Fatal Facts
Edition 31
The NCIS is governed by a Board of Management. Administrative support is provided by the Victorian Department of Justice & Regulation (DJR). The NCIS is funded by each State/Territory Justice Department in Australia and New Zealand, and the Australian Departments of Health & Ageing, Safe Work Australia, the Australian Competition & Consumer Commission, the Australian Department of Infrastructure & Regional Development and the Australian Institute of Criminology.

**Fatal Facts**

*Fatal Facts* is produced by the National Coronal Information System (NCIS) for public circulation. It contains case summaries and coronial recommendations for 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 publically available from the NCIS website. Case numbers are included so that persons with full access to the NCIS database 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 (three 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 December 2011. The NCIS have populated 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.

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In this Edition

Fatal Facts Edition 31 includes cases where the coronial investigation is complete and where the Coronal Finding contains recommendations. Edition 30 includes cases that were closed between 1 October and 31st December 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 31 contains summaries of cases where recommendations were made as part of the formal coronial finding. Of these cases, 58 are Australian cases and 29 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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NZ.2009.4024  Adverse Medical Effects

A medical student died after contracting meningococcal Septicaemia. Despite being sent to hospital, the virus was not diagnosed in a timely manner.

Recommendations

I accept and endorse the recommendations submitted by the interested parties.

The parties agreed that the following recommendations should be accepted by this Court:

- Early warning scoring system for assessing physiological instability
  - The Royal New Zealand College of General Practitioners develop and propagate an objective tool for assessing physiological instability, which integrates multiple physiological markers
  - A national clinical working group for the New Zealand ambulance sector develop and promulgate an objective tool for assessing physiological instability, which integrates physiological markers.
  - That the [location] District Health Board (DHB) present [the deceased’s] case and the early warning system apparently adopted by the [location] DHB to the Chief Medical Officers of the other 19 DHBs with a recommendation that the DHBs adopt a system for escalation of care for physiological instability, which integrates multiple physiological markers.
  - That the tools developed and adopted under the above include a reference to the fact that where a patient presents with influenza-like illness or symptoms, together with markers of physiological instability, bacterial sepsis should be included in the differential diagnosis.
  - That [location] DHB uses [the deceased’s] case for teaching during implementation of the early warning system.

- Information regarding influenza-like illness and possible bacterial sepsis
  - That the Ministry of Health (MoH) communications and guidelines regarding influenza-like illness, whether routine or in response to an influenza outbreak, include the caution that other illness, notably bacterial sepsis, may present with similar symptomology as influenza. In the absence of a cough, sore throat, a differential diagnosis of influenza-like illness should also include possible bacterial sepsis until proven otherwise.

- Protocol for pre-hospital parenteral antibiotics
  - That the Royal New Zealand College of General Practitioners initiate a national working group to develop a protocol for the administration of pre-hospital parenteral antibiotics.
  - That the protocol includes the signs and symptoms of suspected bacterial sepsis and indicators for the taking of blood culture samples, in patients without haemorrhagic rash.
  - That the Royal Australian College of Physicians and the national clinical working group for the New Zealand Ambulance sector be included amongst those invited to participate in this working group.

- Immunisation Policy
  - That the MoH updates its immunisation guidelines and communications to medical practitioners and consumers to ensure the inclusion of the option of vaccination for meningococcal C disease.
  - The University of Vice Chancellors Committee request that all universities amend the advice they give students includes information regarding the option of a vaccination for meningococcal C disease.
  - That the MoH identifies what other institutions or groups present an increased risk of contracting meningococcal disease and ensure that these institutions or groups provide advice regarding options for vaccination for meningococcal C disease. Some of these groups would include boarding schools and sports academies where there are live-in situations.
NZ.2009.4024 continued

- That the Australasian College of Emergency Medicine amends its immunisation policy to specify which vaccine preventable diseases are included in its advice to offer immunisation to emergency medicine health care workers
- That the MoH reviews at the earliest opportunity the cost benefit of a publically-funded vaccination programme for meningococcal C and undertakes appropriate consultation, including with consumers
- It should be noted that the [location] DHB have already undergone a publically-funded programme and the issue whether this should be extended to the other 19 DHBs remains a decision in those respective Boards and the MoH.

- Post-incident response protocol
  - That the MoH review its quality improvement guidelines and workbooks in light of [the deceased’s] case in order to include specific triggers or indicators for review where there is no identified adverse incident.
  - That [location] DHB present a summary of [the deceased’s] case to the Chief Medical Officers of the other 18 DHBs with a recommendation that they review their quality and safety structures in order to include specific triggers or indicators for review where there is no identified adverse incident.

- Activation of ‘code red’
  - That nursing and junior medical staff be reminded of the criteria for the activation of a code red and be encouraged to do so when they become concerned about a patient’s wellbeing rather than delaying the decision to make the call
  - To some extent the activation of a code red is part and parcel of the use of a scoring system for identifying physiologically unstable patients as discussed in early warning scoring system.

NZ.2010.951 Adverse Medical Effects/ Older Persons
An elderly person died in hospital from an acute large bile duct with obstructive jaundice secondary to probable passage of gallstones. The deceased suffered from a number of other conditions including coronary artery atherosclerosis and diabetes. While in hospital, there was a delay with organising an ultrasound of the liver and bile ducts.

Recommendations
I recommend that [location] District Health Board considers whether its policy on mandatory referral to a gastroenterology team for patients diagnosed with ascending cholangitis should be expanded to include a requirement for input into diagnosis from the gastroenterology team where ascending cholangitis is considered a possible diagnosis.

NZ.2011.1636 Adverse Medical Effects/ Older Persons
An elderly patient with diabetes, ischaemic heart disease and chronic renal failure died from acute renal failure caused by a volume overload from multiple enemas given as bowel preparation prior to sigmoidoscopy.

Recommendations
I recommend that the [location] District Health Board devise and implement protocols to avoid fluid overload during bowel preparation of diabetic patients.

QLD.2001.4893 Adverse Medical Effects
A person died a week after being discharged after heart surgery for a mitral valve replacement. The day before the deceased passed away, an ambulance had been called but they decided not to go to hospital. The deceased then suffered cardio-respiratory arrest.

Recommendations
I recommend that the Queensland Ambulance Service reviews its clinical practice manual, and ambulance officer training, to stress the need for a precautionary approach to the decision of whether or not to transport to hospital a patient who has recently had heart surgery.
SA.2008.54  Adverse Medical Effects/ Physical Health

A stroke patient had an undiscovered fistula that haemorrhaged after a tracheostomy.

Recommendations

A number of protocols were produced in the course of the inquest. I agree with counsel for [name] that the protocols produced in this inquest would benefit by a more prominent reference to bleeding as being a warning sign, in certain circumstances, of a catastrophic bleed and a trigger to ward nurses to engage with the intensive care equipment nurse to discuss that possibility.

I therefore recommend that the relevant protocols be reviewed to point out to ward nurses the potential for bleeding to be significant.

[Name] was clearly of the view that all nurses in wards who are looking after tracheostomies should complete the educative workbook entitled ‘Principles for Basic Tracheostomy Management Workbook’ and I recommend accordingly.

As noted by counsel for [name], there is only one question raising the matter of bleeding in the workbook when the workbook asks: ‘After performing tracheal suction you notice that the tracheal aspirate is blood stained. What action would you take?’ I recommend that the workbook be modified to raise the issue of blood appearing in circumstances other than the tracheal aspirate.

The above recommendations are directed to the Minister for Health.

NZ.2008.668  Aged Care/ Adverse Medical Effects/ Older Persons

An elderly person died from a reaction to an antibiotic administered in a care home.

Recommendations

I recommend that a copy of this finding be sent to the Centre for Adverse Reactions Monitoring (CARM) and the Intensive Medicines Monitoring Programme (IMMP) of the Pharmaco Vigilance Centre [location] University to ensure that risk factors associated with Cefaclor (CeClor) and cephalosporin’s generally are recorded.

I recommend that a copy of this finding is forwarded to [location] Hospital. There are, as has been acknowledge by Dr [name], problems with the charting of drugs and recording adverse reactions and cross-reactions. Attention should be given to a programme to address these problems.

I recommend that a copy of the Finding be forwarded to [name] Home.

TAS.2011.52  Aged Care/ Fire Related/ Older Persons

An elderly gentleman in a nursing home died of smoke inhalation after a fire broke out in his room. The fire may have been caused by a lit cigarette igniting a synthetic shirt despite the deceased being told previously that smoking was not allowed in rooms.

Recommendations

In my view, it would be worthy to consider that where there is a breach of the no smoking rules within a care facility such as this that a resident/patient should have any ignition source removed from their possession. In those cases, the person would be provided the ignition source only upon request and when they were located in the smoking area.

This incident could have led to a catastrophic outcome had not the facility been given early warning by its fire detection system and its staff reacting professionally when the alarm sounded. My only concern in relation to this investigation is that the [deceased] had given previous indications of being non-compliant but was still able to maintain possession of an ignition source while using supplementary oxygen. As outlined above, I would recommend the removal of the risk of further breach by such non-compliant residents. The limitation of personal freedom is to be preferred to the risk of harm to the person or to others.
VIC.2008.2706  Aged Care/ Older Persons/ Transport & Traffic Related
An elderly person with dementia absconded from the care home on the day they were admitted. The care home was aware that the deceased was a ‘wanderer’ and confused to the admission, but did not put any measures in place. The deceased wandered onto train tracks and was killed by a train.

Recommendations
• In these circumstances, I recommend that all staff at [location] continue to undertake initial training in regard to dementia policies before their commencement of duty, and further, that each undertake a full retraining in regard to same not less than once every twelve months
• Having regard to my discussion with [name], I further recommend that the interim care admission form be amended to include a mandatory drop down field in reference to strategies to be adopted to protect the applicant. This box would then need to be completed with details of the strategy adopted and implemented, before the remainder of the form becomes active

NSW.2009.6377  Animal/ Falls/ Youth/ Work Related
A youth died after falling from a horse while participating in a TAFE course. The horse was an ex-racehorse.

Recommendations
To: The NSW Minister for Education; The Managing Director, TAFE NSW; The Australian Skills Quality Authority; and AgriFood Skills Australia.

Further amendments to TAFE practice and policy are warranted so as to minimise risk to students in other courses.

