and it was later discovered that the mother had a ruptured uterus.

Recommendations

- That the midwife [name] undertake further training on the reading and interpretation of CTG tracings;
- That the RANZCOG and NZCOM develop a joint statement covering the issues raised in these Findings and issues raised by Commissioner Ron Patterson in his report on Case 07HDC16053;

A copy of these Findings is to be sent to the Ministry of Health, the NZCOM and RANZCOG.

NZ.2009.2987 Child & Infant Death/ Transport & Traffic Related

The deceased child was playing behind a car with the child's mother supervising. The child's sibling was playing in the car and the handbrake has disengaged, rolling over the deceased and the mother. The deceased suffered a serious head injury and was not able to survive.

Recommendations

This death highlights the need for parents to be extremely vigilant to safeguard children from dangerous situations. The dangers should have been apparent to [deceased's] parents, but obviously they were not conscious of those dangers at that time; the deceased's mother was with the deceased behind the car. No doubt it has been an extremely painful lesson for the parents, and I trust that all other parents will learn this lesson without having to go through the same tragedy.

NZ.2010.1444 Child & Infant Death/ Transport & Traffic Related

The deceased child died of crush injuries after being run over by a four wheel drive in the driveway of the deceased's house. The driver, who looked in all mirrors before reversing, nor the parents who were present, were aware that the child was present in the driveway.

Recommendations

I comment that this is another tragic example of a child being run over by a reversing vehicle. Most vehicles appear to have blind spots when reversing. Rear mounted cameras, rear mounted mirrors and sensors assist in reducing the blind spot at the rear of the vehicle. This case involving [the deceased] demonstrates that in some vehicles blind spots exist at the front right side of the vehicle.

It is trite to say that reversing vehicles and young children can be a lethal combination. All reasonable steps must be taken by drivers and persons responsible for supervising children to ensure that children are nowhere near reversing vehicles.

I make, under section 57(3) of the Coroners Act 2006, the attached specified recommendations or comments that, in my opinion, may, if drawn to the public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred:

NZ.2010.1573 Child & Infant Deaths

Infant died of hypernatraemic dehydration and malnutrition caused by insufficient breast milk feeding. When the deceased was found in bed, they were 1kg less than the birth weight 2 weeks prior.

Recommendations

While DA26 sets out the responsibilities of the midwife acting as a LMC and providing postnatal care for a mother and baby, in the light of the death of baby {name} , and in light of the comments made by the paediatrician [name], it is my recommendation

To the Minister of Health

- That there be an inclusion in DA26 a requirement for "weighing of the baby between 7 - 10 days of birth and active management of feeding of a baby still below birth weight".

QLD.2007.5897 Child & Infant Deaths/ Adverse Medical Effects

An infant was born prematurely and died after a catheter was inserted incorrectly.

Recommendations

The Health Quality and Complaints Commission (HQCC) made the following recommendations:

- [location] Hospital considers developing a guideline on the insertion and evaluation of umbilical venous catheter positioning, when this is appropriate for insertion and the short term LMC management by a level II nursery;
- For future umbilical venous catheterisations, [location] Hospital considers referring x-ray scans to a radiologist for skilled interpretation;
- [Location] Hospital, in conjunction with [location] ' Hospital, considers developing a policy or agreement in relation to the criteria for transferring of neonates to a level III nursery for the long term management of umbilical venous catheters.
- The [location] Hospital review their process regarding the communication of neonatal advice to referral nurseries, specifically in relation to the documentation of treatment plans and retrieval advice provided by telephone; and
- The complaint issue regarding the insertion and misplacement of the umbilical catheter by [location] Hospital is referred for conciliation by the HQCC.

I endorse the recommendations of the HQCC and anticipate the HQCC will monitor and review the implementation of the recommendations.

On reviewing the medical records from the [location] hospital it was noted that documentation of observations and medical reviews of a patient are of critical importance and should be meticulously recorded in an accurate, timely and comprehensive way.

QLD.2007.5897 continued

This will assist in ensuring communication between doctors and nurses is effective and best safeguard the patient's wellbeing. It is also noted the [location] Hospital proposes the use of an ultrasound scan to investigate the possibility of clot formation where there is a central indwelling catheter and issues regarding peripheral perfusion. This practice was not routinely performed at the time of [deceased's] admission.

VIC.2009.2455 Child & Infant Deaths/ Transport & Traffic Related

A child died as a result of head injuries sustained in a motor vehicle accident, after falling from a car.

Recommendations

The Transport Accident Commission and WorkSafe should include this issue in their regional road and work safety campaigns. Consideration should be given to an intensive awareness campaign aimed at farming families with young children, in this region.

NT.2009.169 Drugs & Alcohol/ Law Enforcement/ Indigenous

The deceased was incarcerated for a short period of time for drunken rough play, where an object was dropped on him. After release, the deceased's health declined and he passed away of severe internal injuries after a period of waiting at the hospital.

Recommendations

"I can see no justification for the "discounting" the price of alcohol or giving it away as appears to have happened here. Price is a significant factor in minimizing alcohol related harm. I recommend that the Attorney-General and the relevant Minister consider what steps can be taken, either through the tightening of license conditions or the creation of an offence, to ensure this practice is stopped.

- The Royal Commission into Aboriginal Deaths in Custody made a number of recommendations about custodial health and safety that have a direct bearing on this matter. It is apparent that the procedures at the [location] watch-house incorporate most if not all of these recommendations. However, this case emphasizes that complacency is dangerous. A recommendation that merits particular notice is that about de-briefing after important incidents. I recommend to the Commissioner of Police that a de-briefing of the officers involved be undertaken with a view to assessing the effectiveness of forms and procedures
- I recommend that the Commissioner of Police give consideration to additional or "refresher" training for all watch-house officers on the high standards required of them in relation to the screening of the health of prisoners. I also recommend that the health screening and the form used include the question "Do you have any injury?"
- That a nurse or nurses be employed in the two largest watch-houses, [location] and {location] which receive thousands of intoxicated persons each year, often in poor health and sometimes with serious injuries. The deceased's injury was very serious but not obvious to an untrained person. Police officers and police auxiliary officers have limited first aid training (even if more intensive and specialized training is desirable for watch-house officers). They are not paramedics or nurses and cannot be expected to have that level of expertise. The responsibility for screening the health of detainees is an important one but difficult for police and auxiliary officers to discharge effectively. Recommendation 127a of the Royal Commission into Aboriginal Deaths in Custody was that there should be "a regular medical or nursing presence in all principal watch-houses in capital cities and in such other major centres as have substantial numbers detained." I recommend that the Commissioner of Police and the Northern Territory Government consider this matter again.
- There is one more matter that deserves mention. Another of the recommendations of the Royal Commission into Aboriginal Deaths in Custody was that there are direct means of communication between detainees in cells and their custodians (Recommendation 140). The [location] watch-house was built, at very considerable expense, to take into account many of the recommendations of that Royal Commission. It is unacceptable that the intercom in [deceased's] cell was inoperative. If, as appears possible, the intercom in cell M5 has remained inoperative from 13 August 2009 until the hearing of this inquest in June and July 2010 that is a lamentable disgrace. I recommend that the Commissioner of Police give instructions in relation to this immediately. I would be grateful to hear what measures he has taken.
- The treatment of persons in custody, instructs officers to be aware that that intoxicated persons are often unable to offer an informed opinion and to err on the side of caution. In this case the officers did not err on the side of caution. At best they were unobservant. Undoubtedly there is a certain routine in detaining drunks, and routine dulls responses and the sharpness of observations. However, once a person is taken into custody the custodian, which ultimately is the Northern Territory, takes responsibility for the care of that person. I find that responsibility was not satisfactorily discharged.

NZ.2008.4065 Drugs & Alcohol/ Mental Illness & Health

The deceased was a chronic alcoholic who was admitted to hospital with substance abuse and enduring mood disorder. The deceased absconded from the hospital and went drinking, but was later found deceased from the effects of acute alcohol toxicity.

Recommendations

To: Police Superintendent, [location] Police District:

- That the police, in conjunction with CCDHB, enter a robust Memorandum of Understanding to set out clear protocols in respect of the AWOL/missing person process so that immediate steps can be taken to minimise delays with a search process.
- That the police review the notification procedure to ensure a prompt involvement with the SAR personnel at the outset of a missing person notification.

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

- That the CCDHB enter into a robust Memorandum of Understanding with the Police Districts that they are associated with to set out clear protocols in respect of the AWOL/missing person process so that immediate steps can be taken to minimise delays with a search process.

NZ.2009.3090 Drugs & Alcohol

Whilst intoxicated and whilst taking depressants which enhance the effects of alcohol, the deceased has failed to chew properly and has suffered what is known as a "cafe coronary" with a food bolus becoming lodged in the trachea and larynx occluding the airway.

Recommendations

I recommend that a copy of this Finding be brought to public attention in order that the circumstances of the death of [the deceased] serve as a warning to others who, whilst intoxicated, fail to chew their food adequately.

TAS.2009.439 Drugs & Alcohol/ Misadventure

A person died as a result of ethanol (alcohol) toxicity after a weekend football trip.

Recommendations

I commend to Government, sporting clubs and the wider community the recommendations made by [name] at pages 112-115 of her Report. In summary, sporting clubs ought have well documented policies known to their members relating to both alcohol and illicit drug use. Sporting clubs ought take a more active role in supporting and encouraging harm reduction practices such as drug education programmes implemented as part of a wider health promotion focus, provision of information about the club's drug policies, contact details of drug and alcohol services, and a check list tool to allow self-assessment of problematic alcohol use.

There is clearly a community need to support further research into assessing community concern of alcohol use within the sporting environment and to allow a feedback loop to inform sporting clubs and players as to the general community perception of drug and alcohol use within local sporting clubs. Government has a role to play both in implementing policies to assist in breaking the nexus between sporting activities and alcohol abuse, and also to provide funding to assist sporting clubs in their endeavours to break this nexus and also in education of sporting participants and the general community.

It is clear that alcohol fuelled end of season trips of any scale are still an accepted norm within some sporting clubs and therefore there needs to be action taken to identify the extent of the continuing problem and with the input of all stakeholders, map out steps that can be implemented and continued over time to foster a realisation that such conduct is unsafe and unhealthy and to ensure it is not portrayed to the younger participants as normal and acceptable conduct.

TAS.2008.470 Falls/ Older Persons

An elderly patient in a nursing home died following a fall at the nursing home. The deceased also suffered from Parkinson's and dementia.

