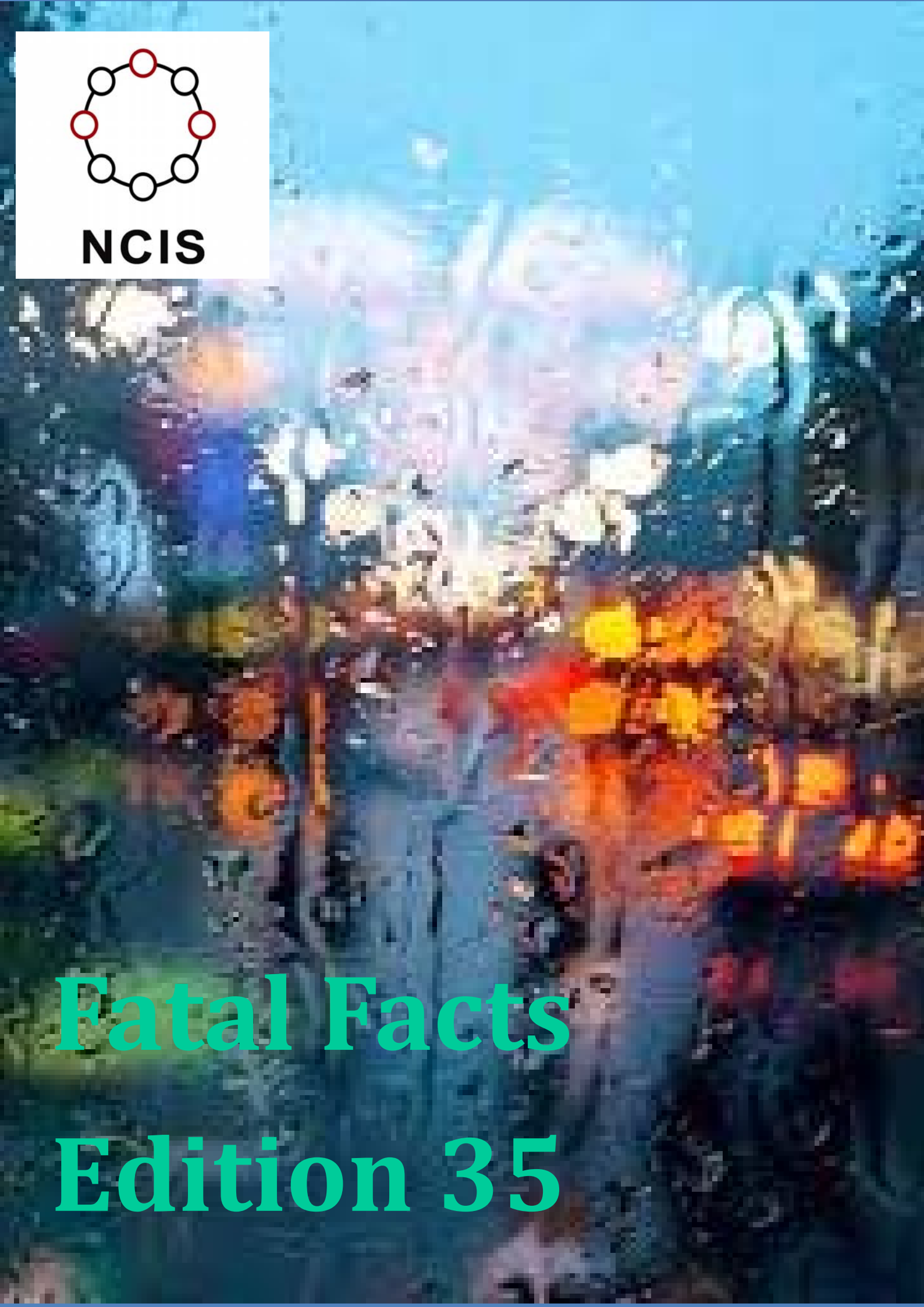
NCIS
Fatal Facts
Edition 35

NCIS Fatal Facts

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 31st December 2012. The NCIS have populated the tool with all past issues of *Fatal Facts* as well as including all recent issues and cases.

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

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

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

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Edition 35 July 2017

In this Edition

Fatal Facts Edition 35 includes cases where the coronial investigation is complete and where the Coronial Finding contains recommendations. Edition 35 includes cases that were closed between 1 October and 31st December 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 35 contains summaries of cases where recommendations were made as part of the formal coronial finding. Of these cases, 43 are Australian cases and 35 are New Zealand cases.

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

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

What is a Coronial Inquest?

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

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NSW.2008.6299 Adverse Medical Effects

A person died as a result of multi-organ failure caused by hepatorenal syndrome and sepsis. The deceased had been discharged from hospital before a definitive diagnosis was made.

Recommendations

I recommend to the Minister for Health and the South Western Sydney Local Health District:

- That patients admitted to hospitals for paracentesis ought not be discharged without being reviewed by a senior member of the treating team on the day of proposed discharge.
- That such patients not be discharged without review of all available pathology results.
- That if some pathology results are outstanding at the time of the review, they be considered as soon as possible afterwards and that, if reasonably practicable, patients be requested to wait for that to be done before leaving the hospital.
- That if patients are discharged before full assessment of all relevant pathology results, a staff member, preferably one of the treating team, document and get in touch with the patient as soon as reasonably practicable if further review is indicated, requesting the patient to return to hospital for that purpose (or, if appropriate, see their GP).
- That the Local Health District consider maintaining full fluid balance charts, measuring inputs and outputs, for all patients undergoing paracentesis.

NSW.2009.2235 Adverse Medical Effects/ Physical Health

A person with a mild intellectual disability died from undiagnosed meningitis. The deceased had been taken to hospital after suffering a seizure and was discharged home with the diagnosis of an inner ear infection.

