NCIS

Fatal Facts

Edition 34

Fatal Facts is produced by the National Coronial 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 publicly 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 30th June 2012. 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 34 includes cases where the coronial investigation is complete and where the Coronial Finding contains recommendations. Edition 34 includes cases that were closed between 1st July and 30th September 2012. *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 34 contains summaries of cases where recommendations were made as part of the formal coronial finding. Of these cases, 38 are Australian cases and 39 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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NOTE: Due to two cases of similar circumstances, where the deceased died after being injected with an iodine dye for a CT scan, the NSW Coroner made the same recommendations for both cases.

NSW.2011.943 Adverse Medical Effects

A person died of a cardiac arrest after being injected with iodine dye for a CT scan and having an allergic reaction.

NSW.2011.2654 Adverse Medical Effects/ Older Persons

An older person died of a cardiac arrest from anaphylaxis after being injected with iodine dye for a CT scan.

Combined Recommendations

To the Minister for Health, NSW and to the Australian Resuscitation Council

- That strong consideration be given to reviewing the guidelines and practice for patients experiencing anaphylactic shock, to outline treatment pathways for bronchospasm and anaphylaxis.
- That Radiology Clinics be required to provide specific training to all staff in emergency resuscitation, and to maintain full emergency equipment including defibrillators and pulse monitors on site at all times.
- That, where possible, Radiology Clinics providing contrast dye imaging ensure that multi-lingual information forms and questionnaires outlining the foreseeable risks, and requiring full medical history information, are given to relevant patients and checked by staff before any procedures are undertaken.

NSW.2011.3342 Adverse Medical Effects/ Older Persons/ Aged Care

An elderly person died of acute pancreatitis in hospital. The deceased had asked to be taken to hospital, but this did not occur as the aged care facility heeded the advice of the deceased's daughter to delay treatment.

Recommendations

A recommendation of this inquest would be that [aged care facility) institute a protocol when dealing with the varying wishes of patients and family members or friends. In all cases such as this where there is discourse between the patient and others, the wishes of the patient should be held to be paramount.

NSW.2011.4854 Adverse Medical Effects/ Falls/ Older Persons

An elderly person with an identified falls risk died of acute exacerbation of chronic heart disease after sustaining a fractured hip in a fall at a nursing home. The nursing home did not initially seek treatment for the deceased and he was later administered morphine despite an intolerance to the drug, which was noted in his medical records. The deceased was then taken to hospital where his condition continued to deteriorate.

Recommendations

All treating medical officers attending patients in nursing homes should record all occurrences with patients accurately.

NZ.2009.3906 Adverse Medical Effects/ Transport & Traffic Related

A motor scooter rider on a clinical trial for heart medication was struck by a car. While being treated in hospital, it was not clear as to what coagulant was used for the clinical trial.

Recommendations

I endorse the recommendations made by the Road Controlling Authorities (RCA) panel. Once they are all implemented they should decrease the risk for future participants in trials and in those trials that involve [district health board] patients.

NZ.2009.3906 continued

I recommend to the District Health Board (DHB) that it ensures that the Concerto patient system is stable enough to function as an immediate primary source for the clinical patient especially in Emergency Department (ED)and that all departments that carry out clinical research institute a system that ensures that all patients who are enrolled in their clinical trials have that information placed in Concerto, thereby allowing immediate access to it by ED staff in an emergency. The information on Concerto to include key local investigators and their contact details and where sham INR's are part of the trial, this should be clearly stated on Concerto. (I note that the trial now has all its trial information on concerto and has done so since just after the deceased's death.

I recommend to the Multi-region Ethics Committee and Health and Disability Ethics Committee's (HDEC's) that in double blinded studies especially, but in all clinical trials of new medicines or new products, that before the trial is approved the Ethics Committee is to be satisfied that the investigators have placed information about the clinical trial on systems that are immediately accessible to Emergency Department staff of hospitals in all the sites in which the trials are taking place.

I recommend that the online application form should have a section specifically containing questions that can satisfy a Committee that ED staff- through their own ED systems, and not just through medic alert bracelets or wallet cards or paper notes- will know immediately on a patient's arrival at ED that they are enrolled in a clinical trial and have immediate information to enable them to properly treat the patient.

This information must thus include that the patient is on a clinical trial the nature of the trial and the contact details of the local investigators. If the patient might be in a drug trial arm this should be stated and also what that trial drug is and its differences to standard medication, whether or not its effect can be reversed, and if so by what means. The information must include what treatment should be commenced. In the case of a trial of an anticoagulant, the fact that a participant's previously recorded INR results might be shams must be included in this information.

Clinical research is by its very nature a trial of something new and thus always carries risks. [The deceased's] participation, like that of so many others who participate in clinical trials, helps pave the way for improvements in the future of health. Since his death the trial and [doctor] have written to the sponsors of ROCKET A-F study about what happened and I commend this. I recommend that knowledge gained from the death of the deceased continues to be disseminated in peer journals and through ongoing education to clinicians to benefit many future patients by making clinicians aware of the risks for participants in clinical trials where ED physicians are needing to treat them in an emergency.

NZ.2011.2001 Adverse Medical Effects

A person undergoing a left lung removal due to a cancerous tumour, died after the surgeon mistakenly severed the arteries to the heart.

Recommendations

I recommend to the District Health Board the following:

- Trial clamping the blood vessels during a left pneumonectomy is to be made mandatory prior to stapling. For clarity my recommendation is limited to clamping during a left pneumonectomy. (According to [name] the arrangement of blood vessels requiring dissection in a right pneumonectomy is such that the risk of loss of anatomical markers is not as great).
- A fatigue risk management system such as is used in Queensland is introduced, if possible, sooner than the six month timeframe recommended by the Root Cause Analysis (RCA) panel.
- If barriers to introducing a fatigue risk management system arise, such as the negative attitude of some cardiothoracic surgeons to the introduction of such a system, then a programme incorporating teamwork, communication and situational awareness should be introduced in the cardiothoracic per operative service.

NZ.2011.2146 Adverse Medical Effects/ Older Person/ Physical Health

An elderly person suffering from Lewy Body Dementia (LBD) died of respiratory failure after being administered the antipsychotic medication, Haloperidol, when he became aggressive.

NZ.2011.2146 continued

Recommendations

To [location] District Health Board

I recommend that:

- Drug availability for sedation on the general wards be reviewed at [name] Hospital.
- The provision of security staff or personnel trained in physical restraint be reviewed at [name] Hospital.

NZ.2011.2927 Adverse Medical Effects/ Physical Health

A person died of a pulmonary thromboembolism that may have been linked to oral contraceptive use and obesity, as well as an enlarged uterus that was not diagnosed whilst in hospital.

Recommendations

The doctors who cared for the deceased have reflected on their practice and made changes to as a result of the deceased's death. In response to analysis of the circumstances of the death, the medical centre [location] identified a number of things it could do differently to improve the standard of care and considered the issues further when it received [doctor's] report. Its clinical Director has confirmed that the medical centre is focussed on reducing risk for its patients. Accordingly, I do not see the need to make detailed recommendations to prevent deaths in similar circumstances in future.

I recommend to the Clinical Director of the medical centre [location]

- That the medical centre reviews the action points identified in its root cause analysis of the circumstances of [the deceased's] death and ensures that all action points have been addressed and implemented.
- That the medical centre uses this finding as a further opportunity for learning.

NZ.2011.2300 Aged Care/ Falls/ Older Persons

An elderly person died after sustaining a fall at the nursing home where she resided. The deceased died from pulmonary congestion and heart failure as a result of the fall, which appeared to have been caused by a spontaneous fracture of the left neck of the femur.

Recommendations

- I recommend that a copy of this Finding be forwarded to [name] Hospital and to the [Location] District Health Board for the information of clinicians and for training and education purposes.
- I recommend that a copy of the Finding and relevant extracts from the file be forwarded to the office of the Health and Disability Commissioner in order that further investigations into the circumstances of the death that are outside the jurisdiction of the Coroner can be made.

NZ.2008.4280 Child & Infant Death/ Homicide & Assault

A three year old child was fatally assaulted by their caregivers.

Recommendations

- That the Government take urgent steps to ensure witnesses to any child abuse must report it immediately. Similarly, that there be significant penalties for failing to so report any such abuse.
- That consideration be given to the provision of an 0800 number with anonymity provided to the caller for reporting child abuse.
- In respect of the above recommendation that wide publicity be given to these new measures.