REVIEW AND AMENDMENTS OF POLICY
• That the Australian Skills Quality Authority, Agrifood Skills Australia and TAFE NSW review the conduct of the units including:
  ◊ The essential performance criteria that students are required to meet in order to be deemed competent.
  ◊ The feasibility of educating beginner riders to a level where they can demonstrate via mustering exercises that “educated horses are controlled and worked as an integral part of stock husbandry routines” in the space of forty (40) hours of tuition and significantly less than forty hours (40) of riding time.
  ◊ The adequacy of relying upon the recognition of staff prior learning and industry experience in the circumstances of this case and in the absence of any independent accreditation of riding skill.
  ◊ Best practice for the assessment of horses for use in the conduct of these units.

TENDER PROCESS
• That TAFE NSW amend policy and practice at TAFE NSW [location] Institute relating to the tender process for the supply of horses for use in the units as follows:
  ◊ Tender documents should require the provision of horses educated for use with beginner riders, experienced in lessons with beginner riders, educated for use around stock and experienced in use around stock.
  ◊ Tender documents should exclude ex-racehorses and horses that are under ten (10) years of age.
  ◊ Tender documents should require applicants to provide information (as within their knowledge) specific to each horse including:
    * Age, breed and height of horse.
    * Date of purchase.
    * From whom purchased.
    * Purchase price.
    * Level of education for use with beginner riders and recent experience with beginner riders in the course of riding lessons.
    * Level of education for use in stock work and experience in stock work.
NSW.2009.6377 continued

- Whether horse has ever been trained for racing (although never raced), and if so, date when such training concluded.
- Whether horse has an Australian Stud Book Microchip Number and if so, the number.
- Whether horse has an Australian Identification Number and if so, the number.
- Details as to how horses would be worked and kept on the days when they were not at TAFE.

- Assessment of applications for tender should take into account the nature of information provided for each horse, recognizing that the relative importance of specific criteria will vary from horse to horse. For instance, if an applicant does not have much historical information but has owned the horse for five (5) years, the lack of historical information would be less significant than in the case where the applicant has owned the horse for five (5) weeks.

- Assessment of applications for tender should include cross checks using the ASB Microchip Number and/or Australian Identification Number if available. This is not to suggest that this assessment as and of itself, obviates the need for other assessments as follows.

**OCCUPATIONAL HEALTH AND SAFETY AUDITS**

- That TAFE NSW undertake an independent Occupational Health and Safety audit at TAFE NSW [location] Institute, Rural Skills Campus (such as via commercially available safety management programs) that includes:
  - Risk assessment of paddocks and properties on which the units are conducted with a view to ensuring that any paddocks that will be used for riding exercises are fit for purpose. This shall include the use of single purpose gates.
  - Risk assessment of equipment to be used in the conduct of the course.
  - Review of the assessment process for horses to be used in the units taking into account the necessary experience required to adequately assess the horses, current practice and the adequacy of the current forms and assessment tool.
  - Guidelines prohibiting use of cameras and phones whilst riding should be strictly enforced.

- TAFE NSW adopt the Australian Horse Industry Council Horsesafe Code of Practice in the conduct of the units.

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**NSW.2008.4754 Child & Infant Death/ Natural Causes/ Water Related**

A six year old had an epileptic seizure while in the bath unsupervised and drowned.

**Recommendations**

I direct that a copy of these Findings together with the reports and evidence including the transcripts of evidence of [names] be sent to the Minister for Health so that Minister might consider:

- What action is appropriate to increase awareness of the risks of drowning in children with a history of epilepsy or other seizures when unsupervised during bathing or when in or near water; and
- Whether and what action should be taken to collaborate with non-government agencies such as the Royal Life Saving Society and the Epilepsy Council of Australia to further increase awareness of such risks.

**NSW.2009.6348 Child & Infant Death/ Water Related**

An 18 month old infant drowned after entering an aboveground swimming pool unsupervised.

**Recommendations**

To: The Minister for Local Government

- That the circumstances of the death of [deceased] be noted
NSW.2009.6348 continued

- That the NSW Government support the efforts by the Australian Competition and Consumer Commission to introduce a requirement of mandatory warnings on portable swimming pools and the packaging in which such pools are sold. Such warnings at a minimum should remind consumers of the need for the constant supervision of children using such products as well as the need to approach local government authorities in order to determine other requirements governing the use of such products in the area in which it is purchased
- That the NSW Government develop an education campaign to bring the safety requirements of the Pools Act to the attention of the community giving emphasis to the application of such requirements to products such as portable swimming pools purchased from retailers and assembled by the buyers themselves

NSW.2010.2647 Child & Infant Death/ Adverse Medical Effects

A twelve year old died as a direct result of a previously undiagnosed propensity to Long QT syndrome complicated by streptococcal infection, which caused the deceased’s organs to shut down. The deceased had been discharged from hospital the day prior.

**Recommendations**
- [Hospital] implement notification of the need for all practitioners to be aware of the possibility of Long QT Syndrome, its diagnosis, effects and treatment.
- The Department of Health of NSW maintain a separate register of all discharge certificates of all patients discharged during each shift. Further, the senior medical registrar of each shift certify that such discharge certificate copy has been placed into the register prior to completion of duties.

NZ.2009.3854 Child & Infant Death/ Sports Related

A six year old child died after being crushed by an unstable scrum machine while playing on the equipment at a rugby tournament being held at a school.

**Recommendations**
- I recommend that:
  - The Ministry of Education circulates a copy of this finding to all schools in New Zealand together with advice that:
    - Schools should take steps to ensure that sports equipment, including scrum machines, is stored safely; and
    - The importance of being vigilant about identifying potential hazards in the school environment
  - The New Zealand Rugby Union highlights to rugby clubs in New Zealand the issues raised by [the deceased’s] death and the importance of safe storage of scrum machines when not in use.

NZ.2011.1004 Child & Infant Death/ Water Related

A two year old child drowned at a swimming pool complex that they were attending with their parents.

**Recommendations**
This death again highlights the need for parents to actively and closely supervise young children at swimming pools, even if the pool complex provides lifeguards. If there is a handover from one parent to the other of responsibility for such supervision, then it is imperative that each parent clearly understands who has that responsibility at any given time. Parents cannot and should not rely upon staff at a commercial pool complex to supervise their young children, as this is not usually the staff’s responsibility.
NZ.2011.2903 Child & Infant Death/ Adverse Medical Effects
An infant died one day after birth from congenital pneumonia, chorioamnionitis and chorionic vessel vasculitis. Although the infant was experiencing distress in the womb, hospital staff went ahead with a vaginal delivery and not an emergency caesarean delivery.

Recommendations
I recommend to the [Location] District Health Board that the Board:

- Require all clinical staff, including Local Medical Committees (LMCs) and Obstetricians complete the K2 training and simulator cases by an appropriate date;
- Require that staff complete the simulator cases annually
- Audit compliance by staff with the Board’s requirements
- Ensure that clinical staff receive teaching with regards to the risk factors for chorioamnionitis, its clinical presentation, risks to the foetus and mother, and management principles
- Develop a guideline for the management of pyrexia in labour
- Develop a massive blood transfusion policy
- Provide a second on-call Obstetrician
- Ensure expectant mothers are aware of an option for a caesarean birth when appropriate
- Provide documentation recording passing of care responsibility from LMC midwives to Obstetricians and vice versa
- Provide protocols to ensure that an expectant mother is aware who is responsible for her care at any stage during the induction and delivery process

I recommend to the Midwifery Council of New Zealand that

- All midwives be required to complete electronic foetal monitoring and CTG interpretation as part of the Recertification Programme.

VIC.2008.2971 Child & Infant Death/ Adverse Medical Effects
A baby died as a result of perinatal asphyxia due to a delay in her delivery.

Recommendations

- That the clinical practice guidelines relating to the interpretation of cardiotocograph (CTG) should include a directive, that if a CTG trace is abnormal or worrying, either the ‘on site’ or ‘on call’ obstetric consultant must be notified of the trace results.
- If foetal lactate sampling is being considered by the attending medical clinician, that the on-site or on-call obstetric consultant must be notified of the intention to conduct the sampling and the clinical indicators for sampling
- All clinical staff members on the birthing suite, medical or nursing, should be authorised to contact the on-call consultant in the face of concerning clinical developments and that this authority be documented and re-iterated in all induction programs in the unit and during the course of in service training.
- Birthing suite patients should be kept informed of the full clinical picture and in circumstances where there are non-reassuring developments, given information regarding birthing options and the options that the clinicians are considering.
- CTG training should be mandatory at induction for all medical and nursing clinicians working on the birthing suite, with refresher training undertaken annually. That training ought to reiterate that the CTG is to be interpreted in the context of the entire clinical picture.
- The on-site or on-call obstetric consultant is to be notified in the event that a medical clinician is required to absent themselves from the birthing suite to attend Code Green and Code Blue calls.
VIC.2009.3709  Child & Infant Death/ Homicide & Assault

A two year old child died a month after sustaining head injuries at home, allegedly caused by a family member. The family were known to child services.

Recommendations

- That Victoria Police give consideration to developing a program of regular training and information dissemination for operational members across all regions of the organisation to ensure familiarity and compliance with the Code of Practice for the Investigation of Family Violence, the Victoria Police Manual pertaining to the investigation and response to family violence, and completion of the Victoria Police Form L17, in order to ensure that requirements of members are well understood, and that appropriate action is taken when police receive reports of, and respond to, instances of family violence and child abuse.
- That all Victoria Police officers be provided with the contact details of Department of Human Services (DHS) Child Protection Services in each region and the Child Protection After Hours Emergency Service, and be reminded that, pursuant to section 181 of the Children, Youth and Families Act 2005 (Vic), all members, not only Sexual Offences and Child Abuse Investigation Team (SOCIT) officers, are protective interveners and mandatory reporters.
- That the 1998 protocol between Victoria Police and DHS, Protecting Children: Protocol Between the Department of Human Services and Victoria Police, be revised and updated to reflect the current legislative requirements of both organisations and clarify the roles and responsibilities of both the DHS and Victoria Police, in respect to investigations of child abuse.
- That DHS give consideration to conducting a thorough analysis of early intervention and family support requirements in the [location] region. This should include consideration of unmet need, client waiting lists and proportional staff ratios to client populations in order to determine the capacity of the region to effectively respond to these requirements, and enable a timely and planned approach to the delivery of early intervention and family support services in this area.
- That DHS Child Protection service and Victoria Police consider providing specific training and/or information to staff members involved in the investigation of child abuse, regarding the significance of bruising and injury patterns that may be indicative of inflicted injuries upon children, in order to afford particular significance to these injuries both at the time of notification and when conducting further investigation.
- That DHS Child Protection, Child FIRST and Victoria Police SOCIT in the [location] region give consideration to engaging in a systematic program of community education (targeting childcare centres, schools and other community groups), regarding the risk factors for, and identification of, possible child abuse and neglect, including an educative component as to when a notification to the DHS Child protection is warranted, in order to facilitate greater community awareness of these issues and promote the visibility of services that are able to assist children either at risk of or exposed to, such violence and abuse.