Recommendations

I recommend that the Minister for Health and the South West Sydney Local Health District (or whichever is more appropriate) consider implementing the following practices, clinical policies and guidelines or revisions to current policies or guidelines:

- That there be a nursing assessment of any 'specific high-risk' patient (as defined in the Hospital protocol 'Emergency Department Supervision') triaged categories 1, 2 and 3 before he or she is physically discharged from the Emergency Department if that has not taken place within 30 minutes of his or her last review and the patient remains within the physical confines of the department.
- That there be a nursing assessment of any patient who requires physical assistance to be transferred from their bed to their mode of transport on discharge unless it is clear that the need for physical assistance was assessed by a doctor at the time of the clinical decision to discharge. Alternatively, I recommend that NSW Health or the Local Health District (as the case may be) consider amending its standard emergency department discharge protocols to include a warning on the discharge documentation that if a patient requires physical assistance to leave the Emergency Department he or she ought not be discharged unless it is clear that the need for physical assistance was assessed by a doctor at the time of the clinical decision to discharge.
- That a guideline that all patients with a presenting complaint of seizure, but who do not have a previous history of seizures, should be assessed by a senior doctor in the Emergency Department, and if a senior doctor is unable within 30 minutes to assess the patient, a full blood count and any other tests that ought be included in a standard battery of tests for such a patient should be ordered.
- That all patients presenting with a Glasgow Coma Scale (GCS) score of less than 15 should have their GCS assessed on admission and prior to discharge.
- That all patients who on presentation were triaged categories in 1, 2 or 3 with development disability should be assessed by a senior doctor before discharge.
- That there should be an annual education of all clinical staff in the Emergency Department in relation to detection of signs of risk factors, signs and symptoms of sepsis in patients presenting to an emergency department and further that the clinical education should include information on tests or investigations that can be performed to identify sepsis in patients and subsequent management with rapid intravenous antibiotics, fluids and source control.

NSW.2009.2235 continued

- That a junior medical officer's differential diagnosis should be documented in the patient's clinical record in the Emergency Department. At [location] Hospital, the appropriate time and place for this may be when the Presentation Plan is formulated.
- That Section 1 (entitled 'Emergency Department Patient Assessment and Review') of the [location] Hospital Emergency Department Supervision Guideline be reviewed in accordance with these findings.
- That the Local Health District consider including in the in-house training given to Emergency Department staff (medical and nursing) a regular session on mental and physical preparation for a shift and self-care during a shift.
- That, in an appropriate forum or manner, the Local Health District emphasise to Nursing Unit Managers and to senior doctors supervising Emergency Departments that the efficiency of their staff will be improved by attention being paid to self -care, especially rehydration, during shifts.
- That the Local Health District consider developing a poster or notice that can be placed in emergency Departments warning staff of the effects of fatigue and urging staff to rehydrate regularly and eat light meals during the shift.

NSW.2009.5120 Adverse Medical Effects

A person died from bacterial meningitis. Upon presentation to hospital, the deceased was diagnosed with a flu-like virus and discharged home. They were found deceased at home seven days later.

Recommendations

To the Minister for Health:

That, when a unaccompanied patient is discharged from a NSW Health hospital emergency department, he or she be asked whether he/she has a carer at home OR whether he/she wishes the listed Next of Kin to be notified that he/she has been treated in hospital.

To the Sydney Local Health District and the Department of Forensic Medicine:

That if, when conducting post mortem investigations, staff specialist forensic pathologists working the Department of Forensic Medicine consider that a case may fall within the scope of s20L of the Health Administration Act, the relevant Local Health District should be notified without delay.

NSW.2010.5057 Adverse Medical Effects/ Older Person

An elderly person died as a result of an anaphylactic reaction to ampicillin, which was administered intravenously in hospital. The deceased had alerted staff to their drug allergy prior to and during their admission.

Recommendations

To the Director General of Nepean Hospital

- That the form titled 'Recommendation for Admission' be changed so that it has adequate space for numerous allergies to be recorded. It should also include adequate space for the practitioners to record their understanding of what happens to the patient when exposed to the allergen;
- That consideration be given to changing the 'Time Out Procedure' so that it takes place prior to administration of any drugs by the anaesthetist in either the anaesthetic bay or the operating theatre;
- That 'Allergy Alert Stickers' be placed on all relevant patient documents, including but not limited to:
    - ◊ Anaesthetic records;
    - ◊ The 'time Out' checklist;
    - ◊ Progress notes;
    - ◊ Operation records.
- That education be conducted for all practitioners and nurses involved in the pre-admission clinic about the dangers and risks of allergies and the importance of correctly identifying and recording allergies. To that end, the use of the deceased's case as a learning tool.

NSW.2010.5057 continued

To the Director-General of NSW Ministry of Health

In light of circumstances surrounding the death of the deceased that consideration be given to the following:

- The importance of the World Health Organisation Surgical Safety checklist.
- Amending the document titled 'Correct Patient, Correct Procedure and Correct Site (Policy Directive)', in particular paragraphs 3.2 and 3.4 to ensure that the Time Out procedure take place prior to the administration of any drugs by the anaesthetist in either the anaesthetic bay or the operating theatre.

To the Health Care Complaints Commission

That the Commission review the role of [name] in the assessment of the deceased at the [location] pre-admission clinic on [date] with a view to identifying any shortcomings in the care he provided.

NZ.2010.2968 Adverse Medical Effects/ Physical Health

A person presented to hospital with shortness of breath and a pericardiocentesis was performed the following day. Post-operative treatment included the use of a Bi Positive Airway Pressure (BiPAP) machine. The person died two days later.

Recommendations

I recommend the circumstances of the delay of some 11 hours in the administration of Frusemide to relieve breathlessness, after the procedure in the morning of [date] be considered by the Cardiology Department, [location] Hospital to ensure that appropriate procedures representing best practice are in place. This recommendation is directed to the Medical Director of Patient Services and the Clinical Leader Cardiology, [location] Hospital.

NZ.2011.2195 Adverse Medical Effects/ Older Person

An elderly person died after a naso-gastric tube penetrated their brainstem. The deceased had undergone bone removal from the nasal area and upon insertion of the naso-gastric tube, it penetrated the surgical site and into the brain.