NZ.2008.4280 continued

- That there be implemented urgently, a system providing appropriate monitoring and oversight of young children with Government agencies providing aid and services, health providers and others.
- That all children from birth be compulsory registered with Government agencies and health providers and other voluntary organisations and that they be compulsory monitored through to and including the age of five. That monitoring to include scheduled and unscheduled visits to the homes where young children are living so that the monitoring will ensure that they are kept safe and then provided with the necessities of life.
- That there be compulsory state intervention and the monitoring oversight of the care of children in the following circumstances:
    - ◊ A single parent family;
    - ◊ A single parent who had previously come to the attention of Child Youth and Family Services (CYFS) in respect of another child;
    - ◊ A single parent who was working fulltime and placing their child in the care of others;
    - ◊ A single parent in receipt of a domestic purposes benefit; and
    - ◊ Wherever there has been domestic or child violence issues arising in a household.
- That the Ministry continue with their enhanced public education campaigns.
- That legislation be enacted to enable the compulsory sharing of information between Government agencies and health providers and others. The provisions of the Privacy Act where necessary need to be overridden. The purpose of the legislation is to ensure that all professionals and other providers are able to identify children in need in a timely manner so that intervention can take place to protect them from harm.
- That legislation be enacted to ensure that there is mandatory reporting by early childhood facilities and schools in respect of identified risk factors, absences, health and abuse concerns.
- That a copy of these Findings be sent to the Ministers of Social development and Justice with the request they implement the Recommendations.

NZ.2008.4290 Child & Infant Death

A one month old infant died from asphyxia after his mother fell asleep while breastfeeding. The deceased's mother was on a methadone program prior to the deceased's birth and was given a sleep apnoea monitor for the deceased.

Recommendations

Given the comments made by the Commissioner for Children and the recommendations made from the Capital and Coast District Health Board reportable event review report, it is recommended:

- That the Neo-natal Intensive Care Unit (NICU) and the Opioid Treatment Service document an agreed process for the management of infants with methadone parents including initiation of liaison with the Opioid Treatment Service prior to an infant's admission to NICU and a joint discharge plan. The Opioid Treatment Service to provide NICU with a documented case manager.
- That the parents be fully explained as to the use of apnoea monitors for their home use.
- Where it is known that a family has been involved with Child Youth and Family (CYF) that a liaison is undertaken with that services and a record of any incidents or involvement is fully documented so that the hospital staff are fully aware of any issues in that area.
- A record of parental attendance as to the infant CPR, safe sleeping and equipment use class must be kept and accurately maintained.

NZ.2011.2591 Child & Infant Death

A two month old infant died of Sudden Unexpected Death in Infancy (SUDI) after co-sleeping with his parents.

Recommendations

I repeat the recommendations made by my fellow Coroners Bain and Evans that the Director General of Health continue with public health advice in relation to safe infant care practices and safe sleeping environments.

NZ.2011.2591 continued

The Ministry of Health should strengthen and broaden this advice so as to make it clear that:

- Bed-sharing by adults, and siblings with infants under the age of six months, exposes such infants to an increased risk of death.
- The safest place for babies to sleep during the first six months of their lives is in a cot besides the parental bed.
- Steps should be taken by the Ministry of Health to ensure that this advice is given by public health educators and health professionals in those public health sectors over which the Ministry have influence.
- The Moe Ora scheme to provide new-born infants with a self-contained sleeping cradle (Wahakura) (Which we are advised by the researchers, goes some way to ensuring safety in a co-sleeping environment), be encouraged. The Ministry of Health should consider providing such a cradle to every new mother if she is unable to afford the purchase.

NZ.2011.2618 Child & Infant Death

An eight month old infant died of Sudden Unexpected Death in Infancy (SUDI) with apparent asphyxia. The deceased became tangled in the blankets in her cot, covering her head.

Recommendations

I recommend to the Ministry of Social Development

- That it develops national pro-active policies and plans that will embed knowledge, understanding and skills about safe sleeping practices and environments into the day to day business of Child, Youth and Family (CYF).
- That it seeks external advice about how to educate CYF social workers and caregivers.
- That using this advice it provides its staff and caregivers with regular and up-to-date training and assistance that equips them with that they need to know, being as [name] said:
    - ◊ Knowledge of the safe sleep principles [including]: *on back, carer near, own space and face clear throughout the whole of the sleep episode;*
    - ◊ Understanding of why these principles are important, how they relate to infant development and how they work together; and
    - ◊ Skills for carrying out a safe sleep check, assessing thermal comfort and how to set up a baby's sleeping environment to ensure protection lasts throughout the whole of the sleep episode.
- That it trains CYF social workers to know what to do in practice when they come across sleep environments and sleep practices that are not safe.
- That it develops a pro-active policy that enables caregivers of babies under twelve months to have them sleeping in the same room as the caregiver.
- That in order to address the impact of development and increasing mobility on sleep related risk and provide a standard of care across CYF practice, it establishes national safe infant sleep standards for babies who are able to move around the sleeping space. And that it defines these standards in terms of sleeping position, sleeping device, sleeping location, bedding arrangements, with specific safety conditions for the older baby under the care of CYF, including conditions that address usual and 'unusual that night' situations where makeshift or different arrangements are in place.
- That it educates all CYF staff on these standards and documents and reports on the implementation of them.
- That it enables CYF to monitor and report on safe sleeping practices of CYF caregivers of babies under twelve months old.
- That the Ministry sets a goal (with a time frame for implementation) to have al placements for babies smoke free. That it develops a national policy to work towards implementation of this goal, beginning with new caregivers and then working with current caregivers.
- That part of this policy is pro-active with mechanisms that enable caregivers who smoke to become smoke free, with support and brief intervention by CYF staff, referral to agencies offering various options including nicotine alternatives, other pharmacotherapies, cessation services and Quitline.

I recommend to the Ministry of Health:

- That it provides stronger advice publicly in the area of safe sleeping practices and environments for the older baby who can move around and change position during the sleep episode.

NZ.2011.2618 continued

- That this advice includes launching an advertising campaign through News Media that promotes safe sleep principles for parents and caregivers of older babies and shows parents and caregivers how to set up a safe sleeping environment to ensure their baby's face is kept clear throughout the whole of the sleep episode.

I recommend to the Social Workers Registration Board (SWRB)

- That it considers whether those social workers who work with placing babies under twelve months with CYF caregivers can safely meet all the SWRB competency standards if they do not have a deep understanding of infant development and safe sleeping principles and how these interact.
- That it considers whether social workers working with CYF caregivers of babies under twelve months need to demonstrate they are competent to assess caregivers' knowledge and understanding of the principles of safe sleeping and how these relate to infant development, and that they know how to assist caregivers to learn the skills needed to put these principles into practice and set up a safe sleeping environment.

NZ.2011.2876 Child & Infant Death

A two month old infant died after co-sleeping with her parents.

Recommendations

- A copy of these findings is to be sent to the Minister of Health and the Minister of Te Puni Kokiri.
- A copy of these Findings is to be send to the [name] as Minister for Whanau Ora.
- The Ministries undertake a project to understand why the message regarding safe sleeping environments for babies does not seem to be reaching the Maori community and take such further steps to address the issue either by supporting existing programmes or the creation of new initiatives, which will promote safe sleeping environments for infants.

NZ.2009.4102 Child & Infant Death/ Physical Health

An eight month old infant with Pierre Robin syndrome died from probable asphyxiation in the context of co-sleeping with an adult on a couch.

Recommendations

The message needs to be made explicit to parents that co-sleeping by adults with infants exposes the infant to the risk of death and should be avoided for every sleep. Additionally, couches are unsafe sleeping environments for babies. In the interests of the child, where the potential consequences are so serious, parents have a responsibility to respect this advice.

Recent coronial findings have made recommendations to the Ministry of Health aimed at ensuring that public health advice in relation to safe infant care practices and safe sleeping environments are strengthened, broadened and consistent among public health educators and health professionals. Whilst I have accepted that [mother] was advised of the safe-sleeping message, the circumstances of [deceased's] death are relevant to these recommendations. Accordingly, a copy of this finding will be sent to the Ministry of Health to consider in the context of these previous recommendations.

TAS.2010.478 Child & Infant Death

A three month old infant died after co-sleeping with family members.

Recommendations

- In line with the SIDS and Kids recommendations, I would urge parents and caregivers to return the infant to his/her own cot before going to sleep themselves, and to place the infant on its back for sleeping. The heartbreak of losing an infant life in such circumstances has far reaching consequences for the family and for the community as a whole.