WA.2009.1497  Child & Infant Death / Transport & Traffic Related/ Law Enforcement

An eleven year old child died after receiving serious injuries when the car they were travelling in was involved in a collision with another vehicle which was attempting to evade police.

Recommendations

I recommend the risk to the general community of excessive speeds of targeted vehicles, in precincts or areas exhibiting high density use, should generally not warrant the commencement of a chase or intercept, without a known greater risk, prior to appropriate authorisation.

NZ.2010.1377  Drugs & Alcohol

A person died of acute cardiorespiratory failure due to poisoning. The deceased had been inhaling large amounts of fly spray.

Recommendations

I recommend that a copy of this Finding be forwarded to the New Zealand National Poison Centre for its information and to the Medical Officer of Health with a request that further publicity be given to the dangers of inhalant abuse.
VIC.2009.4960  Drugs & Alcohol/ Transport & Traffic Related
An intoxicated person died after forcing open a train carriage door and attempted to get off the train. The train started moving and the deceased fell, becoming trapped under the train.

Recommendations
• That Metro Trains Melbourne (MTM) ensure that all trains in service have the modification they developed to alert the operator of a defective Auto Carriage Connection (ACC) switch, undertaken not later than March 2012.
• That MTM re-examine the possibility of fitting an audible alarm system designed to alert the driver to a door having been forced after departure.
• That MTM ensure a revised instruction decal is placed on all trains in service, that clearly sets out how to operate the Passenger Emergency Intercom, in order for passengers to effectively communicate with the driver.

QLD.2007.1218  Electrocution
A person died of electrocution after inadvertently standing on fallen power lines in the dark. There was a delay in de-energising the power lines, and attempts to free the deceased to conduct CPR were futile.

Recommendations
• I recommend that the Office of Fair and Safe Work Queensland (OFSWQ) progress legislative amendments to mandate the reporting to the Electrical Safety Officer (ESO) of all incidents in which Low Voltage (LV) conductors fall to the ground and remain energised.
• I recommend that electrical entities review their call centre scripting to include a specific warning reminding callers where there is a total or partial loss of supply, brown out or other emergency one cause of that situation may be fallen power lines and fallen or hanging power lines should be treated as live.
• I recommend that electricity entities review and if necessary, develop and document procedures to guide control centre staff and field crews to deal with emergency situations involving downed live wires including de-energisation policies where urgent rescue and/or imminent threat is involved.
• I recommend that the Queensland Police Service (QPS), OFSWQ and electricity entities consult and develop a shared understanding of their respective priorities and procedures to enhance the process of scene preservation and the identification and collection of evidence at fatal incidents involving electrical supply networks. I also recommend that the QPS, Work Health and Safety Queensland (WHSQ) and the ESO continue education of their personnel about the importance of early initial contact and consultation between their agencies to promote effective investigation.
• I recommend that the OFSWQ include in their review:
  ◊ Consideration of reassessing lead agency allocation of an electrical incident to the ESO when that incident occurs in a ‘workplace’ or non-domestic premises but does not involve work-related activity
  ◊ Consideration of including in operational policy a requirement for a broader focus of investigations confined not simply to whether a breach has occurred but whether there are broader preventative measures that might be recommended;
  ◊ Clarification of how investigators should consider and verify investigative report completed by other agencies (including electrical entities) including investigators are able to access independent advice;
  ◊ Consideration of improving documentation of investigations including the basis on which decisions are made; and
  ◊ Consideration of ways to improve collaboration between ESO and WHSQ including assessing whether organisational culture may impede that collaboration.
VIC.2007.1791 Falls/ Homicide & Assault
After being refused entry into a licensed establishment, the deceased got into a fight with a crowd controller and fell, hitting his head on the ground. The deceased did not regain consciousness and died in hospital.

Recommendations
Recording of reasons in disciplinary proceedings
- That the Chief Commissioner of Police require Victoria Police members conducting disciplinary proceedings under the Private Security Act to enter written reasons for decisions into the records held by the responsible Victoria Police division.

Probationary licences for crowd controllers
- That the Chief Commissioner of Police together with the Australian Skills and Quality Authority, the Victorian Registration and Qualification Authority and the Department of Justice, review the current requirements of licensing of crowd controllers and in doing so consider introducing a graduated licensing regime comprised of the following: (a) crowd controllers being granted an initial probationary license after completing basic Certificate requirements; (b) the completion of a number of performance hours under the supervision of a full licensed crowd controller; (c) a requirement that the Registered Training Organisation (RTO) must have observed the probationary license holder in his/her workplace on at least one occasion and; (d) that the Licensing authority receive a satisfactory report of the probationary license holder from a current employer.

Drug and alcohol testing for crowd controllers involved in a serious incident in the workplace
- That the Chief Commissioner of Police, together with the Secretary to the Department of Justice consider the introduction of a requirement that a licensed crowd controller may be required to submit to drug and/or alcohol testing if requested by a member of the Victorian police who is investigating an incident in which it appears that serious injury or loss of life may result, in which the crowd controller is alleged to have contributed to that serious injury or loss of life in the course of his or her employment.

NSW.2002.5631 Homicide & Assault
A missing person is believed to have been murdered.

Recommendations
To the Commissioner of Police:
That the responsibility for the investigation of the disappearance and death of [deceased] be transferred to the Unsolved Homicide Unit of NSW Police to be further investigated in accordance with the protocols and procedures of that Unit.

NSW.2005.6142 Homicide & Assault
A person died of multiple blunt force head injuries inflicted by a person or persons unknown.

Recommendations
- I recommend a substantial reward for information leading to the identification of [deceased’s] assailant/s by the Commissioner of Police
- I recommend that a publicity campaign be undertaken by NSW Police to identify the unknown person whose voice is heard on the 000 call of [date]
VIC.2008.356  Homicide & Assault/ Weapon

The deceased was stabbed while attacking his partner. The partner had called police prior to this stating that she needed help, and was carrying a knife. While trying to get the deceased to stop attacking her, she stabbed him once in the chest.

**Recommendations**

**Victoria Police**

- To assist victims of family violence, I recommend that the Chief Commissioner of Police review the Victoria Police Manual provisions that require members to complete and forward the Family Violence Risk Assessment and Management Report (L17) following attendance at family violence incidents. The purpose of this is to ensure that the Manual has clear instructions as to which family member is responsible for ensuring that the L17 is completed and sent to the relevant family violence support service.

- I recommend that the Chief Commissioner of Police review current procedures and directions to ensure that the conditions and outcome of Family Violence Intervention Order applications made by Victoria Police on behalf of affected family members is conveyed in a timely, effective and consistent was to those affected family members.

**Department of Justice**

- That the Secretary to the Department of Justice give consideration to extending the current applicant support worker program to each Magistrates’ Court in the state that is required to deal with Family Violence Intervention Order applications.

**Magistrates’ Court of Victoria**

- That the Chief Executive Officer of the Magistrates’ Court of Victoria review the current applicant support worker system of recording information to ensure that the system meets with the requirements of the role in respect to maintain appropriate records of contact with affected family members at court.

- To ensure quality and consistency in the applicant support worker program, that the Chief Executive Officer of the Magistrates’ Court of Victoria give consideration to including the following components into the current applicant support worker program.

- The development of a training standard and internal supervision process for applicant support workers in the areas of risk assessment, safety planning and service referral;

- The development of written materials regarding the nature and dynamics of family violence and contacts for local family violence and associated support services for distribution to affected family members by applicant support workers at Magistrates’ Courts;

- To ensure continual improvement of the applicant support worker program, a system to be developed of ongoing program evaluation incorporating feedback from the applicant support workers.

NT.2010.174  Indigenous/ Law Enforcement

An Indigenous prisoner died from a colloid cyst in the brain, which obstructed the flow of cerebrospinal fluid and resulted in a seizure and sudden death. The deceased has been complaining of headaches for a number of months but this was usually resolved by the use of Paracetemol.

**Recommendations**

I appreciate that there are privacy considerations concerning patients’ care and illnesses and that medical staff might be cautious about giving information to prison officers about a prisoner’s medical condition. However it would not breach privacy considerations for prison officers to be told to call the on-call nurse if a prisoner’s condition changes. In my view, guidelines on the use of on call nurses should be developed to better assist prison officers in the exercise of their discretion in this regard.

I recommend that Correctional Services develop and implement a policy as to the use of on-call nurses to assist prison officers in the exercise of this discretion.
QLD.2010.659  Indigenous/ Law Enforcement

An Indigenous person in a remand centre died after being located unconscious in his cell. The cause of death was due to massive liver necrosis caused by a hepatitis B and C infection.

Recommendations
I recommend Offender Health Services review the availability of treatment for prisoners infected with viral Hepatitis to ensure reasonable endeavours are being made to contain the spread of this notifiable condition by treating its carriers while they are in custody.

QLD.2010.3181  Indigenous/ Intentional Self-Harm/ Law Enforcement

An Indigenous prisoner intentionally took their own life by making incisions of their forearm which resulted in massive blood loss.

Recommendations
Culturally and gender appropriate Initial Risk Needs Assessment (IRNA)

- To maximise the likelihood of the IRNA gathering reliable information, prisoners should be explicitly asked whether they identify with any ethnic group and if so, whether they would like a person from that ethnic group to be present during their assessment. Similarly, prisoners should always be offered the option of having the assessment undertaken by a counsellor of any gender. I recommend Queensland Corrective Services (QCS) consider mandating such policies to be implemented in all correctional centres.