Recommendations

- I recommend that the [location] District Health Board continue with its development of protocols to avoid the recurrence of the circumstances which have led to the death of the deceased.
- It is inappropriate for a Coroner to be too specific in cases such as this in relation to recommendations. The major issues to be addressed have been identified. All that can be required of the [location] District Health Board is that the lessons to be learned from the tragedy be the subject of critical appraisal and that appropriate enhancement in procedures be later adopted.
- I see the issue, in relation to the fact that critical flags within patient notes being overlooked or buried, as being so important that the lessons learned from the death of [the deceased] be appropriately drawn to public attention by the [District] Health Board. The Board should report on the issues identified at a national level.

VIC.2006.2279 Adverse Medical Effects

A person died following an angioplasty for an occluded artery. During the procedure, the Right Ventricular Outflow Tract (RVOT) of the heart was severed, resulting in fatal complications.

Recommendations

- That [name] Health ensure that the Director of the [location] Hospital Cardiology Unit is an experienced interventional cardiologist who is cross accredited to at least one tertiary cardiothoracic unit performing interventional cardiology and practices interventional cardiology in the [location] Hospital Cardiology Unit.

VIC.2006.2279 continued

- That the Department of Health request the Intensive Care Advisory Committee to consider access to intensive care beds for emergency cardiac surgical patients in the context of the overall supply of intensive care beds in the State.
- That the Department of Health seek advice from the Cardiac Clinical Network in relation to integrating its role in emergency transfer of patients from stand-alone regional PCI Units to a tertiary cardiothoracic unit with the services offered by the Intensive care Advisory Committee and Adult Retrieval Victoria.
- That the Cardiac Society of Australia and New Zealand consult with the Department of Health and the Cardiac Clinical Network in victoria to ensure that the Cardiac Society Guidelines relating to stand-alone regional PCI Units take into account local arrangements which may reduce the time required to organise emergency transfer to a tertiary cardiothoracic unit.
- The Cardiac Society of Australia and New Zealand reconsider their advice about the time required for emergency transfer of patients from stand-alone regional PCI Units to a tertiary hospital with cardiothoracic surgery capability to include the time required to find a bed in a receiving hospital and the time required to arrange emergency transfer.
- The Cardiac Society of Australia and New Zealand review its guidelines to require all interventional cardiologists performing angioplasties in regional stand-alone PCI Suites to be cross-credentialed to perform PCI procedures in a tertiary high volume cardiothoracic unit and to work in that unit for sufficient time to maintain their exposure to emergency responses.

VIC.2010.377 Adverse Medical Effects/ Older Person

An elderly person died as a result of a ruptured abdominal aortic aneurysm. The deceased attended a regional hospital with abdominal pain and was discharged the same day following a diagnosis of a urinary tract infection. A CT scan was not performed at the hospital and they died the following day.

Recommendations

Government funded continuing education in emergency medicine should be available to rural general practitioners who regularly staff rural hospital emergency and urgent care facilities. Such training should not be confined to emergency life saving measures but include the identification and management of differential diagnosis (particularly in potentially life-threatening conditions) in rural settings.

The Department of Health should consider providing fully funded regular specialist training in emergency medicine to general practitioners who staff emergency departments or urgent care centres in rural hospitals.

WA.2008.1521 Adverse Medical Effects/ Physical Health

A person died in hospital as a result of a pulmonary thromboembolism. The deceased had been hospitalised for several months after surgery to remove a pancreatic tumour. The deceased underwent several additional procedures as a consequence of infections at the surgical site.

Recommendations

- I recommend that [location] Hospital creates a separate tab in patient medical files, entitled 'Orders', which records instructions and orders by consultant surgical teams and treating medical practitioners, including all decisions to change patient medications and decisions made not to institute particular medications.
- I recommend that [location] Hospital consider developing guidelines or protocols for obtaining advice and guidance from consultant haematologists in relation to the management of patients at higher levels of risk of developing a deep vein thrombosis or a pulmonary embolism.
- I recommend that discharge summaries prepared by [hospital] (including those prepared for [unit]) be amended to include a section for the surgical consultant discharging the patient to write current orders and directions about the patient, giving short reasons, and contact details for consultation.
- I recommend that [location] Hospital consider developing a Thrombosis Management Service to provide specialist advice in relation to patients with increased risk of deep vein thrombosis and pulmonary embolism.

WA.2009.39 Adverse Medical Effects/ Youth

A young person died as a result of acute lymphocytic meningitis and focal myocarditis. The deceased was suffering from a severe headache and had presented to a hospital emergency department twice, but was discharged home.

Recommendations

- Clinicians dealing with difficult differential diagnoses, such as the difference between bacterial/viral meningitis, or some other inflammatory process, ensure they accurately document the clinic decision-making process, especially where a significant procedure such as a lumbar puncture, is used as part of the diagnostic process.
- Clinicians discharging patients with viral meningitis are mindful there are rare cases of concurrent inflammatory processes which can have an unexpected and fatal outcome.

NZ.2010.3114 Aged Care/ Mental Illness & Health/ Transport & Traffic Related/ Older Persons

An elderly person who suffered from dementia absconded from a rest home with another resident and was struck by a car whilst walking along a highway, which resulted in fatal injuries.

Recommendations

In addition to the steps taken by the rest home, I recommend that they:

- Initiate a process whereby all caregivers in the secure unit are specifically alerted to all instances when residents abscond from the unit so that they are fully appraised of the residents' escape risk;
- Implement individual care/sighting plans for residents whose security risk is known to be so significant- for example, due to previous escapes or persistent attempts to do so- that thirty minute sightings may not be in fact sufficiently protective, and
- Develop special search plans for specific high risk residents having regard to their past behaviour and likelihood that they may rapidly leave the rest home property if they abscond from the secure unit.

NZ.2011.2659 Animal/ Child & Infant Death

An infant ventured into the cattle yard on their parents' farm and was trampled by a cow, resulting in fatal head injuries.