Recommendations

The evidence of the nurses as to transfer of the care of a patient under observation shows shortcomings in the system. It is recommended that in such cases the relief nurse should sign an acknowledgement of receipt of the instructions as to the care of a patient which are out of the ordinary to ensure that the relief nurse is specifically advised of any specific problems and so that there is evidence that the relief nurse was actually advised of those problems.

TAS.2009.532 Falls/ Drugs & Alcohol

A person died from a fall while intoxicated.

Recommendations

I am concerned as to the level of [deceased's] intoxication and again highlight that this was as a result of alcohol purchased at a licensed premises. There is an indication that [deceased] was drinking "shots" the purpose of such drinks to consume a high percentage of alcohol in a short period of time. Once again I am obliged to comment upon the apparent lapse in prescribed obligation of "responsible service of alcohol". The general public concern relating to violence flowing from the actions of persons in and around licensed premises in the early hours of the morning is well documented. This tragic accident illustrates another aspect of the social and personal impact of alcohol abuse. I am unable to report as to whether or not [deceased] was sold alcohol during the night at a time when he would have been clearly drunk, but my suspicion is that he was. In any event, if [deceased] was as obviously intoxicated as indicated by his blood alcohol reading and the description of [name] and the licensee ought to have had in place a system to ensure alcohol was not supplied to him either directly or via others.

Figures from the National Drug Research Institute (2004) show that Tasmania had the third highest rate of deaths caused by alcohol consumption for young people aged 15 – 24 years in the period 1993 – 2002. In the publication Draft Tasmanian Alcohol Action plan 2009 – 2014 produced by the Tasmanian Department of Health and Human Services it is stated at Page 2: *"Alcohol-related harm impacts significantly across a wide range of areas including personal and public safety; property damage; road accidents; law enforcement; workplace productivity; and health care services including ambulances, hospitals and treatment services. The economic, social, legal and health care costs of alcohol misuse are significant and affect all aspects of the Tasmanian community."*

A report by the National Drug Law Enforcement Research Fund, 2008 states:

"There are few, if any, other commodities which exact such social and health costs which are tolerated by the Australian community to the same extent as alcohol."

Those authorised to sell and supply alcohol in licensed premises must take the responsibilities attached to that right seriously. The community must recognise the social impact of alcohol abuse and demand that there is in fact responsible service of alcohol otherwise those failing to meet that standard ought lose or face restriction upon their right to sell alcohol.

VIC.2007.3954 Falls/ Older Persons/Aged Care

An elderly person died from a head injury sustained in a fall at a residential facility.

Recommendations

I recommend pursuant to section 72(2) *Coroners Act* 2008 that [location] Lodge Supported Residential Service develop and implement a professional development educational program for staff providing periodic sessions on all aspects of the management of falls including prevention of risks, assessment and management of injury, and implementation of the Falls Policy.

I recommend that the Victorian Department of Health include the requirement to have a falls prevention policy in the Accommodation and Support Standards of the *Supported Residential Services (Private Proprietors) Act*. This requirement should extend to all SRSs, and be appropriate for the characteristics and needs of residents at each facility. The Department should provide ongoing assistance to SRS operators to develop their falls prevention plans through training courses, guidance material and planning frameworks.

NZ.2009.1480 Fire Related/ Older Persons

An elderly person died from smoke inhalation due to a fire started from an electric blanket in the home.

Recommendations

To the Director of Operations and Training, New Zealand Fire Service

- The issue of the training provided to volunteers in moving persons was raised during the inquest, with the reality of moving a lifeless body which does not have harnesses or handgrips differing from mannequins which are provided with such aids. Therefore, I also recommend that consideration be given to the removal of harnesses and any handgrips on mannequins used in training of fire fighters.
- Continued emphasis be placed on public education to exit a building immediately a fire occurs

NZ.2009.2586 Fire Related/ Drugs & Alcohol

The deceased was socialising with a number of people at home when the deceased went alone to the bedroom with some alcohol and cigarettes. Shortly after, smoke was seen coming from the room, and once the door was opened, the fire intensified. Friends tried to reach the deceased but were unable to.

Recommendations

I recommend that the Ministry of Consumer Affairs, or other appropriate organisation, investigate and consider the possibilities of requiring by legislative process, or otherwise, the use of combustion modified materials in respect of soft furnishing material.

NZ.2008.1382, 3054 Fire Related/ Child & Infant Death

Two children died of smoke inhalation after a fire engulfed the bedroom of the house they were in. It appears that the children were playing with matches and a toy has ignited. The deceased children have tried to put the fire out unsuccessfully with further toys and bedding, without alerting adults, possibly in fear of getting in trouble, and this has also ignited, spreading the flames.

Recommendations

The New Zealand Fire Service has provided a number of recommendations in their evidence which I support and will include in this finding. The recommendation is provided by Senior Station and Fire Safety Officer for Northland Fire Region, [name].

"As a result into the investigation into events of [date and address], the New Zealand Fire Service are urging this particular finding to consider the following recommendations.

- That there be encouragement of agencies such as schools, welfare and parental advisory agencies of the Fire Awareness and Intervention Programme for children with fire lighting tendencies, and that these agencies communicate regularly with the New Zealand Fire Service.
- That landlords take some partial responsibility to ensure smoke alarms in their tenancies are in good, working order - that this be a clause in any tenancy agreement giving reliance and responsibility also on the tenant to maintain the smoke alarms.
- The New Zealand Fire Service, welfare and social agencies are encouraged to promote successful parental responsibility.

SA.2008.526 Fire Related

A person died from burns and lung damage sustained during a house fire, after absconding from a psychiatric ward.

Recommendations

That the Minister for Mental Health and Substance Abuse cause the continued development of protocols relating to treatment centres under the Mental Health Act 2009 to ensure that detained patients who are considered to be at risk of absconding from treatment centres are prevented from doing so;

That the Minister for Mental Health and Substance Abuse consider introducing an amendment to the Mental Health Act 2009 to empower a member of the police force to apprehend, or take into his or her care and control, a patient at large who has absconded from an approved treatment centre during the currency of a period of detention, notwithstanding that that period of detention has expired;

SA.2008.526 continued

That the Commissioner of Police amends police General Orders in the following manner:

- ◇ to direct police officers not to remove a wanted missing flag and the active detention order flag at any time prior to it being established that the person has been returned to the approved treatment centre;
- ◇ to require staff of a police custodial facility to conduct a check when releasing a person in custody as to whether that person has been reported as missing and whether an active detention order flag is in existence in respect of that person;
- ◇ to ensure that officers responsible for compiling and maintaining missing persons reports communicate with staff of a police custodial facility when it is revealed that the missing person has been taken into police custody;
- ◇ to ensure that missing persons reports are immediately vetted by a more senior officer and, in any case, vetted during the period in which the person is still regarded as missing.
- ◇ That the Commissioner of Police review the desirability or appropriateness of civilian staff performing duties that might more appropriately be performed by trained and sworn police officers.

NSW.2008.5611, 5622 Homicide & Assault/ Domestic Incident/ Weapon/ Intentional Self-Harm

The deceased died from a shotgun wound caused by the second deceased person, who then took their own life.

Recommendations:

To the Ambulance Service of NSW/ Minister for Health:

- That the Ambulance Service (AS) introduces training for all relevant management staff relating to their power to refer a staff member for psychiatric assessment, pursuant to the *Ambulance Services Regulation 2005*.
- That the AS introduces clear policies which ensure that reports made by paramedics or other staff relating to their concerns for the mental health of other employees are documented and promptly acted upon if meritorious.
- That the AS investigates the effectiveness of communication between the Risk Management Group and other arms of management, to ensure that the recommendations of Return to Work officers regarding the mental health of employees are taken into account at an early stage and specifically addressed in any management decisions or risk management plans concerning a respondent employee.
- That AS NSW publicises to all staff any reforms introduced since the death of [deceased] that relate to safeguarding the mental health of employees and improving disciplinary and remedial procedures.

NZ.2007.872 Homicide & Assault/ Water Related

The deceased was drowned by family members who believed that the deceased was under a perceived 'curse' and were trying to rid the deceased of this by 'cleansing'.

Recommendations

It is, therefore in my view inappropriate to make a recommendation in this instance that encompasses sufficient directive action to a body or organisation, but what can be stated is that Tohunga and Kaumatua should be consulted by whanau where makutu is suspected so that the whanau receive the correct expert advice as to how to deal with a situation as such advice will surely be tempered by ensuring what is to be carried out by such exorcism remains within the laws of New Zealand as set down by parliament.

NSW.2008.190 Intentional Self-Harm/ Drugs & Alcohol

The deceased committed suicide by hanging after repeatedly stabbing his partner following a fight involving alcohol.

Recommendations

Representation for the parents of the deceased requested a recommendation that the authorities consider an amendment to the *Liquor Act* to close the apparent loophole that allowed the deceased to obtain an amount of liquor from another person who was not subject to the same liquor restrictions as him. While the deceased committed an offence under the *Liquor Act* in possessing liquor not authorized by the terms of his permit, the person who bought him the liquor was not committing any offence unless they were to "sell" it and gain a profit or benefit.

NSW.2008.190 *continued*

"I recommend to the Attorney-General that consideration be given to whether it ought to be an offence for a person to purchase liquor on behalf of another person where that other person is not entitled to purchase that liquor for themselves and the first person knew or ought to have known of that fact."

NZ.2008.398 Intentional Self-Harm/ Location/ Mental Illness & Health

Mentally ill person hung themselves while in hospital waiting for admission by psychiatric services. The deceased had recurrent episodes of depression, severe anxiety consistent with Social Anxiety Disorder.

Recommendations

[The deceased's] preventable death has highlighted systemic shortfalls in the interface between PES and the ED at [location] Hospital. A Sentinel Event Review has identified issues and proposed remedies, which have been implemented as appropriate. [The deceased's] death has highlighted that to the extent possible, dealings with mental health patients should be by trained mental health professionals.

I recommend that CDHB:

- To the extent possible, ensures dealings with mental health patients be by trained mental health professionals.
- Ensures that electronic medical records currently used by Canterbury DHB Mental Health Services be available to assessing staff.

NZ.2008.843 Intentional Self-Harm

The deceased was found hanging by partner at home. The partner wanted to leave the marriage and move on with someone else and the deceased was distraught at this.