TAS.2010.478 continued

- That parents of infants make use of the home and clinic visits and advice provided by nurses from Child, Health and Parenting (CHAPS). This service is critical to ensuring that the messages around safe sleeping are embedded and communicated to families, particularly those who have been identified as vulnerable.
- That all health providers involved with the antenatal and postnatal care of infants take the opportunity, when appropriate, to clearly impart correct safe sleeping practices to parents and those caring for the infant.
- That Child Protection Services and CHAPS continue to implement the positive strategies, as outlined in this finding, targeted to effectively identifying and educating vulnerable families in safe sleeping practices, incorporating use of the educational DVD and information sheet recently developed for this purpose.

VIC.2010.1288 Child & Infant Death/ Water Related

A one year old infant drowned after entering a spa in the backyard of a rental property. The spa was built without council permission and did not comply with fencing requirements.

Recommendations

Life Saving Victoria has made the following submission for other reports provided to the Coroners Court of Victoria and is reproduced here. Their submission includes four recommendations:

- Continued programs for toddler water safety education;
- Placing into legislation a requirement to display at the poolside a sign displaying current cardio-pulmonary resuscitation (CPR) procedures;
- A register of pools and spas; and
- Mandatory inspection of all pool and spa safety barriers every four years by licensed pool safety inspectors.

I support the recommendations of Life Saving Victoria.

I also recommend that Consumer Affairs Victoria amend its tenancy forms and publications created for tenants and landlords to include regulatory information about pool barrier fencing.

I further recommend that the Real Estate Institute of Victoria communicate to their members the importance of property inspections, which are not simply for the management of their client's asset, but also from a duty of care to ensure the health and wellbeing of tenants.

VIC.2011.3063 Child & Infant Death/ Animals

A child was fatally attacked by a dog.

Recommendations

- That the Victorian Parliament legislate to expressly prohibit the breeding of restricted breed dogs and that a criminal sanction attach to any such breeding activity.
- That the Domestic Animals Act 1994 (Vic) be amended to require Veterinary Surgeons to mandatorily report to regulatory authorities if they are called upon to treat or to attend any dog which is a restricted breed dog or may be a restricted breed dog, which is not registered, neutered and micro-chipped.
- That the onus of establishing that a dog, suspected by regulatory authorities to be a restricted breed dog, is not a restricted breed dog, be placed on the owner of the dog and that the Domestic Animals Act 1994 (Vic) be amended to this effect.

VIC.2011.3745 Child & Infant Death

A five year old child died after the brick wall he was climbing on, collapsed.

Recommendations

- That consideration be given to amending the Building Act:

VIC.2011.3745 continued

- ◊ To require a permit before construction of the type of masonry walls and facings currently exempted by Schedule 8;
- ◊ To require a bricklayer constructing such a wall or facing to certify, in writing, that appropriate ties have been used to attach the new brickwork to suitable existing materials;
- ◊ To permit regular overall structural assessment of rental properties.

WA.2007.426 Child & Infant Death/ Indigenous

An Indigenous infant in foster care died of unascertained causes. The deceased had been given Phenergan (promethazine) in the days prior to death.

Recommendations

I recommend the Therapeutic Goods Administration (TGA) ensure all promethazine products marketed in Australia carry product and consumer information advising prescribers, distributors, dispensers and consumers promethazine is contraindicated in infants under two years of age in accordance with the Food and Drug Administration (FDA) black box warnings.

NSW.2010.420 Drugs & Alcohol/ Law Enforcement

A person died of an unintentional heroin overdose the same day they were released from prison.

Recommendations

To: The Commissioner, Corrective Services NSW

That when prisoners identified as suffering from drug dependency issues are to be released from Corrective Services custody they be provided with appropriate warnings as to the dangers of using illicit substances where their tolerance to such substances has been reduced by their period of incarceration.

NZ.2010.2894 Drugs & Alcohol/ Youth

A youth died after inhaling butane.

Recommendations

- I recommend that a copy of this Finding be sent to the Ministry of health with my request that further publicity be created in relation to the dangers of the inhalation of substances not designed for the purposes of inhalation.
- I recommend that appropriate media publicity be given to the dangers of the inhalation of toxic products and the likely outcomes of huffing.

VIC.2009.2033 Drugs & Alcohol

A person with alcohol dependency issues died after ingesting Methadone, Valium and alcohol. There was some conjecture as to whether the drugs were administered by himself or another person.

Recommendations

That the Minister for Health take steps to prohibit the supply of 'take-away' doses of the Schedule 8 drug Methadone by drug addicted persons and require that methadone therapy be delivered and administered at a pharmacy premises under the supervision of a registered pharmacist.

NZ.2010.3162 Falls/ Leisure Activity/ Physical Health

A person with Coeliac disease on a mountain climbing trip tired due to inadequate nutrition and lost her footing, falling two hundred metres.

Recommendations

I recommend that a copy of this Finding be released to Federated Mountain Clubs for inclusion in its Bulletin as a reminder for climbers of the absolute need to take extreme care when moving in exposed positions where the consequences of a fall are fatal.

Those persons taking drugs, even if they are not prescribed and are available for purchase 'over the counter', need to be made aware of the possibility of side effects and guard against the consequences of such side effects. This is particularly the case when the results of such side effects can have the potential to cause injury or death.

NZ.2011.2314 Falls

A person died after falling off a ladder while pruning trees. The deceased lost their balance which caused them to fall and sustain fatal head injuries.

Recommendations

I recommend that the 'ladder safety tips' included in Accident Compensation Corporation (ACC) publications be again drawn to public attention.

- Check your ladder before using it.
- Never use a ladder with missing, broken or loose parts- it's just not worth the risk.
- When setting up a ladder, make sure it is on a firm, even surface. The best advice is to secure the base of the ladder.
- Always keep three points of contact when climbing a ladder (for example, two feet and one hand) and never overreach sideways.
- Ladders are not designed as working platforms. For big jobs such as painting walls, consider using scaffolding or hire a professional.

NZ.2012.1440 Falls/ Leisure Activity

A person died from injuries sustained when he fell while seeking a new hiking route on a mountain.

Recommendations

I recommend that a copy of this Finding, which I will ensure is forwarded to the Federated Mountain Clubs for publication in its Bulletin, receive appropriate publicity to warn those traveling in the mountains of the absolute need to pay attention to their equipment, especially their boots and to concentrate fully on their footing at times where they are exposed to serious or fatal consequences in the event of a fall.

NZ.2010.2648 Falls/ Physical Health

A person suffering from Parkinson's disease and heart disease died from a collapsed lung and haemorrhage after a fall from his wheelchair.

Recommendations

I recommend that a copy of this Finding be forwarded to the [location] District Health Board in order that Board Clinicians may learn from the issues identified and establish protocols for greater patient care and enhanced communication.

NSW.2008.6316 & 6317 Homicide & Assault

A couple went missing in 1981 and have never been found.

Recommendations

That the death of both deceased be referred to the Unsolved Homicide Unit of the NSW Police for further investigation in accordance with the procedures and protocols of that Unit.

NSW.2009.1273 Homicide & Assault

A woman went missing in 1991 and has never been found.

Recommendations

That the death of the deceased be referred to the Unsolved Homicide Unit of the NSW Police for further investigation in accordance with the procedures and protocols of that Unit.

NSW.2009.1275 Homicide & Assault

A woman went missing in 1991 and has never been found.

Recommendations

That the death of the deceased be referred to the Unsolved Homicide Unit of the NSW Police for further investigation in accordance with the procedures and protocols of that Unit.

NSW.2009.6296 Homicide & Assault

A person died of an incised wound to the neck caused by a person or persons unknown.

Recommendations

To the Commissioner, NSW Police Force and the Chief Commissioner, Victoria Police:

That a joint task force be established by the NSW Police Force and the Victoria Police to review the investigation to date of the abduction and murder of [the deceased] and to develop and implement the further strategies necessary.

NSW.2010.1782 Homicide & Assault

A ten year old is missing and presumed deceased.

Recommendations

That the death of the deceased be referred to the Unsolved Homicide Unit of the NSW Police for further investigation in accordance with the procedures and protocols of that Unit.

NZ.2011.2524 Intentional Self-Harm

A person who had discussed ending his own life with family and friends died by suicide.

Recommendations

I recommend to the Ministry of Health

- That it provides strong advice to the public about what to do if a person says they are intending to commit suicide, or says they have engaged in suicidal behaviour.
- That this advice includes launching an advertising campaign through News Media that shows people ways to respond to someone who says they are thinking of committing suicide.

VIC.2009.4088 Intentional Self-Harm/ Law Enforcement

A person serving a community corrections order died by suicide.