Recommendations

I recommend that a copy of this Finding be forwarded to New Zealand Federated Farmers with my request that the organisation give to the finding the appropriate publicity and emphasise to its members the absolute need to take all appropriate care when supervising children and infants in a farm environment.

VIC.2011.2630 Animal/ Transport & Traffic Related

A motorcyclist died following a collision with a cow that had wandered onto the road through a damaged fence.

Recommendations

- That Local Government bodies within [location] carry out an audit of the number of signs in the region advising motorists of the possibility of the presence of animals on the road and consider whether an increase in the number of signs is necessary.
- That the Motor Cycle Riders Association, motor cycle clubs and other organisations associated with the use of motorcycles, reinforce to their members the ever present need-
    - ◊ To ensure that the lights of their motorcycles comply with the Australian Design Rules as referred to herein and,
    - ◊ To ensure that the headlights fitted to their motorcycles ensure proper illumination on (especially) unlit roadways at night.

NSW.2010.3477 Child & Infant Death/ Adverse Medical Effects

An infant died shortly after birth due to extreme prematurity. The deceased was born at 24 weeks gestation, which is considered in the "grey zone" of viability. The doctor failed to consult with the deceased's parents and explain the options available to them. Prior to the birth, the parents requested active medical treatment for the child, however resuscitation was not commenced.

Recommendations

To the Minister for Health

Consideration be given to the creation of a Guideline for the care and treatment of extremely premature babies in the Grey Zone of viability that includes the following:

- The gestational limits of the grey zone of viability;
- The need to develop an informed management plan available to the parents prepared after consultation between the clinicians and parents concerning ongoing treatment and the issue of intensive care and resuscitation;
- The parents are advised as to their rights concerning treatment, resuscitation and end of life decisions;
- The wishes of the parents as to resuscitation and end of life decisions are to be specifically obtained are to be considered of paramount importance;
- The management plan is subject to change at any time after consultation with the parents;
- The need for education of the parents by way of an information package as to the stages of a high risk pregnancy including the risks to the mother and baby and what to expect in the event a baby is born stillborn or born alive but no resuscitation given;
- The need for counselling services being available for the parents throughout the pregnancy and in particular after birth in the event a decision is made not to resuscitate;
- The need for training of nursing and medical staff that encompasses the Australian Resuscitation Guidelines, end of life discussions with parents and explaining to parents the Palliative process in the event resuscitation is not to occur;
- In the event of shared care management between Hospitals, the need for ongoing exchange of information including through multi-disciplinary discussions concerning patient care and any management plan.

To [location] Local Health District

Consideration be given to:

- A review of the High Risk Clinic appointment scheduling to improve continuity of care of a high-risk patient;
- Education of staff of the importance of accurate recording of the minutes of Morbidity and Mortality meetings including conclusions and recommendations for consideration by Hospital management and that there be a regular audit of compliance.

NSW.2011.337 Child & Infant Death

An infant died shortly after birth due to sepsis complicated by an inter uterine growth restriction. The deceased was delivered by emergency caesarean after foetal distress was noted by staff.

Recommendations

To the Director General of NSW Health:

That the director of forensic medicine give consideration to amending the Forensic Pathology code of practice and performance standards in NSW (in conjunction with the Perinatal Society of Australia and New Zealand) to include an additional appendix in relation to standard guidelines to performing autopsies on infants who have died shortly after birth (and not of a forensic nature). Such guidelines should include (in the event a specialist paediatric pathologist is not available):

- The weighing of the placenta with and without the cord and trimmings;
- Taking samples or slides of the umbilical cord from both the maternal and baby end;
- Take a minimum of five sections/samples of the placenta.

NZ.2010.3174 Child & Infant Death

An infant died as a result of unintentional asphyxia after their mother fell asleep while breastfeeding. The deceased and the mother were in the Neonatal Intensive Care Unit in hospital at the time.

Recommendations

To: The Director General of Health, Ministry of Health, [location]

That the Ministry of Health:

- Highlights to the public and to health care and social service providers the risks of a mother or other adult sharing a sleeping surface with a baby when the adult is asleep.
- Advocates for a focus on prevention of suffocation deaths by all health and social service providers.
- Leads an initiative to develop, by consensus of all stakeholders, National guidelines for Safe Sleeping.

To: The Chief Executive Officer, [location] District Health Board and to the Chair, [location] District Health Board

- That [location] District Health Board ensures that it has an explicit safe sleeping policy for infants in the Neonatal Intensive Care Unit that includes all the matters highlighted by the Health Quality and Safety Commission.
- That the District Health Board's Neonatal Intensive Care Unit audits the adequacy and effectiveness of its safe sleeping message to families.

To: The Chief Executive Officers and Chairs of All District Health Boards

- That, as recommended by the Health Quality and Safety Commission in June 2012, all District Health Boards (DHBs) develop and implement as a matter of priority a safe sleeping policy for infants which aims to ensure:
    - ◊ Staff who support families caring for infants receive mandatory training and updates about prevention of Sudden Unexplained Death in Infancy (SUDI) and ways of communicating risks to families;
    - ◊ The modelling of safe sleeping practices for all infants within DHB facilities;
    - ◊ Safe sleeping arrangements are available for all infants after they are discharged home;
    - ◊ Families are provided with education and supports tailored to their level of need about the hazards that arise in some sleeping situations;
    - ◊ Advice on safe strategies for night feeds and settling infants is provided to parents;
    - ◊ All services and staff encourage safe sleep practices in ways that are inclusive of Maori and Pacific cultures and values.
- That those DHBs that currently have safe sleeping policies review the adequacy of those policies and where necessary amend their policies to include the issues identified by the Health Quality and Safety Commission.
- That DHBs with neonatal units ensure that such units have appropriate safe infant sleeping policies.

NZ.2011.2529 Child & Infant Death/ Adverse Medical Effects

An infant died from dehydration due to viral gastroenteritis. The deceased had been discharged from hospital with undiagnosed dehydration and their condition deteriorated rapidly at home.