Recommendations

That with respect to the prescribing of any hypnotic medicines, such as Zopiclone, that the Medicines Adverse Reactions Committee and the Ministry of Health carry out a review with the aim of bringing down a protocol that ensures that the prescribers of such medicines physically review all patients as follows:

- That the maximum amount of medication to be prescribed at one time be no longer than four weeks as is currently undertaken; but to;
- Allow only a further month's renewal of prescription by telephone or nurse intervention, thereafter any further renewal must be by way of examination of the patient.

This, of course, should not limit any prescriber from shortening either of the above time periods.

This recommendation to be sent to the:

- Director General of Health
- Director of Mental Health
- PHARMAC

NZ.2008.2310 Intentional Self-Harm/ Mental Illness & Health

The deceased was a university student who was discovered hanging from a roof truss in a shed located on the property that they lived in. The deceased had been celebrating St Patricks Day the night before with friends, and had been suffering from depression.

Recommendations

- That a copy of this Finding be provided to (a) the Privacy Commissioner; (b) the Health and Disability Commissioner; (c) the Director of Mental Health; and (d) the Law Commissioners.
- That the [University]Student Health and Counselling Services review its protocol as between the general practitioner section and the counselling section to ensure that there is a robust inter-sharing of information with respect to a client's welfare.

NZ.2009.2972 Intentional Self-Harm/ Weapon/ Drugs & Alcohol

The deceased was found in a car with a double barrelled shotgun. It appears that the deceased died of a self-inflicted gunshot wound. The deceased was known to take drugs on a regular basis and had been affected by the aftermath of hard drugs, having not slept for the three days prior to the death.

Recommendations

Without formally making any recommendation under section 54(3) of the Coroners Act 2006, I refer this case back to the [location] Police for further investigation concerning the circumstances of the supply of drugs to [the deceased] in the immediate period before the death.

TAS.2009.18 Intentional Self-Harm/ Mental Illness & Health

A person died as a result of asphyxiation from hanging. The deceased suffered from schizophrenia.

Recommendations

I am unable to find that [deceased] death would not have occurred if he had undertaken a psychiatric review in that week prior to his death. However, such a review may have led either to his hospitalisation or to an adjustment to his treatment plan, either of which may have deterred [deceased] from his fateful and tragic act. These matters lead me to **recommend** that [hospital] carry out a review of its management of [deceased] during the last week of his life with a view to identifying and implementing any appropriate strategies which may help to avoid a like tragedy in future.

TAS.2010.19 Intentional Self-Harm/ Mental Illness & Health

A person died from asphyxia from carbon monoxide poisoning. The deceased suffered from depression.

Recommendations

As part of the investigation of [deceased's] death, a report was obtained from [deceased's psychologist]. It includes these comments;

"Deeply, depressed and distressed males from rural and semi-rural backgrounds with a long term exposure to alcohol mixed with acute dependence on long term romantic relationships with complex dependency needs and issues combined with the absence of elder male figures to guide them are a major group at risk of committing suicide."

"Medicare can only fund up to 18 appointments on a calendar basis and there is no exception to this rule. I believe that after I had ceased to treat [deceased] on a regular weekly to fortnightly basis, his control of his destiny deteriorated at a time when he needed to adjust his future plans. Medicare does not allow payments for the treatment of 3 relationship counselling sessions as relationship treatments are not included on their list of approved treatments."

I consider [psychologist] comments to be most pertinent. They lead me to **recommend** that Medicare undertake a review of its funding with a view to enabling chronic sufferers of depressive illness greater and more generous access to counselling services.

VIC.2007.4949 Intentional Self-Harm/ Mental Illness & Health

A person died as a result of asphyxiation from hanging. The deceased was admitted to a hospital at the time with recurrent major depression.

Recommendations

Pursuant to Section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

- Rooms in the [location] Unit at [location] Hospital that are to be occupied by patients with high or intensive levels of suicidality, be fitted with a nurse call button apparatus that is incapable of being used as a ligature. Potential hanging points within the rooms need to be identified and removed.
- Protocols be established to ensure family members, willing to be involved in the psychiatric care of their loved one, are engaged at the outset and be given the opportunity to contribute to ongoing management options.
- That protocols be established to ensure detailed and accurate notes are maintained of a patient's psychiatric assessment, diagnosis and management plan.

NSW.2008.4965**Law enforcement/ Weapon/ Mental Illness & Health**

The deceased died of multiple gunshot wounds during the course of a police operation. The deceased was diagnosed with schizophrenia and had not taken his medication.

Recommendations (To the Commissioner of Police)

That consideration is given to the development of a training module for general duties police officers to assist them in dealing with mentally ill persons.

That such training module, when developed, form part of the mandatory training obligations of general duties officers.

Recommendations (To the Chief Executive, [location] Health Service)

That where a patient, who is receiving antipsychotic medicine by way of periodic injection, is discharged from the care of a mental health team (the MHT) to the care of a general practitioner the MHT ensure that the general practitioner has in place a system to identify and follow up such patients where they cease presenting themselves to receive the prescribed medication.

QLD.2008.2941**Law Enforcement/ Weapon/ Mental Illness & Health**

The mentally ill person died after attacking police with a knife and was subsequently shot by an officer

Recommendations**Incident management training**

In view of the inherent danger in managing incidents such as this, the increasing frequency with which they are likely to occur and the tendency for officers to become desensitized to such risks, I recommend officers in the Operational Skills and Tactics Program review this incident with a view to utilizing it as a training scenario. The officers involved in the incident might also make a valuable contribution by participating in such training, were they minded to do so.

QLD.2008.8793**Law Enforcement**

A person died after being restrained in prison after assaulting prison officers.

Recommendations**Recommendation 1- Safety Orders and Other Medical Practitioner Services (OMPS)**

I recommend Queensland Corrective Services (QCS) ensure all senior management are aware of the limited numbers of officers authorised to make and cancel Safety Order and of the requirement that upon cancellation of such an order, consideration be given to the need to make an Intensive Management Plan.

Recommendation 2- Corrective Service Officers (CSOs) to call Queensland Ambulance Services (QAS)

In my view, whenever an employee of a correctional centre has reason to believe a medical emergency exists, he or she should be required to call the QAS without waiting for a nurse from the health centre to come and examine the prisoner. I recommend that the commissioner of corrective services cause all correctional centres to amend their policies accordingly.

Recommendation 3- Scene and evidence preservation

In view of the evidence that regional correctional centres such as [location] and [location] have limited procedures in place to ensure the integrity of a death in custody investigation is not compromised by the initial response of officers at the scene, I recommend the Queensland Corrective Services Commissioner seeks the assistance of the Corrective Services Investigation Unit (CSIU) to review existing policies at all correctional centres and where necessary, assist in the provision of training to CSOs.

Recommendation 4- Obligation to provide information

Prisons can be dangerous places. The public has an abiding interest in ensuring they are managed as safely as possible and that the actions of those in charge of them can be effectively scrutinised. Neither prison officers nor prisoners should be able to decline to assist police officers investigating deaths in custody. Accordingly, I recommend the Corrective Services Act be amended to require any person suspected of having information about a death in a correctional centre to provide that information to CSIU officers with the proviso that any information provided cannot be used against them in criminal or disciplinary proceedings.

WA.2008.290 Law Enforcement/ Indigenous/ Natural Cause Death

A person died while in prison from lung cancer.

Recommendations

There be serious consideration given to the appointment of skilled Indigenous Health Workers to co-ordinate and assist AVS members in ways considered appropriate to achieve outcomes which will satisfy general community goals.

NZ.2008.2517 Law Enforcement/ Intentional Self Harm/ Mental Illness & Health

The deceased was on remand in a prison when they were found hanging on the yard side of the window of the cell in which he had been placed. The deceased had previously that month tried to take their own life by hanging and overdose but was found and treated. The deceased was under psychiatric care while on remand, and was also a known drug user.

Recommendations

To the Department of Corrections, Police, and Canterbury District Health Board:

- A review be completed of procedures to ensure timely (including electronic) communication of relevant information impacting on the health and safety of persons detained in [location] Prisons.

To the Department of Corrections:

- Until such time as all identified relevant information is available to assessors, a cautious approach be taken and a person be treated as at risk until a fully informed assessment can be completed.

To the Department of Corrections:

- A Perspex barrier be placed on the exercise yard side of the window in the cell where [deceased] completed hanging (to avoid the horizontal security bars being used as hanging points) and any cells where there are such bars and the windows are not used for ventilation.

NZ.2008.2868 Law Enforcement/ Mental Illness & Health/ Intentional Self Harm

The deceased was an inmate in the [location] Prison and had been put on hourly observation due to being a nuisance, however, no suicidal intention was observed. The deceased was then found hanging by the neck from a sheet that had been threaded through a piece of mesh above the cell door. The deceased had been diagnosed with schizophrenia and depression and is believed to have been on medication for this.

Recommendations

To The Chief Executive, Department of Corrections

The Chief Executive, [location] District Health Board

- I recommend a review be completed of procedures to ensure timely (including electronic) communication of relevant information impacting on the health and safety of persons detained in [location] Prisons

To The Chief Executive, Department of Corrections

- I recommend that persons held on remand and persons released from an 'At Risk' unit where self-harm was a factor for placement in that unit be held for an appropriate period in cells in which the door grill cannot be used as a hanging point.
- I recommend that an officer making a placement of a prisoner in a shared cell following an at risk assessment clearly record whether a further at-risk assessment is required, and provide an appropriate alert if, the cell ceases to be shared with another prisoner.

To the Minister of Corrections:

- I recommend that the Minister consider the introduction of legislation such that when a Coroner makes recommendations following the death of an inmate in prison a written response be completed by the person to whom or public statutory body or entity to which the recommendations are directed. That response must be not later than 3 months after the date of receipt of the recommendations, and must specify a statement of action (if any) that has or will be taken in relation to the recommendations made by the Coroner. A copy of that response should also be forwarded to the Minister (if the recommendation is not directly addressed to the Minister).

NZ.2009.2658 **Leisure Activity**

The deceased had been snowboarding with a sibling and had travelled outside the boundary of the [location] Ski Field before traversing an unmarked and out of bounds area of the mountains.

It appears that whilst travelling through the area, an avalanche has been triggered, enveloping the deceased in approximately 4 metres of snow. The deceased was found after a search involving dogs and RECCO device around 2.5 hours later but was not able to be revived.

Recommendations

At my request, a comprehensive investigation and overview was undertaken by [name], a very experienced and well qualified mountain and ski guide, with over 40 years knowledge of ski field and snow safety industry both in New Zealand and overseas (Senior Guide [name]). I paraphrase the recommendations made by Senior Guide [name].

