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

Reportable Deaths

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

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

For more information about the differences in reportable deaths between jurisdiction, please visit our website.

Fatal Facts Search

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

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

Disclaimer: The précis of coronial findings detailed within this publication have been produced by NCIS staff, with the best efforts made to accurately summarise the circumstances, findings and recommendations made by the coroner in each case. Despite this, it should be noted that they are not authorised summaries or exact replications of coronial findings. The original finding should always be accessed for formal reference.
In this Edition

*Fatal Facts Edition 30* includes cases where the coronial investigation is complete and where the Coronal Finding contains recommendations. Edition 30 includes cases that were closed between 1 July and 30 September 2011. *Fatal Facts* contains a précis of case circumstances and of the coronial recommendations. It is produced by the staff at the NCIS. Every effort has been made to accurately summarise the case circumstances and findings. Despite this, it should be noted the summaries are not authorised or exact replications of the coronial finding. The original finding should be accessed for formal reference.

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

*Fatal Facts Edition 30* contains summaries of cases where recommendations were made as part of the formal coronial finding. Of these cases, 85 are Australian cases and 51 are New Zealand cases.

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

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

What is a Coronial Inquest?

An inquest is a court hearing into a single or multiple deaths. The role of a coroner is to identify the deceased person and the circumstances and causes of that death. An inquest is an inquisitorial process to establish why a death occurred. Once the coroner has heard all the evidence, he or she will write a finding. A finding may include recommendations to a Minister, public statutory authority or entity to help prevent similar deaths.
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NSW.2006.6068  Adverse Medical Effects
The deceased died from undiagnosed and untreated faecal peritonitis after being discharged the day before from hospital. Clinicians diagnosed the deceased as ‘drug seeking’ when presented to hospital asking for stronger pain relief.

Recommendations:
To Minister for Health

- I recommend that [location] Local Health Network consider installing a CT scanner at [location] Hospital.

NSW.2007.820  Adverse Medical Effects
An elderly person died of lignocaine toxicity after being given lignocaine-soaked gauze pads to bite down on to stop bleeding gums after extraction of teeth.

Recommendations:
To Minister for Health and Justice Health:

- That the attached [location] Hospital protocol relating to management of the treatment for post-dental extraction bleeding and the bulletin “Co-Phenylcaine Forte spray” (both documents attached) be provided to all hospitals within NSW with a view to the publication of the contents amongst clinical staff

To the Health Care Complaints Commission:

- That the professional conduct of Dr [name] and Registered Nurse [name] be considered for its appropriateness.

NOTE: Due to two cases of similar circumstances, where the deceased were elderly patients who were delivered medication without ventilator support, the Coroner made combined recommendations for both cases, despite holding separate inquests.

NSW.2007.6277  Adverse Medical Effects/ Older Person
An elderly person died in hospital as a result of two types of medications being delivered intravenously without ventilator support.

NSW.2007.6277  Adverse Medical Effects/ Older Person
An elderly person died in hospital as a result of the administration of Atracurium delivered intravenously without ventilator support

Combined recommendations
To NSW Department of Health

- A NSW Health Safety Notice be issued warning all medical practitioners and nursing personnel of the potential negative side effects of neuro-muscular blocking agents and that those agents should not be used without appropriate ventilator support
- Take steps to promote the exercise of access by Visiting Medical Officers (VMO) to such services and advice as are available from Clinical Nurse Consultants (CNC) and Clinical Nurse Specialists (CNS) in the field of palliative care in general and pain relief in particular. Those steps should include the monitoring, on an annual basis, of the use of those services throughout the State in non-metropolitan hospitals, which principally rely upon General Practitioners as VMOs for the provision of medical services.
- That the Department of Health undertake a review, in conjunction with the NSW Nurses’ Association and other industry participant groups, of the support processes for whistle-blower staff.
- That the Department of Health reviews education and training programs for health professionals and support staff with a view to ensuring that there is a significant emphasis and focus upon
  - Their role as advocates for clients of the health system
  - The role of each person when a complaint has been made
NSW.2007.6277 & 6278 continued

To [location] Area Health Service

- Take steps to ensure that the Executive Director of Medical Services for [location] Health Service monitors the attendance of VMOs at weekly meetings with Health Service Managers at [location] Health Service hospitals, and that if the attendance of VMOs at such meetings is unsatisfactory, such unsatisfactory attendance be dealt with by way of VMO performance reviews, at least annually.

NSW.2008.4183

Adverse Medical Effects/ Physical Health

The obese deceased died of multiple system organ failure two days after presenting at the Emergency Department with severe thigh pain. The cause of the pain was misdiagnosed and his treatment was compounded by errors, delay and failure to properly monitor and detect blood loss.

Recommendations

- Where practicable, all patients presenting to the Emergency Department at [hospital] are weighed. If the patient cannot be weighed, and an estimate recorded, the patient’s medical record should contain a clear notation alerting all staff to the fact that weight has been estimated
- Training is conducted at [hospital] so that nursing staff are aware of the availability of bariatric scales to weigh obese patients and how those scales are to be utilised. That training should include emphasis of the requirement to weigh all patients or, where impracticable, properly record estimated weights
- An information sheet is developed to be provided on discharge from the Emergency Department to all patients who are to receive outpatient anti-coagulation therapy provided by Community Acute Post Care Service (CAPAC). The sheet should contain:
  - Confirmation that the patient will be contacted by CAPAC to arrange a home visit
  - Confirmation that instructions in relation to prescribed medications (i.e. Clexane and Warfarin) will be given by the CAPAC nurse on the first home visit (and no medication is to be taken until those instructions are provided);
  - What action(s) the patient should take in the event that the patient develop certain (specified) symptoms, and
  - Whom the patient should contact (with relevant telephone numbers) in the event that the patient develops these symptoms
- Consideration be given to the development of an induction programme to emphasise the requirement for medical staff to note the times of their attendance upon patients
- Audits are conducted every three months of a reasonable sample of medical records to identify if proper record keeping is being maintained by staff (including the provision and copying of discharge letters, recording the time of examinations and recording investigations, treatment and the provision of medication)
- The new ‘Subcutaneous Enoxaparin Protocol’ developed by the [hospital] and adopted by [Area health service] be further reviewed to make clear if the protocol differs in relation to patients being treated in the community by CAPAC or in hospital and if risk assessments should be conducted in relation to morbidly obese patients
- [Hospital] give consideration to the development of an automatic policy of contacting a haematologist if a patient has a bleeding complication associated with the administration of Clexane.
- [Hospital] review the training programs and materials (including those provided by sales representatives) for the education of nursing staff with respect to Vacuum Assisted Closure (VAC) therapy and monitoring to ensure that nursing staff are conversant with the requirement for, and frequency with which, VAC drains should be monitored, and the parameters within which medical staff should be called to review a patient in the event of excessive drainage.
- [Hospital] give consideration to the development of a dedicated VAC dressing chart like that used at Northern Sydney Area Health and at the least, amend the operative report currently in use at [hospital] to make provision for the operating surgeon to document:
  - The settings for the VAC drainage
  - The frequency with which monitoring is required; and
  - The parameters within which medical staff should be contacted
- A directive be issued to all surgical staff at [hospital] to ensure that post-operative instructions in relation to VAC dressings are clearly recorded until new charts are devised
- [hospital] give consideration to the introduction of a system whereby patients who miss medical review at ‘wards rounds’ receive medical review within a reasonable period and at the least, are seen by a doctor within 6 hours.
NSW.2008.4183 continued

- [Hospital] require that trainee sonographers provide, as a condition of employment, a binding statement of intent to enrol in a suitable course leading to the Diploma of Medical Ultrasound (DMU) qualification or other recognised qualification:
  ◊ Within six months of commencing the traineeship if the employee is in a full-time position; and
  ◊ Within twelve months of commencing the traineeship if the employee is in a part-time position
- That all other proposed changes, recommendations and audits proposed by Prof [name] in his statement to this inquest are supported by the [Area health network] and implemented as soon as possible

NZ.2008.232  Adverse Medical Effects

A person died in hospital from a total bowel infarction after surgery for an enlarged gall bladder

Recommendations
I recommend that a copy of this Finding be forwarded to the [location] District Health Board [location] Hospital for the information and education of its clinicians.

NZ.2009.1146  Adverse Medical Effects/ Older Persons/ Physical Health

An elderly person died after a cancer biopsy procedure, when the needle inserted nicked a small artery in the lung and a haemorrhage formed. The surrounding tissue was made fragile by the advanced state of her cancer.

Recommendations
I recommend that a copy of this finding be forwarded to [hospital]. Although all of correspondence has already been forwarded to the hospital, it is appropriate, for training and educational purposes, for two additional observations to be made:

- When considering any procedure, the risk-benefit must be closely analysed. With patients of advanced age, clinicians should note that, even with the confirmed diagnosis, treatment options may be compromised
- Although not strictly a ‘circumstance of the death’ the facts surrounding the death of the deceased do indicate that there could be enhancements to the obtaining of informed consent for procedures

Those clinicians performing the Computer Topography (CT) guided Fine Needle Aspiration (FNA) should have the circumstances of the death of the deceased drawn to their attention

QLD.2009.8560  Adverse Medical Effects/ Natural Causes/ Physical Health

An elderly person died in hospital of multiple organ failure. The deceased suffered from a number of ailments including motor neurone disease and chronic kidney disease and presented at the hospital with sudden severe pains in his lower limbs. Despite the Deceased’s GP speaking to the hospital, the hospital failed to treat the deceased quickly enough, and the deceased suffered irreparable organ damage.

Recommendations
The Health Quality Complaints Commission (HQCC) did however consider that there were matters of concern in reviewing the care of the deceased. They made the following recommendations:

- [location] Hospital review the frequency of emergency centre doctors providing temporary cover for patients admitted to [location] hospital. Based on these results, [location] hospital to determine whether a review of admission policy and criteria for temporary management of patients is required
- The hospital ensure nursing staff clearly document in the patient’s medical chart any occurrences and interactions regarding clinical management disagreements raised by family (such as incident with Dr [name])
- The hospital ensure nursing staff clearly communicate with the treating clinician specifically in relation to changes in a patient’s fluid intake, output and hydration status when experiencing multiple co-morbidities
- The hospital ensure nursing and medical staff clearly document all clinical reviews and notations in a patient’s medical chart, including the date and time of all notation

The HQCC is monitoring these recommendations which the hospital has accepted

The Coroner has reviewed these recommendations and considers they are appropriate and notes with approval the monitoring function performed by the HQCC in this regard.
SA.2007.563  Adverse Medical Effects/ Natural Causes
A middle aged person died of a myocardial infarction after having been discharged from hospital the day prior for chest pain.

Recommendations
I recommend that the Department of Health reissue instructions to all medical staff working in country hospitals that:
- The requirements and protocols set out within the Integrated Cardiovascular Clinical Network South Australia (ICCnet SA) management of Chest Pain/ Suspected Acute Coronary Syndrome Guideline should be strictly adhered to and, in particular, that staff should be directed to strictly adhere to the requirements of the low risk protocol and;
- That regardless of whether the low risk protocol criteria are satisfied, medical staff should only discharge patients where there is in existence an alternative explanation for their chest pain and where that explanation has a high degree of certainty.

SA.2008.1616  Adverse Medical Effects
A person died of pneumococcal meningitis which was not diagnosed in hospital. The deceased had a severe ear infection prior to hospitalisation, and his son had recently had meningitis.

Recommendations
I recommend that the Minister for Health bring to the attention of the Chief Executive Officer of all public Hospitals the [location] Medical Centre protocol of March 2010 relating to Ear, Nose and Throat (ENT) patients with suspected meningitis. I further recommend that the Chief Executive Officers of all public hospitals give consideration to the issue as to whether such a protocol should be employed in each such hospital.

SA.2008.1704  Adverse Medical Effects/ Natural Causes
A person died of cancer that originated from a melanoma on the sole of his foot which was not diagnosed by doctors until it was too late.

Recommendations
- That the Australian Health Practitioner Regulation Agency draw to the attention of the medical profession and the podiatry profession the need to medically review and re-evaluate the diagnoses of foot ulcers that fail to heal within an expected time frame;
- That the Australian Health Practitioner Regulation Agency and the Australian Medical Association (SA) draw this matter to the attention of the wider medical and allied health professions for the purposes of education;
- That the Minister for Health and the responsible person at [location] Hospital give consideration to establishing a multi-disciplinary clinic, such as those that exist in the Lyall McEwin Hospital, the Royal Adelaide Hospital, the Queen Elizabeth Hospital and the Flinders Medical Centre, that is designed to manage, treat and properly diagnose foot ulcers in a timely manner;
- That the Minister for Health give consideration to the establishment of the role of a ‘patient advocate’ within the public health system to promote better communication between patient’s family members and clinicians and to avoid tension between the wishes of a patient’s family members and the clinical opinions and judgments made by medical practitioners responsible for the patient’s management.
NOTE: Due to two cases of similar circumstances, where the deceased died as a result of a perforation during a laparoscopic procedure, the Coroner made combined recommendations for both cases.

**SA.2008.1735  Adverse Medical Effects/ Older Person**
An elderly person died as a result of multi-organ failure due to overwhelming sepsis from a perforation of the colon sustained during a laparoscopic gynaecological procedure.

**SA.2009.1146  Adverse Medical Effects/ Older Person**
An elderly person died as a result of a brain haemorrhage following treatment for a perforation of the small bowel sustained during a laparoscopic gynaecological procedure.

**Combined recommendations**
- That the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) consider promulgating a requirement that members and Fellows of the College who profess to have the competence to perform, and who do perform, abdominal vaginal prolapse surgery of the kind with which this Inquest is concerned, demonstrate to the College that they have the necessary training, experience and competence to perform such surgery safely and that they demonstrate this by way of examination. Such a demonstration should include convincing evidence that the practitioner is able competently to perform a proper risk assessment in respect of the nature of the surgery to be performed that should include consideration of risk posed by the presence, or potential presence, of adhesions within the abdomen and consideration of whether a drain should be placed following abdominal surgery, particularly where diathermy has been used to divide adhesions. The practitioner should also be required to demonstrate that he or she has the necessary skill to competently perform the repair of an injured bowel if necessary;
- That RANZCOG consider promulgating a requirement that members and Fellows of the College who profess to have the competence to perform, and who do perform, abdominal vaginal prolapse surgery of the kind with which this Inquest is concerned, obtain a Certificate of Urogynaecology from RANZCOG;
- That the Australian Health Practitioner Regulation Agency and the Australian Medical Association (SA) draw these findings and recommendations to the attention of the wider medical profession.