Recommendations

I endorse the proposed actions to address the causation statements set out in the action plan following an analysis of serious event provided by [location] Hospital, and expect that all of those actions will be implemented.

NZ.2011.2679 Child & Infant Death

An infant died after co-sleeping with parents and siblings.

Recommendations

I repeat the recommendations made by my fellow Coroners Bain and Evans and the recommendation made in my Finding in respect of the death of baby [name] dated [date] and I ask that the Director General of Health and the Ministry of Health continue with public health advice in relation to safe infant care practices and safe sleeping environments.

NZ.2011.2679 continued

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

- Bed sharing by adults and siblings with infants under the age of six months (particularly both parents who smoke cigarettes) exposes such infants to a substantially increased risk of death.
- The safest place for babies to sleep during the first six months of their lives is in a cot beside the parental bed.
- Steps should be taken by the Ministry of Health to ensure that the advice on safe sleeping is given by all public health educators and health professionals in all public health sectors over which the Ministry of Health has influence.
- The Moe Ora Scheme to provide newborn infants with a self-contained sleeping cradle (wahakura) (which researchers advise goes some way to ensuring the safety of an infant 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 cost of a purchase.

NZ.2011.2741 Child & Infant Death/ Adverse Medical Effects

An infant died from fulminating necrotising enterocolitis and E.coli sepsis after undergoing laser eye surgery.

Recommendations

To: The Director-General of Health, Ministry of Health

That in accordance with the advice of [name], Ophthalmologist, the Ministry give consideration to the taking of those steps necessary to ensure the availability within New Zealand of the eye drop combination Cyclomydril (Cyclopentolate Hydrochloride 0.2 per cent with phenylephrine Hydrochloride 1 percent).

NZ.2011.2945 Child & Infant Death

A newborn died as a result of unintentional asphyxia after being breast fed by their mother in hospital.

Recommendations

To: The Director General of Health, Ministry of Health, [location]

That the Ministry of Health:

- Highlights to the public and to health care and social service providers the risks of a mother or other adult sharing a sleeping surface with a baby when the adult is asleep.
- Advocates for a focus on prevention of suffocation deaths by all health and social service providers.
- Leads an initiative to develop, by consensus of all stakeholders, National Guidelines for Safe Sleeping.

To: All District Health Boards

- That, as recommended by the Health Quality and Safety commission in June 2012s, all District Health Boards (DHBs) develop and implement as a matter of priority a safe sleeping policy for infants which aims to ensure:
    - ◊ Staff who support families caring for infants receive mandatory training and updates about prevention of Sudden Unexplained Death in Infancy (SUDI) and ways of communicating risks to families;
    - ◊ The modelling of safe sleeping practices for all infants within DHB facilities;
    - ◊ Safe sleeping arrangements are available for all infants after they are discharged home;
    - ◊ Families are provided with education and supports tailored to their level of need about the hazards that arise in some sleeping situations;
    - ◊ Advice on safe strategies for night feeds and settling infants is provided to parents; and
    - ◊ All services and staff encourage safe sleep practices in ways that are inclusive of Maori and Pacific cultures and values.
- That those DHBs that currently have safe sleeping policies review the adequacy of those policies and where necessary, amend their policies to include the matters identified by the Health Quality and Safety Commission.
- That DHB's monitor the impact of their safe sleeping policies to ensure desired outcomes are being achieved.

NZ.2011.2945 continued

To: The Director General of Health, Ministry of Health, [location]

- That the Ministry of Health ensures that all Birthing Centres and private maternity hospitals that receive public funding for maternity services have safe sleep policies for infants that include all matters identified by the Health Quality and Safety Commission.

To [Hospital]

- That [hospital] reviews the safe sleeping policy introduced in October 2011 to ensure the policy includes all the matters identified by the Health Quality and Safety Commission.
- That [hospital] ensures that its current mandatory staff training on SUDI includes specific training on risks of SUDI arising from bed sharing/co-sleeping.
- That [hospital] assesses whether midwifery and nursing staff are adequately trained to be able to effectively communicate the risk of SUDI to parents and ensures further training if required.
- That [hospital] monitors the impact of its amended safe sleeping policy to ensure desired outcomes are being achieved.

NZ.2012.1853 Child & Infant Death

A infant died from bronchopneumonia after co-sleeping with their mother on a mattress on the floor.

Recommendations

- A copy of these findings be referred to Ministers [name] and [name] for dissemination of a copy of the anonymised version of these findings and recommendations to all marae throughout the country.
- All marae committees should encourage their whanau to use safe sleeping practices when attending hui or tangihanga by promoting the use of wahakura or a pedi-pod or similar devices, which provide a safer sleeping environment for babies in circumstances of a shared sleeping environment such as on a marae.

TAS.2011.86 Child & Infant Death

An infant died after co-sleeping with their parents.

Recommendations

It is well recognised that the safe sleeping recommendations for infants need to be imparted to any one parent on three separate occasions for them to be effective. If the advice is simply given on one occasion to a parent shortly after the birth of the child, it is unlikely to be fully absorbed; this is due to many other matters occupying the mind of a new parent.

As I have stated in previous findings, there is a particular ongoing need for targeting and education of high risk sub-groups in the Tasmanian population, so that important messages for risk reduction in sudden infant death become entrenched.

I am aware that there is currently a Model of Care review occurring within Child, Health and Parenting (CHAPS) that will focus on vulnerable families and children. The review is working to move the focus from a primary intervention to a secondary intervention, being targeted support for those families who most require support.

The Department of Health and Human Services (DHHS) has also recently developed a 'Safe Sleeping' DVD for use by professionals. The DVD is targeted towards those families who are most at risk of co-sleeping with their baby while under the influence of drugs or alcohol. It is an excellent initiative in emphasising to high risk parents the possible tragic consequences of sleeping with their infant whilst they are under the influence of alcohol or drugs. I urge the department to ensure that continued steps are taken to maximise the use of the DVD by appropriate professionals, including CHAPS, when working with vulnerable families.