Continuity of care

- In view of the lengthy and unnecessary interruption of the deceased’s prescribed medication after their incarceration, I recommend Queensland Health urgently develop guidelines to assist visiting medical officers engaged by offender Health Services to make appropriate judgments concerning continuity of care for newly received prisoners and implement procedures that ensure verification of existing prescriptions occurs in a timely fashion.

Pain Management Guidelines

- In view of the inadequate pain management provided to the deceased in this case and the paucity of guidelines available to Occupational Health & Safety (OHS) staff on how to respond to chronic pain, a disproportionately common complaint among their patient population, I recommend that Queensland Health urgently develop guidelines to assist visiting medical officers engaged by Offender Health Services make appropriate judgements concerning the assessment and treatment of the condition.

Prisoner Access to the Health Quality and Complaints Commission (HQCC)

- In view of the generally poor health and vulnerability of prisoners, I recommend QCS require all prison operators to make information about the role and function of the Health Quality and Complaints Commission readily available to prisoners and allow free telephone calls to the agency.

NOTE: Due to five cases of similar circumstances, where the deceased was an Indigenous person that died of natural causes in a remote location, the SA Coroner made combined recommendations for all cases.

SA.2005.2943  Indigenous/ Natural Causes/ Geographic

An Indigenous person died of lobar pneumonia in a remote location.

SA.2006.1408  Indigenous/ Natural Causes/ Geographic

An Indigenous person died as a result of pneumonia, cardiomyopathy, chronic obstructive airways disease and non-insulin dependent diabetes mellitus in a remote location.
SA.2006.1420 Indigenous/ Natural Causes/ Geographic
An Indigenous person died as a result of a right lung abscess and right pneumonia in a remote location.

SA.2009.1131 Indigenous/ Natural Causes/ Geographic/ Drugs & Alcohol
An indigenous person died as a result of a gastrointestinal haemorrhage with contributing alcoholic liver disease in a remote location.

SA.2009.1574 Indigenous/ Natural Causes/ Geographic/ Drugs & Alcohol
An Indigenous person died as a result of cardiomegaly and alcohol-related seizure activity in a remote location.

Combined recommendations
Taking all of the evidence into account as well as counsel’s submissions, I make the following recommendations which I direct to the following entities:

- South Australian Minister for Health;
- Chief Executive Officer of the Department of Health;
- Chief Executive Officer of Housing SA;
- Regional Manager for Housing SA in relation to the [location] area;
- Executive Director of Drug and Alcohol Services, South Australia;
- Executive Officer, Director of Nursing of the [location] Hospital;
- Chief Executive Officer of the [location] Aboriginal Health Service;
- Members and delegates of the [location] Senior Officers Group;
- Officer in Charge, SAPOL [location] Local Service Area;
- Commissioner for the Office of the Liquor and Gambling;
- Manager of the Indigenous Coordination Centre, [location] (Australian Government);
- State Manager (SA) of the Commonwealth Department of Health and Ageing;
- South Australian Minister for Aboriginal Affairs and Reconciliation;
- Federal Minister for Health and Ageing;
- Federal Minister for Indigenous Health.

- That the Commonwealth, State and relevant local Governments recognise that chronic ill health and alcohol abuse poses a serious threat to the wellbeing and functionality of traditional Aboriginal communities and that it poses specific threats to the health and longevity of the individual members of those communities;
- That the Commonwealth, State and relevant local Governments recognise that the threat to the health, wellbeing and functionality of the members of these Aboriginal communities is a reflection of the extreme social disadvantage that occurs within those communities;
- That the Commonwealth, State and relevant local Governments recognise that in the [location] township and environs there has been, and still is, an ongoing need to reduce the supply of alcoholic liquor to transient Aboriginal populations;
- That the Commonwealth, State and relevant local Governments recognise that in the [location] region there is a need to strengthen and promote amongst the Aboriginal community primary healthcare, housing opportunities, education, literacy and employment;
- That the Commonwealth, State and relevant local Governments recognise that there is a need amongst the transitional Aboriginal communities, and the members of those communities, to have meaning in their lives such as might be provided by full employment and the pursuit of recreational and educational activities so as to provide those members of the community with a disincentive to abuse substances, particularly alcohol, and to prevent and minimise the incidence of relapse among rehabilitated individuals;
Combined recommendations continued

- That the Commonwealth, State and relevant local governments remind themselves of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody relating to the abuse of alcohol and other drugs (set out in Appendix A herein), many of which continue to have current relevance;

I make the following specific recommendations:

- That the [name] Transitional Accommodation Centre in [location], otherwise known as the Town Camp, continue to be maintained as an accommodation centre for transient Aboriginal persons. I further recommend that strict enforcement in relation to the possession and consumption of alcoholic beverages on site be maintained;

- That the [location] communities for the time being continue to be dry and that the possession and consumption of alcohol in those communities continue to be prohibited;

- That supply of alcohol to members of transient Aboriginal communities in [location] be reduced by employing one or both of the following strategies:
  - Prohibiting within the region the sale of certain identified kinds of alcohol including fortified wines such as port in casks, as well as cask wine;
  - That greater resources and effort be provided to address the supply and sale of alcohol to transient Aboriginal people in [location] and remote communities of [location] and [location];

- That a declared sobering up centre pursuant to the Public Intoxication Act 1984 be established in [location] such that:
  - The declared sobering up centre is sufficiently resourced to accommodate at least fifteen (15) individuals;
  - That it be situated in close proximity to the Accident and Emergency Department of the [location] Hospital and preferably be housed within the same building;
  - That it be staffed and be situated so as to promote efficient interaction between the staff of the sobering up centre and the clinical staff of the hospital, and in particular to better promote and facilitate the detoxification and withdrawal treatment of persons attending the sobering up centre either voluntarily or those under apprehension pursuant to the Public Intoxication Act 1984;
  - That the sobering up centre be sufficiently staffed and resourced so that it can remain open and receive patients at all times;
  - That it have the capability as required under the Public Intoxication Act 1984 to detain patients in a secure and therapeutic environment for the statutory period of time stipulated under the Public Intoxication Act 1984, namely eighteen (18) hours;
  - That the sobering up centre be regarded by police as the option of first resort upon apprehending a person pursuant to section 7(3) of the Public Intoxication Act 1984 where detention of the person is believed to be necessary and desirable;

- That the Executive Director, Director of Nursing of the [location] Hospital continues to develop strategies that engender within the hospital a culturally appropriate environment with a view to inducing Aboriginal patients to remain in hospital until such time as their treatment has been completed;

- That the recommendations made by Dr [name], as set out within these findings, be implemented, namely:
  - 'I would recommend that [location] Hospital develop an agreement with the [location] Sobering Up Shelter to ensure that medically supervised detoxification is available to people referred from the Sobering-Up Shelter when required.
  - I would recommend the development of a strategy for the management of alcohol addiction in the [location] area, involving all health services including the hospital. Such a strategy should include a plan about who should be notified if a patient with a known alcohol problem discharges himself or herself against medical advice, to maximise the chances of ongoing medical and social support.
  - I would recommend that appropriate and sufficiently-resourced alcohol rehabilitation facilities be established within the vicinity of [location], [location] and [location] as a priority.
  - I would recommend that ongoing counselling services be available to support the management of alcohol addiction.
  - I would recommend that ongoing training and support be provided to general practitioners and other primary health care personnel in [location], particularly at [location] [name] Aboriginal Health Service, to up-skill them in the medical management of alcohol addiction.'
Combined recommendations continued

- That an alcohol rehabilitation centre or facility be established that possesses the following elements, namely:
  - That it be established at a location on the west coast;
  - That it be situated sufficiently close to the Aboriginal communities who would utilise it on the west coast;
  - That the rehabilitation centre, wherever situated, engages with and is culturally sensitive to members of the Aboriginal community;
  - That it be situated well away from licensed establishments and other sources of alcohol;

- That the South Australian legislature consider enacting legislation that would provide for the mandatory detention and treatment of persons with severe substance dependence, particularly if an alcohol rehabilitation facility were to be situated at [location] or at some other location in close proximity to licensed premises or other suppliers of alcoholic beverages.

**NOTE:** Due to five cases of similar circumstances, where the deceased was an Indigenous person that took their own life in a remote location, the WA Coroner made combined recommendations for all cases.

**WA.2008.801** Indigenous/Intentional Self-Harm/Geographic/Youth
An Indigenous youth took his own life by way of hanging in a remote community.

**WA.2009.317** Indigenous/Intentional Self-Harm/Geographic
An indigenous person took his own life by way of hanging in a remote community after a dispute with a love rival.

**WA.2009.568** Indigenous/Natural Causes/Geographic/Mental Illness & Health
An Indigenous person who suffered from a mental illness, took his own life by way of hanging in a remote community.

**WA.2009.821** Indigenous/Intentional Self-Harm Geographic/Youth
An Indigenous youth took his own life by way of hanging in a remote community.

**WA.2010.1007** Indigenous/Drugs & Alcohol/Geographic/Mental Illness & Health
An indigenous mentally ill youth, who had a solvent abuse problem (petrol/solvent sniffing) was found dead in the bush three weeks after being reported missing from a remote community. The cause of death was unascertained.

**Combined recommendations**

- I recommend that the State Government consider implementing legislation similar to the Volatile Substance Prevention Act 2005 (NT) which would enable the making of treatment orders specifying treatment programs and the facility or place where the treatment programs are to be provided for volatile substance abusers at risk of severe harm.

- I recommend that the State Government consider funding, or at least working with Aboriginal organisations such as Kimberley Aboriginal Law And Culture Centre (KALACC), to provide culturally based solutions that address the issues of substance abuse and youth justice diversionary schemes.

- I further recommend that consideration be given to relaxing the tendering procurement process in appropriate cases in recognition of the fact that the organisations which are capable of providing such services are very limited in number.

- I recommend that the Department of Child Protection consider including as a factor in determining whether the Child Protection Income Management Program should be implemented for parents or guardians of children of school age and ask the question of whether those children are attending school as part of the overall assessment of the child care being provided.

- I recommend that in cases of repeated non-attendance at school by children of compulsory school age resort should be had to the powers contained in the School Education Act 1999 and the Parental Support and Responsibility Act 2008.