Recommendations

- To increase the safety of patients who are also registered sex offenders, the Department of Health Mental Health, Drugs and Regions Division and Department of Justice Community Correctional Services, review their application of the 2008 Protocol between Mental Health, Drugs and Regions Division and community Correctional Services. Particular emphasis should be given to addressing any perceived barriers to communication between services and a patient's right to privacy.
- To increase community safety and reduce the risk of sex re-offending, the Sex Offender management Branch review the process of criteria, assessment, wait listing and commencement of a Sex Offender Program to enable sex offenders who are required to complete the program as part of their parole to participate in the program in a timely manner.

NT.2012.10 Law Enforcement/ Indigenous/ Drugs & Alcohol

An Indigenous person died in a Watch House from alcohol intoxication, positional asphyxia and aspiration. The deceased was arrested for public intoxication and consumed more alcohol following his arrest, which he obtained from another person in custody. The deceased's condition was not closely monitored at the Watch House.

Recommendations

To the NT Police force

- That police be directed that the practice of dragging detainees or prisoners on the ground in the Watch House is unacceptable and should not occur, save for the most exceptional circumstances. Where prisoners are unable or unwilling to walk, they should be assisted to their feet and helped to walk. When this is not possible, more than one officer should assist and carry them wherever that is practicable.
- That police consider obtaining for each Watch House a wheelchair, stretcher or other suitable device that can be safely stored and used where practicable to transport prisoners who are unable to move themselves.
- That police implement and maintain rigorous auditing of Watch House rosters to ensure that the role of 'Watch House Keeper' is maintained.

To the Northern Territory Government

- That the NT government gives urgent attention to providing nursing staff on a daily basis to the Watch Houses in Darwin, Alice Springs, Katherine and Tennant Creek, together with the provision of a suitably equipped medical room within the Watch Houses.
- That the NT Government convenes an urgent meeting with stakeholders in the Alice Springs community, including the Licensing Commission, Police, the Department of Health and the People's Alcohol Action Coalition, and commits to all available, reasonable measures to reduce the supply of excess alcohol from take away outlets.

NZ.2009.3891 Law Enforcement/ Mental Illness & Health/ Intentional Self-Harm

A remand prisoner who suffered from mental health issues took his own life in a prison cell.

Recommendations

I make the following comments to the Chief Executive, Department of Corrections and to the Chief Executive of Serco:

[Location] closed in [date]. Because of this, recommendations related to matters that might prevent deaths at that prison in similar circumstances are not relevant. However, the circumstances of [deceased's] death highlight issues that present ongoing challenges for the Department of Corrections and any private prison provider contacted by the Department of Corrections, as they strive to reduce the risk of prisoners taking their own lives in prison. In particular:

- The need to ensure that there are sufficiently robust assessment processes for identifying prisoners at risk of self-harm to themselves in place in New Zealand prisons.
- The need for all custodial staff and health staff working in prisons to be well enough trained to be able to identify prisoners at risk of harm to themselves and capable of being proactive in identifying situations when assessment of such risk should be done.
- That environmental risks such as hanging points are identified and where possible eliminated or the risks mitigated.
- That systems and procedures put in place to administer medication prescribed to prisoners are robust and the keeping of accurate clinical records is maintained to an appropriate standard.

NZ.2011.2774 Law Enforcement/ Intentional Self-Harm

A remand prisoner died from hanging in a prison cell.

Recommendations

- My first recommendation is that if it is not already occurred, all similar ligature points in cells throughout New Zealand should be eliminated in a similar way as soon as reasonably possible, as a proactive protection measure.
- That the Department of Corrections carefully review its training protocols in respect of risk assessment and when doing so, adopt detailed professional advise as to the structure, content and implementation of a programme to train prison officers, in risk assessment and management. Also in respect of the structure and content of any tools or aids that may be used by officers in undertaking such assessments. I don't mean that to be an exclusive list by any means but there should be, at least a checklist of interview techniques and of standard observations, things to look for and standard questions to ask.
- That there should be some easy to follow directions available, either by way of pamphlet or by way of a noticeboard for visitors to see but both the noticeboard and pamphlet should be out of view of prisoners. I think it's particularly important the prisoners themselves shouldn't see their whanau that if they have concerns, they can go to a particular person and voice those issues. The notices or the pamphlets should be worded in simple, user-friendly terms and there should be a simple user-friendly way- I don't attempt there to quantify what that might be as there are better and more able people than me who can do that- to approach a senior Corrections staff member about genuine concerns that a family and whanau may have.

VIC.2008.1271 Law Enforcement/ Intentional Self-Harm

A prisoner who had previously attempted self-harm took his own life in a prison cell.

Recommendations

- I recommend that a written discharge note be prepared in respect of all [location] prisoners earlier housed in either [units], for reasons connected to psychosis or suicide/self-harm. Such discharge note to be prepared by a Consultant Psychiatrist or a Psychiatric Registrar or a Psychiatric nurse as deemed appropriate by the Senior Consultant. Further, any psychiatric nurse prepared discharge notes should be reviewed and counter signed by the duty psychiatric Registrar or above.

VIC.2008.1271 continued

- In conjunction with the first recommendation above, I further recommend that discharge notes for prisoners released from the [location] who have during their present incarceration previously been held in either [units] are to be received and acknowledged as read prior to a [location] general prison population admission by:
    - ◊ Suicide And Self Harm (SASH) Officers by reference to same in an amended SITUPS or like document.
    - ◊ The Risk Review Committee, or equivalent at any other such receiving prison, with the documentation employed to record such deliberations, to be amended to include reference to the receipt and reading of, such a discharge summary.
- I further recommend a withdrawal of the stipulation presently found in the Reception Summary form, which suggested that a reference to a psychiatrist for psychiatric assessment or medication review should only be ordered in respect of prisoners classified as P1 or P2.
- I also recommend that the training of [organisation] psychiatric nursing staff should better instruct on this matter, and better emphasise the need to seek advice upwards concerning the position of a prisoner, who like the deceased, has a documented history of suicidal behaviour and who demonstrates a fluctuating mental state presentation.
- In the circumstances, I therefore recommend:
    - ◊ That the Office of Correctional Services Review undertakes a comprehensive review of the conditions at [prison block] and other similarly designed units at [prison] and advises the State of its findings and recommendations.
    - ◊ That unless or until the State is able to introduce appropriate structural changes at [prison block], that the Commissioner of Corrections directs that the housing of 'at risk prisoners' in all un-renovated cells at the [prison] be suspended indefinitely.
- I recommend that the Office of Correctional Services Review (OCSR) consider staffing arrangements at the [prison block], with a view to determining whether staffing levels permit prison officers the opportunity to undertake their duty of care to prisoners, to an appropriate level. I make this recommendation despite the fact that current staffing levels have received the approval of the Australian Prison Officers Association (APOA).
- I further recommend that the OCSR undertake a review of Exhibits 14(c) , 32(d) and (e), and other [prison] materials relevant to training reference 'at risk' prisoners as required, (to include training and update training records) to seek to ensure that both training and training updates are being carried out in a timely way with appropriate course content, having particular regard to the need for all [location] Prison Officers and Staff to fully comprehend:
    - ◊ The role of the caseworker and the backup caseworker;
    - ◊ The purpose and ambit of 'meaningful conversations', in regard to a prisoner on observation watch and recording of that matter;
    - ◊ First principle identification of SASH risk issues, as set out in training manual Exhibit; and
    - ◊ The importance of proper minute taking in all Risk Review Team (RRT) meetings, which minutes should fully reflect any division in views, which may occur at any such review meeting.
- Having regard then to Counsels submissions and discussions held, and to best help ensure that these roles are understood especially by those who will continue to work on the RRT, I recommend that the suggestions made in the Department of Justice (DOJ) submission be formally adopted by the Governor of Corrections Victoria and be included within an amended [prison] Operational instruction 107.
- To avoid doubt on the matter of ordering, I further recommend that a full clinical review, the observations and findings of which are recorded on a properly developed risk assessment tool, should be sought prior to presentation of the particular matter to the RRT or like, and that any recommendation should not go before the RRT unless or until the analysis document tool, recommends with cause, a downgrade of the relevant classification.

Instruction 107 should also be amended to reflect this ordering.

[Prison]- 'At Risk' Prisoner medication

- This is a complex matter and it is relevant to report that all Australian states and territories maintain a similar approach to the one described in court. It is also the case that mental illness and drug dependency and dependency withdrawal treatment are in many presentations, inter-related conditions, with the symptoms of each difficult to differentiate (and difficult to address). I am satisfied however that there is potential for a great improvement in both prisoner care and prison management, if hard and fast rules can be made more flexible allowing in appropriate cases, for the need for an early intervention to be identified.