In previous findings, I have recommended that the government provide funding for an additional SIDS and Kids employee, so that the education functions and much needed grief counselling function of that organisation could cope with state wide demand. Such a recommendation remains relevant.

VIC.2006.1014 Child & Infant Death/ Adverse Medical Effects

An infant died as a result of liver failure, blood loss and shock after undergoing a liver biopsy. The liver biopsy was performed to identify the cause of their jaundice.

Recommendations

- Royal Australasian College of Physicians, Paediatrics & Child Health Division and the Royal Australian College of General Practitioners advise paediatricians and general practitioners that all babies who present with unresolved conjugated jaundice at about eight weeks, particularly those for whom liver biopsy is being considered, should undergo further plasma amino acid screening to exclude the possibility that their symptoms are associated with Type 2 citrullinaemia.
- Victorian Clinical Genetics Services establish genetic screening for babies who would otherwise undergo liver biopsies and have characteristics associated with increased likelihood of citrin deficiency.
- Victorian Clinical Genetics Services provide genetic screening for parents of children who have been identified as carriers of citrin deficiency.
- [Location] Hospital review their protocols in the light of changes introduced by [name] Health Pre and Post Liver Biopsy Protocol into their protocol in September 2006 and September 2008.
- [Name] Health continue to actively promote a ward culture of accessing protocols when patients are booked for rarely performed procedures including awareness of their Paediatrics- Pre and Post Liver Biopsy Protocol.
- [Name] Health retain digital images of all ultrasound radiology of paediatric procedures.
- [Name] Health host a discussion between senior nursing staff in the Endoscopy Suite and Ward [name] and paediatric radiologists and gastroenterologists who perform endoscopy procedures to clarify and specify the content and frequency of standard post-operative observations.
- [Name] Health explore the possibility of introducing permanent recording pulse oximeters in Ward [name] and the Endoscopy Suite.

VIC.2012.47 Child & Infant Death/ Work Related

A child died when a hay bale spike fell onto them whilst their father was working on a tractor at a farm.

Recommendations

- That specific guidance material be published to target the hazards and risks associated with children and young persons on farms.
- That appropriate alerts be published regarding hazards and risks associated with children being near tractor implements and to warn of the hazards and risks associated with free standing farm implements or attachments.
- That the 'Farmsafe' programme which concentrated on young persons in the rural and farming environment be revisited.

NZ.2010.3021 Drugs & Alcohol

A person died as a result of respiratory depression caused by a large intake of alcohol.

Recommendations

There have been recommendations made by other coroners in the past for warnings on alcohol containers but, as yet, these recommendations have gone unheeded. Yet, as shown by this death and by many previous ones, alcohol is an inherently dangerous substance as it can kill when consumed in excessive amounts.

It seems to me that the makers of products containing an inherently dangerous substance have an ethical obligation to warn consumers of its dangers.

I endorse the recommendations of other coroners, and I recommend:

To the Health Promotion Agency (care of its CEO and also its Board)

That the Health promotion Agency advises Government and the alcohol industry that every container containing alcohol should be labelled with an explicit warning that excessive use of alcohol can kill you.

NZ.2011.1891 Drugs & Alcohol/ Natural Causes

A person died from a cardiac arrhythmia attributed to their self-medicating of excessive amounts of ibuprofen.

Recommendations

I recommend that a copy of this Finding be forwarded to the Minister of Health in order that further publicity be given by the Ministry of Health to both the dangers of taking non-prescription medications in amounts in excess of those which are recommended by the manufacturers and the dangers of individuals failing to heed medical advice and self-medicating to the exclusion of taking prescribed medication and treatment.

NZ.2011.2501 Drugs & Alcohol

A person died from alcohol toxicity after consuming a large quantity of beer, wine and spirits.

Recommendations

- That the appropriate government agency consider making it a legal requirement that every container of alcohol carry a label warning consumers of the risk of death if an excessive amount is consumed.
- This recommendation is directed to the government agency responsible for controlling the sale of alcohol.
- That all agencies concerned with the potential harmful effects of excessive consumption of alcohol institute or support an education campaign alerting the general public to the risk of death associated with excessive consumption of alcohol.
- This recommendation is directed to the Alcohol Advisory Council of New Zealand, for dissemination to all other agencies that the Council considers appropriate.

NZ.2011.2646 Drugs & Alcohol

A person died of a drug overdose after ingesting a large quantity of alcohol and self-administering methadone, which was obtained illegally.

Recommendations

I recommend that a copy of this Finding be forwarded to the Minister of Health. The Ministry of Health could consider a public education programme specifically directed to the users of recreational drugs drawing to their attention the dangers and specifically identifying the fact that some drugs taken recreationally can have a depressant effect which exacerbates the central nervous system depressant effects of alcohol.

NZ.2011.2656 Drugs & Alcohol

A person suffered a cardiovascular arrest caused by the ingestion of central nervous system depressants, including alcohol and a number of prescription medications.

Recommendations

I draw to public attention the dangers of drinking alcohol to excess, particularly when alcohol is consumed in conjunction with medication, either prescription or non-prescription, which has a central nervous system depressant effect. In particular I note the advice, given with the prescription of Promethazine, that patients taking this drug must be warned to avoid alcohol.

NZ.2011.2705 Drugs & Alcohol

A person who travelled overseas died after consuming Arak, a local spirit that had been laced with methanol.

Recommendations

I recommend that a copy of this Finding be forwarded to the Ministry of Foreign Affairs and Trade (MFAT) so that the Ministry can give publicity to the dangers to which tourists to [location] may be exposed when drinking in hotels and bars in that location. The local alcoholic drink Arak has been known to contain, or be contaminated by methanol, and the effects of drinking methanol can be fatal. I ask that MFAT forward a copy of this Finding to the authorities in [location].

NSW.2011.822 Electrocution/ Drugs & Alcohol/ Misadventure

A tourist died as a result of electrocution from the overhead wiring system on the roof of a train after they climbed onto the roof in an intoxicated state.

Recommendations

To the Minister for Transport:

I recommend that the Rail Corporation NSW incorporate into its school student education program information about the electrical systems on the roof of a train.