**TAS.2009.294  Adverse Medical Effects**
A patient died undergoing a revision of a lap band surgery after complications with the band and a fatty liver resulted in internal bleeding. Due to the deceased’s religion, clinicians were unable to administer a blood transfusion.

**Recommendations**
No criticism should be made of [the deceased and husband] for their choice of religious faith. However, as baptised Jehovah Witnesses (JW) they were obligated by their religion to abide by its doctrine that forbid the ingestion of blood or blood products. Their compliance with this doctrine has had the most tragic consequence. I accept that this doctrine has been an entrenched principle of the Jehovah Witness religion since 1945 despite considerable debate and that the prospects of it being abandoned or at least moderated are remote. Nevertheless, [the deceased’s] death most graphically illustrates the consequence of the rigid adherence to that doctrine and brings me to recommend, perhaps forlornly, that the Jehovah Witness Governing Body and its elders give consideration to a relaxation of its doctrine concerning blood so that any member confronted with an unexpected medical emergency is permitted access to all life-saving treatments without breaching the rules of their faith and attracting punishment including shunning.

The [hospital] convened a Serious Incident Panel to investigate the circumstances of [the deceased’s] death. [Name], a vascular surgeon and the [hospital’s] Medico Legal Coordinator for Clinical Services reports that the panel made five recommendations as a consequence of [the deceased’s] death. Those recommendations and [name’s] comments upon each follow:
- Standardisation of a consent form for patients who are identified as JW’s with specific forms for children and adults.

A consent form for patients who refuse blood products including JW’s, has been developed.

This has been a collaborative effort by the Legal Unit Department, the Department of Anaesthetics and the Pathology Department (haematology).

This has been a difficult area as there are a number of different and complex blood products that can be given to patients. Unfortunately, there are some products that are acceptable to some JW patients that are not acceptable to others. There are also some products which contain human blood products but this is not obvious. The consent form thus needs to be exhaustive and complete.
TAS.2009.294 continued

- Standardisation of comprehensive screening tool incorporating review by a haematologist for patients identified as JW with a separate tool for adults and children.

Patients identified as JW's who are admitted for elective surgery will be identified by a modification to the current request for admission form.

Once these patients have been identified they will receive a copy of the patient information sheet and consent form covered above. When patients attend the pre-assessment clinic prior to their surgery, they will be categorised into one of three groups:

- Risk or non-existent risk, e.g. cataract surgery, minor skin lesions, hand surgery under tourniquet. No further action will be required for these patients.
- Small risk of major bleeding but anticipated blood loss less than 500 ml i.e. major bleeding not likely to occur for that particular surgery, e.g. any intra-cavity procedure such as minor laparoscopic procedures, shoulder surgery, thyroid surgery. These patients will be asked to sign the above consent form. During this consenting process the risks and benefits of blood products will be explained to the patient by the anaesthetist and specific details of what the patient would accept or not will be documented.
- Anticipated blood loss of 500 ml or more on average for the planned surgery, e.g. major open vascular surgery, laparotomy, thoracotomy, joint replacement surgery.

These patients will have review by the haematology team (having been referred by the anaesthetists) in order to optimise their condition prior to surgery. A more detailed consenting process will occur, again discussing the risks, benefits and alternatives to blood products with both the anaesthetists and haematologist.

- Standardisation of comprehensive screening tool for patients identified as bariatric.

With respect to this recommendation, the intention was to develop a screening tool to identify inclusion and exclusion criteria for those patients identified as suitable to undergo bariatric surgery. To this end, the Royal Hobart Hospital has undertaken a multidisciplinary internal review of the process for the selection and management of patients for bariatric surgery. This report has now been published.

This report has been accepted by the Department of Health for state wide implementation. Mechanisms will now be put in place to offer a more comprehensive preoperative multi-disciplinary assessment and management pathway for bariatric patients.

- Department of Surgery undertake an independent review of current processes, elective and non-elective bariatric surgery. The Serious Incident Panel recommends an independent assessment of the current practice regarding bariatric surgery at the [location] Hospital.

This would normally involve independent specialists, probably from mainland Australia, coming to Hobart and conducting a thorough review of the current pre-operative selection and assessment of patients recommended for bariatric surgery, a review of the procedures performed with documentation of complications and outcomes, and a review of the post-operative inpatient and outpatient management of these patients.

I am not aware of any plans for such an extensive review.

It would appear that the Royal Hobart Hospital have used the proposed and now accepted Careway to cover this recommendation.

- Cease public funded elective lap band surgery at the [location] Hospital for up to six months.

This recommendation had been implemented from 2 March 2010. I understand that plans are now well advanced to restart this service in line with the approved careway. Currently, it appears that funding for the allied health aspect of the careway is the hold up.

Once this has been resolved, the service will be implemented and lap bands restarted at the [Location] Hospital and the [location] Hospital.

The careway provides for a significant increase in allied health input to the management of these patients which has created new funding and staffing issues.

It must also be acknowledged that there is significant pressure being applied to the Department of Health and specifically to the [location] Hospital to reinstate this service as quickly as possible as there is a growing waiting list for this procedure and an increasing number of urgent cases to attend to”

I have set out above the recommendations made by the Serious Incident Panel arising from deceased's death. I support each of them and am confident that, if adopted, they will enhance the safe surgical management of Jehovah Witness patients and bariatric patients generally. I observe that if the recommended screening tool had been in place at the time of deceased’s presentation it is likely that she would have been assessed as having a ‘small risk of major bleeding’ and thus had explained to her the risks and benefits of the blood product alternatives and her choices (if any) identified.
TAS.2009.294 continued

The Panel’s recommendations do not indicate whether, at this stage an autologous blood transfusion (i.e. the pre-surgery collection and later re-infusion of a patient’s own blood or blood components) or intraoperative blood salvage would have been identified as options for [the deceased]. It is my understanding that these two blood collection and re-infusion procedures are accepted by some Jehovah Witnesses as being permissible and it would be my recommendation that they specifically be advised to all Jehovah Witnesses who are assessed as having a small or greater risk of major bleeding at surgery.

VIC.2007.1082  Adverse Medical Effects/ Older Person

An elderly person died of a pulmonary embolism after a lengthy delay in being transferred to a bigger hospital.

Recommendations
I adopt the recommendations of the Root Cause Analysis (RCA) report, set out in paragraph 11 of this finding. I do so, as I am satisfied that a thorough and comprehensive analysis of the circumstances surrounding [the deceased’s] death was conducted by the RCA team, which has led to appropriate recommendations being made. What remains unclear, however, is whether all the recommendations have been implemented since they were made in 2007. By adopting the recommendations they become recommendations made by the coroner, pursuant to s72 Coroners Act 2008. This section mandates the statutory authority or entity that has received the coroner’s recommendations to provide a written response, not later than three months after the date of receipt, specifying a statement if action that has, is or will be taken in relation to the recommendations. Following receipt of the response, the coroner is then required to publish it on the Internet and to provide a copy to interested parties.

NZ.2008.3510  Aged Care/ Older Person/ Natural Causes/ Falls

An elderly aged care resident died of broncho-pneumonia indirectly related to a fracture of the arm after a fall from his rest home bed.

Recommendations
I recommend that a copy of this finding is sent to [rest home] for its information and to ensure the appropriate staff training is given.

I recommend that a copy of this Finding is sent to the [location] District Health Board for its information and to ensure appropriate staff training is given.

NSW.2009.118  Child & Infant Death/ Animal

A three year old child died of multiple injuries after being attacked by four dogs.

Recommendations
To: The Minister for Local Government
That this finding, together with the Statement of [Detective] and the reports prepared by [doctor] together with the recommendations contained therein as to the management of dogs and investigation of dog attacks, be referred to the Companion Animals Taskforce for consideration by that body in providing advice to Government on companion animal issues.

To: The Commissioner of Police
That the NSW Police Force in conjunction with officers of the Department of Local Government and other relevant bodies, develop a protocol specifying the forensic examinations that should be undertaken of dogs involved in fatal and serious dog attacks and that once such examinations have been undertaken the subject dogs should be destroyed and then disposed of.

To: The General Manager, [Shire Council]
That the Council undertake a review of the tranquillisers made available to animal management officers to assist them to control dogs and other animals that pose a threat to the community and other animals so as to ensure that the most effective product is made available to them.
NSW.2009.1343  Child & Infant death/ Adverse Medical Effects

A child died from septic shock after a burst appendix led to peritonitis. There was a sufficient delay in diagnosing the deceased’s condition.

**Recommendations**

- To South Western Sydney Local Health District and to Sydney Children’s Hospital Network that steps be taken to ensure the ready availability to medical and nursing staff at the emergency departments of Liverpool Hospital and the Children’s Hospital at Westmead of a one page guideline regarding the circumstances in which appendicitis may call for urgent surgical treatment and the steps to be taken in such instances;
- To South Western Sydney Local Health District, that steps be taken to ensure the ready availability to medical and nursing staff at the emergency department at Liverpool Hospital of a protocol to ensure the prompt and efficient transfer of paediatric patients requiring surgery not to be performed at that hospital such protocol to include:
  - A requirement that the degree to which surgery is urgent be documented,
  - A requirement that the mode of transport chosen and the estimate of time required in which to complete the transfer to another hospital be documented,
  - A requirement that, subject to the need to avoid delay in transfer, the paediatric patient be reviewed by the most senior clinician present in the emergency department at the time,
  - A requirement that the paediatric patient be appropriately monitored until transfer and that such monitoring be documented,
  - A requirement that, in the event that transfer is delayed, the changing needs of the paediatric patient requiring surgery be considered and responded to and that those needs and any responses be documented, and
  - A requirement that, in the event of a decision to transfer a paediatric patient requiring surgery to another hospital, the medical officer making that decision liaise with the hospital to which the patient is to be sent with a view to ensuring that, subject to the need to avoid delay as regards the transfer, the patient is properly prepared for surgery and that such attempts to liaise and any instructions of the hospital to which the child is to be transferred and any preparations for surgery be documented;
- To South Western Sydney Local Health District that steps be taken to advise paediatricians and general practitioners in the area served by Liverpool Hospital and the NSW Ambulance Service and to keep them advised of the policy of Liverpool Hospital regarding the provision of paediatric surgical services.

NSW.2009.5847  Child & Infant Death / Water Related

A three year old child drowned in a backyard swimming pool after being left unsupervised in the yard.

**Recommendations**

To: The Minister for Local Government, responsible for the administration of the Swimming Pools Act 1992

That the Swimming Pools Act 1992 be amended so as to:

- Require that all swimming pools be registered with the local government authority for the area in which they are situated.
- Require that within a specific period all swimming pools be required to be brought into compliance with Australian Standard AS1926.1-2007
- Require that all owners of property on which swimming pools are constructed be required to provide a certificate of compliance with the provisions of the Swimming Pools Act 1992 to the relevant local government authority on a periodical basis.
- Provide that the right of entry to properties for the purpose of inspection of swimming pools provided to local government officers contained within the Swimming Pools Act 1992 be extended so as to allow such officers entry in order to determine whether or not a swimming pool exists on a particular property
- Provide that where inspections of properties are undertaken by officers of a local government authority the authority be entitled to impose a fee for the purpose thereof that allows the authority to recover the actual and incidental costs of such inspection

To the Minister for Finance and Services and the Minister for Fair Trading, conjointly responsible for the administration of the Conveyancing Act 1919

That the Conveyancing (Sale of Land) Regulation 2010 be amended so as to require that a certificate of compliance with the provisions of the Swimming Pools Act 1992 be a prescribed document where the property a subject of a contract for the sale of land has erected thereon a swimming pool.
**NSW.2009.5847 continued**

To the General Manager, [NAME] City Council
That the policies and procedures of the [NAME] City Council be reviewed with a view to ensuring that where issues relating to compliance with the safety provisions of the Swimming Pools Act 1992 are identified, either at the initial construction stage or at a later time, effective action is taken to ensure that compliance is brought about in a timely manner.

To the Chief Executive Officer, LJ Hooker Conveyancing
That the policies and procedures of the organisation be reviewed so as to ensure that where it is acting for a purchaser of a residential property on which is constructed a swimming pool, the terms of the warning concerning swimming pools contained in Clause 15, Schedule 1 of the Conveyancing (Sale of Land) Regulation 2010 be brought to the specific attention of the purchaser and it be recommended to such purchaser that, if one is not already attached to the contract of sale, a certificate of compliance with the provisions of the Swimming Pools Act 1992 be obtained.

**NSW.2010.149 Child & Infant Death/Water Related**

An infant drowned after falling into a backyard swimming pool. Pool is not fenced and easily accessible.

**Recommendations**

To: The Minister for Local Government, responsible for the administration of the Swimming Pools Act 1992

That the Swimming Pools Act 1992 be amended so as to:

- Require that all swimming pools be registered with the local government authority for the area in which they are situated.
- Require that within a specific period all swimming pools be required to be brought into compliance with Australian Standard AS1926.1-2007
- Require that all owners of property on which swimming pools are constructed be required to provide a certificate of compliance with the provisions of the Swimming Pools Act 1992 to the relevant local government authority on a periodical basis.
- Provide that the right of entry to properties for the purpose of inspection of swimming pools provided to local government officers contained within the Swimming Pools Act 1992 be extended so as to allow such officers entry in order to determine whether or not a swimming pool exists on a particular property
- Provide that where inspections of properties are undertaken by officers of a local government authority the authority be entitled to impose a fee for the purpose thereof that allows the authority to recover the actual and incidental costs of such inspection

To the Minister for Finance and Services and the Minister for Fair Trading, conjointly responsible for the administration of the Conveyancing Act 1919

That the Conveyancing (Sale of Land) Regulation 2010 be amended so as to require that a certificate of compliance with the provisions of the Swimming Pools Act 1992 be a prescribed document where the property a subject of a contract for the sale of land has erected thereon a swimming pool

To the Law Society of NSW

That the Society bring to the attention of members, and others engaged in the purchase and sale of residential properties, the terms of the warning concerning swimming pools required by Clause 15, Schedule 1 of the Conveyancing (Sale of Land) Regulation 2010 and that where a property that is to be purchased has constructed on it a swimming pool, the terms of the warning be brought to the specific attention of the purchaser.

**NZ.2008.2559 Child & Infant Deaths/ Adverse Medical Effects/ Physical Health**

A child who suffered from muscular dystrophy died of heart failure ten days after a tonsillectomy.