- I recommend that the New Zealand Mountain Safety Council, the Department of Conservation, the Ski Area Association, Snow Boarder and Skier user groups and Local Authorities should liaise more closely to provide information and education for the public who use our hills and mountains for recreation. There is a general need for greater awareness of the risks by individuals who access steep snow slopes beyond Ski Area boundaries. Such persons must be educated in the risks and advised to adopt appropriate precautions and carry appropriate essentials - a beacon, a probe, a shovel, and not to travel alone.
- Senior Guide [name] advises that the New Zealand Mountain Safety Council is currently facing funding difficulties and, particularly, constraints to its avalanche advisory programme. In light of the fact that New Zealand (from the evidence of Senior Guide [name]) has the third highest per capita avalanche fatality rate in the world, it is essential that all appropriate precautions are taken, and I will ensure that a copy of this Finding is forwarded to the appropriate Ministers with my request that the necessary funding be continued.
- The recommendation of Senior Guide [name] is that the Ski Area Association New Zealand (SAANZ) Snow Safety Group should review signage and fencing of Ski Area operating boundaries during the current revision of the 2003 Ski Area Management Guidelines (SAMG) goes further than my recommendation. I recommend that Coronet Peak Ski Area enhance its signage and fencing specifically in the upper [location] area, which to the best of my knowledge, is the only ski lift accessible part of the mountain from which skiers and boarders are likely to go out of bounds. I suggest a double rope and a specific avalanche hazard warning.

Since considering evidence at the Inquest hearing I have conducted further research. My investigations have been assisted by Senior Guide [name]. We draw to public attention the availability of safety equipment which is appropriate for skiers and boarders to consider if skiing or boarding other than on a patrolled Ski Area.

- "Avalanche Floatation Devices"
These are self-contained balloon systems housed within a backpack. When caught in an avalanche the wearer can deploy the device by pulling a handle which activates the release of compressed air or gas thus inflating the balloon. This increases the volume of the wearer and helps to prevent burial in the snow.
- "The Avalung" or similar breathing devices allow the user/wearer to breath under the snow utilising a tube from the mouth which allows available air in the snow and pockets around the buried victim to be inhaled. Exhaled CO can be diverted.

Senior Guide [name] considers that (in spite of the cost of such devices) they will be in common use by regular off piste skiers and boarders within 3 to 5 years as a backup to avalanche beacons which are already in common use.

NZ.2010.577 **Leisure Activity/ Falls/ Physical Health**

The deceased was a tourist on a bus tour with approximately 30 other tourists. They went on a guided tour at the [location] Glacier. The tour party split into 3 groups based on fitness and ability on the ice. The deceased fell behind his group and struggled to fit through a narrow section of a crevasse. As the group continued to the next crevasse, he slipped over and became wedged in the bottom of the crevasse. The guides tried to free him using a rope and pulley system but were unable to do so. The deceased was not in a position for full CPR to be administered and he was unable to be resuscitated once he was free from the crevasse.

NZ.2010.577 *continued*

Recommendations

I make no formal recommendations, other than noting that [location] Glacier Guides has undertaken its own internal investigation and noting that the circumstances of a person's fitness to undertake a given activity will always be a matter of judgment. For a big person, such as the deceased, this was a fairly ambitious activity for them to be undertaking. That was a matter for the deceased's judgment as well as the guides who were with him.

A copy of my findings will be sent to those concerned, including the [location] Glacier Guides.

VIC.2008.1803 **Leisure Activity/ Water Related/ Fire Related**

A person died of injuries sustained from a boat explosion

Recommendations

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

I have considered the submissions made concerning the present regulatory framework for the licensing of leisure motor vessels and operators as well as the registration of ownership generally, in the State of Victoria.

I am informed that Marine Safety Victoria and Victoria Police have recently carried out a review, in connection with plans to amend the existing legislation. I am not aware of the results of that review and I do not believe that I should further comment on it, save for two matters of concern, which arise from the evidence before me.

The first matter of concern to me is that Marine Safety Victoria has argued in this inquest that the best way to ensure ongoing compliance with existing safety requirements is to maintain the Government's present emphasis on educating the public about the dangers involved in careless boating practice.

I note that this emphasis has apparently been maintained over many years in a climate where anecdotal evidence suggested that we have had an understaffed and under resourced Marine Police Unit, tasked to investigate and prosecute instances of regulatory non-compliance.

I have considered the concerns, which have been expressed about the numbers of suitably qualified persons presently available to carry out this work. See particularly the views expressed in the submission made by the Boating Industry Association Ltd. This evidence does not establish that the numbers of such vessels which are 15 years or older, is so great as would preclude the carrying out of this work.

I further recommend that a transitional provision might reasonably require such an initial 'fit for purpose' survey, be carried out within two years of the enactment of the amended legislation.

In the case of new vessels which have been produced as a class, the initial survey might, at the discretion of the Director of Marine Safety, be undertaken by the manufacturer under the broad supervision of Marine Safety Victoria personnel, this at the option of the owner and at the owner's expense.

Having regard to liability issues, I see little risk that such a survey will be compromised by a lack of independence.

I would simply observe that in my view a combination of enforced regulatory control supported by adequate policing and prosecution in appropriate cases, (together with ongoing public education), is far more likely to achieve the Marine Safety Victoria's objectives in this area, than that which has been secured under current arrangements.

- To this end, I recommend that the resources currently available to the Police Marine Units be reviewed and that going forward adequate resources be made available to Victoria Police to allow for an increase in the level of policing in this area.
- Having regard to all of the evidence, I also recommend that Marine Safety Victoria and Victoria Police Marine Division continue their campaign and further highlight the dangers involved in the use of petrol driven inboard motor cruisers, particularly following a period of disuse.

The second matter of concern relates to present arrangements in regard to issues of public safety pertaining to design and maintenance standards, of petrol fuelled inboard leisure vessels.

In my view, the evidence provided in this inquest reveals that the present arrangements pay insufficient regard to the need to establish enforceable parameters, which broadly standardise our approach to boat safety. An unintended result of this omission is that important and reasonable basic safety requirements have been compromised in a manner, which has created an ongoing threat to leisure boat enthusiasts.

VIC.2008.1803 *continued*

- 1) To meet this threat I recommend that the State of Victoria introduces legislation which will require that all non-commercial, petrol powered inboard motor cruisers, boats or other similar vessels, operated within Victorian waters, which are greater than 15 years old, be surveyed by a suitably qualified marine surveyor.¹⁶¹
- 2) I further recommend that all new non-commercial petrol powered inboard motor cruisers boats or other similar vessels be surveyed on first registration, and thereafter on each occasion that a change of ownership registration in respect of any such vessel is sought.

Where that is not possible or acceptable to either party or the Director, the initial survey should be carried out by a person approved by the Director, any of which class of persons should also be responsible for the survey of vessels which are 15 years or older, or (other) second hand vessels which are offered for sale.

A sale within 12 months of the last survey might be accepted as a reasonably proximate survey for the purpose of such a requirement.

If adopted these legislative changes would become part of wider requirements made of those seeking to register their vessels and also therefore form part of the guidelines provided to those entrusted by the Director with the responsibility of conducting surveys. By extension they would also become an integral part of the design process, in regard to vessels intended for sale to the Victorian market.

This recommended approval list at least in regard to how it applies to marine surveys, is not of course intended to be complete. Rather a full list of complimenting guidelines (for both designers and surveyor's consideration), should be determined by the Director following consultation between the Boating Industry Association, Surveyors Representatives, and Marine Safety Victoria. Other areas, which I would expect to see made a part of such guidelines include hull and superstructure, and mechanical and electrical systems.

The emphasis of such guidelines should be to ensure that basic safety standards are required to be met across all classes of petrol powered in board leisure vessels, having regard to reasonable industry views of what constitutes 'fit for purpose' and the financial implications of meeting same.

- 3) I also recommend that the State of Victoria introduce legislation to establish general design standards, which include as a minimum requirement for the registration of all petrol fuelled leisure vessels,
- that all engines and fuel delivery systems are maronised;
 - that petrol tanks are easily accessible and are capable of being cleaned and tested;
 - that petrol tanks have adequate venting to atmosphere outside the boat, by reference to volume;
 - that flammable fuel detectors are attached; and
 - that carburettors are properly fitted to drip trays with collected fuel directed to absorbent material which prevents fuel evaporation.

4) Further I recommend that such legislation make it an absolute offence punishable by the imposition of a significant financial penalty *'to own at sea, or to sell, rent, or take to, or to control at sea, any petrol driven inboard powered leisure vessel'*, which has not passed survey in accordance with these requirements.

5) To further support the interests of public safety I also recommend that the Boating Industry Association continue its work with Marine Safety Victoria, to set up an appropriate dealer accreditation programme.

In my view a useful model for that scheme would involve a consideration of the accreditation scheme currently applicable to traders in the new and used car industry and accordingly I recommend that approach.

NT.2009.73 **Mental illness & Health/ Law Enforcement**

The deceased suffered from mental illness and was apprehended by police following a welfare call. While being restrained after erratic behaviour, the deceased had breathing difficulties and passed away.

Recommendations

"I am encouraged by the fact that the Commissioner of Police...is continuously reviewing the use of Tasers to ensure that there is no abuse of this device. I recommend that police training in relation to the use of Tasers be such that police understand quite clearly that Tasers should not be used simply as a compliance tool and their use should only be considered in the most serious of circumstances."

NT.2009.73 continued

"I recommend the Commissioner to continue with his review of the use of Tasers and I consider the amendments proposed as set out in the evidence given by [police] to be appropriate. In particular, I note that Sergeant Hansen accepted that a further amendment that should be considered to the Good Practice Guide is an inclusion in relation to "target areas", which would include provision that the recommended point of aim be to the back when practical and that where such shots are not practical the point of aim should be to the lower centre of mass for front shots. I would encourage the Commissioner of police to consider such an amendment be included in any amendments proposed by police to their ECD Good Practice Guide in future."

NZ.2007.194 Mental Illness & Health/ Adverse Medical Effects

The deceased was found dead in the Mental Health Unit of [Hospital] after being given medication by hospital staff and going to sleep. She was unable to be roused. She had a long history of mental unwellness, the principal diagnosis throughout being schizophrenia, not otherwise specified. And was in hospital for a 14 day compulsory treatment under Section 29 (3) (1) of the Mental Health Act.