NZ.2012.2068 Falls/ Leisure Activity/ Weather Related

A tourist died whilst mountain climbing when they slipped on a wet surface and fell down the face of the mountain, resulting in fatal injuries.

Recommendations

I adopt and enlarge upon the recommendations given by [name]:

- Mountain Information Services should continue to provide information on the hazardous nature of many of our mountain access routes, particularly in wet conditions.
- Climbers, when wearing heavy packs on exposed access routes may pay particular attention to their personal safety and specifically ensure that their chosen footwear is the most appropriate for the terrain.
- Climbing or tramping in wet conditions on steep access routes in [location] can be particularly hazardous.
- Individuals should consider their security by always using two or three point contact when soloing or scrambling. The use of a belay rope should always be considered when the exposure is great, conditions are adverse and the risk of a fall, and death, is high.
- Helmets provide limited but useful protection when an inadvertent head bump could cause the loss of a hand grip and fall.

VIC.2009.3287 Falls/ Law Enforcement/ Drugs & Alcohol

A person on parole was found deceased in a laneway with a head injury. It is unknown whether the deceased was assaulted or fell whilst affected by alcohol and drugs.

Recommendations

- To enhance the ability of Community Correctional Services staff to detect drug usage among parolees subject to abstinence conditions (particularly in the absence of any other testing conditions) and put in place interventions to manage associated risks, I recommend that within twelve months, Corrections Victoria revise the Deputy Commissioner's Instruction 5.7 to establish a minimum frequency of mandatory random urine tests for an offender subject to an abstinence condition.
- To enhance the ability of Community Correctional Services staff to detect drug usage among parolees on abstinence orders (particularly in the absence of any other testing conditions) and put in place interventions to manage associated risks, I recommend that within twelve months, Corrections Victoria revise the Deputy Commissioner's Instruction 5.7 to provide far more detailed assistance on how a case manager is to evaluate an offender's presentation and circumstances to determine whether or not a targeted urine test is required. The revised Instruction should explicitly address how the offender's history of substance use, and links between substance use and offending should inform development of a testing regime.

VIC.2009.3287 continued

- To enhance the ability of Community Correctional Services staff to detect problematic drug usage among offenders on parole orders and put in place interventions to manage associated risks, I recommend that Corrections Victoria provide re-training to all Community Correctional Services case managers regarding their responsibilities under Deputy Commissioner's Instruction 5.7 on urine testing. The re-training should emphasise that the case manager must retain responsibility for implementation of urine testing requirements attached to parole orders, regardless of whether general practitioners or others involved in the offender's care are administering urine tests.
- To ensure that Community Correctional Services staff involved in parole assessment are aware of all relevant issues that relate to the offender's mental and physical health and drug use history, and therefore can put in place adequate safeguards to manage known risks, I recommend that Justice Health provide an accurate summary of an offender's medical history to the Community Correctional Services staff member responsible for that offender's parole assessment. The summary should include any substance use and relevant treatment in prison, and any medications prescribed including the conditions they were prescribed to treat.
- To ensure that current parolees are being managed as safely and appropriately as possible, I recommend that Community Correctional Services and Justice Health urgently collaborate and share information to identify any current parolees who received methadone and/or buprenorphine while in prison for opioid dependence but who successfully misrepresented to Community Correctional Services staff during parole assessment that the drug was actually for pain management. This collaborative project will enable Community Correctional Services and Justice Health to gauge the extent of prisoner misrepresentation of treatment for opioid dependence, and enable Community Correctional Services to put in place targeted measures to manage risks relating to opioid use among vulnerable parolees.

VIC.2008.2147 Fire Related/ Older Persons/ Physical Health

An elderly person who was bedridden and profoundly deaf, died in a fire caused by a lit cigarette. The deceased was a heavy smoker and refused the fitting of smoke alarms in their home.

Recommendations

- That during initial needs assessment, community care providers advise community care clients that it is mandatory for all homes in Victoria to have a working smoke alarm.
- In homes where community care is to be provided and there is no smoke alarm, the installation of a smoke alarm is organised in line with service provision. In homes where smoke alarms are installed, these are checked by the community care provider to ensure they are in working order.
- That community care providers promote regular testing and maintaining of smoke alarms to the client, their family and/or friends or provide assistance for their clients to test and maintain smoke alarms if required.
- In homes where the client smokes, community care providers promote the use of high–sided ashtrays or sealed containers to allow for properly discarded smoking materials.

I direct that the recommendations in relation to the provision of community care services are distributed to all community care providers operating in Victoria by the primary funding entities of the Aged Care Branch Victorian Department of Health, the Transport Accident Commission, the Commonwealth Department for Health and Ageing, and Veterans' Home Care Commonwealth Department of Veterans' Affairs.

VIC.2011.3155 Fire Related/ Older Persons

An elderly person died in a house fire caused by either the overheating of a toaster or an electrical fault within the toaster.

Recommendations

I direct the following recommendations to agencies who fund programs who provide 'in home' services to older people in Victoria, specifically the Aged Care Branch, Victorian Department of Health, the Commonwealth Department for Health and Ageing and the Commonwealth Department of Veterans Affairs:

- That the 'Basic Home Fire Safety Training Materials', as endorsed by the Australasian Fire and Emergency Service Authority Council, are mandated for use by community aged care providers in Victoria, through inclusion of the information into the induction processes for new community aged care workers. These materials should also be used for skills maintenance sessions/programs conducted by community aged care providers for existing workers.
- That basic home fire safety is incorporated into policy and practice guidelines for assessment processes used to assess older people for 'in home' services. In residences where the client is considered at greater risk due to health or lifestyle factors (as defined in Essential Knowledge: Basic Home Fire Safety, Section 2), additional smoke alarms should be installed to provide the earliest possible warning of a fire for the occupant.

VIC.2008.4886 Homicide & Assault/ Youth

A young person died after being struck to the head during a fight at a party and falling to the ground. Despite regaining consciousness and leaving the party, the deceased's condition deteriorated overnight and they died in hospital two days later.