**Recommendations**

I recommend that a copy of this Finding be used (in conjunction with the report of [doctor] for training purposes at [hospital])

I recommend that a copy of this Finding be forwarded to the office for the Health and Disability Commissioner, who may be satisfied with the outcomes, and who may discontinue his enquiry.
NZ.2009.2912  Child & Infant Death
A four month old infant died of Sudden Infant Death Syndrome. The deceased had been sleeping with his head raised by an adult pillow as he had a nasogastric tube in for feeding.

Recommendations
The circumstances of the deceased’s death (and evidence by Dr [name]) highlight the need for parents to be advised (and have it emphasised) that lying babies in the first year of their life on adult pillows increases the risk of SIDS/SUDI and that this practice should be avoided. That advice should be provided antenatally, on obstetric wards and postnataally by community child health services.

Accordingly, a copy of this finding be forwarded to the Ministry of Health to consider the increased risk when adult pillows are used, together with the appropriate messages to be given to parents, in the context of other recent coronial recommendations around SIDS and SUDI risks. Those recommendations are directed at ensuring that public health advice in relation to safe infant care practices and safe sleeping environments are strengthened, broadened and consistent amongst public health educators and health professionals.

I recommend to [location] district Health Board that they reflect on these findings and Doctor [name’s] advice (which has been provided to it) with a view to considering the role of ‘propping’ with pillows in the management of babies with gastroesophageal reflux and/or nasogastric tubes. I also recommend that [district Health Services] reviews and strengthens the advice given to parents of babies with gastroesophageal reflux and/or nasogastric tubes, about the increased SUDI/SIDS risks associated with using adult pillows to ‘prop’ their babies for these conditions.

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NZ.2009.4043  Child & Infant Death/ Transport & Traffic Related
A six year old child died after the quad bike she was riding in a bike park overturned. The park had a poor standard of signage and track maintenance.

Recommendations
I recommend that:
- Consideration be given to the urgent development and implementation of guidelines for this activity by MCNZ and the Department of Labour
- The [location] Council reconsider the Resource consent granted to [name] on [date] by [Location] District Council for Land Use as a Commercial Motor Bike Trail
- That in the interim [Location] Park improves the safety of the park by implementing the practicable steps outlined in paragraph five of this finding

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NZ.2010.1555  Child & Infant Death
An infant died of Sudden Infant Death Syndrome after co-sleeping with a sibling using an adult pillow.

Recommendations
The circumstances of [the deceased’s] death have highlighted the ongoing need for parents to be given very explicit messages about what safe sleeping means- and the risks of ignoring the research in this area. This includes the need for the message to parents to be made explicit that lying babies in the first year of their life on adult pillows is a hazard that increases the risk of SIDS, and that this practice should be avoided and also that bed sharing is potentially unsafe and should be avoided. This advice should be provided at every opportunity- antenatally, on obstetric wards, and postnataally by community child health services.

Accordingly, a copy of this finding will be forwarded to the Ministry of Health to consider in the context of other recent coronial recommendations around SIDS risks. Those recommendations are directed at ensuring that public health advice in relation to safe infant care practices and safe sleeping environments are strengthened, broadened, and consistent amongst public health educators and health professionals.

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NZ.2010.1636  Child & Infant Death/ Transport & Traffic Related
A twelve year old was killed after the speeding driver of the vehicle she was travelling in took a bend over the speed limit and lost control, crashing into a bank. A large speaker that was loose on the back of the car struck the deceased in the head, causing a fatal injury.
**Recommendations**

Pursuant to section 57 (2) Coroners Act 2006 I recommend that the local authority erect warning signs at the bend indicating the shape of the bend, the advisory speed and direction of travel as per paragraphs 12.1 and 12.2 of [police] Serious Crash Report. A copy of this recommendation is to be sent to the appropriate council.

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**NZ.2010.1676  Child & Infant Death**

A five month old baby died of Sudden Infant Death Syndrome after sleeping in a bed with siblings.

**Recommendations**

This is yet another tragic death of an infant that brings into play aspects of co-sleeping and other matters as suggested by the Pathologist. This is a subject well traversed by myself and other Coroners. In a recent decision by His Honour, Coroner Bain of Rotorua, in re [name], he repeated the recommendations made by His Honour, Coroner Evans, re [name] that public health advice in relation to safe infant care practices and safe sleeping environments be strengthened and broadened to make it clear:

- Bed sharing by adults and siblings with infants under six months exposes the infant to the risk of death and such practice should be avoided; and that
- The safest place for babies to sleep for that first six months is within a self-contained compartment/cot beside the parental bed
- That steps be taken by the Ministry of Health to ensure that the same advice is given by public health educators and health professionals within the public health sectors.
- His Honour, Coroner Bain, made reference in respect to the availability of ‘alternative cots’ that are available such as the ‘Wahakura’ (flax cradle) and ‘pepi pod’ as being available to mothers of young children.

Given these previous recommendations, I do not intend to formerly make any further or new recommendations, but re-emphasise those made earlier by Coroner Evans.

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**NZ.2010.2219  Child & Infant Death/ Transport & Traffic Related**

An eleven year old died after riding his motorbike on a country road and was hit by a car. The deceased’s mother was travelling in front of the deceased at the time but was unable to stop the deceased heading into the path of the oncoming car.

**Recommendations**

I have considered whether there are any recommendations that I could usefuly make which may prevent further deaths occurring in the future in similar circumstances. Given that this death occurred in part as a result of a breach of the law by the deceased, and condoned by his parents, I do not consider there are any such recommendations to be made. Having said that, there are comments I feel compelled to make in the hope that people living in rural areas will take on board lessons learned from the [deceased’s] death.

I am aware that sometimes exigencies require farmers to travel on roads while not conforming strictly to legal requirements. But these exigencies usually relate to matters of convenience, as in the deceased’s case, rather than emergency situations. In this case, the most convenient means for the deceased to get home was also the most dangerous and ultimately resulted in his death. This death demonstrates the terrible price that can be paid for taking such risks to personal safety. I trust that those living in rural communities will appreciate that non-compliance with laws governing travel on country roads can cost lives.

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**NZ.2010.3077  Child & Infant Death/ Adverse Medical Effects**

An infant died two days after birth due to a brain injury. The deceased’s mother was in the antenatal ward and nurses failed to notice that the baby’s heartbeat had slowed. This occurred as a handover from night to day shift was taking place. The alarms on the monitor had also been turned off.

**Recommendations**

I recommend that the CMDHB report to [deceased’s] parents when their response to this finding has been completed. The obstetric and midwifery staff of the CMDHB consider how the lessons learnt from this tragedy might be reported widely throughout maternity services in New Zealand.
NZ.2011.1051  Child & Infant Death/ Transport & Traffic Related

A twelve year old died after veering into the path of a van while riding his mountain bike from his home to his school.

**Recommendations**

With a view to reducing the chances of the occurrence of other deaths in circumstances similar to those in which the death of [the deceased] occurred, I recommend:

To [Location] District Council

- That a legal pedestrian crossing replace the Kea Crossing outside [Name] School on [Location] Road, [Location]

TAS.2010.463  Child & Infant Death/ Transport & Traffic Related/ Work Related

A two year old died after falling from a moving tractor onto agricultural machinery while on the family’s working farm.

**Recommendations**

This is an example of the risk posed by farm and agricultural machinery, particularly for young children. Such machinery is inherently dangerous. Young children behave in a spontaneous and unpredictable way. They do not properly appreciate risk or danger. Even a momentary lapse in supervision can have tragic consequences.

Children in rural areas of Australia are often around tractors, trucks and other mobile farm machinery. Injuries and deaths are common, but are usually preventable. Toddlers are most at risk. Agencies such as WST and Farmsafe Australia Inc. are already working to educate farmers on safe work practices. Incidences such as this one reinforced the need to continue and if possible intensify those efforts.

VIC.2006.3606  Child & Infant Death

An infant died two days after an extraction delivery due to a knot in the cord that stopped oxygen to her brain.

**Recommendations**

I recommend:

That the Maternity Handbook be reviewed and amended to provide specific direction about the care, retention and documentation of the placenta and cord in any circumstances where pathology and histopathology is warranted. The instruction should also emphasise the importance of maintaining the placenta and cord intact. I also recommend that the taking of photographs of the placenta and cord be included as routine in all obstetric adverse outcomes.

I recommend that [location] Hospital continue in its endeavours to secure 24 hour per day, 7 days per week on site obstetric Registrar cover and to report in its response pursuant to section 72 (3) and sub-section (4) to this recommendation, the steps they have taken to achieve this outcome since the close of evidence in this Inquest to date and their strategic plan for the future in this regard.

VIC.2010.1531  Child & Infant Death

A child died from pneumococcal meningitis.

**Recommendations**

That the Minister for Health implements an inquiry into:

- The current state of preventative medication available to immunise children against Pneumococcal meningitis
- The availability of funds to investigate the means of combating all currently known variants of the disease.
- The most appropriate method of applying those funds to the research and development programs aimed at providing appropriate protection/vaccines
- As to the adequacy of facilities that are in place to:
  - Speedily provide the Minister with advice as to any trends in increasing population of country communities which may require an increase in the provision of emergency services
  - Maintain a watch over levels of staffing within the ambulance service which will ensure that those people who choose to live away from big cities or even large rural towns are not disadvantaged in their reasonable access to the expertise of MICA and, similar levels of specialist ambulance training

That the Department of Health conduct a public awareness campaign (directed at all areas of the community, but in particular, those people in regular contact with children) on the signs and indicia of Pneumococcal meningitis and the need to seek urgent medical advice if the presence of those various symptoms is noticed or reasonably suspected.
**VIC.2010.3384  Child & Infant Death/ Physical Health**

An eleven year old child with cerebral palsy died of hanging after his clothing became caught on a metal bar at the end of his special-purpose bed.

**Recommendations**

- I recommend that ‘Hendicare’ review the design of their special-purpose beds, giving proper consideration for safety and the elimination of any potential hanging points.
- I direct that a copy of this finding be distributed to the following parties, in the hope that [the deceased’s] death may lead to a broader awareness of the potential risk of hanging involving special-purpose beds:
  - [Name], [Location] Hospital- TOCAN Group (The Transportation of Children and Youth with Additional Needs Partnership)
  - Caroline Mulcahy, Chief Executive Officer- Carers Victoria
  - Arthur Rogers, Executive Director- Disability Services Division, Department of Human Services

**NSW.2008.6051  Drugs & Alcohol**

The deceased died from opiate toxicity that was of undetermined intent.

**Recommendations**

To the Commander, Cabramatta Local Area Command

That the investigation into the manner of death of [deceased] be referred for review and proper and complete investigation by an appropriately qualified senior investigator.

**NT.2010.110  Drugs & Alcohol**

A person died in hospital of severe hypoxic brain injury after an accidental overdose of a non-prescription drug for erectile dysfunction while overseas.

**Recommendations**

I recommend that relevant agencies give consideration to investigating and promoting the dangers of non-prescription erectile dysfunction products.

**NZ.2010.878  Drugs & Alcohol/ Transport & Traffic Related**

An intoxicated person died after being struck by a vehicle while walking on a dark rural roadway in dark clothing.

**Recommendations**

In furtherance of my obligation to make recommendations to ensure the safety of the public in the future, I note that I have now sat on too many inquests involving intoxicated pedestrians. A common theme is that not only do such persons drink to excess, and to the extent to which he cannot take responsibility for their own safety, they also walk on rural roads with no street lighting and invariably dressed in dark clothing. Such pedestrians are effectively invisible to the drivers of vehicles using the road legitimately and travelling at appropriate speeds.

If a pedestrian chooses to walk on a rural road (or any road) at night, either drunk or sober, such pedestrians ought to wear appropriate clothing such as a Day-Glo or a reflective jacket and carry a light. The principle of ‘see and be seen’ would save many lives.

I recommend that a copy of this finding be forwarded to LTNZ to ensure that publicity be given to my comments in relation to the safety of pedestrians on rural roads at night.

**NZ.2010.1673  Drugs & Alcohol/ Transport & Traffic Related**

An intoxicated person who was lying in the middle of the road and was struck by a vehicle.
NZ.2010.1673 continued

Recommendations
I recommend that a copy of this Finding be sent to the Alcohol Reduction Officer of the New Zealand Police at [location]

I recommend that a copy of this Finding be forwarded to NZTA as a further example of the tragic consequences of the combination of alcohol and a pedestrian.

NZ.2011.1121 Drugs & Alcohol/ Mental Illness & Health
A mentally ill person died of alcohol toxicity after drinking a large bottle of whiskey.

Recommendations
This death is another example of a person drinking himself to death while most likely unaware of the danger that drinking excessive amounts of alcohol carries, or else reckless as to the risk to his safety. Such ignorance or recklessness is difficult to understand given the publicity generated by recent deaths in relation to excessive consumption of alcohol.

Of equal concern is the fact that no medical assistance was sought when it was noticed that the deceased was highly intoxicated and having difficulty breathing. This death serves to reinforce earlier calls made for medical assistance to be sought whenever a person is noted to be highly intoxicated rather than simply being left to sleep it off.

NOTE: Due to two cases of similar circumstances, where the deceased died of mixed drug toxicity after taking methadone prescribed as a ‘take away’ dose, the Coroner made combined recommendations for both cases.

TAS.2007.87 Drugs & Alcohol
A person died unintentionally of mixed drug toxicity after injecting ‘take away’ doses of methadone that was not prescribed to him.

TAS.2007.370 Drugs & Alcohol
A twenty year old person died of mixed drug toxicity after injecting ‘take away’ doses of methadone that were prescribed for someone else

Recommendations
The issue of the abuse of prescribed takeaway doses of methadone by those on the methadone program has been the subject of comments and recommendations by coroners.

This case particularly highlights the consequences of prescribing takeaway doses of methadone, particularly to those who are suspected of unlawfully supplying their doses to others.

In 2008 Coroner Stephen Carey made the following comments in a finding:
"In an investigation finding published on 6 February 2007 which dealt with another case in which the illicit use of take-away doses of methadone had caused death, I made a number of recommendations. In summary, I considered that if as certain evidence suggested, the Alcohol and Drug Service believed that the rate of prescription of take-away doses of methadone was too high then steps ought to be taken to reduce it. Options that may have been considered were to establish explicit and rigorous rules concerning the access to take-away doses, or providing that a request for take-away doses be sanctioned by an expert panel independent from the prescriber. It was apparent that there was a need to ensure that an appropriate balance was achieved between the encouragement of rehabilitation of certain individuals by providing for the ability to be prescribed take-away doses and the alternate being the opportunity to divert those doses for illicit use.