Recommendations

To: The Chief Executive Officer, Auckland District Health Board,

- That the Board take the necessary steps immediately to ensure that patients in its Mental Health Units receive at all times the same standard of medical care as patients in other Wards and Units.
- That the Board give favourable consideration to the implementation of such practical changes as may be recommended by the Clinical Director of [hospital], in the light of these Findings.

It is directed that a copy of these Findings be sent to the Chief Executive Officer, Auckland District Health Board; Director of Mental Health, Ministry of Health and Director of Area Mental Health Services, Auckland District Health Board.

NZ.2007.242 Mental Illness & Health/ Water Related

The deceased was on a compulsory treatment order to attend [location] Mental Health Services on a daily basis as an outpatient for a long standing diagnosis of Paranoid Schizophrenia. The deceased arrived at the Acute Day Centre and then ran from the Centre, with staff giving chase. Police were called the next day but no sign of the deceased was found. He was then located 19 days later in a creek on the Hospital grounds.

Recommendations

To: Police Superintendent, [location] Police District:

- That the Police, in conjunction with Capital & Coast District Health Board (C&CDHB), enter a robust Memorandum of Understanding to set out clear protocols in respect of the AWOL/missing person process so that immediate steps can be taken to minimise delays with a search process.

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

- That the CCDHB enter into a robust Memorandum of Understanding with the Police Districts that they are associated with to set out clear protocols in respect of the AWOL/missing person process so that immediate steps can be taken to minimise delays with a search process.
- That the CCDHB undertake a complete independent process of reviewing the AWOL process and the alignment of the myriad of ad hoc mental health facilities so that at any given situation there is an absolute communication demarcation. This may already include steps taken with the appointment of an access facilitator and patient safety officer, but an independent review may strengthen that process.
- Due to the extremely large reserve area around the [location] Hospital it is recommended that consideration of erecting a substantial boundary fence be investigated to partition off the bush surrounding area (perhaps this land may be superfluous to the hospital's needs and could be disposed of).

NSW.2007.4991 Natural Cause Death

The deceased was an elderly woman who lived alone and died of unascertained natural causes.

Recommendations (To Minister for Housing):

I recommend that the Housing NSW Tenant Connect program be re-funded at the conclusion of the current four-year program.

WA.2007.1678 Older Persons/ Natural Cause Death

An elderly patient died in hospital following a period of pulmonary oedema and aspiration pneumonia.

Recommendations

- The implementation of a diary system for families of residents.
- I would envisage it being a document which family members and visitors to a resident could complete as a separate entity from the progress notes.
- It would provide a comprehensive history to attending doctors as to individual circumstances and reasons for requests for doctors' appointments. Had the deceased's fracture been diagnosed prior to displacement, it is possible her prognosis could have been improved, although I am unable to say definitively the outcome would have been different.

NSW.2006.2957 Physical Health

The deceased died after from pneumonia and sepsis after being taken to hospital. The deceased was disabled and lived with family who were unequipped to deal with someone with disabilities.

Recommendations: (To the NSW Minister for Aging, Disability and Homecare (DADHC)):

That DADHC should give strong consideration to:

- Developing and implementing a policy to ensure that the disabled with complex needs living with family, particularly in remote areas, are allocated a caseworker who together with a General Practitioner and other service providers ensures that an annual health care plan is developed and met and all services co-ordinated.
- Reviewing and implementing the allocation of human resources to and within the Broken Hill office to ensure that case-workers are able to complete the currently required annual plans and three-monthly reviews and whether further training is required. This might include the appointment of Clinical Nurse Consultants to assist with health care plans and ensure on going case management.
- Implementing a respite care discharge protocol which requires that issues arising during respite care, including any health problems and their treatment or future treatment are communicated to the primary carer and the DADHC case worker, and a decision made as to who bears the responsibility for following up where necessary.
- Developing a protocol which could be incorporated in to the existing three monthly review for recognising 'flags of concern' (to include weight loss, pressure sores, absence from contact or refusal to accept services) in order that early consideration be given if necessary to an application to the Guardianship Tribunal.
- Providing urgently a protocol for managing prolonged staff absences including physiotherapist, occupational therapists, social workers, speech pathologists and dieticians, at least by the case manager advising all service users of the likely duration of the absence, seeking advice for alternative assistance from local hospital staff, and considering whether funding private access to allied health services might be provided.
- Promoting awareness among staff, patients and primary carers of the "Clinical Practices, Pressure Ulcer Prevention-Policy Directive-NSW Department of Health-PD2005_257" and of "Taking the Pressure Off-Wound Care Association of NSW Inc.-2008" guide.

Recommendations (To the Manager of [location] Clinic, [location] and to the General Secretary of the Nurses Association)

- In the same terms as paragraph (1)(f), that strong consideration should be given to promoting awareness among staff, patients and primary carers of the "Clinical Practices, Pressure Ulcer Prevention-Policy Directive-NSW Department of Health -PD2005_257" and of "Taking the Pressure Off-Wound Care Association of NSW Inc.-2008" guide.

Recommendations (To the Manager, [location] City Council)

- In the same terms as paragraph (1) (f), that strong consideration should be given to promoting awareness among staff, patients and primary carers of the "Clinical Practices, Pressure Ulcer Prevention-Policy Directive-NSW Department of Health -PD2005_257" and of "Taking the Pressure Off-Wound Care Association of NSW Inc.-2008" guide.
- Strong consideration should be given to developing a protocol and training for carers to recognise, and report to the case manager, 'flags of concern' (to include weight loss, pressure sores, absence from contact or refusal to accept services) and to recognise and have knowledge of the treatment of pressure sores including communication of that knowledge to primary carers.

NSW.2006.2975 continued

Recommendations (To the Minister for Health)

- That NSW Health be commended for its consideration of establishing specialised multidisciplinary teams, and recommended to give priority to the provision of the teams to regional areas with limited or no access to specialist services
- The Greater Western Area Health Service to consider consulting a wound care specialist in relation to the Area Health Service's policies and protocols in respect of:
- ◇ The assessment of pressure ulcer risk on admission to hospital;
 - ◇ The provision of care and treatment in order to prevent the development of pressure ulcers in hospital, including through the provision of pressure reducing equipment;
 - ◇ The treatment of pressure ulcers in hospital, including through the provision of pressure reducing equipment;
 - ◇ The documentation of steps taken to assess, prevent and treat pressure ulcers in hospital.

Reform of the Coroners Act

An issue arose during the course of the Inquest concerning the ability of a Coroner to make a non-publication order covering submissions relating to the question of referral of the papers 3 to the Director of Public Prosecutions under s. 78 of the *Coroners Act*. The clear policy behind various provisions of the *Coroners Act* is to ensure that the coronial process does not interfere with the future course of criminal justice: see, for example, sections 76 and 81(3). However, there is no express power to order non-publication of submissions made in relation to whether a known person may have committed an indictable offence. In some cases, the publication of such submissions could have real potential to cause prejudice to the future conduct of criminal proceedings. Such prejudice could impact on the case of either the Prosecution or the accused person.

Accordingly, I make the following recommendation to the Attorney General:

The Attorney General and New South Wales Parliament consider amending the *Coroners Act* by:

- Inserting the words „or any submission or any part of the proceedings“ after the word ‘evidence’ in s. 74(1)(b) of the Act.
- Adding the following paragraph to s. 76: ‘(d) any submissions by legal representatives or comments made by the coroner in relation to whether an Inquest should be suspended under s. 78’.

NZ.2008.1034 Sports Related/ Falls

The deceased was competing in the [location] Mountain Bike Race (Location) and took a tumble off the track during the latter part of the race. The deceased fell down a bank and landed in a position that meant that the airway was obstructed. The deceased was found 6 hours later but was unable to be revived.

Recommendations

My recommendation is to The New Zealand Association of Event Professionals, and Tile Department of Labour, and Bike NZ, and SPARC. I recommend that these organisations and organisers set up meetings and talk with each other and with off road event organisers to establish an industry safety standard or code of practice or protocol for off road events' incorporating the following requirements:

- A method of ensuring competitors have come off the course.
- Written instructions to be provided to marshals, including to radio back to Base any information passed onto them by competitors.
- A dedicated Safety Director to deal with enquiries about missing persons.
- The presence of a helicopter at all off road events (other than short ones and ones that have no means of being able to fall off a course) and to remain there until the event has finished and all competitors are off the course. I want to make it clear that this is *not* a recommendation for an air ambulance. It is for an ordinary helicopter to be present right through the event to be available able to do a sweep of the area to try to locate a missing person and to get first aiders as close as possible to injured people.
- Radio contact to be maintained between Base and officials out on the course until it is clearly established that all competitors are accounted for.
- Check points to be placed at numerous points along the course and at these places competitors should call out their race number, which is then written down and ticked off against the master list, and once all competitors have passed through that check point the information should be radioed back to base that the area is clear.
- A means by which potential participants can, if they chose to do so, obtain information about the terrain and its comparative difficulty level.

NZ.2008.1034 continued

I acknowledge that there will always be people who do not read the information provided, and many do not read through information in a waiver before they accept it, so consideration must be given to setting well-advertised, realistic, but reasonable, cut off times.

NZ.2009.650 Sports Related/ Physical Health

The deceased had entered a Mountain Biker Race, despite being on medication for heart related problems. The deceased got partway through the race, but then complained of chest, back and elbow pains. Despite medical treatment from passers-by, the deceased lost consciousness and could not be revived.

Recommendations

St John Communications take steps to ensure that call details are entered into the database as soon as possible.

- St John Communications, when faced with similar events requiring the allocation of rescue resources, conduct a more robust evaluation of competing priorities.
- The Police give consideration to the establishment of a formal process whereby advice from event organisers can be more accurately recorded and then accessed by rescue resources and services.
- Southern Communications Centre enhance its processes and procedures as a result of lessons learned from the tragic death of [deceased]; specifically the more accurate recording, cross referencing and tracking programmes mentioned in the evidence and a more accurate method of incident identification.
- That the 'adventure race' promotion and organisation industry cooperate to establish an Industry Standard - perhaps based on Sparc Publication "Risk Management of Events" and to otherwise address matters of mutual concern and interest to ensure the safety of participants in such events.

NT.2009.257 Transport & Traffic Related

A person died after a single car accident where the car hit a pine log barrier.