VIC.2008.1271 continued

- Accordingly, I recommend that [organisation] and [name] Corrections Health Service, in consultation with the Commissioner of Corrections and [prison], develop protocols, which recognise that the provision of appropriate drug substitution medication within [prison] is a medical rather than an administrative issue. Further, such protocols should be developed with a firm steadfastness to the ideals concerning a healer's duty to a patient, to be the driver of decision making in this area.
- Under such an approach, I would expect that with the assistance of nursing staff, the duty medical officer would henceforward seel to corroborate any prisoner claims about his relevant drug history.
- A medical review, such as that recommended in this instance by [name] should then be undertaken with a view to making an informed medical decision about the need to prescribe and the timing of commencement of delivery, to meet any particular presentation.
- Further, such a review should (where a best practice medical need is so indicated) result in the prisoner being given timely access to the appropriate medication as a response to his presentation, and without regard to a waiting list which may or may not exist, for any particular 'programme', at that time.
- In the circumstances, I recommend that henceforward only those psychologists, who obtain endorsement as clinical psychologists from the Psychology Board of Australia, be permitted to undertake such suicide risk assessment evaluations in [prison] and [prison]. I note with approval that both prisons, with the support of Corrections Victoria and Justice Health have, in fact, recently downgraded the risk assessment role being undertaken by staff, who are not appropriately endorsed. This, in favour of clinically trained staff employed by [organisation] and [organisation], respectively.
- To further support this Department of Justice initiative, I recommend that the Commissioner of Corrections Victoria amend the existing Directive, to reflect this change of approach.
- I also recommend that both Corrections Victoria and Justice Health henceforward seek to ensure that only those persons who have applied for and received clinical psychologist Board endorsement, are contracted to undertake this specific aspect of the work of psychologists, within Victorian prisons.

General- The Office of the Chief Psychiatrist

- Finally, I note that the Office of the chief Psychiatrist has a clinical review programme which is part of its Quality Assurance Committee, and that its jurisdiction extends to Victorian prisons.
- In the circumstances, I recommend that medically qualified specialist staff, under the auspices of the Chief Psychiatrist, be invited by the Corrections Commissioner to undertake periodic prison visits to both prisons. Such a course to be undertaken to further support the State's objective that at risk prisoners accommodated within both prisons, are being provided with appropriate ongoing mental health support.

NOTE: Due to four cases of similar circumstances, where the deceased died in prison of intentional self harm, the WA Coroner held a joint inquest and made the recommendations for all cases.

WA.2008.1342 Law Enforcement/ Intentional Self-Harm

A person in custody took his own life in a prison cell.

WA.2009.847 Law Enforcement/ Intentional Self-Harm/ Indigenous

An Indigenous person in custody took his own life in a prison cell.

WA.2009.1280 Law Enforcement/ Intentional Self-Harm

A person in custody who had previously attempted suicide took his own life in a prison cell.

WA.2009.1626 Law Enforcement/ Intentional Self-Harm

A person in custody who had been registered on the At-Risk Management System (ARMS) took his own life in a prison cell.

Combined Recommendations

- That the existence of a right of appeal and details of how it can be accessed should be included in the form of application for permission to attend a funeral.
- That upon a prisoner's return to prison after being sentenced, a self-harm risk assessment (not necessarily as extensive as that provided for the prisoner's initial reception) be incorporated into the applicable management and placement check-list for that prisoner.
- That the Department liaise with the Health Department with a view to establishing procedures to ensure that all relevant information relating to hospital staff's perception of the 'at risk' level of any prisoner being released from hospital into custody be recorded in a discharge letter which accompanies that prisoner, and be recorded in a manner that stands out for the benefit of prison officers receiving that prisoner.
- That the Department act to ensure that all relevant information in possession of sections of the Department that deal with offenders who are not in custody be recorded in a manner (e.g. on the TOMS database) that will make that information readily accessible by prison officers receiving such offenders, should they be incarcerated.
- That the Department, when entering into contracts with corporations providing custodial and security services, such as were being provided by GLS on 09 October 2008, incorporate in such contracts terms to ensure that information within the knowledge of the staff of such a corporation is transferred as accurately, reliably and expeditiously as possible, particularly where the information relates to a prisoner's status with regard to health, mental health, or otherwise being 'at risk'.
- The Department take all possible steps to ensure that prisoners who are at chronic risk of self-harm, but unsuitable for ARMS, are subject to on-going supervision under Support And Monitoring System (SAMS).
- That the Department formulate a clear and unambiguous policy as to what comprises an ARMS check and include it in the ARMS manual.
- That the Department takes steps to ensure that ARMS checks are made according to the relevant ARMS schedule, regardless of whether other checks are made in between scheduled checks.
- That the Department formulate a policy as to how the concerns expressed by family members for the safety of prisoners known to be 'at risk' are to be received and recorded, and to whom they are to be directed and, if practicable, whether a dedicated telephone line should be provided for that purpose.
- That the Department, subject to the requirement that those participating should be visible (as, for example, through glass doors), take all reasonable and practicable steps to ensure that the Prison Counselling Service have at all times private spaces available for the purposes of interviewing prisoners without intrusion or interruption.
- That the Department take all practicable steps to ensure that self-harm risk assessments (especially those at reception) and ARMS checks are, wherever possible, conducted by officers who have completed the gatekeepers course, and that where that is not the case, that lack of qualification should be recorded on the relevant documentation.

WA.2010.99 Law Enforcement/ Indigenous/ Natural Causes

An Indigenous prisoner died from an epileptic seizure in his prison cell.

Recommendations

- All prisoners have annual health reviews to ensure all chronic conditions relevant to that prisoner are being appropriately managed, with a prescribed plan for those conditions requiring more regular and specific review, embedded within the overall health management plan for each prisoner.
- Improved health care facilities for [prison] to support clinically appropriate health services especially the dispensing of medication.
- Suitable custodial support for the provision of clinically appropriate health services.
- Funding to facilitate identification, acquisition and implementation of a suitable electronic medical records system which will properly assist in the provision of comprehensive and workable health care plans and services in the prison system.

NSW.2011.3575 Leisure Activity

A person died due to compression of the neck while abseiling.

Recommendations

To the Outdoor Recreation Industry Council of NSW;

- Further publicity be given to the absolute necessity of full training for abseilers.
- Abseiling without suitable training or equipment (including a knife) may lead to injury or death.
- Abseiling should be avoided without a companion.

To [location] Shire Council;

- That the [parents of the deceased] should be permitted if they choose to do so, to have a small plaque placed at the site to act both as a memorial to [deceased] and a reminder of danger to other abseilers.

NZ.2010.2780 Leisure Activity/ Natural Causes/ Older Person/ Water Related

An elderly person suffered a fatal cardiac arrhythmia while rowing. The deceased's skiff overturned, trapping him underneath.

Recommendations

I draw to the attention of Rowing New Zealand that consideration be given to safety enhancements to avoid a repeat of a similar event in the future.

NZ.2011.2730 Leisure Activity/ Water Related

A tourist died in hospital after receiving injuries while snowboarding. The deceased removed his snowboard to walk across a slope and slid across the snow into a stream, resulting in head injuries. The deceased was not wearing a protective helmet at the time of the incident.

Recommendations

Protective helmets

- As highlighted in the recent report of [name], Neurosurgeon, at the inquests into the deaths of three persons who died at [location] in 2010 and supported by [name] of the New Zealand Mountain Safety Council at this inquest, I make a general recommendation directed to skiers and snowboarders that helmets be worn in mountainous terrain and that every encouragement is given to that use. This is not a recommendation as to mandatory use of helmets.
- I recommend the New Zealand Mountain Safety Council actively encourages ski areas in New Zealand to promote (by such means as websites, signage, and the avoidance of promotional images of skiers/snowboarders who are not utilising protective helmets) the use of protective helmets by all skiers and snowboarders.
- I recommend the [location] Ski Club actively promotes (by such means as websites, signage and the avoidance of promotional images of skiers/snowboarders who are not utilising protective helmets) the use of protective helmets by all skiers and snowboarders at its ski area.

Snowboard limitations back-country

- I recommend the New Zealand Mountain Safety Council promotes awareness of snowboard limitations in back-country use and in steep terrain with firm snow conditions as highlighted by this fatality. Central to this recommendation, as highlighted by [name] of the New Zealand Mountain Safety Council, is the need for skiers and snowboarders to be capable of basic self-arrest techniques.

NZ.2011.2730 continued

I recommend the New Zealand Ski Instructors Alliance:

- Promotes awareness of snowboard limitations in back-country use and in steep terrain with firm snow conditions as highlighted by this fatality. Central to this recommendation, as highlighted by [name] of the New Zealand Mountain Safety Council, is the need for skiers and snowboarders to be capable of basic self-arrest techniques;
- Includes in ski school syllabuses a requirement for instruction in basic self-arrest techniques.