In so far as the misuse and abuse of methadone illustrated by this case, I note that there is presently before interested persons and professional bodies within Tasmania a draft "Tasmanian Opioid Pharmacotherapy Program Policy and Clinical Practice Standards (2008) for the use of Buprenorphine and Methadone in the treatment of opiate dependent (TOPP)". I understand that this provides a conservative and clinical risk management approach to the use of Pharmacotherapy treatment for those persons dependent upon opiate products.
TAS.2007.87 & 370 continued

This program provides for the use of Buprenorphine rather than methadone as it is at least two orders of magnitude less likely to be associated with an opiate toxicity related death. I also understand that the use of take-away doses would be significantly curtailed and a detailed clinical risk assessment approach would apply to all persons on the program and any person identified as a risk would not receive take-away doses.”

In 2009 Coroner Chris Webster stated:

“Death relating to illicit overdose of drugs remains a problem within the community.  The illicit use of morphine and methadone within Tasmania appears to remain at a high level.   Anecdotal evidence suggests that a large portion of legally obtained drugs are being diverted into the illicit market due to the financial gains available.”

In 2009 Coroner Carey stated:

“It is my further recommendation that any decision made to authorise the use of “takeaways” be continuously reviewed by clinical assessment and by consideration of information provided by the patient and by other health professionals regarding the patient’s living and social circumstances. Assessment of clinical stability and of any patient and public safety issues should form a routine part of clinical assessment each time the patient is reviewed by his/her prescriber. Such review will enable the prescribing physician to consider his/her assessment of the patient’s need for “takeaway” doses in the light of any change in the patient’s circumstances including his/her domestic arrangements.”

I adopt these comments and urge all methadone prescribers to remain vigilant in prescribing takeaway doses of methadone.

The new draft prescribing guidelines (TOPP) referred to above have still not come into force. Clinical Director of Alcohol and Drug Services, Dr Adrian Reynolds, has provided for this investigation a summary of the new prescribing guidelines referred to in Coroner Carey’s comments above. He states:

“The Alcohol and Drug Service has reviewed the Tasmanian Methadone Policy 2000, and has developed a (new) “Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards” (referred to as the TOPP), in accordance with National policy. This document remains in draft form and is currently going through an internal stakeholder review before going out to external stakeholders for comment, prior to its publishing.

The National Opioid Pharmacotherapy Policy 2007 states that methadone and Buprenorphine should be consumed under direct supervision, but that under certain circumstances it may be appropriate for authorisation of takeaway doses, and further that individual jurisdictions may vary in the limits applied to takeaway doses.

The new Tasmanian Opioid Policy and Clinical Practice Standards will restrict the number of methadone and Buprenorphine takeaway doses to no more than two(2) in any week and these takeaway doses will be provided only when there is very good evidence of clinical stability and evidence that this medication can and will be safely stored by the patient and taken only as directed by their prescribing doctor.

More specifically, a patient will be allowed a maximum of one methadone or Buprenorphine takeaway dose each week after demonstrating three months of continuous clinical stability, as well as a need for and capacity to benefit from such take-away dose privileges. A patient may be granted two takeaway doses each week but not on consecutive days, when they have demonstrated six months of continuous clinical stability.

These takeaway dose privileges will be removed immediately and for at least three months when there is evidence of poor treatment compliance or other behaviour that is assessed as placing the patient or the public at risk. Where there is evidence that a patient is clinically unstable and at risk, they will be clinically monitored more closely and when willing and within the constraints of available professional resources, will be engaged in appropriate counselling to assist them in addressing their life problems including unsanctioned alcohol or other drug use where this is the issue of concern.

Detailed risk assessment and risk management guidelines and clinical management strategies are described in the TOPP. Following the completion and publishing of the TOPP, attention will then focus on training and on networking with, supervising and mentoring prescribers and other health professionals involved in the opioid pharmacotherapy program. The TOPP includes a risk and protective framework that requires an evaluation of the safety of the home environment as well as the safety of children who may be affected by their parents substance use. The legislation section of the TOPP will also highlight the reporting requirements around neglect and harm to children in accordance with the Children Young Persons & Their Families Act.”

I support this revised policy and encourage all those involved to efficiently pursue its implementation in the hope that there will be a reduction in the number of deaths involving the abuse of takeaway doses of methadone.
NZ.2010.876  Falls/ Drugs & Alcohol
A person fell down a 1.5 metre embankment at a golf course camping ground and sustained fatal injuries. The deceased had been drinking prior to this incident.

**Recommendations**
That the [location] City Council as the responsible Territorial Authority inspect the camping ground site at the [location] Golf Course to ensure it meets the Camping Ground Regulations and that the Council meet with the Golf Club to consider the camping ground’s future or means to ensure it is of an acceptable standard.

NT.2011.16  Fire Related
A person died of smoke inhalation and burns after an accidental house fire

**Recommendations**
The Northern Territory Fire and Rescue Service made a submission to government recommending that consideration be given to legislating for mandatory installation of smoke detectors (alarms) in all public buildings and residences. I also recommend that government give consideration to the introduction of such legislation as per Deputy Coroner Celia Kemp’s recommendation following the death of [name] on [date].

NZ.2010.2527  Fire Related
A person died after a leakage of LPG gas from a fridge, and the starting of a heater, has caused a fire in a campervan, of which the deceased was unable to escape.

**Recommendations**
There are hundreds of vans in New Zealand similar to the one which is the subject of this investigation, where the conversion to a camper has been done by a home handyman. Some of these conversions will, to a point, be relatively safe but a number will not be as some basic rules need to be followed, particularly in respect to the LPG installations. These are:

- Seek advice from a registered gas fitter as to what is to be achieved with the installation
- Use only those types of tubing and fittings that are approved for use with LPG
- Use permanently fixed gas piping to reduce the potential of mechanical damage
- Ensure fixed LPG burning equipment like stoves and refrigerators are ventilated directly to the outside so that any malfunctioning appliance will discharge leaking gas safely outside the vehicle.
- LPG cylinders should not be stored in the space that they are supplying gas to. Cylinders should be located in a cupboard or recess with external access only and well ventilated. The cupboard or recess must be completely sealed from the interior of the vehicle.
- Test all connections, fittings etc. with a soapy solution to detect leaks
- Have the installation checked periodically by a registered gas fitter and carry out any maintenance or repair work prior to further use

I note the above findings and recommendations from the New Zealand Fire Service

VIC.2009.1583  Fire Related/ Drugs & Alcohol
A person died after a house fire in which they suffered burns and smoke inhalation, which exacerbated their liver and kidney disease due to alcoholism. The deceased then passed away in hospital.

**Recommendations**

- In light of the difficulties that Telstra Corporation reports arising from its dealings with emergency services providers outside of its control, that Telstra Corporation review the criteria by which it determines staffing numbers at the emergency call centre to ensure that there are sufficient staff members available to meet unexpected call demand and delays arising from emergency service providers.
- That Telstra configure its emergency RVA to commence no later than 10 seconds after connection of a 000 emergency call
- I direct that a copy of these findings be provided to the: family; interested parties; Honourable Peter Ryan MP, Minister for Police and Emergency Services (Victoria); Chief Commissioner of Police (Victoria); Officer in Charge [location] Police Station; Telstra Corporation Legal Services Director
NSW.2003.6418  Homicide & Assault
A young woman is presumed dead, and is believed to have been murdered.

Recommendations
I recommend that the case be given to the Unsolved Homicide Squad for further investigation.

NSW.2007.2308  Homicide & Assault
A person disappeared in 1983 and is presumed dead

Recommendations
Recommendation made pursuant to section 82(2)(b) Coroners Act 2009:
Matter referred to the Unsolved Homicide Squad, NSW Police.

NSW.2011.1302  Homicide & Assault
A person is believed to have died in September 1987. Cause and manner of death are unknown.

Recommendations
To the Officer in Charge, Missing Persons Unit of the New South Wales Police
That the efforts to locate [name], brother of the [deceased] be continued with a view to obtaining from him a DNA sample to be used to assist in the identification of unidentified remains should such remains be that of [deceased].

NT.2010.51  Homicide & Assault
A person died after being shot in the head and was buried in a shallow grave at a remote location. The identities of the people present at the murder have been established.

Recommendations
I find that in all the circumstances a crime has been committed and refer the matter to the Commissioner of Police and the Director of Public Prosecutions.

NT.2010.69  Indigenous/ Adverse Medical Effects/ Natural Causes
An Indigenous person, who suffered from a number of ailments including diabetes, renal failure kidney disease and hypertension, died of myocarditis which occurred as a result of a systemic viral infection. The deceased was at a regional clinic that was unable to treat her symptoms and died while waiting to be airlifted to a larger hospital.

Recommendations
At the conclusion of the evidence in this matter, I considered that it was essential that I make a recommendation to the Minister that the awarding of the tender for the new service be finalised without delay. I was persuaded by the evidence before me that this was an essential service that needed to be finalised and appeared to be taking a very considerable time to do so. As I stated during the course of closing addresses, so far as this death is concerned, it appears it may have been preventable with intensive care at [hospital] but it also may not have been.

Since the conclusion of evidence, and whilst preparing these reasons, I have received correspondence from [name] of the Department of Health informing me that Care Flight had been awarded the tender for the Top End Medical Service. I note that in terms of that service, I was also advised as follows:
‘The integration of the new service will begin in January 2012, with an implementation to occur over the coming 12 months. The full service should be in place by 1st January 2013.

It is not clear to me as to why there is such a considerable ‘integration’ and ‘implementation’ period, however given the contract has been awarded, I no longer consider it necessary to make a specific recommendation in this regard. However I do recommend the Government, and specifically the Department of Health, work hard at ensuring that the new service, which is clearly an improvement for the lives of many people across the Top End, is implemented as quickly as possible.
SA.2009.695 Indigenous/ Law Enforcement/ Natural Causes
An Indigenous prisoner collapsed in the prison medical centre and died of ischaemic heart disease due to coronary atherosclerosis.

Recommendations
- I recommend that the Department for Correctional Services institute a 24 hour nursing service at [location] Prison and investigate the institution of such a service at all other prisons within the State.
- I recommend that the Department for Correctional Services provide public access defibrillators or automated external defibrillators to any prison in the State that does not have 24 hour nursing facilities.
- I recommend that the Department for Correctional Services and the South Australian Prison health Services investigate the provision of enhanced cardiac screening for prisoners as suggested by [doctor].

WA.2008.1258 Indigenous/ Law Enforcement/ Natural Causes
A 25 year old Indigenous prisoner died of cardiovascular disease in prison. The deceased had been quite unwell for some time before his death.

Recommendations
- The Department of Corrective Services take action to ensure that as soon as practicable prisoners are not housed in cells which fail to meet the department’s design guidelines.
- I recommend that the Department of Corrective Services take steps to formulate a clear and unambiguous policy to replace policy directive 08 which sets out precisely how a terminally ill prisoner is to be identified and managed and de-
tails the steps which should be in place to refer the case to the Minister for a consideration for clemency.

NSW.2009.1336 Intentional Self-Harm/ Work Related/ Weapon/ Mental Illness & Health
A police officer suffering from depression took their own life with a service revolver while on duty.

Recommendations
I make the following recommendations to the Commissioner of Police:-

- That a psychiatrist or psychiatrists be employed in the Health and Well Being Unit of Welfare Safety Command or retained so as to ensure qualified psychiatric oversight of all police fitness assessments where mental health or emotional stability are an issue;
- That appropriate criteria be developed and established to guide and inform police medical officers in assessing the fitness of police officers for various duties within the police force and the fitness of police officers to have possession of a firearm;
- In particular, that the criteria so developed and established provide that fitness for duty and to carry a firearm is not merely a matter of the absence of a diagnosable psychiatric condition or mental illness;
- That police medical officers be encouraged to explore with police officers referred by commanders for a fitness assessment the history of that officer and any current or recent medical diagnoses and treatment plan or plans and the identity of that officer’s medical practitioner and to seek the consent of the police officer to that medical practitioner providing appropriate medical information to the police medical officer and that unwillingness to provide that consent be among the matter to be reported to the referring commander;
- That psychologists assisting in the preparation of fitness assessments be accorded independence from police medical officers;
- That police medical officers be reminded of the provisions of the Health Records and Information Privacy Act 2002 and, so far as the provision of information to commanding officers is concerned, be encouraged to act in accordance with its terms;
- That the practice of placing reliance on psychological tests in the preparation of fitness assessments be reviewed by an independent expert;
- That the freedom of commanding officers to make their decisions as to the removal or restoration of firearms informed by considerations other than those dealt with by police medical officers be encouraged;
- That commanding officers be reminded of their entitlement to the provision of information pursuant to the Health Records and Information Privacy Act 2002;
- That consideration be given to the establishment of a mentoring system of young officers by more senior officers with a view to the guidance, support and oversight of the performance of those young officers.
NSW.2009.4877  Intentional Self-Harm/ Mental Illness & Health
A mentally ill person died after hanging themselves at their home.

**Recommendations**
To the Minister of Health:
- That the [location] Local Health District allocate a Carer Advocate to each patient across the Mental Health Services who would inform families of their existence and be available for communication at all times.
- That the discharge checklist utilised by the [Location] Mental Health Services be revised to include a requirement to confirm that verbal and written communication of discharge and treatment plan has been provided to external services providers and family/carers. The discharge checklist be confirmed and signed by the treating psychiatrist.
- That the [location] Mental Health Services immediately ensure that the input of families/carers into the assessment and development of care plans is actively facilitated, encouraged with patients and include provision of written material.

**NOTE:** Due to two cases of similar circumstances, where both deceased died from inhaling helium gas, the Coroner handed down combined recommendations.

NZ.2009.2847  Intentional Self-Harm
A person took their own life by utilising helium gas and placing a plastic bag over his head, leading to asphyxiation.

NZ.2010.1520  Intentional Self-Harm
A person died of asphyxiation after intentionally inhaling helium gas within a plastic bag that had been secured around their head.

**Combined recommendations**
To the Minister of the Environment
That a Review be undertaken pursuant to the Hazardous Substances and New Organisms (HSNO) Act and the Environment Risk Management Authority (ERMA) with respect to the classification of inert gasses (Helium in particular) as a determination of this gas as being Hazardous/Toxic to the Health of the public can be considered given that it can be fatal when inhaled as it effectively stops oxygen to the body with resultant asphyxiation

To the Minister for Consumer Affairs
That a review be undertaken regarding the recreational sale of helium gas to the public in particular to consider that this gas should be an age restricted sale. Recreational sale of the gas should be by way of a container that has a restrictor valve that is irremovable; and/or as to whether recreational sale of gas should be only in terms of a helium/oxygen mixture.

QLD.2010.3685  Intentional Self-Harm/ Fire Related
A person set herself alight with kerosene on purpose.