Recommendations

It is the opinion of the investigating officer that the use of horizontal pine log beams is unsafe. "The structures are commonly used to stop vehicles from entering grassed medians or road side verges. In many instances the horizontal beams run parallel to the roadway increasing the chance of penetration when a vehicle crashes." In February 2009 a similar accident occurred in Darwin where a female passenger was seriously injured when she was impaled by a pine log after the driver lost control of the vehicle. I recommend that the practice of using pine log barriers be examined by the relevant authorities, and that horizontal logs be removed and replaced, if necessary, with safer alternative barriers.

NZ.2007.926 Transport & Traffic Related

The deceased was riding a motorbike when they slid into a reinforced wire rope barrier at a connection point with the road surface after colliding with a barrier support. The deceased died at the scene of injuries sustained in the crash.

Recommendations

That the Minister of Transport considers whether the use of tinted motorcycle visors at night should be prohibited.

NZ.2008.3240 Transport & Traffic Related/ Youth

Youth hit a parked truck while riding a motorcycle. The deceased was wearing dark glasses at night, and a full face helmet with a tinted visor, which may have reduced visibility. The straps of the helmet worn were not secured. This resulted in the helmet coming off the deceased's head at time of impact.

NZ.2008.3240 continued

I recommend that publicity be given to the circumstances of the tragic death of [deceased], drawing public attention to the need for truck operators and truck drivers to ensure vehicles left on the street at night, in a position where they may cause danger to other road users, to ensure that they are adequately and legally illuminated.

- I draw to public attention the need for road users, motorists, motorcyclists and cyclists to take every opportunity to ensure that they have the best visibility available to them and not to drive or ride in the dark wearing dark glasses.
- Motorcyclists should always ride wearing a properly designed crash helmet securely fitted.

NZ.2009.1451 Transport & Traffic Related

The deceased, a tourist, had just arrived in New Zealand after a non-stop long trip. The deceased's partner was driving and due to fatigue, crashed into a lamp post causing serious injuries to the deceased, who died in hospital.

Recommendations

To New Zealand Transport Agency [location]

- I recommend that consideration be given to raising the testing standard for the prevention of loads displacement from the boot into the cabin of a vehicle during impact.
- I recommend also that NZ Transport Agency [location] promote a public awareness campaign on how to transport loads in the boot of a vehicle, including how and where to place items to try to avoid dynamic impacting and how to tie down items with ropes using the fixing lugs in the vehicle, which might keep the items in place during an impact.

NZ.2009.2299 Transport & Traffic Related

The deceased was a tourist who was the sole occupant of a vehicle that had a head on collision while driving on the wrong side of the road, with another vehicle. The deceased died on impact.

Recommendations

I recommend that a copy of this Finding be forwarded to New Zealand Transport Agency (NZTA) for its information. Issues arise in respect of driver licensing for New Zealand drivers on a restricted licence, licensing requirements for visitors from overseas whose licence in their home country may have expired, and the continuing problem of drivers from overseas driving their cars on the incorrect side of the road.

NZ.2009.2302 Transport & Traffic Related

The deceased was the driver of a car that was hit by a vehicle travelling on the wrong side of the road.

Recommendations

I recommend that a copy of this Finding be forwarded to New Zealand Transport Agency (NZTA) for its information. Issues arise in respect of driver licensing for New Zealand drivers on a restricted licence, licensing requirements for visitors from overseas whose licence in their home country may have expired, and the continuing problem of drivers from overseas driving their cars on the incorrect side of the road.

NZ.2009.2357 Transport & Traffic Related/ Drugs & Alcohol

The deceased had been drinking and seeing a speeding car, remonstrated in response by walking on the road. The deceased was then struck by a campervan, driven by a tourist.

Recommendations

Pursuant to section 54 (3) of the Coroners Act 2006, I endorse the recommendation of Senior Constable [name that the road controlling authority (Transit New Zealand) review the layout of [location] with consideration to design modification to draw motorists' attention to the need to slow (such as construction of pedestrian havens in the median strip at each end of the township, combined with curb extension adjacent to each raised haven to form a visual obstruction inducing traffic to slow).

- I recommend to the Senior Police Officer, [location] District, that where possible serious injury incidents be attended by more than one investigating officer; and Police response in such cases take account of probable outcome - in this case requiring the scene to be treated as a "fatal".

NZ.2009.2357 continued

I will recommend to the Commissioner of Police and the Chief Coroner that in fatal incidents involving overseas visitors, investigating Police closely liaise with the Coroner concerning the obtaining of evidence from such persons before their departure from New Zealand, with the possibility also of the Coroner convening an early inquest for the taking of evidence.

NZ.2009.836 Transport & Traffic Related

The deceased was a back seat passenger in a vehicle being driven by a restricted license holder. The car failed to take a bend, and slid into a yaw, striking a brick wall and slid sideways into a power pole. The deceased, who was intoxicated and not wearing a seatbelt was ejected and later died from injuries sustained from the crash.

Recommendations

To: [location] City Council, C/O [name] Transport and Green Space Unit Manager

- I recommend that the 45kph sign is moved so that it is clearly visible at night to those drivers unfamiliar with the road.
- I recommend that the lane limit on the western side of [location] is clearly defined

NZ.2009.2575 Transport & Traffic Related/ Leisure Activity

The deceased was a tourist who was on a South Island Tour that travelled by bus to each location. The bus has left the road due to icy conditions and rolled, with the deceased being thrown from the bus. The bus then landed on the deceased, sustaining fatal injuries.

Recommendations

I recommend that a copy of this Finding be forwarded to New Zealand Transport Agency (NZTA) in order that my comments on the wearing of seatbelts by bus passengers be the subject of an education programme.

NZTA could also continue with an oversight of road maintenance programmes. The phenomenon of black ice has caused the deaths of a number of road users in the past and continues to be a hazard about which continued vigilance is necessary.

NZ.2009.2776 Transport & Traffic Related/ Child & Infant Death

The deceased, had just arrived in New Zealand after a non-stop long trip. The deceased's grandfather was driving and due to fatigue, crashed into a lamp post causing serious injuries to the deceased, who died in hospital. The deceased was not in an approved child restraint.

Recommendations

To New Zealand Transport Agency [location]

- I recommend that consideration be given to raising the testing standard for the prevention of loads displacement from the boot into the cabin of a vehicle during impact.
- I recommend also that NZ Transport Agency [location] promote a public awareness campaign on how to transport loads in the boot of a vehicle, including how and where to place items to try to avoid dynamic impacting and how to tie down items with ropes using the fixing lugs in the vehicle, which might keep the items in place during an impact.

NZ.2009.3597 Transport & Traffic Related/ Work Related/ Drugs & Alcohol

The deceased was driving a Kenworth Truck that was attached to a maxicube trailer. The deceased lost control of the truck as it negotiated a sharp right hand bend with a 25km/h advisory sign and plunged 40 metres into a lake. The deceased had a background of extensive traffic offending and speeding and had traces of drugs in his system.

Recommendations

Questioning the merits of the fact that at the age of 22 [the deceased] was able to gain Classes 3F, 4F and 5F in a workplace training programme Constable [name] noted "This workplace training programme is still a current programme and considering that compared with other countries New Zealand has one of the highest incidents of roll-over and loss of control crashes involving heavy motor vehicles. I would recommend that prospective drivers be closely vetted and monitored before they are recommended for fast-tracking through the workplace training programme".

NZ.2009.3880 Transport & Traffic Related/ Older Persons

The elderly deceased had been driving when the car exited out of a 'loop road' quickly and slammed into a lamp post. It appears the deceased may have mistaken the brake and the accelerator. The deceased was not wearing a seatbelt, and died from injuries sustained in the crash.

Recommendations

Whilst it might not be applicable in this instance, it is recommended that the local authority consider the application of the Raptar (wrap around crash cushion) product to be placed around strategic power poles or trees that have a likelihood of vehicle impact.

NZ.2010.630 Transport & Traffic Related/ Falls

The deceased was standing on a flat tray attached to the rear of a tractor driven by the deceased's partner. The tractor and tray lurched and the deceased fell backwards off the tray, striking the head on the asphalt surface of the road. The deceased was transferred to hospital but passed away.

Recommendations

Prior to investigating [the deceased's] death I had not heard of a fatality or indeed accident occurring in similar circumstances. I had ridden on a tractor tray in similar ways many times and I had never thought of the particular dangers that might be associated with that. [The deceased's] death has caused me to reflect and reconsider. As a consequence I consider that publication and recommendation would be worthwhile.

A copy of this finding will be forwarded - as is routine - to the local media. In addition however, a copy will be forwarded to the New Zealand Farmer magazine - or if no such publication presently exists - any similar magazine published to the farming community. That would enable the editor of such magazine to give this finding such publicity as he or she thinks fit.

I recommend that any person reading the details of this decision, who is in the practise of transporting or being transported in similar circumstances to review this practice. It is clearly potentially dangerous - potentially fatal.

I do not intend to make any recommendation beyond that already recorded. This is probably a very rare occurrence.

NZ.2010.2016 Transport & Traffic Related

The deceased was riding a motorcycle along with another friend. They came to a line of stationary vehicles waiting to cross a single lane bridge. The deceased followed the riding companion up a side path alongside these vehicles, however when braking heavily, has slid into the rear left side of a stationary vehicle. The deceased has fallen from the motorcycle and was not able to be revived.

Recommendations

That the road authority responsible for [location] erect signs on this particular curve warning motorists that they may face stationary traffic around the corner.

TAS.2008.246 Transport & Traffic Related/Law Enforcement/ Drugs & Alcohol

A person died of multiple injuries after a car collided with a concrete wall. The car was involved in a police pursuit prior to collision, and the driver was intoxicated.

Recommendations

Notwithstanding the breaches of procedure, I find that the actions of police did not contribute to the death of [deceased]. I further find that this was not a death in custody.

Nevertheless, it is recommended that Tasmania Police ensure the protocols/procedures for police motor vehicle pursuits are at all times implemented and complied with and that existing officers be retrained in those procedures from time to time and all new officers receive such training. I make no recommendations to amend or add to the current relevant provisions of the TPM.

TAS.2009.301 & 308 Transport & Traffic Related/ Weather Related

Two people died as a result of a two vehicle collision on a road with patches of ice.

Recommendations

I am satisfied that a thorough and detailed investigation has been carried out into the deaths of [deceased] and [deceased] and that there are no suspicious circumstances.