- I recommend that the Health Department give consideration to reviewing facilities available for adolescents and children suffering from mental health problems in the [location] with a view to provision of facilities for secure admission so that these persons can be treated as involuntary patients in the [location].
NOTE: Due to three cases of similar circumstances, where the deceased was in an immigration detention centre and took their own life, the NSW Coroner made combined recommendations for all cases.

**NSW.2010.3989**  
**Intentional Self-Harm/ Law Enforcement**  
An overseas citizen in immigration detention who was going to be sent back to his country of origin died after jumping off a balcony while officers were attempting to remove him using force. The deceased was fearful for his life if he was to be sent back to his home country.

**NSW.2010.4860**  
**Intentional Self-Harm/ Law Enforcement/ Mental Illness & Health**  
An overseas citizen in immigration detention, who suffered from a mental illness, took his own life by hanging after being told he was to be sent back to his home country.

**NSW.2010.5143**  
**Intentional Self-Harm/ Law Enforcement**  
An overseas citizen in immigration detention took his own life by hanging after being told he was being sent back to his home country.

**Combined recommendations**  
To the Honourable Chris Bowen MP, Minister for Immigration and Citizenship:

**Use of force in effecting a removal**

Department of Immigration and Citizenship (DIAC) should revise:

- The Serco Contract and the Procedures Advice Manual (PAM) 3 (Removals from Australia) to make clear provision as to the procedure to follow and who has authority to abort a removal in a situation where a detainee is resisting his or her removal and is threatening self-harm or suicide; and
- Its policies on use of force to provide guidance to DIAC officers as to what matters should be taken into account when they are requested to give a use of force authorisation in order to effect a removal.
- The Detention Services Manual should be amended to prohibit notification of negative decisions including removals on a Thursday or a Friday

**Case Management**

In relation to case management of detainees, DIAC should:

- Direct Case Managers that they are responsible for making referrals for risk assessments to International Health and Medical Services (IHMS) as soon as risk factors become apparent;
- Implement a policy that all referrals for risk assessment be made to IHMS in writing; that there be periodic follow-up of the results of risk assessment in writing and that the results of the risk assessment be documented in writing and recorded in Portal;
- Direct all staff with responsibilities towards detainees to make contemporaneous notes in Portal regarding their dealings with respect to the detainees, and to specifically record any observations made in relation to risk factors and any information received from DIAC, IHMS or Serco regarding the mental health or well-being of a detainee;
- Implement a procedure whereby when information is obtained by DIAC suggesting that a detainee is at risk of self-harm or suicide the DIAC Case Manager is required to seek all information held by DIAC on the detainee and also obtain corroborative/clarifying information to the extent that that is reasonably practicable to do so in the circumstances.

To Serco Australia Pty Ltd

Serco should develop procedures for:
Combined recommendations continued

- Encouraging Serco officers to proactively seek information on the outcome of risk assessments where Serco is aware that risk factors have been identified with respect to a detainee and/or a detainee has been referred to IHMS for a risk assessment risk
- Documenting in detainee files the presence of risk factors; the referral of risk assessments to IHMS and the outcomes of risk assessments;
- Ensuring that where there is a need for additional vigilance with respect to a detainee, that need is effectively communicated to all Serco officers in the compound in which the detainee is accommodated
- That Serco formulate a policy on the basis upon which authority to use force is to be used, including the assessment of risk, appropriate planning to reduce risk and the consideration of de-escalation techniques

To International Health and Medical Services Pty Ltd:

In relation to assessing a detainee’s risk of self-harm or suicide, IHMS should:

- Develop a standard procedure for such an assessment which inter alia provides a clear guidance as to what topics should be canvassed with the detainee; what instruments/risk assessment tools should be used to guide clinical judgement; stresses the importance of seeking corroborative information where it is available; provides for the documentation of corroborative information obtained; and provides clear guidance as to what must be documented by the clinician;
- Periodically train its mental health staff on the above procedure and on the minimum requirements to be satisfied in documenting their consultations with and assessments of clients; and
- Notify DIAC and Serco on the outcome of its risk assessments in writing

To the Honourable Chris Bowen MP, Minister for Immigration and Citizenship, to Serco Australia Pty Ltd and to International Health and Medical Services Pty Ltd:

Detainee Mental Health - Collaboration between DIAC, Serco and IHMS:

- DIAC, IHMS and Serco should work together to develop policy guidance on what information about a detainee’s mental health can be provided by IHMS to DIAC and Serco officers and in what circumstances on the basis of the ‘need to know’ without having to first consult via Detention Health Services.

To the Honourable Chris Bowen MP, Minister for Immigration and Citizenship and to Serco Australia Pty Ltd

- That DIAC and Serco formulate a policy with the NSW Police Force or the Federal Police to permit the police to provide timely assistance, including trained negotiators for high risk situations

To the Honourable Chris Bowen MP, Minister for Immigration and Citizenship and to International Health and Medical Services Pty Ltd:

- DIAC and IHMS give consideration to changing the clinical governance structure at [location] in relation to the provision of mental health services so that they are overseen by a consultant psychiatrist.

NZ.2011.2820 Intentional Self-Harm/ Falls
A person took their own life by jumping from a cliff, sustaining fatal injuries.

Recommendations
To the Mayor and Councillors, [location] City Council

It is recommended that the Council investigate the construction of a short protective fence section to the lay-by look-out area at [location]. Such fence to impede the Public gaining access to a cliff face, but not to restrict the Public’s view from the lookout itself.
VIC.2009.1425 Intentional Self-Harm/ Law Enforcement
A first time prisoner with potential self-harm risk factors died in his cell after cutting his wrists with a razor.

Recommendations
To improve the safety of first time prisoners with additional known self-harm risk factors who are initially assessed with either an unknown or low risk self-harming rating, a follow-up formal and recorded session with either a Forensicare or Correction Victoria staff member must take place after the first 24 hours of imprisonment to further assess risk and adjustment issues.

WA.2008.1571 Intentional Self-Harm/ Weapon/ Law Enforcement
The deceased took his own life with a gunshot wound to the head in the presence of police officers. The deceased, who had access to firearms through his business, had previously that day been issued with a 72 hour police order against his partner and was upset.

Recommendations
I recommend that consideration be made to amending the Restraining Orders Act 1997 so that when a police order is made pursuant to section 30A of the Act, that order would normally include a restraint prohibiting the person who is bound by the order from being in possession of a firearm and enable police officers to seize any firearms in that person’s possession or available to that person through a corporate firearms licence or otherwise.

VIC.2007.3553 Law Enforcement/ Natural Causes
The deceased who had just arrived at prison to commence their sentence, was found unresponsive in their cell. The prisoner suffered from epilepsy and it was ascertained that they had died of natural causes.

Recommendations
- That the [location] Assessment Prison and [Location] Prison ensure protocols are in place that confirm the original medical file accompanies a prisoner upon transfer to another prison i.e. that transfer does not occur until the file is available.
- That the [location] Assessment Prison and [location] Prison ensure protocols are in place that confirm timely dispensing of prescribed medication and that a prisoner’s medication accompanies him upon transfer to another prison.

NZ.2008.939 Leisure Activity/ Water Related/ Natural Causes
An experienced diver experienced heart failure while deep diving at a ship wreck. The deceased’s bail out equipment was different to his dive partners’ and when decompressing, they were unable to decompress safely.

Recommendations
The recommendations set out at paragraph 16 of the Police National Dive Squad report are of a general nature. As they are associated with this case, they may imply shortcoming on [the deceased’s] part which do not accord with the evidence. I recommend that the following substitute for the recommendations in the police report. In some instances I have made a small adjustment.

The following are recommendations for divers undertaking technical dives:
- Ensure persons dive with dive buddies and remain in close proximity throughout the dive especially during the ascent
- Ensure a pre-dive check is undertaken and includes a check of dive buddies’ equipment (but with responsibility for the equipment remaining with the diver concerned) including bail-out equipment and systems (particularly gas types).
NZ.2010.1129  Leisure Activity/ Water Related

A tourist experienced difficulties while swimming with dolphins and died from an acute pulmonary Oedema. The charter boat, while reacting to the emergency swiftly, was not equipped with an Automatic External Defibrillator which may have assisted in their care.

Recommendations

For snorkelling and similar marine charter activities

- Individual waiver forms should be used, not a group form
- Vessels should comply with Maritime NZ regulations (e.g. Rule 40A, Appendix 8) and the New Zealand Ultimate (NZU) code of practice for dive operators
- First-aid equipment should comply with Maritime NZ requirements and be checked monthly. It should also meet any local or specific needs. An example of this for snorkelling/scuba diving activities might be to not stock a bronchodilator, this being replaced by stocking ‘asthma snorkels’ and ensuring that an asthma sufferer’s own inhaler is immediately to hand.
- An oxygen cylinder of appropriate size (determined by the likely length of time to obtaining emergency services assistance) and an oxygen kit, such as those marketed for the diving environment by the Divers Alert Service Asia-Pacific (DAN, a not-for-profit organisation) is carried. This should be checked daily and kept in good condition. Not all oxygen kits are suitable for the marine environment.
- All employees on board should be trained first-aiders including Basic Life Support resuscitation, at least two should be trained Oxygen Providers and (if appropriate) AED use and all should undertake annual refreshers. Courses specific to diving and snorkelling activities are the most appropriate, such as those of DAN or the Professional Association of Diving Instructors (PADI), Emergency First Responder, Oxygen Provider, etc. NZU also provides a syllabus for a Dive Activities Supervisor (DAS) programme.
- Manning levels should comply with Maritime NZ regulations and be sufficient to ensure that customers are not essential to providing first aid or resuscitation. This implies an absolute minimum of three people - a skipper, a DAS (current Maritime NZ requirement is 1 per 18 snorkelers) and either a deckhand or diving assistant/trainee. Client should only ever be involved if they voluntarily bring specific expertise to the situation.
- Rescue and emergency procedures, including man-over-board, fire and emergency on board, should be documented and practiced regularly.
- An emergency protocol for obtaining assistance should be in place and practiced/tested at regular intervals. All staff should be trained to operate the vessel’s radio on the emergency and local channels.
- Further investigation be undertaken as to the appropriateness of an Automatic Emergency Defibrillator (AED) being carried (and in particular the safety of operating such device in a water environment). These recommendations are directed to Maritime New Zealand

I also make the following recommendation

- That [location] Hospital be equipped with a Continuous Positive Airway Pressure (CPAP) device and that protocols for its use be established and medical staff be trained in its use.