Advice as to conditions and terrain

- I recommend the New Zealand Mountain Safety Council promotes to ski area operators the importance of a rigorous policy concerning advice as to conditions and terrain, if sought from ski area personnel, being given by designated personnel.
- I recommend the New Zealand Mountain Safety Council in conjunction with ski area operators, promotes a consistent policy for giving advice to persons who wish to leave the ski area boundary.

[Location] terrain management

I recommend that the [Location] Ski Club:

- Gives consideration to extending its ski area boundary in appropriate conditions to include the upper section of [area].
- In appropriate conditions provides markers to assist in skiers/snowboarders in exiting [area] to meet the access road.
- Provides on-field information as to the status of [area] and whether the run is 'open' or 'closed', preferably differentiating between the upper basin and the lower basin.
- Includes information in its promotional material and signage as to difficulties of egress from the lower reaches of [area] and the hazards highlighted by this inquest.
- Continues to update its signage to international signs and symbols, as indicated by [name].

TAS.2011.166 Leisure Activity/ Natural Causes

A person died from natural causes after becoming disorientated while bushwalking. The deceased suffered from exercise related hyponatremia due to an excessive consumption of water.

Recommendations

Professor [name's] comments, and the circumstances of this case, suggest that there is a need for greater education in the community in relation to the danger associated with excessive consumption of fluid during exercise. I recommend that health authorities consider and address the question of whether public health education in this area is adequate and/or accurate, having regard to current scientific knowledge.

NSW.2009.5683 Mental Illness & Health/ Drugs & Alcohol

The deceased suffered from mental health issues and died as a result of the interaction of her prescribed medications.

Recommendations

To the Minister for NSW Health

That consideration be given to:

- A review of procedures in relation to the completion and dissemination of discharge summaries/care plans following mental health admissions to NSW Hospitals, in order to ensure:
    - ◊ Adequate details of current medications, current treatment plan and any other recommendations for ongoing treatment are included;
    - ◊ Discharge summaries are disseminated to all necessary recipients, including Methadone Clinics involved in the patient's care, where clinically indicated; and

NSW.2009.5683 continued

- ◊ The formatting of discharge summaries prompts administrative staff to confirm that summaries have been sent to all intended recipients.

- A review of the Discharge Planning Process of Mental Health Patients by the Local Health District in light of the Discharge Planning Directive that suggests on a reading of the document the need for creation of and provision to the patient of a Care Plan.
- In the event Guidelines and Directives do not already require it, consideration be given to developing a standardised document to be provided to a patient and/or family at discharge setting out:
  - ◊ Diagnosis made during admission (if available);
  - ◊ Medication regime at discharge;
  - ◊ Details of the next outpatient or private appointment; and
  - ◊ Contact details should the patient or family have questions arising from discharge.
- Consider amending the New South Wales Opioid Treatment Program Clinical Guidelines to highlight the need for prescribers to consider Fluoxetine interaction with Methadone and the capacity of Fluoxetine to inhibit metabolism of Methadone and thereby raise plasma Methadone levels.

To the Chief Executive Officer of the [location] Local Health Network

That consideration be given to:

- Taking appropriate steps to reinforce through further education and training at the [location] Hospital Mental Health Unit the importance of accurate record keeping in particular accurate recording of medications on discharge summaries and recording in the clinical notes decisions to cease medications.
- Taking appropriate steps to reinforce through further education and training at the [location] Hospital Mental Health unit the desirability when prescribing anti-psychotic medications to limit repeat authorisations to those cases where repeats are clinically indicated.
- Taking appropriate steps to reinforce through further education and training at the [location] Community Mental Health Team the importance of record keeping and the need to chart depot authorisations and administration.
- Taking appropriate steps to reinforce through further education and training at the [location] Community Mental Health Team the importance of communication of a patient's current and proposed treatment plan with those Health Professionals who are to assume care after discharge from [hospital].

NSW.2010.1802 Mental Illness & Health/ Natural Causes

A patient absconded from a mental health facility and died of complications of Hashimoto's Thyroiditis.

Recommendations

To the Director General, NSW Ministry of Health

- That consideration be given to the development of a state wide approach to managing continuity of care for an involuntary patient who absconds from an inpatient mental health facility. This approach should address, but not be limited to, the requirements for returning the patient to the facility where they are usually treated where it is considered clinically appropriate and in the interest of the patient.

- That the practice of discharging an involuntary patient who absconds from a mental health facility from both the facility itself as well as the relevant involuntary treatment order be reconsidered and that consideration be given to a two stage process whereby if the patient is discharged from the facility consideration be given as to whether or not it is in the interest of that patient for the treatment order to remain in place in order to assist the return of the patient to an appropriate mental health facility if located by police or other relevant parties.

NSW.2010.5228 Mental Illness & Health/ Intentional Self-Harm

A person experiencing financial and personal difficulties attended a mental health facility where he was asked to wait by staff. The deceased left the premises before taking his own life.

Recommendations

To the Minister for Health:

To consider reviewing, in consultation with experienced psychiatric medical and nursing staff the current policies and documents for assessing patients presenting to Mental Health unit, with the view to de-emphasising their bureaucratic and promoting more person clinical consultation.

NSW.2011.3590 Mental Illness & Health/ Intentional Self-Harm

A person with bipolar affective disorder who had been granted day leave from the mental health ward at a hospital took his own life within the hospital grounds.

Recommendations

That the NSW Minister for Health be provided with a copy of these Findings, noting that similar issues are raised to those in the coronial matters of [name] and [name]- incidents in hospitals where there were delays in notifying police. It is recommended that any NSW Police and NSW Health protocol developed should extend to the circumstances and timeframes in which police should be notified of incidents at hospitals.

NZ.2009.4101 Mental Illness & Health/ Intentional Self-Harm/ Weapon

A person suffering from anxiety and depression took their own life by using a nail gun. The nail gun had been hired from a company without a firearms licence.

Recommendations

To the Honourable Minister of Consumer Affairs, [location]. It is recommended that wherever a gun able to be described as a bolt or stud gin is to be hired to an individual, that individual must produce a copy of a licence to operate such equipment before the hire is able to be completed.

NZ.2011.2494 Mental Illness & Health/ Drugs & Alcohol

A person subject to a mental health treatment order and living in a residential care facility died of cardiac arrhythmia in association with toxic levels of the drug Clozapine. The medication was taken at the correct dosage level, however a build-up of Clozapine was identified in the deceased, which may have been attributed to a reduced clearance rate of the drug.

NZ.2011.2494 continued

Recommendations

I recommend that a copy of this Finding be sent to the Centre for Adverse Reactions Monitoring (CARM) for the information of that organisation and for it to take such action as it considers appropriate in the circumstances.

NZ.2011.2590 Mental Illness & Health/ Falls/ Drugs & Alcohol

An intoxicated person who had previously threatened suicide and been involved with mental health services fell from a cliff.

Recommendations

That Mental Health Services in the light of the circumstances of this case review:

- Practices as to frequency of assessments of a patient by a psychiatrist where a patient repeatedly presents in crisis situations.
- The circumstances of [father] being told following his daughter being seen by a mental health staff member, that she had 'just been naughty, take her home' (as alleged by [father]).

The above recommendation is directed to Mental Health Services of [location] District Health Board.

NOTE: Due to two cases of similar circumstances, where the deceased is thought to have jumped from a bridge, the TAS Coroner held a joint inquest and made the recommendations for both cases.

TAS.2011.306 Mental Illness & Health/ Intentional Self-Harm/ Water related

A mentally ill person is believed to have jumped from a bridge however the body has not been recovered.

TAS.2011.488 Mental Illness & Health/ Intentional Self-Harm/ Water Related

A mentally ill person jumped from a bridge and drowned after sustaining head injuries.

Combined Recommendations

As noted in my findings, an inference has been made that [deceased] jumped from the [location] Bridge. There is no direct evidence as to that fact. I therefore repeat the comments I made in a recent matter that involved a similar circumstance: (first case)

As noted in my findings, an inference has been made that [both deceased] jumped from the [location] Bridge. There is no direct evidence as to the second case.