The location of the crash site historically shows one other incidence of a loss of control type crash during wet and icy conditions. This collision resulted in property damage and occurred some 650 metres to the west of the subject crash location. The Department of Infrastructure Energy and Resources (DIER) have recorded two other crashes in the vicinity. There is no evidence to suggest strong patterns or trends of crashes occurring in this area.

I note that DIER has since erected warning signage in the locality advising 'Slippery When Frosty'.

I strongly recommend the implementation of strategies that can only assist in the management and prevention of future incidents occurring in this area by eliminating ice on this section of the roadway.

TAS.2009.437 Transport & Traffic Related

A person died while attempting to tow a vehicle free from the mud. The deceased was seated in the car at the time, and the towing equipment broke, smashing through the front windscreen and hitting the deceased in the head.

Recommendations

Having considered all the material before me I **recommend** the motoring public, particularly those using 4WD vehicles be made aware and reminded of the dangers of using snatch straps in recovery operations. ***It is important to correctly attach (following the manufacturers recommendations) the recovery strap to a motor vehicle. A standard tow ball or vehicle tie-down point is not designed for this purpose and may result in the strap or a vehicle component detaching from a motor vehicle and striking and seriously injuring or killing a person. Only attach the strap to a vehicle recovery point or device that is suitably rated for use with the strap.***

VIC.2010.410 Transport & Traffic Related

A non-Australian national visiting Australia for a holiday died of head injuries following a one vehicle accident on a country road.

Recommendations

- Tourism Victoria should distribute the publication Travel Safely in Australia airside at Melbourne Airport for the purpose of providing international visitors with safety information. Australia Pacific Airports PTY Limited and the Australian Customs and Border Protection Service should facilitate Tourism Victoria's distribution of safety information at this site.
- Tourism Victoria should develop a comprehensive safety strategy for international visitors to Victoria, involving other relevant State Government agencies and the tourism sector. The strategy should focus on international visitor safety from an 'all hazards' approach, including that of road safety. The strategy should provide for a regular review of the incidence and nature of injuries to international visitors to assist in the development and targeting of further initiatives
- Tourism Victoria should monitor the recent proposal in South Australia to provide safety information and visual safety messaging in all rental vehicles and to consider whether a similar initiative in Victoria would be appropriate.
- The Federal Department of Foreign Affairs and Trade and the Department of Immigration and Citizenship should consider ways to promote the distribution of the publication Travel Safely in Australia to international visitors prior to their entry into Australia.
- Tourism Australia and Tourism Victoria should ensure that safety information, such as the publication Travel Safely in Australia should be readily available in prominent links throughout their official tourism websites.

WA.2003.1140 & 1141 Transport & Traffic Related

Two persons died from injuries sustained in a helicopter crash.

Recommendations

I accept Civil Aviation Safety Authority (CASA) is the regulatory body and the Australian Transport Safety Bureau (ATSB) the investigatory body. However, any recommendation suggested to CASA in the form of the implementation of further regulation would be sent to the ATSB, as the investigative body, for consideration as to its reasonable implementation. It is frustrating the ATSB considers itself in a position of not being able to comment on whether or not a suggested recommendation is feasible, other than in the scope of implying they have already suggested it.

WA.2003.1140 & 1141 *continued*

Certainly publication of the relevant findings of ATSB investigations need to be well circulated in the flight industry to ensure all involved in modification and maintenance understand the importance of manufacturer recommendations.

As a non-expert, receiving expert input, I am of the view all the recommendations suggested are worthy of consideration by CASA.

In addition, in view of the importance of the basic, unavoidable, weight of a helicopter to its safe operation I consider the GMW of a helicopter should be displayed in a prominent position on the structure. Somewhere like alongside the fuel inlet on the main fuel tank. Whenever a modification is made to the helicopter which affects the GMW the displayed weight should be obliterated and replaced with the new applicable GMW in a conspicuous manner.

I understand work orders and engineering certificates as recorded in manuals are supposed to achieve the same outcome but believe something so crucial should actually be obvious at a glance when completing a task which also affects the weight and safe operation of the helicopter.

To move onto recommendations including those as suggested by counsel assisting, I am in agreement there should be recommendations as follows:

- CASA consider the prohibition of passengers being carried in Robinson R22 helicopters engaged in low flying operations.
- CASA consider prohibiting the carrying of non-crushable items in the under seat compartments of R22 helicopters engaged in low flight operations.
- CASA seek input from the ATSB as to the reasonableness of mandatory inspection of both yoke and clutch shaft attachments in helicopters operating at low height for evidence of fretting in view of the fact this seems to have been a factor in failure of the A166 component in an R22 in 1992, 2003 and 2005.
- CASA require all helicopters involved in low flying operations to display current GMW figures in a conspicuous position.
- ATSB continue to circulate relevant investigation findings to the industry to remind operators and maintenance engineers manufactures recommendations are made for sound technical reasons.

NZ.2007.1357 **Water Related/ Leisure Activity**

The deceased was with three other people who travelled in a small boat to go scuba diving. The deceased and a diving buddy commenced a scuba dive but the deceased failed to surface. The deceased's body was located on the sea floor the following day by the dive buddy who had gone back to search for the deceased.

Recommendations

[Police officer] listed the following recommendations that all dive industry and recreational divers should consider in the future. These were as follows.

- Ensure persons diving have dived recently and have appropriate skills for that depth and conditions.
- Ensure that buoyancy is checked prior to the dive to achieve neutral buoyancy.
- Ensure that divers plan to be on the surface at 50 Bar.
- All divers should remain together especially during the ascent even if it means holding on to one another.
- Ensure divers check their own and others equipment thoroughly.
- Do not dive with equipment that is suspect/ faulty.
- Ensure divers monitor their air contents gauges as well as their dive buddies
- Ensure divers monitor their depth and time
- Ensure divers have a plan if an emergency occurs during the dive.
- All divers should avoid diving to or close to their maximum limits which includes depth, time, and their experience.

NZ.2008.3329 **Water Related/ Leisure Activity/ Physical Health**

A tourist got into difficulties whilst scuba diving and failed to surface safely. The deceased was found after a dive without his mask or snorkel, and it appears that they may have panicked with the choppy surface conditions present. The cause of death was either drowning or an air embolism. The deceased was an obese person who had not dived in open water for over 5 years.

Recommendations

- I adopt the recommendations in the Police National Dive Squad Report and comment on these as appropriate within my Finding.

NZ.2008.3329 continued

- I recommend that [dive company] conduct a thorough audit of its dive equipment
- Although I cannot attribute equipment failure as being a cause of the death, or contributing as a circumstance of the death, it is of concern to me to note the observations by the Police Dive Squad that the Buoyancy Control Device (BCD) was either incorrectly assembled or that the wave action altered its position from its being in the sea overnight
- There is also a concern that the mouthpieces needed replacing due to holes
- It is of concern that the dive cylinder had a fault with the cylinder neck O-ring leaking tank contents
- I recommend that [dive company] and any dive operator in [location], observe the Police Dive Squad recommendation of Defense and Civil Institute of Environmental Medicine (DCIEM) tables as noted in its report.

NZ.2008.3934 Water Related/ Transport & Traffic Related

The deceased had been 4 wheel driving in a river bed (shallow water and gravel beds) with friends after drinking. The deceased's car got stuck and he phoned for help. Due to the remote location, weather conditions and intermittent phone reception, the police and friends were not able to find the deceased, who was later found face down in shallow water.

Recommendations

- I make no criticism of the Police in the way this incident was handled; the critical factor from the Police perspective was the lack of detailed information on [deceased's] location. Having said that, I consider that the Police may wish to consider whether further training should be given to Comms operators in an effort to prevent such deaths occurring in the future in similar circumstances.
- I therefore make the following recommendation:
- That Police consider reviewing their procedures with regard to Comms staff contacting the Search and Rescue Co-ordinator to discuss marginal situations such as existed in this case. This recommendation is directed to the New Zealand Police

NZ.2008.4231 Water Related/ Leisure Activity

The deceased, a tourist, was in a group of people riverboarding down the Kowarau River. The deceased got forced into some rocks because of the swift current of water, and became trapped underneath the water against the rocks. It appears that it was the middle of the body that was trapped for 20 minutes until the rest of the riverboarding party was able to release the deceased, who was taken to shore but was not able to be revived.

Recommendations

I concur with the findings of Judge Callaghan in relation to [deceased's] death and the findings and recommendations of the Department of Labour in its report and support the actions of the New Zealand Government in lopping compulsory registration and related initiatives to ensure best practice in managing risk within the adventure tourism industry.

NZ.2009.765 Water Related/ Leisure Activity

The deceased was collecting paua in the sea but lost footing on slippery rocks and was unable to gain safe ground. The deceased then drowned. The deceased was very fit and was a competent swimmer and lifeguard, but had recently been having problems with balance due to his ears.

Recommendations

- I recommend that a copy of this Finding be forwarded to The Order of St John and to Southern Communications drawing to the attention of those organisations the need for early recognition to be given to available rescue resources. The availability of helicopter and appropriate medical support in regions needs to be constantly updated so that the most appropriate support is tasked to an incident.
- I adopt the recommendations in the Dive Squad Report: "The following are recommendations for free divers:
 - ◇ Ensure persons dive with a dive buddy.
 - ◇ Do not enter the water in adverse conditions.
 - ◇ Wear fins while free diving.

NZ.2009.765 continued

- ◇ Use a weight belt with a quick release buckle.
- ◇ If in difficulty on the water surface abandon the weight belt and catch bag early before the situation manifests or gets out of hand.
- ◇ Carry a knife
- I recommend that a copy of this Finding be sent to Water Safety New Zealand, the National Diving Coordinator, Occupational Safety and Health, and Dive New Zealand Magazine to ensure that publicity is given to the circumstances of the death so as to comply with my obligations under section 57(3) of the Coroners Act 2006.

NZ.2009.1624, 1789 & 1790 Water Related/ Leisure Activity

The three deceased friends had been on a fibreglass fisherman’s vessel that struck a submerged object while travelling at high speed. All three deceased, who were not wearing life jackets or carrying personal location beacons, were thrown into the water and drowned.