**Recommendations**
It is recommended the establishment of a Donor Skin Bank and Skin Culture Laboratory in Queensland be progressed as soon as possible. It is noted that these facilities have been approved by the Queensland State Government and are awaiting final regulatory approval by the Therapeutic Goods Administration and it is recommended that this final hurdle be overcome expeditiously.

VIC.2007.5097  Intentional Self-Harm/ Mental Illness & Health
A mentally ill person hung themselves at their home after becoming distressed about a custody hearing.

**Recommendations**
- To improve the safety of patients with mental health issues who are in crisis, the [location] Mental Health Services should review the current guidelines for patients who present to the organisation’s Emergency Departments to:
  - Comply with the Department of Health 2010 Working with the suicidal person- Clinical Practice guidelines for emergency departments and mental health services. Particular emphasis should be given to ensuring that the assessment of patient risk of self-harm and completion of a mental state examination are identified and clearly articulated
VIC.2007.5097 continued

- Develop clear guidelines for the timely review by community mental health services for patients who have undergone assessment and are consequently discharged

- To improve the safety and engagement of the patient, and to mitigate the risk of clinical deterioration, [location] Mental Health Services should review current guidelines regarding how best to support a case managed patient on a Community Treatment order when there are custody issues pertaining to the patient.

I also direct that this finding be distributed to Department of Human services and Department of Health, Mental Health, Drugs and Regions Division for their information.

NSW.2008.6204  Law Enforcement/ Natural Causes

A prisoner died of hypoxic brain injury consequent upon cardiac disease, possible viral infection of the lungs and general suboptimal health. The deceased had been feeling unwell at least three days prior to being hospitalised but was not taken to hospital until his condition sufficiently declined.

Recommendations

I recommend to the Minister for Health being the Minister responsible for Justice Health and to the Attorney-General and Minister for Justice as the Minister responsible for Corrective Services NSW as follows:

- That in any internal review of a death in custody whether conducted by Justice Health or Corrective Services NSW, the author (s) of such reviews take all appropriate steps to interview and/or obtain information from relevant staff on duty or involved with the deceased person in the forty eight hours prior to that person’s death or transfer to an external medical facility and the cellmate(s) of the deceased;

- That if it is not already the case, the Patient Request Forms, known as Green Forms, form part of an inmate’s Justice Health medical file;

- That any written communication to Justice Health clinically relevant to an inmate’s medical condition should form part of the inmate’s Justice Health medical file;

- That in correctional facilities where Patient Request Forms (Green Forms) are in use, these should be reviewed by a Registered Nurse on the day they are submitted by an inmate;

- That Justice Health promptly investigate and seek to devise a policy and procedure or supplement any existing policy and procedure to ensure that any complaint of an inmate regarding breathing difficulty, chest pain and/or respiratory distress to be immediately assessed by a medical professional; and

- That Death in Custody Reports prepared for Justice Health following the death in custody of an inmate include an endorsement by the person responsible to the Chief Executive for the report confirming that that person has had access to the relevant medical records of the deceased inmate prior to submitting that report to the Chief Executive and enumerating all and any source documents relied upon in the preparation of the report.

NSW.2009.4420  Law Enforcement/ Intentional Self-Harm/ Mental Illness & Health

An inmate suffering from mental illness and psychosis hung himself in his cell.

Recommendations

To the Minister for Health and Justice Health

- That there be compulsory mental health training for all nursing staff employed by Justice Health, according to the recommendation made after the death of [name] at [Location] Correctional Centre

- That Justice Health implement an urgent review of all aspects of the care and treatment of [deceased] from his reception into the prison system in March 2009 until his death on 10th September 2009, to be provided to both the CEO and the Chairperson of the Board of Justice Health on the last day of September 2011

- That there be an urgent review of staffing levels at [location] Correctional Centre and in particular [location] Correctional Complex to address the growing waiting lists for inmates requiring the services of Mental Health Nurses and/or Psychiatrists, taking into account the forthcoming opening of a new clinic at [location] Correctional Complex and the large number of transferee inmates. At least one further full time mental health nurse position to be considered for appointment to each Centre.

To the Minister for Corrective Services, and the Minister for Justice Health

- That consideration be given to ways of improving access to health care for inmates on protection or in the Special Management & Protection (SMAP) programme.
**NSW.2009.4420 continued**

- That consideration be given to amending Clause 297 of The Crimes Administration of Sentences Regulation 2008 to allow for details of those special needs of inmates with mental health issues to be given to Corrective Services staff responsible for the transfer of prisoners in order that they be taken into accounts.
- That consideration be given by the Department of Corrective Services to the allocation of a Case Officer to an inmate immediately after a Case Plan is developed, regardless of whether the inmate has reached the gaol of classification.

**NZ.2008.2570 Law enforcement/ Mental illness & Health/ Adverse Medical Effects**

A mentally impaired prisoner died of Clozapine induced cardiomyopathy in hospital.

**Recommendations**

I recommend that:

- *location + District Health Board:* makes available to other District Health Board Mental Services and Forensic Services in New Zealand its updated Clozapine Best Practice Guidelines (to the extent it has not done so already); and
- *Makes available to Medsafe and the Health & Quality Safety Commission its updated Clozapine Best Practice Guidelines* All District Health Boards
- Ensure that their Clozapine Guidelines are up to date and aligned with international best practice

_The Health Quality and Safety Commission_

- Assists in providing national leadership to ensure that the Clozapine Guidelines of all District Health Boards are aligned with international best practice standards and consistent across the country; and
- Identified a process for developing national best practice guidelines for the prescription and monitoring of medications such as Clozapine for which practitioners throughout New Zealand require particular clinical guidance.

I direct that a copy of these findings be sent to the Director General of Health; Medsafe; The Health & Quality Safety Commission; The Centre for Adverse Reactions Monitoring and the Chief Executives of all District Health Boards

**NZ.2009.3403 Law Enforcement/ Weapon/ Youth/ Transport & Traffic Related**

A seventeen year old youth was driving his vehicle when he was shot in the chest by a stray bullet fired by a police officer. The police officer had fired his weapon at an armed offender who had been terrorising the area.

**Recommendations**

The Police have completed an internal review of the pursuits in this case. I support all of the recommendations made and commend them to the Police as deserving of attention. I also make the following recommendations pursuant to section 57 (3) Coroners Act 2006 to emphasise some of the points raised:

- Police continue to work on equipping their fleet of vehicles with automated AVL technology
- Police should ensure that radio protocols are strictly enforced and in particular, continue work to encourage its members to log on with the appropriate Communications Centre manually where an automated system has not been installed
- Police should review the section on Aerial Surveillance contained in the Fleeing Driver Policy, in light of the circumstances of this case, to assess if further guidance is necessary to assist Pursuit Controllers in the appropriate use of aerial surveillance
- Police should initiate steps to purchase and install video surveillance capability for Eagle. Fitting of video equipment will enable Northern Communications Centre to watch events in real time and facilitate better incident management
- That Police look at a means of identifying general police vehicles in operational use by the AOS. Such identification systems should be visible to other vehicles on the ground, and from the air
- Police should continue to develop AOS training modules which endeavour to more closely resemble operational settings
- When deploying on operations, AOS Commanders should acknowledge and take account of the relative experience of its squad members and where possible team squad members with little operational experience with a squad member with more operational experience
- Police investigate the establishment of a Critical Response Vehicle as recommended by [name]
- A copy of these Findings are to be sent to the IPCA.
VIC.2009.1731  Law Enforcement/ Natural Causes
A prisoner died of chronic liver disease and liver cancer while incarcerated.

Recommendations
- Both the Office of Correctional Services Review (OCSR) and Justice Health should ensure the smooth implementation of the proposals contained in their submissions in accordance with best practice principles and including Justice Health
  Proposals to:
    ◊ Amend the Notifiable Incident/ Event Report template and guidelines including review of medical alert rating, risk rating, medical status and outcome;
    ◊ Develop a template palliative care plan to be used with palliative care prisoners; and
    ◊ Review the process to the followed for the purpose of a plea for mercy, so that a formal protocol is provided to contracted health service providers
- The Office of Correctional Services Review proposal to amend the terms of reference and content of their reports and identify any deficiencies to better inform.

WA.2009.1080  Law Enforcement/ Intentional Self-Harm
A prisoner who was going to be charged with murder hung themself in prison. The deceased had jumped from a balcony after committing the serious offence and had injuries but was not deemed a high risk of self-harm by psychiatrists.

Recommendations
- The Department of Corrective Services acts to ensure that all relevant information received on the transfer of a prisoner from WA Police of G4S (or its equivalents) is retained and provided to those tasked with receiving new prisoners and undertaking health, mental health and at risk checks
- The Department of Corrective Services put in place procedures to ensure that information provided by hospital or medical staff prior to a prisoner’s arrival at a prison is retained so that it will be available to those officers tasked with receiving new prisoners and undertaking health, mental health and at risk assessments
- That the Department of Corrective Services when entering into new contracts with custodial providers (such as G4S or SERCO) ensure that the contract provides terms which require important corporate knowledge to be transferred as expeditiously as possibly including information relating to observations during hospital sits and other similar observations
- The Department of Corrective Services act to ensure that those involved with ongoing risk assessments of prisoners receive training under the gatekeeper program and that reviews of the At Risk Status of prisoners be undertaken by officers who have received training under that program
- The Department of Corrective Services take steps to formulate a clear and unambiguous policy as to what comprises an ARMS observation and how often it is expected that members of staff will take positive steps to determine the prisoner’s mood and behaviour
- The department of Corrective Services explore the possibility of using CCTV to provide better monitoring of at risk prisoners
- The Department of Corrective Services liaise with WA Police with a view to ensuring that important information about such remand prisoners as the deceased is communicated to those responsible for their supervision and care

NZ.2009.1232  Leisure Activity
A tourist died after being buried in an avalanche while heli-skiing.

Recommendations
Pursuant to section 57(3) of the Coroners Act 2006 I recommend that:
- The New Zealand Heliski Operators Group (NZHOG) in consultation with other relevant parties continues to develop an industry code of practice
- The NZHOG code of practice be the minimum standard for heli-skiing and other mechanised backcountry skiing
- The NZHOG in consultation with other international operators continue to monitor the efficacy of safety equipment available and leading edge trends in the use or otherwise of new safety equipment
- That probes and shovels for each client, and on-board oxygen and rescue equipment be considered as a minimum standard for heli-skiing in avalanche-prone terrain, particularly during periods of poor stability
- The New Zealand Police as lead agency for New Zealand Search and Rescue continue to develop and update avalanche rescue pre-plans for key locations having potential for an avalanche accident
NZ.2010.1979  Leisure Activity/ Water Related
An experienced surfer died after entering the surf at a dangerous spot, hitting his head on the rocks and subsequently drowning.

Recommendations
I recommend that the [location] District Council give further consideration to erecting a sign at [location] Bay warning beach users of the hazards of entering the water from [name] Rock.

NZ.2010.2691  Leisure Activity
A skier died after falling outside the ski boundary and sliding on firm snow with icy patches, colliding with rocks. The deceased’s protective helmet had become dislodged on impact with the rocks, causing a severe head injury.

Recommendations
I make a general recommendation directed at skiers and snowboarders that helmets be worn in mountainous terrain and that every encouragement is given to that use. This is not a recommendation as to mandatory use of helmets.

I recommend that NZ Ski Limited:
Ski Helmets
• Actively promote the use of ski helmets at all reasonable opportunities including on LED signs and avoids promotional material that depicts skiers or snow boarders in head gear other than protective helmets
Terrain Hazard Management
• In its terrain hazard management applies a strict criteria for opening terrain, particularly off-trail or off-piste, in hard snow or ‘icy’ conditions;
• Gives clear warning of such conditions and of the consequent sliding hazard in reports and information available to customers, particular to the conditions on the day;
• Gives emphasis to the snow surface hazard in addition to the avalanche hazard in signage relating to ski area boundaries;
• Ensures such signage adequately highlights the natural and unprotected hazards that exist beyond the ski area boundary;
South west face
• Monitors from time to time skier/snowboarder access to the south west face and levels of competence of skiers/snowboarders;
• Gives further consideration to measures to counter any adverse activities, if changing trends give concern, particularly as to numbers and expertise (or lack of same) of skiers/snowboarders accessing the south west face.

I recommend that commercial ski areas in New Zealand collectively review Guide to Producing a Ski Area Management Safety Strategy 2004 by way of regular review and update and that this be an ongoing basis of minimum standards in the operation of commercial ski areas. Such review should address
• Criteria to be applied for opening terrain, particularly off-trail or off-piste, in hard snow or ‘icy’ conditions
• Terminology in snow reports and the need for clear warnings of sliding hazard in reports and information available to customers; and
• Access to lift-services backcountry areas.

NOTE: Due to two cases of similar circumstances, where both deceased died from snow related activities while not wearing a helmet, the Coroner handed down combined recommendations.

NZ.2010.2724  Leisure Activity
A snowboarder died after falling and sliding beyond the ski boundary on hard ice and into a creek. The deceased was not wearing a helmet.

NZ.2010.3063  Leisure Activity
A tourist died after sliding on snow and striking rocks, landing on her head. The deceased was not wearing a helmet.

Combined Recommendations
• I make a general recommendation directed at skiers and snowboarders that helmets be worn in mountainous terrain and that every encouragement is given to that use. This is not a recommendation as to mandatory use of helmets.
NZ.2010.2724 & 3063 continued

I recommend that NZ Ski Limited:

Ski Helmets
- Actively promote the use of ski helmets at all reasonable opportunities including on LED signs and avoids promotional material that depicts skiers or snow boarders in head gear other than protective helmets

Terrain Hazard Management
- In its terrain hazard management applies a strict criteria for opening terrain, particularly off-trail or off-piste, in hard snow or ‘icy’ conditions;
- Gives clear warning of such conditions and of the consequent sliding hazard in reports and information available to customers, particular to the conditions on the day;

I recommend that commercial ski areas in New Zealand collectively review Guide to Producing a Ski Area Management Safety Strategy 2004 by way of regular review and update and that this be an ongoing basis of minimum standards in the operation of commercial ski areas. Such review should address
- Criteria to be applied for opening terrain, particularly off-trail or off-piste, in hard snow or ‘icy’ conditions
- Terminology in snow reports and the need for clear warnings of sliding hazard in reports and information available to customers; and
- Access to lift-services backcountry areas.

VIC.2008.3254 Leisure Activity/ Natural Causes

A twenty nine year old person collapsed while lifting weights at a gym and died from a cardiac arrest. There were no staff members present who had a first aid qualification.