'Although there are cameras affixed to the [location] Bridge they are primarily for vehicular traffic flow management and operate on a 'real time' basis with no recording. In order to secure evidence of pedestrian incidents on the bridge and also to provide a means for possible emergency service intervention, it is recommended that consideration be given to:

- Ensuring that the cameras affixed to [location] Bridge can monitor pedestrian as well as vehicular traffic;
- Provide a 24 hour recording capability from those cameras which is held for a reasonable period (at least one week) to allow access for investigation purposes not only for pedestrians incidents but also vehicular accidents;
- Provide a capability for a 24 hour, 7 day a week monitoring of the 'real time' camera transmission to allow ability for a timely intervention if a pedestrian is noted to be acting dangerously, inappropriately or suspiciously on the [location] Bridge. Possible facilities where such a monitoring system could be established might include the Police Radio Room, [location] Police Station Enquiry Office, or Tasmania Ports Control Room.

TAS.2012.52 Mental Illness & Health/ Intentional Self-Harm

A person suffering from depression refused treatment and died by suicide.

Recommendations

This tragic event is yet another sad example of a person who is obviously suffering poor mental health not wishing to or feeling unable to seek support or intervention of some kind. I encourage those public and private organisation who have made excellent endeavours in recent years to increase public awareness of mental health and to break down barriers to continue those efforts.

WA.2009.428 Mental Illness & Health/ Intentional Self-Harm

A mentally ill person died after jumping from a cliff. The deceased had had an altercation with her housemate in which she was taken to hospital, however was discharged and after further altercations, took her own life.

Recommendations

If, after assistance from a Mental Health Liaison Nurse (MHLN) in person and a psychiatrist by phone, a plan cannot be agreed between the treating doctor and psychiatrist in respect of the patient, a psychiatrist (if requested to do so) must attend [location] Emergency Department to provide psychiatric review and assistance. This attendance will be at the earliest possible opportunity, allowing for periods when there is no psychiatrist rostered after hours.

G Ward provide written protocols to [location] Emergency Department for discharge of patients from Emergency Department who have required psychiatric input, whether it be by MHLN or a psychiatrist, to ensure known concerns surrounding discharge have been addressed and minimised.

ACT.2003.253 Physical Health/ Adverse Medical Effects

A person diagnosed with autism and an intellectual disability died of cardiac arrest which was attributed to acute bilateral pneumonia. The deceased had recently been discharged from hospital following surgery to remove his wisdom teeth.

Recommendations

In the interests of the public health and safety, I recommend to the Attorney-General that:

- Any proposal for surgical treatment for a person in high need of care and who poses a high risk of danger to themselves or others should involve careful planning between carers, Disability ACT, the client's guardians, family members and medical staff. The whole planning process should be recorded and include all steps and responsibilities for the patient's care, physical, mental and emotional, and for regular monitoring and treatment of any post-operative complications, major or minor, and cover the whole period from admission to hospital up to the point where successful post-surgical recovery has been achieved to the satisfaction of the treating medical staff and carers;
- Any changes to pre-operative care plans involving such a patient should only be made after consultation with the relevant stakeholders;
- At the final stages of implementation of a pre-operative care plan involving such a patient representatives of the care and health systems should review it and agree on outcomes;
- Disability ACT should ensure that carers of high-risk clients are given medical training appropriate for the needs of such clients;
- A high risk patient with a tendency for challenging behaviour should have a high level of nursing care after discharge from hospital until such time as the treating medical staff and carers agree that the carers can manage the patient without such nursing care;
- Both the carers and nurses of high risk clients should be responsible for ensuring that they have current contact particulars of each other and that each communication is recorded;
- Consideration be given to the establishment of a facility in the ACT for treating high risk patients, in cases similar to [deceased] where appropriate treatment can be given in a setting of safety for both medical staff, the patient and carers.

I note that some of these recommendations have been implemented by Disability ACT as a result of the Root Cause analysis it conducted into [deceased's] death. I also note that in [date] a decision was made to establish an Interdepartmental Working Group between ACT Health and the Department of Disability, Housing and Community Services to consider matters including the development and/or improvement of medical facilities to provide for cases such as the [deceased]. I commend the steps that have been taken. Nevertheless, I consider it important that the recommendations be placed on record.

NZ.2011.3034 Sports Related/ Water Related

A crew member died when her power boat overturned at high speed while competing in a race.

Recommendations

- I recommend that Maritime New Zealand (MNZ) give consideration to the creation of a protocol to ensure that, before any boating event which is required to be approved by MNZ is approved, that MNZ consider more carefully the safety and rescue implications of the event. Event organisers should be required to create an analysis of risk to ensure what level of rescue and ambulance care is necessary to cover all foreseeable eventualities which may occur. During high speed racing on the water, the loss of control and rollover of a boat participating is foreseeable and the injuries from such a high speed crash could, potentially, be catastrophic. For such an event the level of rescue and care needs to be greater than that required for an event conducted at a lower speed and fewer objective dangers. MNZ, before certifying the event, should require the organiser to liaise with St John Ambulance in order that the expertise of St John Ambulance assists with the assessment of risk and the level of support necessary. If, for any reason, St John Ambulance cannot support an individual event supervised by MNZ, then the event ought not to take place.

NZ.2011.3034 continued

- I recommend that St John Ambulance continue with the education and training programme identified in the Root Cause Analysis report. St John ambulance ought to create, and continue, with a robust ongoing clinical competence review of staff to ensure that training and skills are not lost.
- I recommend that St John Ambulance take steps to address the other issues identified in the root Cause Analysis specifically relating to identified failures to pass on appropriate information between crews.
- I recommend that the New Zealand Boat Marathon Association take steps to ensure an enhanced scrutineering process is adopted to take into account the lessons learned from the crash of [boat] and the death of the deceased. Although I accept it is unclear as to whether or not a failure of the transom was the real cause of the loss of control and rollover, it is a likely cause and if evidence of a failure can be identified at scrutineering, then it ought to be so identified.
- In accepting that there are contraindications to the wearing of safety harness for crew of racing boats, I recommend that the New Zealand Boat Marathon Commission give consideration to the fitting of seatbelts to ensure that crew are not thrown from the boat in the manner which caused the deceased to suffer the injuries which proved fatal.
- Although I consider, from the evidence I have heard, the contribution to the crash to be unlikely, I adopt the recommendation of MNZ that the organisers of boat races conduct studies of lakes, affected by tides, to establish minimum water depths along the course of the race so as to ensure that there is an adequate factor of safety to ensure that skegs on outboard motors do not strike the lake bottom.

NT.2011.157 Transport & Traffic Related

A passenger died after a large granite rock went through the windscreen of the car she was travelling in, and hit her in the head. The rock had fallen from a truck, and had been run over by a car travelling in front of the deceased's vehicle, causing it to fly up into the deceased's car.

Recommendations

To the Northern Territory Government

- That consideration be given to amending the Northern Territory Road Traffic Regulations any other relevant legislation so that any vehicle carrying product out of a quarry must do so with a covered load.
- That consideration be given to amending the Northern Territory Road Traffic Regulations and any other relevant legislation so that a 'loose bulk load' is defined to include rocks the size and/or weight of that involved in this accident.

NZ.2010.3099 Transport & Traffic Related/ Drugs & Alcohol/ Falls

An intoxicated person died after falling off his motorised skateboard and sustaining head injuries. The deceased was not wearing a helmet at the time of the incident.

Recommendations

The deceased was not wearing a helmet and there was no legal requirement that he do so. I consider it an anomaly in a legal and in a practical sense that riders of motorised skateboards are not required to wear helmets, given the speeds they can reach and sustain without the physical effort of the rider, and the fact that these boards are, by definition in the Land Transport Act, motor vehicles that are required to be ridden on the road. I recommend that the Land Transport (Road User) Rule 2004 be amended to that riders of motorised skateboards are required to wear helmets.

NZ.2011.2052 Transport & Traffic Related

A motorcyclist lost control while negotiating a bend and was thrown over his handlebars, resulting in fatal injuries.

NZ.2011.2052 continued

Recommendations

That the relevant Roading authority consider erecting appropriate speed advisory warning signage at the bend where this crash occurred.

NZ.2011.2172 Transport & Traffic Related/ Physical Health

A person with a history of seizures died after they drove through a roundabout at speed and collided with a tree. The deceased had been instructed by medical practitioners not to drive.

Recommendations

This case highlights the absolute necessity for people with medical conditions to heed the advice of their medical professionals on whether or not they are safe to drive a motor vehicle. It is obvious that, had [the deceased] heeded the advice of both her neurologist and her general practitioner not to drive, this crash would not have occurred and both the deceased and her passenger would not have died.

NZ.2011.2340 Transport & Traffic Related

A truck passenger died after the driver lost control while negotiating a bend and rolled. The deceased was ejected from the vehicle and subsequently crushed. The deceased was not wearing a seatbelt at the time of the incident.