Recommendations

- I endorse the recommendations made by Maritime NZ. I recommend to Maritime NZ through the National Pleasure Boat Safety Forum (NPBSF) that the list of matters to be promoted through the recreational boating community including:
 - ◇ the importance of using the clip and lanyard system associated with the emergency stop switch.
 - ◇ the safe use of lifejackets/Personal Floatation Devices
 - ◇ the correct methods for in-water survival techniques
 - ◇ the steps that can be taken to reduce the effects of hypothermia
 - ◇ the need to be prepared for any emergency situation
 - ◇ the need to carry several forms of communication.
- I endorse the proposal of the NPBSF that the carriage of appropriate communications equipment be mandatory on recreational craft, and that lifejacket wearing be made mandatory for recreational craft less than six metres unless the skipper authorises them to be taken off at times of very low risk

The inquest also highlights the particular dangers of glacial-fed waters often characterised by high sediment concentrations, giving an opaque or milky appearance reducing visibility and obscuring potential hazards. This observation applies also to other glacial-fed lakes such as [location]. I recommend that the controlling authority, Environment [location], highlight this feature to recreational users in such manner as it considers appropriate.

NZ.2009.1886 Water Related/ Leisure Activity

The deceased and a friend went kayak fishing using a kayak that was damaged. They did not have any lifejackets, flares or signals for help, and only one paddle. The kayak began taking water, and subsequently overturned. The deceased was a poor swimmer and became separated from the friend. The deceased was found lying on the sea bed deceased. The cause of death was drowning with massive tissue loss due to shark bites and massive blood loss.

Recommendations

Putting aside the involvement of the shark, this death may have been prevented if the two individuals had taken greater safety precautions before setting out on a fishing trip on a kayak. Whether or not [the deceased] would have survived the swim had they been wearing a life jacket is a moot point, as they may still have been attacked by a shark. Nevertheless, wearing a life jacket while on the ocean in a kayak has to be a very basic safety requirement. If in fact [the deceased] drowned before being attacked by the shark, then a life jacket may well have saved their life.

NZ.2009.2773 Water Related/ Leisure Activity

The deceased had been fishing from a stone wall at the [location] river mouth. One of the rods ended up in the water and the deceased jumped into the water to retrieve it. The rod could not be found and the deceased could not get up onto the rocks to get out of the water. Despite the deceased’s brother trying to help the deceased get onto the rocks using fishing line, and later jumping into the water himself and accessing help, the deceased could not be revived. The deceased had smoked marijuana prior to going fishing.

NZ.2009.2773 continued**Recommendations**

Since the tragedy steps have been taken to improve safety and help avoid tragedy at the river mouth. [name], one of the people involved in [the deceased's] rescue, took the initiative by putting a case to the [location] Community Board in November last year asking that a life buoy be installed. A life buoy has been installed beside the danger warning sign on the approach to the [location], and an emergency push button phone has been installed at the surf club to enable people to summons emergency services directly from the beach. This initiative has been paid for by the [location] District Council, the [location] Boat Club and the [location] Community Board.

I consider that the installation of the life buoy and the phone should go some way towards avoiding drowning at the beach in the future, and I note the issue has been raised that the buoy may be more effective if it is closer to the [location]. I will refer that issue to the [location] District Council to investigate. In the circumstances though, I make no other recommendations.

NOTE: Due to a number of cases where the deceased had died in a spa park in NZ, the Coroner held a joint inquest with combined recommendations**NZ.2008.2509 Water Related/ Leisure Activity**

The deceased, a tourist, died while at a popular swimming hole. After bathing in the thermal area, the deceased and a friend entered the main river but were caught in a current and swept further into the river flow. Despite efforts to save the deceased, they disappeared beneath the surface and drowned.

NZ.2010.1387 Water Related/ Leisure Activity

The deceased had gone to the spa park with a friend and the friend's siblings, after drinking heavily the night before. The deceased and his friend swam out to the middle of the river, where the deceased began panicking and went under the water. Despite the fact that the friend and a passer-by jumped in to the river to pull the deceased from the water, the deceased was unable to be revived.

NZ.2010.1485 Water Related/ Leisure Activity

The deceased and 11 friends were swimming in the Waikato River. There were drifting from near the [location] Bungy to the hot water stream at Spa Park. The deceased disappeared and was then found by [location] Coast who had been called.

Combined recommendations

- I recommend that the work of the River Safety Committee continue.
- The installation of signs by the [location] District Council continue forthwith.
- The Council liaise and continue to liaise with St John to see whether it is feasible to build the signs into the mapping system in some way, either with the GPS location or a numbering system.

TAS.2010.58 Water Related/ Leisure Activity

A person died from drowning as a result of a boat overturning while on a boating trip.

Recommendations

This tragic accident highlights the need for all boat owners and their passengers to consider if wearing a PFD1 classification of this type of manual inflation vest is suitable for them as they offer no protection to persons in the water who are unconscious or unable to activate them due to injury or other circumstances. It also highlights the need for a skipper, before setting off on any recreational vessel that is carrying passengers, to conduct a safety brief to the passengers about the safety equipment being carried or worn and advising them what to do in the case of an emergency.

I find the skipper of the vessel was not at fault at the time of this incident. However the incident highlights that at times when weather conditions are marginal, as a general rule when considering whether to venture out one should err on the side of safety. The boat was considered to be sufficient in size and in good condition. The skipper was considered experienced enough to handle the conditions under normal circumstances, by all accounts the wave that capsized the boat was unusually large and appeared unexpectedly. However boat owners must be aware that the sea is rarely constant or consistent and that there is always variation which in rough conditions can account for large unexpected waves.

NSW.2007.6226 Work Related

The deceased died of Acute Necrotising Pulmonary Disease, probably Goodpasture's Syndrome, which manifested itself while they were working as a shearing hand.

Recommendations (To Workcover Authority of NSW)

- I recommend that the Workcover Authority of NSW produce and disseminate through appropriate sheep industry bodies, such as the Shearing Contractors Association, the Australian Workers' Union, the Farmers' Federation of NSW, Farmsafe NSW, Farmsafe Australia and rural TAFE Colleges, an industry alert or fact sheet incorporating the content of Section 12 of the Workcover Health and Safety at Work (2002) Guide for the shearing industry in relation to Emergency Response and First Aid.
- I recommend that the Workcover Authority of NSW consider regulating to require owners of active sheep shearing sheds to display signs outlining emergency response procedures and the location of first aid kits and emergency communications.

Recommendations To Shearing Contractors Association of NSW, Farmsafe NSW, Farmsafe Australia, the NSW Farmers' Federation and Australian Workers' Union

- I recommend that the Shearing Contractors Association of NSW, Farmsafe NSW, Farmsafe Australia, the NSW Farmers' Federation and Australian Workers' Union advise shearing contractors of the desirability of training at least one member of their teams in the provision of First Aid, and of the need to alert members of their teams as to the locations of First Aid facilities and to identify to all members of their teams a means of communication with emergency services in the event of emergencies.

NZ.2007.1154 Work Related/ Transport & Traffic Related

The deceased was driving a forklift on the open road from one work site to another work site. The forklift rolled and the deceased was trapped under the roll over protection structure and died at the scene. The deceased had not been wearing a seatbelt.

Recommendations

- That [company] ensures that its policies on forklift use are in accordance with the "Safety Code for Forklift Operators" and the "Approved Code of Practice for Training Operators and Instructors of Powered Industrial Lift Trucks (Forklifts)" both published by the Department of Labour.
- That the Department of Labour conducts a workplace visit to [company] to ensure that the company has effective health and safety systems in place in relation to issues identified in this inquiry, and to provide information and advice in this regard, if required.
- That the Department of Labour and New Zealand Police finalise an updated Memorandum of Understanding in respect of the administration of health and safety legislation, together with an Operational Agreement made under that Memorandum, to replace the Memorandum and Operational Agreement that expired in June 2007.

NZ.2008.2459 Youth/ Weapon

Youth was shot accidentally at close range in the chest by another youth. Both youths were not licensed gun owners and had taken the deceased's father's guns in order to go rabbit hunting. The gun was accidentally discharged while it was being loaded.

Recommendations

That Parliament consider the review of the law around the careless use of firearms to provide for a range of charges to reflect the circumstances of usage, perhaps establishing a higher charge of Dangerous Use as well as that of careless use and perhaps further consideration of a strict or absolute liability.

I direct that a copy of this decision be given to the Minister of Justice for the above consideration.

NCIS - FATAL FACTS WEB TOOL CATEGORY TAGS

CATEGORY TAG	DESCRIPTION
Adverse Medical Effects	Adverse after effects from a recent medical or surgical treatment, failure to comply with medical advice
Aged Care	Incidents that occurred in an Aged Care or assisted living facility or residence including a retirement village
Animal	Incidents where the an animal was involved in the cause of death.
Child & Infant Death	Any case involving a child or infant - 12 years old and under
Domestic Incident	Fatal incident that occurred as a result of domestic injury or event
Drugs & Alcohol	Death where drugs or alcohol or both were a primary or secondary cause of death
Electrocution	Cases where electrocution is the primary cause of death
Falls	Incidents where a fall was involved in the circumstances or cause of death
Fire Related	Incidents where a fire was involved in the circumstances or cause of death
Geographic	Cases where the geographic region is significant to the cause of death eg - remote location
Homicide & Assault	Includes interpersonal violence and family domestic violence
Indigenous	Cases related to a specific demographic group
Intentional Self-Harm	Cases determined ISH by coronial investigation
Law Enforcement	Includes police pursuit, death in custody, parole issues, pending or previous court cases including family court, restraining order and coronial investigation procedures.
Leisure activity	Any leisure actively that directly influence the circumstances including holiday activity or location
Location	Cases where the location of either the incident or the discovery of the body is of significance, does not refer to geographic location
Mental Illness & Health	Incidents where the existence of mental illness issues were involved in the circumstance on death, both diagnosed and anecdotal. Please note mental health is included as a contributing factor to death at the discretion of the Coroner.
Misadventure	Risk taking behaviour such as train-surfing, unintentional drug overdose
Natural Cause Death	Cases where the death is due to natural causes
Older Persons	Cases related to a specific demographic group or where the age of a person was a factor in the death.
Physical Health	Cases where the existing physical health of the person contributed but were not necessarily cause the death
Sports Related	Cases where a sports incident significantly impacted the cause of death.
Transport & Traffic Related	Cases involving road, water and air vehicle incidents, motorised or naturally powered. Also include cases where pedestrians are impacted by transport vehicles.
Water Related	Includes swimming, scuba, snorkelling, boating, fishing and all water related activity in both a recreational or commercial context
Weather related	Cases where the environmental conditions such as heatwave or storm conditions were significant to the cause of death
Work Related	Includes cases where work is related to the death and also where unemployment is significant
Weapon	Cases where the involvement of a weapon is significant
Youth	Cases related to a specific demographic group