NSW.2005.3779  Mental Illness & Health/ Drugs & Alcohol/ Adverse Medical Effects

A mentally ill psychiatric patient died of multi drug toxicity in hospital after being given ‘Panadeine Forte’ after a self-harm attempt. This medication reacted with the deceased’s regular anti-psychotic medication.

Recommendations

The ‘Close Observation’ Form

- Consideration be given by Health NSW to requiring the completion of a ‘close observations’ form by the relevant nursing staff which has the following features:
  - That it takes into account that observations are more likely to be conducted less regularly than every 10 to 15 minutes. It is recommended that the nurse write in the actual time that the observation was carried out;
**NSW.2005.3779 continued**

- That the nurse performing the close observation is required to write at least a summary comment of observations made on each occasion and the purpose for which that observation is made.

- **The Administration of Drugs**
  - Whenever material changes are made to a patient's drug regime, consideration is given by NSW Health to requiring a suitably experienced and qualified medical practitioner be engaged to advise as to the effect of the change in drug regime and to give consideration as to what special considerations are required, including the need to change the nature and/or frequency of any observations.

- **The Treatment of Mental Health Patients for Non Mental Health Illness and Injury**
  - Consideration be given by NSW Health to the most appropriate way to treat mental health patients ordinarily kept within the mental health unit, for non mental health illness or injury, whether it be by regular visits from a relevant consulting medical practitioner, treatment in a non mental health ward or otherwise.

- **The Training and Education of Mental Health Staff**
  - Consideration be given by NSW Health as to the knowledge of pharmacognerics/pharmakinerics and the interactive, including any toxic effects, of medications given to mental health patients by all medical officers, nursing staff and pharmacists employed by NSW Health mental health wards and, where necessary, that any further training and/or education be provided.

- **Appropriate Training of Staff**
  - Consideration be given by NSW Health as to the best way in which mental health nursing staff can update their general nursing skills and knowledge base, including where possible and appropriate, the rotation of mental health nursing staff onto general medical and surgical wards.

**NSW.2009.2238 Mental Illness & Health/ Intentional Self-Harm**

A mentally ill person died after jumping from a cliff. The deceased had been discharged following hospitalisation, and follow-up treatment sought by the family was not provided.

**Recommendations**

To the Minister for Health

- That consideration be given to ensuring the implementation of an electronic file system to be accessed by all mental health service providers be treated as a matter of urgency

- That consideration be given to ensuring that all mental health service providers confirm verbal and written communication of discharge and treatment plans to external service providers and families or carers

- That the changes outlines by [name] as contained in his statement dated [date] be formally implemented and audited in a six month period.

**NSW.2009.4426 Mental Illness & Health/ Intentional Self-Harm**

A mentally ill person died after hanging themselves while being a patient in a mental health unit.

**Recommendations**

To the Minister for Health and the Minister for Police

That NSW Health and NSW Police develop a protocol governing procedures to be adopted in the investigation of critical incidents that occur in NSW Hospitals. Such a protocol will be expected to cover the procedure for advising police of such incidents in a timely manner, the preservation of the ‘crime scene’ (that is the physical location of the incident), the securing of exhibits and other relevant documents, the identification of relevant witnesses and the taking of statements from such witnesses.
NZ.2007.400  Mental Illness & Health/ Intentional Self-Harm
A mentally ill patient took their own life by hanging within the bathroom of the hospital.

Recommendations
To: The Chief Executive, [Location] Health Board

• That in reviewing the Board’s present policy relating to increased patient observations, careful considerations be given to the guidelines for levels of observation in inpatient units, appended (Appendix 6) to the Ministry of Health’s Best Practice Evidence-Based Guideline, The Assessment and Management of People at Risk of Suicide (May 2003).

• That the Board give favourable consideration to the implementation of such practical changes as may be recommended by the Clinical Director of [hospital] [name] in the light of these findings, including the locking of bathroom/shower room doors by patients and the searching of patients and their rooms for objects that may be used for wilful harm or self-destruction.

NZ.2009.3155  Mental Illness & Health/ Intentional Self-Harm/ Water related
A mentally ill patient who was carrying a surrogate child, failed to return from day leave from a hospital ward and was found to have taken her life by drowning at the local beach.

Recommendations

• I recommend that a copy of this Finding be forwarded to the [location] District Health Board for the education and training of both its Fertility Services and Mental Health teams.

• I recommend that a copy of this finding also be forwarded to the Ethics Committee on Assisted Reproductive Technology (ECART) so that the organisation can also learn from the tragic death of [the deceased] specifically to emphasise the need for all involved with the care of a surrogate mother to be totally candid in their reports in relation to all issues affecting the surrogacy.

NZ.2010.2656  Mental Illness & Health/ Intentional Self-Harm/ Weapon/ Drugs & Alcohol
A mentally ill person, who had attempted suicide by overdose forty eight hours prior and had been released from hospital, took their life by way of a gunshot wound to the head. The deceased had consumed a large amount of alcohol prior to the incident.

Recommendations

I recommend that the [location] District Health Board (DHB) Mental Health Service reassess its assessment procedures in respect of potential suicide victims. In particular, if there are family support people present at an assessment or if such people can be contact at the time of the assessment by telephone— if not present— these people should be spoken to independently and separately from the patient and their candid views as to the patient’s condition should be sought.

A patient’s answers to questions should on no account be taken at face value but should always be challenged. If this has not already occurred, a questioning protocol should be developed which is specifically designed to contain with it its own checks and balances so it becomes difficult for a patient and/or its patient’s support person to provide responses simply designed to convey that all is well when it is not.

SA.2009.23  Mental Illness & Health/ Older Persons
An elderly person suffering from dementia died from aspiration of gastro-intestinal contents as a result of a small bowel obstruction due to small bowel torsion. The deceased had been asked questions by the doctors but had given incorrect answers due to her mental illness, leading to the obstruction being overlooked.

Recommendations

It would appear that the Mental Health Directorate has recognised the lessons to be learned from, not only [the deceased’s] case but those other cases that were the subject of the Root Cause Analysis. I recommend that the Minister for Health note this Finding and endorse the recommendations of the Root Cause Analysis.
VIC.2009.3970  Mental Illness & Health/ Intentional Self-Harm/ Transport & Traffic Related
A mentally ill person absconded from a mental health hospital ward and subsequently ran into a path of an oncoming truck.

Recommendations
As previously indicated, I am satisfied that [the deceased] absconded by climbing over the courtyard wall. It is recommended that the wall be modified in such a way as to prevent climbing over it and/or to secure any courtyard furniture so that it cannot be used as a climbing aid.

WA.2007.1266  Mental Illness & Health/ Law Enforcement
A mentally ill involuntary hospital patient, who attacked a fellow resident, died after being restrained by staff while being transferred to a secure ward.

Recommendations
- I recommend that there be a review of the approach taken by [location] Hospital to the searching of seriously ill patients, particularly involuntary patients, and consideration be given to there being regular searches conducted of their property with a view to identifying any alcohol or drugs retained by the patients or any items which could be used as a weapon and place other patients and staff at risk of harm.
- I recommend that [location] Hospital administration review arrangements in place at the hospital with a view to restricting the access of involuntary patients housed in open wards to alcohol and illicit drugs
- I recommend that WA Health conduct a review of appropriate restraint procedures, focusing on the extent to which the head is held during restraint and particularly during escort with a view to minimising the possibility of injury to patients and staff
- I recommend that WA Health review training provided to staff in respect to commencing manual restrain of patients with a view to minimising the likelihood that those initial restraint actions will provoke a violent response, particularly where the patient is not threatening immediate violence at the time when restraint is first applied.
- I recommend that WA Health review the nature and extent of training being provided to staff in respect to restraining aggressive and potentially violent patients, particularly in the following respects:
  - There needs to be in place a comprehensive and clear manual which describes in an unambiguous manner a number of alternative restraint procedures which can be used. That manual should be available to persons undergoing training as a resource or reference.
  - There should be a comprehensive review of the restraint holds being taught with a view to ensuring that the restraint holds are appropriate to different circumstances and provide the least possible risk to patients and staff. While it needs to be recognised that all restraint procedures involve potential risk of injury, those risks should be kept to a minimum.
  - Consideration should be given to whether the extent of training is adequate and in particular consideration should be given to increasing the initial training course from two days to three days and ensuring that refresher courses are undertaken at no more than twelve month intervals and adequately cover de-escalation techniques as well as restraint holds. In the event of any significant changes in training being adopted or after every three years (or such other period considered more appropriate) persons trained should be again given the full training course.
  - The training should include a focus on when smaller or more frail staff members should be involved in a restraint and when it would be unsafe to embark on a restraint at all. There should be a focus on when evacuation is the safest option and when it is best to wait for more staff to become available to assist with a restraint or to call for police or other outside assistance.
NZ.2010.3130  Natural Causes/ Older Persons/ Transport & Traffic Related
An elderly person suffered a heart attack while driving, causing their vehicle to lose control and crash. While the deceased did sustain injuries in the accident, it was the prior heart attack that was the cause of death.

Recommendations
I recommend that a copy of this Finding be forwarded to New Zealand Transport Authority (NZTA) for the information of the organisation. It is not considered that the death of [the deceased] was a road crash death but other issues arose as circumstances of the death required the attention of NZTA.

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NZ.2009.4092  Older Persons/ Drugs & Alcohol
An elderly woman died from a combination of malnutrition, pressure ulcers and cerebrovascular accident. While in hospital, clinical records show that she was also over-medicated, which may have contributed to her death. The deceased’s son, who was her carer, was not aware of being able to access any services to help with his mother’s care.

Recommendations

Neglect Issue
• The circumstances of [the deceased’s] death raises questions about public awareness of, and access to, community services to assist in elder care. I note that Age Concern operates an Elder Abuse and Neglect Prevention Services focussed on public awareness and the early identification of, and prevention of elder neglect. A copy of these findings will be sent to that organisation for consideration within their neglect prevention programme of the specific factors in this case which limited the deceased’s (and her son’s) opportunity to access help and assistance and how such factors may be alleviated.