Recommendations
That the Minister for Health and the Minister for Sport and Recreation consider enacting regulations mandating the presence of an employee with minimum current Level 1 First Aid qualification, including automated external defibrillator device enhancement, at all times during the operating hours of fitness centres in Victoria.

I direct that a copy of these findings be provided to the interested parties and to:
- The Honourable David Davis MLC, Minister for Health;
- The Honourable Hugh Delahunty MP, Minister for Sport and Recreation;
- The Secretary, Department of Health;
- The Secretary, Department of Sport and Recreation;
- The Chief Executive Officer, Fitness Australia Inc.
- St Vincent’s Hospital Clinical, Risk Management Department;
- Each of the witnesses in these proceedings


An intoxicated, mentally ill Indigenous person died after falling from a tower and impacting with the ground. Due to the mental illness, it is believed that the deceased had a notion that he could ‘fly’ and this may have been a reason why he had climbed the tower.

Recommendations
Upon hearing from the family members their recommendations are:
- That all rural mental health practitioners be more receptive to family concerns regarding family members with mental health problems AND conversely,
- That family members of mental health patients be aware of the necessity of bringing family members with mental health problems to appropriate rural health professionals.
- The family also indicated the apparent undue influence of the Christian religion, more particularly identified as the [name] and [location], upon Aboriginal members of the community with mental health issues.

I have duly recorded these recommendations in the findings of my inquest.
NT.2010.117  Mental Illness & Health/ Intentional Self-Harm
A person suffering from a severe mental illness hung themselves at home while on day release from a psychiatric ward.

Recommendations
As stated previously, the family of the deceased have understandably been shocked and upset by the loss of their loved one. They expressed on many occasions the frustration of the lack of education and assistance received by the family in such situations. I note that there is a difficulty in the sharing of confidential information with family, particularly where a patient is not psychotic and is willing to undertake treatment, as was the case with the deceased. I consider however that there can, and must be, an improvement in the assistance that is provided to family following a suicide attempt.
As I indicated during the course of proceedings, every other Coroners Office in Australia has grief counsellors. The Office of the Coroner of the Northern Territory does not provide this service. This must be addressed. Grief counsellors are trained social workers/psychologists, who are experienced in meeting and talking with bereaved parents and relatives. This is a very important and necessary function.

As a result I recommend that the Northern Territory Government give consideration to the merits of funding such a service here in the Northern Territory. If other jurisdictions in the country can recognise the vital need for such persons, and such a service, I suggest the department and Justice consider it.

NZ.2008.1443  Mental Illness & Health/ Intentional Self-Harm
A psychiatric patient who was on unescorted leave from the ward, died after jumping from a bridge.

Recommendations
To: The Chief Executive Officer, [location] District Health Board [address]
That whenever a patient is granted leave of absence from [hospital] (whether escorted or unescorted), the terms and conditions of such leave, the risks to which the patient remains subject and all necessary interventions (including monitoring) shall be documented in the Multi-Disciplinary Team Plan (together with those other particulars prescribed by the Board’s Leave Management Service Users Policy) AND if the patient is to be placed in the temporary care of family members/whanau/caregivers or friends, a copy of such plan should be made available to them.

NZ.2009.1424  Mental Illness & Health/ Water Related
A person suffering from depression and anxiety died of drowning after being found in a harbour. There is doubt as to the intentions of the deceased.

Recommendations
I recommend that a copy of this Finding be sent to [location] Hospital Board for the information of its Mental Health Team.

NZ.2009.1816  Mental Illness & Health/Intentional Self-Harm/Transport & Traffic Related
A psychiatric patient, on a four hour trial period of leave from the hospital, deliberately drove their car into an oncoming truck.

Recommendations
I endorse the recommendations set out in the New Zealand Transport Agency report that the “[Transport] Industry and regulators should consider the introduction of certified headboards as mandatory when carting these types of loads’ (in this case poles and planks of wood used for scaffolding).
NZ.2009.2510  Mental Illness & Health/ Natural Causes
A person under an indefinite compulsory treatment order died from coronary artery atrophy in his home. The deceased lived in squalid conditions and despite family asking mental health services for help for hygiene matters, it was determined that the deceased did not qualify for this help.

Recommendations
To the [location] District Health Mental Services
That they carry out a review of their protocols as to ensuring that where a patient is under a community based order, that the patient is placed in the community with the requisite health hygiene and care facilities and that these are robustly monitored.

To the Minister of Health
That where such patients under an indefinite compulsory community treatment order, ensure that they receive adequate medical treatment, hygiene and general welfare care. It is clear that this did not occur in this instance. I have read extensive notes provided to the Court by the Family of the deceased. I have viewed photographs of the deceased’s residence. It is clear that it was an unhealthy environment. It was not hygienic.

NZ.2009.2665  Mental Illness & Health/ Intentional Self-Harm/ Weapon/ Drugs & Alcohol
A mentally ill person died after shooting themself. The deceased had consumed a large quantity of alcohol and cannabis before death.

Recommendations
- I recommend that a copy of this Finding be forwarded to Dr [name], Medical director, Mental Health Services [hospital] for education and training purposes
- I recommend that a copy of this Finding be sent to the Director General of Mental Health
- I ask that the issues that I have identified in relation to the mental effects on young males who consume cannabis be considered and that the Mental Health [Compulsory and Treatment] Act 1992 be reappraised with a view to creating a further degree of compulsion for patients to adhere to treatment programmes short of a restraint under the terms and conditions of the Act.

NZ.2010.601  Mental Illness & Health/ Intentional Self-Harm
A mentally ill person took their own life by hanging after becoming depressed over an upcoming court case.

Recommendations
I recommend that a copy of this Finding be forwarded to [hospital] for its information and for training and education purposes.

NZ.2010.1551  Mental Illness & Health/Intentional Self-Harm/Weapon
A mentally ill person took their own life by a gunshot wound to the head.

Recommendations
I recommend that a copy of this Finding be forwarded to the [location] Health Board for its information and for training purposes.

NZ.2010.1969  Mental Illness & Health/Drugs & Alcohol
A mentally ill person who was facing a number of police charges, died of a drug overdose. The intent of the deceased is unknown.

Recommendations
I recommend that a copy of this Finding be forwarded to the [location] Health Board for its information.
NZ.2010.1997  Mental Illness & Health/ Intentional Self-Harm
A mentally ill person, who was looking at the possibility of a jail sentence, took their own life by carbon monoxide poisoning.

Recommendations
I recommend that SDHB be forwarded a copy of this Finding with my request that the content of the Sentinel Event Review and particularly the Summary including recommendations be actioned.

SA.2008.1618  Mental Illness & Health/ Drugs & Alcohol
A psychiatric patient was found deceased in his bed from an overdose of prescription drugs. It is unknown whether the deceased took his own life, or whether it was an accidental overdose.

Recommendations
- That the principal administrative officer or equivalent of the Margaret Tobin Centre give further consideration to the implementation of SAPOL recommendations within this finding.
- That the principal administrative officer or equivalent of the Margaret Tobin Centre take the necessary steps to ensure that upon the death of a patient within the Centre, all CCTV footage is retained and not overwritten until permission to do so has been obtained from the State Coroner or SAPOL.

SA.2008.1907  Mental Illness & Health/ Intentional Self-Harm
An inpatient at a psychiatric ward hung themselves from the shower tap in the bathroom of their hospital room.

Recommendations
At the conclusion of the evidence and final addresses in this Inquest I delivered a brief extempore finding and recommendation that I now repeat.

I recommend that the alteration which includes, as I understand it, the replacement of shower taps similar to this that the deceased used as a ligature point, be expedited. I direct that recommendation to the Executive Director of the Adelaide Health Service, Mental Health Service, Central and Northern and would add that I would also recommend that the alterations and modifications and replacements of other identified hanging points, as mentioned in the material attached within and to the affidavit of [doctor] be implemented as soon as possible.

I make the following additional recommendations directed to the Minister for Mental Health:
- That ACIS workers refrain from making an assessment of risk of self-harm that differs from that of the referring medical practitioner or other health care professional without consulting that medical practitioner or other health care professional. In this regard, I refer to a similar recommendation made by this court in the matter of the death of [name] on [date] 2002.
- That ACIS workers be required in making any assessment of risk of self-harm that they endeavour to access all information about the longitudinal mental health history of the patient that is in the possession of ACIS or other Department of Health entity;
- That ACIS workers be required in making any assessment of risk of self-harm that they endeavour to seek as much information as they are able from relatives and family members of the person being assessed;
- That systems be developed within the Department of Health that would enable staff of the SAMHS to access all information regarding the mental health history of a patient however stored, whether electronically or otherwise. In this regard, I refer to the comment made by [doctor] in his report that the case: ‘Does again highlight the desirability of one treating area being able to readily access past details of admissions, rather than simply obtaining discharge summaries. I understand that there have been repeated coronial recommendations in this regard and progress has been slow’;
- That clinicians employed at psychiatric facilities of public hospitals be reminded of the need to obtain ‘collateral information’ concerning recently admitted patients and that the information should be obtained as soon as possible following admission, even if it means that the information has to be obtained on a weekend or on a public holiday.
TAS.2008.24 Mental Illness & Health/ Intentional Self-Harm
A mentally ill inpatient, who was involuntarily detained in a psychiatric ward at a hospital took their own life by hanging.

**Recommendations**
A coroner has a statutory obligation to establish how, why and when a person died and, when appropriate, make recommendations upon ways of preventing further deaths and also, where appropriate, make comment upon any matter connected with the death including matters related to public health. There is an expectation, I believe, both on the part of the family of a deceased person and on the part of the community generally that the coroner will have access to all relevant information which enables him/her to fulfil these obligations. Any obstruction to that access brought about by resort to s4 of the Health Act 1997 has, in my view, the potential to undermine public confidence in the integrity of public health administration and in the capacity of the coroner to meet his/her statutory duties. The need for there to be absolute transparency and unfettered disclosure is particularly necessary, in my opinion in those cases, as has occurred here, where the death involves a person involuntarily detained in a secure mental health unit pursuant to the provisions of the Mental Health Act 1996.

The foregoing leads me to support any move to legislate for a revision of the confidentiality provisions which attach to quality assurance committees so that the coroner has unfettered access to all information received by such a committee in the course of a death investigation including all recommendations which may follow from its deliberations. I acknowledge that there may exist, as Professor [name] has identified ‘attitude and cultural issues’ on the part of some health professionals in the public sector which may make them reluctant to participate in committee investigations if unprotected by confidentiality provisions.

It is thus my recommendation that any steps to remove the confidentiality provisions be accompanied by the implementation of a programme to educate all medical professionals upon the need for and the benefits of their participation in the investigation of all adverse medical deaths and that they be conducted in a totally open and transparent environment.

VIC.2007.1880 Mental Illness & Health/ Intentional Self-Harm/ Weapon
An elderly person with extreme fits of jealousy and mental illness died after shooting himself with a handgun. The deceased had shot his partner just prior to taking his own life.

**Recommendations**
To assist in the raising of awareness and development of understanding of the increased risk of harm within intimate personal relationships of pathological jealousy, I direct the distribution of this Finding to the following organisations and entities for their information only:
- The Office of the Chief Psychiatrist, Department of Health, Victoria
- The Royal Australian and New Zealand College of Psychiatrists
- The Australian Psychological Society
- The Royal Australian College of General Practitioners

VIC.2008.310 Mental Illness & Health/ Intentional Self-Harm/ Drugs & Alcohol
A person with a history of anxiety and depression died after an intentional drug overdose. The deceased stole the drugs from his workplace, a major hospital.

**Recommendations**
While the [location] Hospital cannot be expected to prevent all instances of theft of this kind, I recommend that details of this case be provided to those responsible for the management of unused anaesthetics at the Hospital with a view to giving emphasis to the need for the ongoing careful auditing of unused supplies

VIC.2008.3345 Mental Illness & Health/ Intentional Self-Harm/ Drugs & Alcohol
A mentally ill and drug addicted person, who suffered from a personality disorder, took their own life by hanging. The deceased and his family had sought emergency treatment before his death but were unable to due to a lack of available beds.
VIC.2008.3345 continued

Recommendations
- That public health authorities work towards the development and provision of integrated dual diagnosis services for those with mental illness (including personality disorders) and substance dependency and that those services be made available to those being treated in both the public and private mental health systems.
- That the provision of mental health services to persons diagnosed with personality disorders be reviewed to ensure that a consistent approach to the characterisation and classification of personality disorder as a mental illness is adopted by public mental health services in Victoria.
- That the effectiveness of the operation of the Alcoholics and Drug Dependent Persons Act 1968, be enhanced by the provision of long term in patient involuntary and voluntary treatment beds for persons with alcohol and drug dependency.
- That a review be undertaken of the operation of the Alcoholics and Drug Dependent Persons Act 1968, to ascertain its effectiveness in enabling the detention and enforced treatment of persons unable to function in the community as a result of alcoholism and/or drug dependency.
- I direct that a copy of these findings be provided to the interested parties and to each of the witnesses in the proceeding, together with: The Honourable Mr David Davis MLC, Minister for Health (Victoria); The Honourable Ms Mary Woolridge MP, Minister for Community Services (Victoria); The Office of the Chief Psychiatrist, Dr Ruth Vine; The Secretary, Department of Health (Victoria); The Secretary, Department of Human Services (Victoria)

VIC.2009.4919        Mental Illness & Health/ Intentional Self-Harm/ Drugs & Alcohol

A person suffering from severe mental health issues overdosed on prescription medication intentionally. There had been a delay in getting treatment from mental health providers, despite intervention from a GP.

Recommendations
- That the Secretary, Department of Health, review mental health services practices in relation to the patient’s residential address being the determinant of the location of care. In particular, in relation to patients with prior attendance history at an area mental health service.
- That the Secretary, Department of Health, review the manner in which referral by General Practitioners to Public Mental Health Services are made and prioritised or triaged, to ensure that GP’s as frontline mental health providers, have access to appropriate levels of support and assistance when making referrals.
- I direct that a copy of these findings be provided to the interested parties: The Honourable Mr David Davis, MLC Minister for Health (Victoria); The Secretary, Department of Health (Victoria); The Executive Officer, North West Mental Health Service; The Office of the Chief Psychiatrist, Dr Ruth Vine; The Royal Australian College of General Practitioners and Dr [name].

NZ.2009.1214        Natural Causes/ Adverse Medical Effects

A person died of natural causes as an outcome of ‘swine flu’. The deceased had visited a medical centre prior to passing away but the swine flu was not diagnosed.