Recommendations

This case highlights again the need for all people in a motor vehicle to have their seatbelts fastened at all times. Although there is evidence that the outcome for [the deceased] would have been different had he been wearing his seatbelt, I consider that his chances of surviving this crash would have been considerably improved if he had been buckled in.

NZ.2011.2351 Transport & Traffic Related/ Older Person

An elderly person died after the vehicle she was driving collided with a train at a level crossing.

Recommendations

KiwiRail should negotiate- if necessary with the private land owners- and remove the trees along the railway track to the south of the intersection and along Jacksons Road as it approaches the intersection.

As a consequence of the removal of the trees, KiwiRail should not downgrade this intersection from the upgrade list to automated warning signs- bells and whistles or barrier arms.

NZ.2011.2381 Transport & Traffic Related

A driver lost control while negotiating a bend at high speed and collided with another vehicle. Whilst the deceased was under the legal limit for alcohol, she had been using her cellphone and this may have contributed to the collision.

Recommendations

- That the relevant roading authority consider widening the road surface in the area where this crash occurred to include a sealed safety shoulder. This recommendation is directed to the [location] District Council.
- That the Police maintain or increase their ongoing public awareness campaign and enforcement action with regard to the dangers of drivers being distracted due to cellphone use while driving. This recommendation is directed to the National Road Policing Manager of the New Zealand Police.
- That the responsible government agency reduce the legal limit for the amount of alcohol in the blood of a driver to 50mg of alcohol per 100mL of blood, in line with the majority of overseas countries.

NZ.2011.2601 Transport & Traffic Related/ Water Related/ Youth

A sixteen year old driver lost control of his vehicle in a road works area. The car rolled down the bank of a river and became submerged in water. The deceased subsequently drowned.

Recommendations

I recommend that a copy of this Finding be forwarded to New Zealand Transport Agency (NZTA) in order that my observations relating to roadworks signage can be further considered.

I will draw the bravery of those who attempted the rescue of the deceased (and particularly the efforts of [name]) to the attention of the Royal Humane Society.

NZ.2012.444 Transport & Traffic Related

A person died after the vehicle they were driving collided with a truck. The deceased failed to observe the truck and proceeded through a 'Stop' sign.

Recommendations

I note that the Serious Crash Unit (SCU) report does not suggest that there have been a large number of crashes at this particular intersection. The report does note, however, that the complex roading arrangement presents a hazardous environment. The implication to my mind is that there could be other deaths at this intersection in the future. I therefore recommend that the roading authority responsible for this particular intersection consider what improvements could be made to make this intersection safer.

NZ.2012.1178 Transport & Traffic Related/ Drugs & Alcohol

An intoxicated and drug affected person died after he lost control of the quad bike he was riding and it overturned into a ditch. The deceased was trapped beneath the quad bike and died from traumatic injuries and positional asphyxia.

Recommendations

I recommend that public attention be drawn to the potentially fatal consequences of driving, or riding, a motor vehicle whilst affected by drugs and/or alcohol.

NZ.2010.2889 & 2890 Water Related/ Leisure Activity

Two tourists drowned when their kayak overturned in rough conditions. The clothing worn by the deceased persons was considered unsuitable for kayaking and their life jackets were worn inside out.

Recommendations

- At the conclusion of evidence I heard a submission from [name] and [name] in relation to initiatives to brief visitors to the [location] region on the dangers posed by water activities. I recommend that [location] Council and [location] Coast Guard continue with the creation and distribution of the cards produced at the Inquest Hearing designed to educate water users on safe practice.
- I recommend that a copy of this Finding be forwarded to Maritime New Zealand and the Pleasure Boating Council with the request that the making of the wearing of appropriate life jackets by small boat users be made compulsory nationally.
- I recommend that Maritime New Zealand and the Pleasure Boating Council consider the evidence given to the Inquest Hearing in respect to the visibility of lifejackets. It is clear that searches with night vision goggles are able to locate fluorescent strips on lifejackets from a considerable distance. The manufacture of lifejackets incorporating reflectorized material would have obvious benefits. Consideration ought to also be given to the alteration of the NZ Standard to ensure all lifejackets or PFDs are manufactured in high visibility colours.

NZ.2011.2914 Water Related/ Leisure Activity

A person drowned when they were caught in a rip while swimming at a beach. The beach was only accessible by climbing down cliffs and was not patrolled by life savers.

Recommendations

To the Chief Executive, [location] Council:

In view of the evidence that people are informally accessing [location] Beach despite the lack of a Council provided track, I recommend to [location] Council that it considers:

- Whether to erect signs at the start of the [Location] loop track and the [Location] circuit ([name] track) advising that there is no access to [location] Beach from the tracks.
- Whether to erect signage at the start of possible informal access way (s) to [location] Beach warning of the dangers of the steep and hazardous cliffs.
- Whether to erect signage at [location] Beach warning of the hazards for swimmers at that location.

NZ.2010.2741 Work Related/ Law Enforcement/ Falls

A prison guard died after being physically assaulted by a prisoner. The deceased sustained fatal head injuries when he struck the concrete floor.

Recommendations

- The Department of Corrections develop a policy which deals with the transfer of prisoners that have been classified (or reclassified as the case may be) as a maximum security prisoner. The policy should, amongst other things, clearly establish the time frame within which a prisoner so classified should be transferred from the facility, in which the prisoner is currently housed, to a maximum security facility. The policy should also deal with the recording of all relevant information and the process of the request for transfer to ensure that accurate information is recorded and communicated.
- The Department of Corrections consider formally adopting the use of the alternative unlock procedure discussed within this finding when dealing with maximum security prisoners who are being temporarily held in a non- maximum facility, those prisoners on directed segregation, and prisoners with aggression issues, or otherwise displaying any elevated level of risk to staff, the circumstances in which the alternative unlock procedure should be used and train its staff accordingly.
- The Department of Corrections reinforce the training of Corrections Officers regarding the reporting and recording of threats and the importance of this to staff safety and the maintenance of a safe environment for the staff and other prisoners.
- Such training would be enhanced by reference to the death of [the deceased] and the circumstances leading to his death as I have found them to be. Current training manuals should be adjusted accordingly.
- The Department of Corrections should reduce the time frames for developing management plans for the management of directed segregation prisoners to within one day.
- The Department of Corrections adopt the suggestion that the control and restraint stance be incorporated within its training and internal instruction manuals as the stance to be adopted by an officer when unlocking a prisoner.

NZ.2011.2020 Work Related/ Electrocution

A mechanic died when a defective mechanics crawler he was lying on connected with the exposed wiring on a hand held electric lamp, resulting in a fatal electric current.

Recommendations

To the Ministry of Business, Innovation and Employment:

- That consideration be given to the inclusion in both AS/NZS 3000 and Electricity (Safety) Regulations for a requirement for the use of Residual Current Devices (RCDs) or similar safety devices when hand-held appliances are used in industrial and commercial sites.

NZ.2011.2076 Work Related/ Transport & Traffic Related

A farmer died after losing control of the quad bike he was riding in steep and slippery conditions. The quad bike and trailer it was towing travelled down a slope into a gully where it overturned, trapping the deceased underneath.

Recommendations

I particularly recommend that all those in charge of four wheel drive (quad) bikes on farms be instructed in their use and in their dangers, notwithstanding their experience. A course of instruction is likely to identify hazards unknown to operators, even those who have been riding them for years.

I will ensure that a copy of this Finding is forwarded to the Department of Labour, and to Accident Compensation Corporation (ACC), for them to include the relevant information in their future publications.

I refer to, and adopt in part, the Department of Labour Recommendations in their Guidelines:

- Riders must be trained/ experienced enough to do the job.
- Choose the right vehicle for the job.
- Always wear a helmet.
- Do not let kids ride adult quad bikes.

There is no evidence of a head injury to the deceased which may have caused or contributed to his death but I endorse the recommendation that crash helmets should be worn, the evidence of their benefits being overwhelming.

VIC.2010.4080 Work Related/ Transport & Traffic Related

A farmer died after being struck by a bulka bag on a moving tractor.

Recommendations

In the interests of prevention of a similar death, I note that during the investigation, [name] of Worksafe undertook an extensive review of the scene and provided a report to the Coroner. [Name] expresses the opinion that despite the Australian Standard, the safest system of operating the tractor with a bulka bag on board would have been to operate the tractor in reverse, possibly with the rear window open. I agree with this assessment.
I recommend that Worksafe review the contents of the 'Safe use of Tractors with Attachments' handbook to reflect the above recommendation.

NCIS - FATAL FACTS WEB TOOL CATEGORY TAGS

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