Medication administration
• Notwithstanding [name’s] opinion regarding the role of morphine and midazolam in [the deceased’s] death, and my findings in this respect, it is extremely concerning that the clinical records show, at least in the case of midazolam, that twice the prescribed dose was administered on [date]. This is especially worrying in light of the [deceased’s] fragile physical state. It is difficult to understand how such an error occurred given that a checking system was clearly in place (as evidence by the chart itself). I recommend to [location] District Health Board that this case be reviewed to identify how the error occurred, and that steps be undertaken to assist in the prevention of similar errors occurring in the future. Given the ambiguity of the clinical record as it pertains to the administration of morphine, such review should also consider and re-emphasise the importance of accurate and legible record-keeping.

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Four people died after a fuel tanker lost control and rolled, hitting a car. The tanker then sprayed fuel as it rolled, with both the tanker and car catching alight.

Combined Recommendations
To the Minister of Roads and Ports NSW
• I recommend that the Roads and Maritime Services undertake a review of the signage and speed limits for heavy vehicles for the princes Highway between Termeil and Batemans Bay having regard to the circumstances of this collision. I recommend that the review include an investigation as to the feasibility of making advisory speed limits mandatory or heavy vehicles.

To the Federal Minister for Infrastructure and Transport
• I recommend that an amendment be made to the Australian Dangerous Goods Code to make it mandatory that any vehicle used for the transportation of Dangerous Goods be fitted with a stability control system.

To the Minister of Transport and Environment NSW
• I recommend that an amendment be made to the Dangerous Goods (Road and Rail Transport) Regulation NSW 2009 to make it mandatory that all vehicles used in the transport of dangerous goods be fitted with a stability control system.
NSW.2009.6289, 6290, 6291 & NSW.2010.26 continued

To the Minister of Environment and Heritage NSW

- I recommend that the ‘relevant authority’ responsible for the certification of persons who are authorised to transport dangerous goods include in the certification process a training component on the causes of rollover incidents.

To the Chairman of the Australian Trucking Association

- I recommend that a training and education package be developed for the benefit of members of your association incorporating the facts and findings from this Inquest and addressing the causes and prevention of heavy vehicle rollovers.

NSW.2009.6316  Transport & Traffic Related

A driver died after his vehicle collided with another vehicle that had been hit by a truck. This forced both vehicles to become wedged underneath a second truck. All vehicles involved were trying to avoid an overturned campervan on the road.

Recommendations

To the chairman of the Australian Competition and Consumer Commission

- The Australian Competition and Consumer Commission should consider these findings together with the expert reports of [names] and their annexures with a view to ensuring the safety and stability of campervans already registered and on Australian roads.

To the Minister of Transport

- The Roads and Traffic Authority should make recommendations to the Australian Motor Vehicle Certification Board (AMVCB) Working Party that Code LH11 (Campervan, Motorhome conversion) of the Vehicle Standards Bulletin 14-National Code of Practice for Light Vehicle Construction and Modification January 2011 (VSB 14) be amended to require the following:

  ◊ The centre of gravity of the vehicle must be determined. In order to reduce the centre of gravity and the vehicle’s propensity to overturn, the heavier items that are permanently fixed to the vehicle as part of the modification must be fitted as low as practicable and cisterns and other containers that can be temporarily filled with fluids must be fitted as low as practicable.

  ◊ The load distribution on axles in modified vehicles must be assessed. If the load distribution is outside the manufacturer’s specifications or where a manufacturer’s specifications are not available, the vehicle must be modified to ensure the vehicle can accommodate the proportion of load on each axle.

  ◊ Notice(s) should be placed in the vehicle indicating where temporary loads should be placed and any limitations and/or restrictions clearly displayed.

  ◊ Vehicles to be modified as a campervan must successfully complete the lane change manoeuvre test specified in Code LT of VSB14.

NZ.2009.1388  Transport & Traffic Related/ Older Persons

An elderly person died of injuries sustained in a vehicle incident where the other driver appeared to be on the wrong side of the road.

Recommendations

- I recommend the authority governing road safety signage consider providing appropriate signage for cars that engage the [location] intersection of [location] to stay in the left lanes as required by the road laws of NZ.

- In the Serious Crash Report prepared by [name] he makes a note at paragraph 9.1.2 that ‘there are no signs immediately before and after the intersection reminding people to keep left’.

- I note there are arrows parallel to each other in the north and south bound lanes respectively, one pointing north, the other south, in excess of 20 metres approximately south of the intersection, which in my view provides no real assistance as to which lane a car should be travelling out of the intersection.
NZ.2009.1388 continued

- I would suggest a better use of the painted arrows approach to ensure drivers stayed left in their respective lanes when leaving this intersection, would be painting a large arrow approximately five (5) metres up from the intersection in the north bound lane. This would assist the awareness of the driver. With respect to vehicles turning right into the south bound lane, as they clear the ‘T’ intersection, having a large painted arrow pointing south bound, in the south bound lane, would also assist the driver.

- I would suggest the reassignment of the arrows would strategically enhance their effectiveness. This would be a better use of the use of the painted arrows to assist drivers to stay in the correct lanes.

NZ.2010.1846 Transport & Traffic Related/ Drugs & Alcohol
A farm worker on a tourist visa died after they lost control of the vehicle they were driving and it overturned, leading to fatal injuries. The deceased was intoxicated and not wearing a seatbelt, and was ejected through the sunroof, with the vehicle crushing him.

Recommendations
I recommend that a copy of this Finding be sent to New Zealand Traffic Agency (NZTA) as a further example of the tragic combination of the consumption of excess amounts of alcohol, driving at speed and failing to wear a seatbelt.

NZ.2010.2480 Transport & Traffic Related/ Older Persons
An elderly person died when she attempted to overtake another vehicle and travelled onto the wrong side of the road, colliding head on with an oncoming car. The oncoming car was a dark grey and despite flashing its lights to warn the deceased, and braking heavily, they were unable to avoid the crash.

Recommendations
I intend forwarding a copy of this Finding to New Zealand Transport Agency (NZTA). I recommend that NZTA give consideration to researching the colouration and visibility of vehicles and the contribution to road crashes of vehicles of less visible colours. NZTA could also consider whether it is appropriate that all vehicles have headlights on all of the time.

NZ.2010.2525 & 2914 Transport & Traffic Related
Two people died when a learner driver, who was exceeding the speed limit without a licensed driver in the car, crashed head on into another vehicle. Both deceased died as a result of injuries sustained in the crash.

Recommendations
I recommend that an advisory speed sign be placed prior to the bend at which this crash occurred.

NZ.2011.2750 & 2874 Transport & Traffic Related/ Drugs & Alcohol
A driver who was under the influence of cannabis, and his passenger died of head and neck injuries after losing control of his vehicle and colliding with an oncoming vehicle.

Recommendations
I note that [name] in his report made some recommendations concerning high profile police enforcement 24 hours a day on main arterial State Highway networks. I endorse his recommendation, but note of course that this will be a matter of police resourcing. Certainly having a high profile police presence on our roads does tend to slow down traffic.
QLD.2010.1882  Transport & Traffic Related/ Fire Related
A driver was incinerated after the vehicle they were driving travelled across an area of road works and skidded off the road, colliding with a tree. Exceeding the speed limit and the inadequacy of signage were major contributors to the accident.

Recommendations
- That the Department of Transport and Main Roads give serious consideration to including in the Manual of Uniform Traffic Control Devices (MUTCD) training and information on the parts of the Main Roads Technical Standard (MRTS) which contain regulation of signage controls
- That the Department of Transport and Main Roads give serious consideration to the inclusion of guidelines in the Manual of Uniform Traffic Control Devices (MUTCD) in relation to the conduct of risk assessments for road works in order to ensure that a consistent and sufficiently rigorous process is followed in the interests of public safety.

VIC.2008.1238  Transport & Traffic Related
Driver was killed after a sixteen year old learner driver, suffering from possible fatigue, drifted into the path of an oncoming truck. The truck hit the learner driver’s car first, without fatality, and then hit the deceased’s car.

Recommendations
- VicRoads should consider strengthening its message on fatigue on long journeys, especially in relation to young and other experienced drivers.
- Consideration should also be given to some assessment procedure for qualifying prospective supervising drivers.
- VicRoads should consider recommending a legislative amendment to the Minister, setting out clearly the roles and duties of a supervising driver, either in the Act or the Regulations.

VIC.2009.4450  Transport & Traffic Related/ Aged Care/ Falls
A care home patient died of injuries sustained when a van crashed into his wheelchair and it overturned, causing the deceased to hit his head. The van’s handbrake was not engaged at the time, and the driver only held an international drivers’ licence.

Recommendations
That the licensing regulator VicRoads, review the question of whether a person who is not the holder of a Victorian Drivers License ought to be entitled to be engaged or employed to drive a motor vehicle and convey passengers, relying on a country of origin license and international drives license, and without meeting local licensing testing standards.

VIC.2010.1365  Transport & Traffic Related
A motorbike rider died after colliding with a car that failed to stop or look sufficiently for traffic at a ‘Give Way’ Sign. The rider and his passenger were both thrown from the bike.

Recommendations
Victoria Police had made a recommendation to VicRoads for a prominent sign saying ‘Look Right’ be installed at the end of the centre island where [location] Street ends in order to draw attention to possible traffic approaching from the south that may have been missed when checking further back in the intersection. Police have noted that realigning the intersection would create other risks.

I adopt this recommendation and ask VicRoads to undertake the remedial work as soon as possible.
WA.2008.1543, 1544, 1545, 1546  Transport & Traffic Related/ Fire Related
All the deceased persons were on a scenic helicopter flight that crashed and caught fire. All occupants died of thermal burns as well as head and neck injuries.

Recommendations
I recommend that the Operator advise clients on its designated scenic flights the flight conditions are not suitable for amateur photography of small localised features.

I recommend that CASA implement a requirement for endorsement and recurrent annual training on [name] Helicopter Company R44 helicopters to address the preconditions for, recognition of, and recovery from, low main rotor RPM and decay.

NZ.2011.340  Water Related/ Leisure Activity
A cruise ship passenger on a day trip to an island died from drowning associated with aortic regurgitation while snorkelling.