Recommendations
I recommend that a copy of this Finding be forwarded to the Medical officer of Health and to [location] Medical Centre for their information.

VIC.2009.5214        Natural Causes/ Falls/ Drugs & Alcohol

A person died from ischaemic heart disease after falling from a roof while installing an antenna. The deceased had suffered from heart problems previously and was taking an imported substance from the USA to treat this.

Recommendations
I would recommend that the Chief Health Officer for Victoria/ the Department of Health consider sponsoring the joint development of a public education campaign about the dangers and risks of sourcing medical information and products online involving all the relevant stakeholders.
NZ.2009.815  Older Person/ Falls/ Natural Causes
An elderly person died of cancer exacerbated by hypothermia. This was due to being discharged from hospital, returning to a locked house and in a panicked state, has fallen and sustained injuries including a concussion.

Recommendations
I recommend that a copy of this Finding be sent to [location] Hospital. [Location] Hospital should learn from the discharge experience of [deceased] and make sure that future discharges are accompanied by more strict protocols to ensure that patients recently discharged receive timely and appropriate support at the place to which they are discharged.

TAS.2007.362  Older Person/ Falls/ Adverse Medical Effects/ Physical Health
An elderly person had a fall at home, fracturing his spine and died in hospital after surgery to remove an extradural haematoma. The deceased suffered from scoliosis which attributed to the fracture.

Recommendations
The circumstances of the [deceased’s] death were also the subject of an investigation by a Serious Incident Panel convened by [location] Hospital. That investigation led to the following recommendations:

- That the [hospital] Neurosurgical Unit review and formalise its transfer process for patients who are transferred from the north of the State; and
- The transfer process be modelled similar to the system in place within the [hospital’s] Department of Plastics and Reconstructive Surgery
- I note and support the recommendations arising from the reviews undertaken by the Serious Incident Panel and the Division of Surgery. It is in particular hoped that the [hospital] now has in place a transfer process which guarantees the timely and comprehensive provision of all relevant patient information by all regional hospital so that the risk of similar tragic outcomes can be minimised.

TAS.2011.180  Older Person/ Natural Causes/ Falls
An elderly person had a fall at home and fractured his neck. Due to his frail state and possibility of fatality during surgery, the hospital did not operate. The patient was found deceased in his hospital bed two days later.

Recommendations
I am satisfied that the care and treatment provided to the deceased by [hospital] was proper and appropriate and no criticism can fairly be made of it. However, there is one matter that requires comment. It was evident from the outset that the deceased’s fatal neck injuries were the consequences of an accident at his home. The Coroners Act 1995 provides that any death that appears to have resulted from an accident is a reportable death which must be reported to the coroner as soon as possible. Failure to comply with this obligation is an offence. The material provided to me indicates that the coroner was not advised of the deceased’s death until one week after its occurrence. This is an unsatisfactory circumstance. It causes me to recommend that the [hospital] take immediate steps to educate its staff upon the reporting requirements of the Coroners Act 1995 and to put in place protocols to ensure compliance with them.

VIC.2009.3299  Older Persons/ Falls/ Aged Care
An elderly woman fell at a nursing home and hit her head, fracturing the right neck of the femur. The deceased was unable to get to her personal alarm that was fixed to the wall until sometime after the fall. She was taken to hospital. but her condition deteriorated and she passed away.

Recommendations
The development of residential care standards for Supported Residential Services (SRS) offers the opportunity to encourage a review of personal alert systems, to determine whether viable options exist to have alarms which are fixed to the resident. It is therefore recommended:

The Department of Health, in the development of the Accommodation and Support Standards of the Supported Residential Services (Private Proprietors) Act, should review the ‘best practice’ arrangements for alarm systems to determine whether alarms which can be fixed or worn by residents should be mandated to reduce the consequences of unwitnessed falls in residential care settings.
VIC.2011.60  Older Person/ Falls
An elderly person died of an intracerebral haemorrhage after an unwitnessed fall at a regional hospital.

Recommendations
I recommend that Falls Risk Assessment Tool (F.R.A.T) assessments include, where possible, speaking to family members to ensure accuracy of information in relation to a patient’s fall history.

TAS.2010.269  Physical Health
A resident in a shared care facility with a severe intellectual impairment died after choking on gastric contents.

Recommendations
It is not possible to say with certainty that the deceased’s death may have been preventable if his bedroom had been fitted with some form of easily accessible emergency alert device. I recommend that the organisations that manage accommodation of this nature investigate the installation of such devices. I would also recommend that support organisations review their procedures to assess the viability of night time carers carrying out periodic checks of residents particularly those who might from time to time be suffering any illness.

NSW.2010.2522  Sports Related/ Adverse Medical Effects/ Youth
A youth died after being tackled in a rugby game. The deceased was discharged from hospital but died the following day from a ruptured duodenum.

Recommendations
To the Minister of NSW Health:
Noting that the Garling Report made a recommendation concerning the supervision of junior clinicians which appears to be very useful but does not cover the situation for overseas trained doctors that have more than two years post graduate experience in countries outside of Australia, I make the following recommendation:

- NSW Health should consider developing and implementing state-wide policies setting out a best practice model for the supervision of overseas trained non specialist doctors working in Australian hospitals for the first time. This policy should:
  - Define supervision
  - Define the objectives and content of supervision
  - Define the supervisory relationship including the roles and responsibilities of clinical supervisors and trainees;
  - Set out mechanisms for resolving difficulties relating to inadequate supervision and
  - Recognise the importance of the supervisors role

To the Executive Officer of the Australian Medical Council
- The Australian Medical Council should consider introducing specific topics in the examination required for the registration of overseas trained doctors which address the following:
  - Communication skills
  - Handover; and
  - Note taking

To the Executive Officer of the NSW medical Board:
- The NSW Medical Board should give consideration to the need for better pathways of supervision for overseas trained non specialist doctors working in NSW Hospitals for the first time and that the NSW Medical Board should liaise with NSW Health in this regard
**QLD.2010.964 Sports Related/ Water Related**

A surf lifesaver competing at National Championships was hit by a board in strong waves and subsequently drowned.

**Recommendations**

- **Make safety paramount**

  Because surf life-saving carnival organisers have to deal with so many competing demands, it is possible the paramountcy which safety deserves can be intentionally diminished. Accordingly, I recommend SLSA review the safety section in the Surf Sports Manual with a view to ensuring event organisers are directed to focus on safety in a way that does not invite them to seek to balance competing views as to whether competition should continue. Event officials should be required to suspend competition whenever there is a reasonable basis for concluding there is a risk of serious injury.

- **Continuing review of safety devices**

  As it is impossible to eliminate the risk of a competitor in a surf ski or board event being struck by a craft, it is essential that injured competitors be rescued as quickly as possible. This would be enhanced by devices that make the competitors easier to see and cause them to float to the surface even if unconscious. I recommend SLSA collaborate with designers of such devices with a view to making the wearing of them compulsory once the organisation is satisfied they are suitable. Consideration should also be given to the use of helmets by competitors in surf craft events.

- **Queensland Police Service (QPS) Search and Rescue Mission Coordinator (SARMC)**

  I recommend that the QPS contingent at large surf lifesaving events includes at least one officer with advanced marine search and rescue training that will equip the officer to plan and coordinate the emergency response should a competitor or official go missing in the water.

- **Surf Patrols for marine MPs**

  I sympathise with those who express frustration that better use was not made of the many lifesavers present when [the deceased] went missing. I acknowledge the need for any response to be planned and coordinated and for there to be various alternatives depending upon the emergency that presents. Accordingly, I recommend that SLSA investigate whether surf patrols could coordinate a search by swimmers for a person missing in the sea as an alternative to a search by a power craft in appropriate cases.

**NT.2010.165 Transport & Traffic Related/ Drugs & Alcohol**

An intoxicated person died after losing control of the quad bike he was riding, and was ejected from the bike, with it landing on top of him. The deceased was not wearing a helmet.

**Recommendations**

I recommend that the government give consideration to assessing safety concerns to quad bike riders who do not wear helmets and the community benefit of legislating that helmets be worn by quad bike riders and passengers.

**NZ.2009.991 Transport & Traffic Related**

A driver died after the car they were driving struck an over dimension load being transported on a truck and trailer during hours of darkness, at a time when the truck and trailer unit had no authorisation to be on the road.

**Recommendations**

I recommend pursuant to section 57(3) of the coroners Act 2006 with particular respect to Category 3 and 4 over dimension loads, that:

- New Zealand Transport Agency (NZTA) puts in place a travel time restriction crosscheck to reduce the opportunity for breaches of travel time restrictions
- NZTA/ New Zealand Police take a strong line in enforcing compliance with travel time restrictions
- NZTA requires all holders of Class 1 pilot licences to sit an approved training course and be found competent in the theory and practical aspects of piloting at regular intervals
- NZTA considers how to better achieve continuous compliance of over dimension load requirements including the expansion of its national auditing function of over dimension loads using its existing resources of Vehicle Transport Officers in conjunction with Police commercial Vehicle Investigation Unit staff
- NZTA through the Over dimension Permit Issuing Authority (OPIA) remedies the situation highlighted by this case concerning after-hours movement notifications for over dimension vehicles and loads be either requiring that all movement notifications be made during office hours when a specialist OPIA officer is available or (preferably) proving an on-call OPIA officer for after-hours movement notifications
NZ.2009.991 continued

- NZTA considers the requirements for illumination of over dimension loads that lack bulk and visual substance, with particular reference to the effects of lights from following vehicles affecting visibility of oncoming motorists in times of darkness, with possible banning of the transportation of such loads during hours of darkness.
- New Zealand Police consider the means of better utilising the knowledge and expertise of Police Commercial Vehicle Investigation Unit staff and NZTA Vehicle Transport Officers in the policing of over dimension vehicles and loads, and making this expertise available to other front line staff involved in vehicle surveillance.

NZ.2009.2687  Transport & Traffic Related/ Mental Illness & Health/ Natural Causes

A person suffering from dementia died in hospital from acute myocardial infarction, with an underlying condition being multiple injuries sustained in a car accident eight days previously, in which the deceased’s car travelled onto the wrong side of the road and crashed head on into another vehicle.

Recommendations
I recommend that the relevant agencies (The Ministry of Health, Ministry of Transport and the New Zealand Transport Agency) consider whether:

- Occupational therapy assessment of fitness to drive or other approved test (that includes on-road testing) should be made mandatory where medical practitioners require assessment of driving risk for people with dementia or other cognitive impairments.
- Funding should be made available for such testing.

NZ.2010.389  Transport & Traffic Related/ Work Related

A midwife died after she fell asleep after a night shift and lost control of her car, colliding with trees and sustaining fatal injuries.

The airbags in the car had inflated once the vehicle had hit the first cluster of trees, but had deflated in the few seconds it took the car to hit the second cluster of trees.

Recommendations
I recommend that a copy of this Finding be sent to Land Transport New Zealand for its information and so that the issue in relation to the failure of the airbags fitted to the car to adequately and appropriately protect the car driver and passenger can be investigated.

NZ.2010.644  Transport & Traffic Related/ Drugs & Alcohol

A farmer died after riding his quad bike through temporary fencing wire and being thrown off the bike, striking the ground. The deceased was not wearing a helmet and had been drinking.

Recommendations
I direct that a copy of these findings be sent to the Department of Labour, the Accident Compensation Corporation, Federated Farmers and FarmSafe to highlight the safety issues raised in this matter, including the potential hazard temporary fencing erected across vehicle access ways in the course of farming business poses for those using the access way and the need for vigilance by farmers in the use of such fences.

I recommend that the circumstances of the [deceased’s] death are brought to the attention of Coroner Shortland for consideration as part of his wider inquiry into quad bike deaths and direct that a copy of these findings be sent to him for his assistance.

NZ.2010.1302  Transport & Traffic Related/ Sports Related/ Youth

A fifteen year old died after losing control of a motorbike while attempting to complete a jump at a motorbike park, and landed on his head.
NZ.2010.1302 continued

**Recommendations**

- I recommend that a copy of this finding be forwarded to Motorcycling New Zealand in order that the lessons learned, in such tragic circumstances by the family of [deceased] are not repeated.
- I recommend that a copy of this Finding be forwarded to St John Ambulance to ensure that the site [location] Park is identified in their records as one which may require possible helicopter service.

NZ.2010.1450  **Transport & Traffic Related/ Drugs & Alcohol**

A person died of extreme internal crush injuries after getting out of a car and being struck by the attached boat, and falling under the trailer which then ran over him. The deceased had consumed alcohol prior to the incident, which may have affected his balance while getting out of the car.

**Recommendations**

I recommend that a copy of this Finding be forwarded to the New Zealand Transport Authority for its information.

NZ.2010.1814  **Transport & Traffic Related**

A person died when they lost control of the vehicle that they were driving around a bend and collided with an oncoming vehicle that was driving on the correct side of the road.

**Recommendations**

I recommend that a copy of this Finding be forwarded to the Land Transport Authority of New Zealand for its information.

NZ.2010.2252  **Transport & Traffic Related/ Older Persons**

A person with possible visual problems due to age died after the car that they were in failed to check for traffic before entering a road and collided with a logging truck.

**Recommendations**

I recommend that a copy of this Finding be forwarded to New Zealand Transport Agency for its information and in order that New Zealand Transport Agency may investigate further the issue drawn to our attention by [optometrist] and the family of the deceased in relation to Visual Standards.

TAS.2009.48  **Transport & Traffic Related/ Youth/ Drugs & Alcohol**

A seventeen year old was killed after the vehicle she was travelling in drove onto the wrong side of the road while overtaking, and lost control, overturning the vehicle. The deceased was not wearing a seatbelt. The driver of the car had consumed marijuana before driving, and had never held a license.

**Recommendations**

I urge young drivers to drive with the upmost caution and in obedience to the road laws. In the context of this tragic case, it should also be emphasised that cannabis use before driving can impair co-ordination and impact adversely on reaction times and judgment. Of course, many younger drivers are responsible road users. However, it cannot be emphasised strongly enough that over-confident and risk-taking driving behaviour can result in tragic and unnecessary loss of life.
An interstate tourist died after the vehicle they were travelling in left the roadway and collided with a stand of poplar trees.

**Recommendations**
During the investigation [police officer] drew attention to the placement of the stand of poplar trees at the crash scene. He observed that many trees in this area are within the boundary fences of the farms adjacent to the highway and do not pose a threat to motorists. However, the trees at the crash location are only 3.2 metres from the sealed edge of the roadway and are on the exit side of a sweeping corner. The trees appeared to [police] as having grown unchecked.

I would recommend that the highway authorities inspect the placement of these trees and remove them to provide greater safety to road users.

**VIC.2004.2665 Transport & Traffic Related**
The deceased was the pilot of a small aircraft that crashed with six occupants on board. All were fatally injured.

**Recommendations**
But for a reading of section 72 (2) of the Coroners Act 2008 which does not encompass federal Ministers, public statutory authorities or entities, I would have recommended that the Civil Aviation Safety Authority reconsider the introduction of a requirement that aircraft with a passenger capacity such as TNP be fitted with a Terrain Awareness and Warning System.

**NOTE:** Due to twelve cases of similar circumstances, where the deceased persons died after rock fishing, the Coroner handed down combined recommendations.

**NSW.2009.6352, 6353 Water Related/Leisure Activity**
Two people were presumed drowned after being washed off rocks while fishing.

**NSW.2009.6364 Water Related/Leisure Activity**
A person drowned after being swept off rocks while rock fishing and became tangled in his fishing line.

**NSW.2010.1864, 1884, 1885, 1886, 3063 Water Related/Leisure Activity**
Five people drowned after being swept off rocks while rock fishing.

**NSW.2010.2016 Water Related/Leisure Activity**
A person drowned after falling or being swept off rocks while rock fishing.

**NSW.2010.3188 Water Related/Leisure Activity**
A person drowned after being washed off rocks while fishing.

**NSW.2010.3412, 3413 Water Related/Leisure Activity**
Two people drowned after being washed off rocks while fishing.

**Combined Recommendations**
I endorse and incorporate here the recommendations made to the then Minister for Industry and Investment by His Honour Deputy State Coroner Magistrate McMahon in the inquests that he held into rock fishing deaths earlier this year.

‘That research be undertaken under the authority of the Department to:
- Identify the demographic groups most at risk of drowning related to rock fishing fatalities, and identify and assess the effectiveness of all educational, enforcement and engineering safety methods currently used to prevent such fatalities
- That the results of such research be used to develop a rock fishing safety program for NSW’

The terms of His Honour’s recommendations are wide and many of the issues highlighted by the evidence before me, would seem to fall within the terms of his Honour’s recommendations which I have adopted. I consider it appropriate though, given some of the issues that have arisen in the evidence before me, to make specific recommendations to the Department of Primary Industries, that it consider the following specific issues in developing an enhanced rock fishing safety plan for NSW.
Combined recommendations continued

- To consider whether the time taken for local government authorities and other relevant agencies to approve the erection of appropriate warning signs and the provision of safety devices in relevant locations is an acceptable time period. To consider what steps to be taken to speed up the process involved in approving the erection of such warning signs and flotation devices
- To consider what is the most appropriate portable flotation device that should be carried by those involved in rock fishing. The Department ought consider whether or not it should be compulsory for any such device to be in the possession of a person who engages in rock fishing
- To consider whether the level of funding available to organisations such as the Alliance and Surf Life Saving NSW for education campaigns about the dangers of rock fishing, particularly for campaigns directed at Australians of a non-Anglo Celtic background is sufficient.

NZ.2010.453 Water Related/ Leisure Activity
A person drowned after his boat was struck by a large wave and overturned. The deceased was not wearing a life jacket.

Recommendations

- I recommend that a copy of this Finding be sent to MNZ to express my support for their continuing education programme
- I recommend that a copy of this Finding be forwarded to the [location] Regional Council whom I am advised is the appropriate agency to supervise safety findings in the area

NZ.2010.3036 Water Related/ Youth
A schoolboy died of pneumonia after a near drowning on a school excursion. The deceased did not get permission from his parents to attend the excursion, and was caught in rough waves while observing an educational lesson in the water.

Recommendations

- I recommend that the Board of Trustees and the Principal of [Location] College review the documentation used, and reconsider the safety instructions, the site and the supervision standards of shoreline activities on any future Education Outside The Classroom trips taking into account advice from, in particular, Surf Lifesaving New Zealand.
- I recommend that The Board of Trustees of [Location] College report to the [deceased’s] family when the above process has been completed.
- I will send this finding to the Minister of Education for distribution as the Minister sees fit.

TAS.2009.573 Water Related/ Leisure Activity/ Physical Health
An intellectually disabled person drowned after their fishing boat sank. The deceased was trapped in the cabin area, and refused to let go of a handle while the boat was sinking. The deceased was wearing a positive buoyancy style life jacket.

Recommendations

Apparently the vessel took on water over a low transom. It is also possible that buoyancy tank voids under the floor contained water as stagnant water was removed from these areas after the vessel was recovered. Given the layout of the vessel and the flooring the vessel would have contained a significant amount of water before it became noticeable above floor level. At that stage the water pump and bailing would have had difficulty in resolving the problem. The weight of water taken in lowered the stern even further which with increasing seas meant more water was entering the vessel. The design of the vessel was such that the occupants in normal operation would occupy the rear 30% of the vessel thus placing more weight at the stern and compromising the low transom. The lack of positive buoyancy fitted to the vessel meant it would sink quickly, stern first. This vessel was constructed before the introduction of the Australian Builders Plate in July 2007 which prescribed the requirement for positive buoyancy to be fitted to vessels. I am aware of an extensive publicity campaign conducted by MAST to have boat owners check their vessel’s buoyancy and retrofit positive buoyancy where necessary. I strongly encourage all boat owners to heed this message.
Although CPR was conducted upon [the deceased] subsequent to his recovery from the water the adults involved were reliant upon advice from young persons on the vessel who had received instruction at an “Austswim” program. It is timely to highly recommend that persons involved in any form of water based recreational activity ensure that they have at the very least the knowledge and ability to conduct basic CPR.
**TAS.2010.290  Water Related**

A diver died of a cerebral gas embolism while diving for scallops. The deceased was using an air compressor brand called ‘hookah’ which appeared to have had a leak.

**Recommendations**

The defects with the Hookah equipment are outlined herein and it is of concern that these deficits were not known to or able to be recognised by the users of this machinery. I am not aware of whether the number of instances of diving accidents associated with the use of Hookah equipment warrants the cost associated with a formal regulatory system, but at the very least there needs to be readily available public information stressing the need for professional assessment and periodic servicing of such equipment. Such information needs to stress that diving, especially in deeper water, is a hazardous activity and any equipment faults or shortcomings would accentuate the risks associated with this activity.

I am unable to say upon the information available whether or not the medical advisors of the deceased were aware of his recreational activities, in particular diving. I would have thought however that any public information that is provided about diving should address the risk factors and the need to ensure that those involved in the activity have sought advice from their doctor as to whether there is anything concerning that persons health that either precludes them from engaging in diving or at the very least gives that person an understanding of any increased risk that they need to accept should they continue that activity.

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**NSW.2002.3355  Work Related**

A security guard was found deceased in a gymnasium from the effects of carbon monoxide poisoning from a water heater.

**Recommendations**

The dangers of carbon monoxide produced by domestic heaters.

[The deceased] died when an external gas heater produced CO and because it was enclosed the CO was able to accumulate in the area in which [the deceased] was required to be in the course of his employment. During the course of the inquest evidence was given that the danger of CO poisoning was not as well-known as it was in colder northern hemisphere countries. It was suggested that in addition to dangers in the nature of that which led to [the deceased’s] death with the growing number of apartment dwellers in Australian cities problems could occur where balconies on which gas barbecues were located were enclosed. It was submitted that it would be appropriate for recommendations to be made in accordance with section 82 that would bring such dangers to the attention of persons managing buildings and the community in general. I consider that to make such a recommendation would be appropriate and propose to do so.

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**NSW.2009.2875  Work Related/Fire Related**

A welder was killed after a large stainless steel wine tank blew up during a welding operation after ethanol vapours ignited. The deceased was killed in the explosion.

**Recommendations**

- I recommend that the Work Cover Authority of NSW consider developing a simple and practical method of bringing the Notification of Dangerous Goods requirement to the attention to consignees of Dangerous Goods.

- I recommend that the Work Cover Authority of NSW consider conducting a one-off publicity campaign within the wine industry reminding wineries of the risks associated with the storage and use of ethanol. Consideration of a similar campaign in the metal fabrication industry is also recommended.
**NZ.2008.4250  Work Related/ Water Related**

A sailor performing a training exercise was thrown into the water after a connecting rope broke and the sailor drowned.

**Recommendations**

At the outset of this Finding I indicated that the RZNZ had seriously considered the lessons from this tragedy. They have made significant changes to the HMNZS Canterbury in terms of safety features and conditions in which their sailors work. They have spent huge amounts of money in correcting deficient systems.

The most important recommendation that should be noted is that no naval ship or major military asset should be accepted into service until proper and credible trials are complete and have been critically reviewed. The trials being mechanical and operational familiarity.

Acceptance of certifications at various stages does not equate to a fully safe functioning vessel as was the case in this tragedy. There should be a proper and full safety certification process upon completion of the vessel. I accept this is a complex process.

The haste shown to rush the HMNZS [name] into service has only contributed to the unnecessary and preventable death of [deceased]. In an environment where fiscal responsibility and restraint tends to dominate major decisions this by no means should be a factor that compromises features of safety for sailors and their working conditions.

All military personnel that work on or with a military asset, whether it be a naval ship or some other asset, is entitled to perform their duties in a situation that is as safe as it can possibly be, recognising there is an inherent risk and danger in the activities they are involved in. It is incumbent upon procurement authorities and government to ensure they provide an asset that has had the appropriate safety audits before seeing action. There is no room for unnecessary deaths.

The [deceased’s] death illustrates that safety is paramount and no expense should be spared in establishing good safe and reliable systems.

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**NZ.2009.3726  Work Related**

A mountain guide died after becoming buried in an avalanche while heli-skiing.

**Recommendations**

Pursuant to section 57(3) of the Coroners Act 2006 I recommend that:

- The New Zealand Heli-ski Operators Group (NZHOG) in consultation with other relevant parties continues to develop an industry code of practice
- The NZHOG code of practice be the minimum standard for heli-skiing and other mechanised backcountry skiing
- The NZHOG in consultation with other international operators continue to monitor the efficacy of safety equipment available and leading edge trends in the use or otherwise of new safety equipment
- That probes and shovels for each client, and on-board oxygen and rescue equipment be considered as a minimum standard for heli-skiing in avalanche-prone terrain, particularly during periods of poor stability
- The New Zealand Police as lead agency for New Zealand Search and Rescue continue to develop and update avalanche rescue pre-plans for key locations having potential for an avalanche accident

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**NZ.2010.390  Work Related/ Transport & Traffic Related**

An experienced farm hand was thrown from, and crushed by, a tractor as it rolled down a hill. There was no seatbelt fitted in the tractor.

**Recommendations**

I endorse the recommendations of [name] below and note they appear to reflect industry views

This is another unfortunate accident involving agricultural work. The work in inherently dangerous and positive moves by industry and Federated Farmers should support the adoption of compulsory fitment and use of operator restraints in agricultural vehicles fitted with ROPS to prevent rollover deaths.

Rollover of agricultural tractors can occur on any topography. It is therefore recommended that, irrespective of the topography where the agricultural tractor is used, all tractors used in agricultural operations should have a rollover protective structure.
NZ.2010.390 continued
It is further recommended that the coroner supports a change in legislation requiring the compulsory fitment and use of operator restraints in all vehicles fitted with ROPS. It is recommended that the coroner also acknowledges and highlights the duty of sellers and suppliers of plant to ensure that it is indeed safe for its intended use.

NZ.2011.14  Work Related/ Transport & Traffic Related
A farmer died of injuries sustained when a quad bike he was riding reversed off a track and over a bank. The quad bike then landed on top of the deceased, pinning him to the ground with the tow bar ball.

Recommendations
It is for farmers to be aware of the terrain in which they operate vehicles, the dangers of vehicle rollover, the circumstances in which such rollovers may occur, the safety features that are available to prevent such rollovers and the safety features available to prevent injury if such a rollover occurs. The safety features are many and various and depend on the vehicle used. However with a view to preventing deaths occurring in circumstances similar to the death in which the deceased occurred, I consider it appropriate to recommend that all quad bikes be fitted with an audible alarm that activates when the vehicle is in reverse gear.

TAS.2011.7  Work Related/ Transport & Traffic Related
A crane driver died after the crane he was driving along an open road, overturned. The deceased was not wearing a seatbelt, and was thrown through the window, with the crane coming to land on top of him.

Recommendations
It should be emphasised by trainers and employers of crane drivers that seat belts should be worn at all times on open roads, and that safe traveling speeds for cranes (and indeed any heavy vehicle) is less than that of a normal motor vehicle.

VIC.2004.3131  Work Related/ Falls
The deceased was working on a high rise building site when the formwork he was working under collapsed on top of him

Recommendations
I recommend that The Minister for Planning endorse and oversee a review conducted by the Building Regulations Advisory Committee, Building Commission, of compliance of existing building regulations and industry guidelines along with compliance of industry accepted practises in the specific division of working with formwork.

I further recommend that the Building Commission as the statutory authority whose purpose is to ensure the safety, liveability and sustainability of our built environment, in consultation with Work Safe, review the effectiveness of current means of monitoring compliance of the Building Regulations 2006, compliance with the Occupational Health and Safety Regulations 2007 specific to the area of formwork construction and how compliance can be better achieved and/or enforced.

VIC.2008.2431  Youth/ Transport & Traffic Related
A youth was run over by a bus at a shopping centre while trying to flag it down.

Recommendations
• That Westfield Group review the current design and operation of that part of the bus terminal at [shopping centre] that exits on to [location] Street to consider whether or not safety could be enhanced by traffic lights or signs being used to control the movement of buses on to [location] street and that the outcome of that review be provided to Transport Safety Victoria for its consideration.
• That in the context of the facts in this finding, Transport Safety Victoria review the current safety warning signs and awareness campaigns and literature available around busy and complex bus terminals with a particular focus on inexperienced bus travellers to enhance awareness of the safety hazards for pedestrians around buses taking off.
VIC.2010.1545  Youth/ Natural Causes

A sixteen year old collapsed at a party and died. The cause of death was myocardial fibrosis (scarring of the heart muscle), most likely caused by a previous episode of glandular fever.

Recommendations

That the Minister or Health:

- Authorise a public advertising program raising awareness of the dangers of Glandular Fever; such program should be funded by the Health Department and must highlight the need for people with symptoms of the disease to seek medical advice as to the effects and the long-term dangers of glandular fever, specifically myocardial fibrosis.
- Investigate the adequacy of both current and planned levels of ambulance services provided for those who choose to live away from more densely populated areas.
## NCIS - FATAL FACTS WEB TOOL CATEGORY TAGS

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