Recommendations
The recommendations made by the Police National Dive Squad which I endorse are:

- Ensure the divers’ experience is clear to those planning or organising a dive trip
- Do not enter the water in adverse conditions
- Do not enter the water if you are not confident and without proper training
- If in difficulty at any time on the water surface, abandon the dive and seek assistance early before the situation gets out of hand
- Be completely familiar with the dive equipment used and its correct set up.

NZ.2008.4000  Work Related/ Falls
An electrical worker fell seven metres to the ground while working on power lines, when the pole fractured below ground level.

Recommendations
I recommend that:

- The Electricity Engineers’ Association review the processes for updating its relevant safety manuals (Note: it was apparent in this case that there was a need for updating the relevant manuals in the period since the previous (2004) editions of those manuals. The updating has now occurred. However, a continuous review process with associated progressive updating of manuals may more readily align best practice with changing industry requirements.)
- The Electricity Engineers’ Association (EEA) takes such steps as are available to it to best ensure that industry employers implement effective practices in accordance with the requirements set out in relevant EEA publications with particular reference to
  - Pole safety assessment and situations involving changes to pole top loading
  - The use of elevating work platforms in appropriate circumstances particularly when dealing with assets that through age or for other reasons may be more likely to fail.

NZ.2010.1064  Work Related/ Transport & Traffic Related
A person died when the fertiliser spreader truck that they were driving slid on a slippery slope and overturned, causing the deceased to be thrown about the cab of the truck, as they were not wearing a seatbelt. The deceased died from a laceration of the right ventricle from a broken rib, and cardiac arrhythmia.

Recommendations
I recommend that a copy of this Finding be forwarded to the Department of Labour to prompt further involvement with the New Zealand Ground Spread Fertiliser Association in the creation of further safety enhancements.
NZ.2010.1064 continued

- I ask the industry and the Department of Labour work together to clarify the benefits of operators using safety belts and investigating methods to ensure these are more ‘user friendly’ for drivers in difficult situations. The New Zealand Ground Spread Association should investigate the provision in the trucks of its members of an emergency call and tracking system not dependent upon cell phone and radio coverage or the continuing consciousness of an operator who may have been disabled in a rollover.
- The Association and the Department of Labour should give consideration to establishing a protocol between customers, contractors and employees, ensuring the fact that employees are not pressured to complete spreading tasks beyond safe parameters.

NZ.2010.1185 Work Related

A farmer died from extensive brain fractures and brain injuries due to a severe impact. While assisting with the unloading of grain from a truck using an auger powered by a tractor power take off (PTO) shaft, the PTO attachment failed and fractured, allowing an end to come free, rotate and strike the deceased in the head.

**Recommendations**

I recommend that a copy of this Finding be forwarded to both the Department of Labour in order that appropriate publicity be given to the circumstances of the death of [the deceased] in the hope that such circumstances are not repeated, and I also recommend that a copy of the Finding be forwarded to Federated Farmers in order that a summary of the circumstances of the death of the deceased be published to members to similarly identify contributors to the death.

NZ.2010.1268 Work Related/Older Persons

An elderly person died in hospital two months after sustaining injuries when he was hit by part of a tree that was being felled.

**Recommendations**

I recommend that a copy of this Finding to the Department of Labour for the information of the Department of Labour and for its further submission to the New Zealand Arboricultural Association. There is a lesson of safe practice which has been learned from the tragedy and this lesson requires publicity.

NZ.2010.2788 Work Related

A tree feller died from multiple internal injuries with mechanical asphyxiation and compressive injury which was sustained when a tree he was cutting down fell on him.

**Recommendations**

The inquiry into the circumstances of [the deceased's] death has revealed what I consider to be shortcomings in his employer’s management of Health and Safety issues, particularly in relation to the tree felling process that [the deceased] was using when he died. This process involves connecting a tree to the mainline of the cable hauler prior to felling it, not to assist with the determining the direction of fall, but to stop the tree sliding away and being difficult to retrieve once felled. Accordingly, the effect of the tree being connected to the mainline should not be realised until the tree is down, and this can only occur if there is sufficient slack on the mainline from the outset. This process does not appear to be an industry recognised practice, nor does it appear to be used widely within the industry, although [the company] employees were well familiar with it. Since [the deceased] died, [company] has produced a one page Health and Safety policy document regarding use of the process, but in my view further action should be taken to formalise training and identify competencies required if this process is to be persisted with. In particular, the training should cover the means by which the person using the process can determine the tension in the mainline when the line is unsighted.
**TAS.2009.112  Work Related/ Youth**
A youth was pinned between a crane arm and the side of a boat while working.

**Recommendations**
The use of overhead cranes is an intrinsically dangerous activity which requires the application of properly considered risk management practices to minimise the risk of harm to all persons working within their vicinity. In this case, such practices should, in the least, have included:

- The creation of a standard operating procedure for the safe exchange of floatation buoys utilising the crane
- Proper training and instruction of the crew in the application of the operating procedure
- The appointment of a crew member, in this instance most probably [name], to be supervisor and the person responsible for the task being undertaken and to ensure that the operating procedure was complied with

- The standard operating procedure should have included these specific requirements:
  - That the crane operator have proper training in the use of the crane including the remote control device. Such training should include familiarisation with the equipment’s’ Operator’s Manuals and most specifically the directions concerning use of the Stop button
  - The delineation on the deck of the [boat name] of the hazardous work area created by the boom of the crane
  - A specific instruction that the Stop button on the remote control device be engaged and remain engaged at all times whilst a crew member was within the crane’s hazardous work area.
  - A specific instruction that the crew member responsible for the operation of the remote control device not carry out any other tasks whilst wearing that device.

In my view, there is a very real likelihood that the deceased’s death would have been prevented if [company] had, following a proper risk management assessment, put in place and followed a standard operating procedure which incorporated those elements which I have set out above.

This tragedy should serve as a reminder to the aquaculture industry in particular and industry generally of the very real need for the risk assessment of all aspects of their operations and for the creation and implementation of strategies designed to minimise the risk of harm to their employees.

**TAS.2011.117  Work Related/ Transport & Traffic Related/ Older Persons**
An elderly person died after becoming pinned underneath his tractor on a farm.

**Recommendations**
The failure of the park brake has been the causative factor in this most unfortunate incident. The tractor was left out of gear with the engine running which should be regarded as contributory factors.

I note that [the deceased] was a very experienced farmer who was described by those who knew him as being very careful in the operation and maintenance of machinery. However, it is essential that owners and/or operators of this type of machinery ensure they are maintained in accordance with manufacturer’s specifications. When stopping and/or parking machinery, the operator should always follow manufacturer’s recommended operating procedures.
TAS.2010.226  Youth/ Law Enforcement/ Transport & Traffic Related
A sixteen year old youth died of head injuries after crashing his car into a ditch following a police pursuit.

Recommendations
Errors of judgment were made possibly brought about by inexperience and the suddenness of the events, and again I adopt and endorse the recommendations of [name] that the police officers involved in this case and any other police officers likely to be involved in similar but hopefully infrequent events, should have further training and awareness of operational and supervisory issues highlighted by this case.

These failures contributed to Radio Dispatch Services (RDS) operators and supervisors failing to fully appreciate what had actually occurred and from a Coroner’s perspective the available evidence for the inquiry, the following of those protocols may well have assisted the investigation by making plausible corroborative evidence available from the outset.

I accept that police officers are place in an invidious position when it comes to a decision whether it is in the community interest to pursue or not a person suspected of a crime or likely to become involved in a crime including minor traffic breaches which may escalate into more serious driving events and consequences. It is almost a situation of ‘being damned if they do and damned if they do not’. Initial detailed training in and constant review of the published policies and protocols and adherence to them will obviously assist them in that decision making process. I am informed and accept that Tasmania Police will invoke its own internal actions in relation to the two police officers for having breached procedures and have no doubt that it will adopt my recommendations into continuing training in the implementation and compliance with existing policies/procedures and protocols relating to these or similar circumstances.
<table>
<thead>
<tr>
<th>CATEGORY TAG</th>
<th>DESCRIPTION</th>
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<tr>
<td>Adverse Medical Effects</td>
<td>Adverse after effects from a recent medical or surgical treatment, failure to comply with medical advice</td>
</tr>
<tr>
<td>Aged Care</td>
<td>Incidents that occurred in an Aged Care or assisted living facility or residence including a retirement village</td>
</tr>
<tr>
<td>Animal</td>
<td>Incidents where the an animal was involved in the cause of death.</td>
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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>
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<tr>
<td>Domestic Incident</td>
<td>Fatal incident that occurred as a result of domestic injury or event</td>
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<tr>
<td>Drugs &amp; Alcohol</td>
<td>Death where drugs or alcohol or both were a primary or secondary cause of death</td>
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<tr>
<td>Electrocution</td>
<td>Cases where electrocution is the primary cause of death</td>
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<tr>
<td>Falls</td>
<td>Incidents where a fall was involved in the circumstances or cause of death</td>
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<tr>
<td>Fire Related</td>
<td>Incidents where a fire was involved in the circumstances or cause of death</td>
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<tr>
<td>Geographic</td>
<td>Cases where the geographic region is significant to the cause of death e.g. - remote location</td>
</tr>
<tr>
<td>Homicide &amp; Assault</td>
<td>Includes interpersonal violence and family domestic violence</td>
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<tr>
<td>Indigenous</td>
<td>Cases related to a specific demographic group</td>
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<tr>
<td>Intentional Self-Harm</td>
<td>Cases determined ISH by coronial investigation</td>
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<tr>
<td>Law Enforcement</td>
<td>Includes police pursuit, death in custody, parole issues, pending or previous court cases including family court, restraining order and coronial investigation procedures.</td>
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<tr>
<td>Leisure Activity</td>
<td>Any leisure actively that directly influence the circumstances including holiday activity or location</td>
</tr>
<tr>
<td>Location</td>
<td>Cases where the location of either the incident or the discovery of the body is of significance, does not refer to geographic location</td>
</tr>
<tr>
<td>Mental Illness &amp; 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>
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<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>
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<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>
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<tr>
<td>Work Related</td>
<td>Includes cases where work is related to the death and also where unemployment is significant</td>
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<tr>
<td>Weapon</td>
<td>Cases where the involvement of a weapon is significant</td>
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<tr>
<td>Youth</td>
<td>Cases related to a specific demographic group</td>
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