Recommendations

I recommend that Victoria Police Safer communities Program incorporate onto its website and into the Partysafe Kits basic information about the dangers of any form of head strikes.

I recommend that Victoria Police Safer Communities Program ensure that the updated Partysafe kits make clear the need for zero tolerance of any violent behaviour in and around the party and the perils of allowing uninvited people to linger in and around the party area.

WA.2010.358 Indigenous/ Law Enforcement/ Natural Causes

An Indigenous person died of natural causes in a cell at a Watch House. The deceased was an insulin dependent diabetic and was taken to hospital by police on two occasions following their arrest due to their blood sugar levels. The deceased was regularly checked upon returning to the Watch House, however there were no CCTV cameras operating in the cell.

Recommendations

- I recommend that action be taken by WA Police to ensure that closed circuit television vision of cells is recorded. Adequate protections must be put in place to ensure that any such recordings are not misused, with limited numbers of officers have access to the recordings and provision for significant penalties in the event of misuse of recordings.
- I recommend that custody officers receive training specific to their function relating to diabetic prisoners which would include information in relation to how to determine the quantity of insulin being self-administered by a prisoner. In addition, training should be provided in relation to the importance of monitoring carbohydrate intake of a diabetic prisoner taking insulin, with specific emphasis on the importance of ensuring that sufficient carbohydrates are taken to enable the insulin to act effectively.

NSW.2009.6207 Law Enforcement/ Mental Illness & Health/ Weapon

A person suffering from a mental illness was fatally shot by police when they advanced on officers with a knife.

Recommendations

To the Commander of [location] Local Area command:

Please give consideration to additional training being provided to serving police officers in order to raise awareness of the contents of the [location] Local Mental Health Protocol.

NSW.2011.4194 Law Enforcement/ Weapon

A driver involved in a road rage incident was fatally shot by police after he produced a firearm and pointed it towards officers.

Recommendations

To the Commissioner of Police I make the following recommendations:

- That the New South Wales Police Force investigate and/or consider:
  - ◊ The introduction of visual identification by which plain clothed officers and detectives are readily identifiable as police officers. Such consideration might include the introduction of caps, hats or other headwear, vests or other items clearly marked with police and/or the wearing of large police badges attached to a chain to be worn around the neck.
  - ◊ Introducing a system by which such items are readily accessible in police cars and police stations.
  - ◊ The introduction of training and protocols designed to encourage the use of such means of visual identification by detectives and plain clothed officers.
- That the words of the NSW Police Force FACT Sheet entitled 'Firearms Registry, Safe Storage Inspections/Firearm Inspections' be amended to reflect the mandatory terms of s.42 of the Firearms Act stating: 'If you have reasonable grounds to believe that a firearm is not being stored in accordance with the Act you MUST seize that firearm.'
- That the document or publication entitled Overview NSW Forearms Licensing Scheme be amended to reflect the mandatory terms of s.42 of the Firearms Act stating: 'If you have reasonable grounds to believe that a firearm is not being stored in accordance with the Act you MUST seize that firearm.'
- That the NSW Police Force maintain (or introduce) a system whereby the staff of the Firearms Registry are authorised and encouraged to raise questions with licensing police about action, or inaction, in relation to possible breaches of Firearms licenses, legislation and regulations.
- That the NSW Police explore the viability of technology incorporating cameras on pistols issued to NSW police officers as is being done in the United States and United Kingdom and consider trialling such weapons.

The Minister for Police I make the following recommendation:

- That in light of the current review of the Firearms Act and regulations, the NSW Government consider amending gun licensing regulations so that gun-club pistol licenses (Class H licenses) may be issued on condition that the registered gun be stored only in safe facilities at the club to which the owner belongs when not in use according to the conditions of the license.

NSW.2012.1000 Law Enforcement/ Drugs & Alcohol/ Weapon

A person affected by the drug LSD was shot by police with a Taser in the course of an arrest. Police also used capsicum spray and physical restraint to subdue the deceased. They died shortly after their arrest from unascertained causes.

Recommendations

To the Commissioner of Police

- That the conduct of Officers [name], [name], [name], [name] & [name] in their actions during the pursuit and restrain of the deceased be considered for disciplinary charges.
- That the actions of police during the pursuit and restraint of the deceased be referred to the Police Integrity Commission.
- That there be an immediate review of the contents of the relevant NSW Police Standard Operating Procedures and associated training relating to the use of Taser, OC spray, handcuffing, restraint and positional asphyxia to:
    - ◊ Ensure that officers are aware of the dangers of:
    - Positional asphyxia;
    - The multiple use of Tasers and their use in drive stun mode;
    - The multiple use of OC spray;
    - ◊ Ensure that guidance provided to officers is clear and consistent, in particular removing the term 'exigent circumstances';
    - ◊ Review the criteria for the use of Tasers;
    - ◊ Consider imposing limitations on the use of Tasers in certain circumstances;
    - ◊ Consider prohibiting the use of Tasers drive stun mode, other than where officers are defending themselves from attack;
    - ◊ Improve training techniques and education in the appropriate and/or prohibited use of all of the above;
    - ◊ Consider whether Probationary officers should continue to be authorised to carry Tasers;
    - ◊ Ensure that the safe management of risks of asphyxia by crush, restraint or position are included not only in the Standard Operating Procedures for the use of OC spray but wherever use of force must be applied to a person by a police officer.
- That there be a review of communication procedures to ensure that signs of mental disturbance in any person the subject of a police report be communicated, and other trained further to respond accordingly.
- That there be an examination of NSW Police VKG (radio dispatch) procedures to ensure accurate categorisation of any incident reported.

NSW.2011.510 Leisure Activity/ Water Related

An experienced scuba diver died as a result of an immersion pulmonary oedema. One year prior to their death, the deceased had been involved in an incident whilst diving where they experienced breathing difficulties. The deceased was assessed by dive physicians and a cardiologist and undertook approximately fifty dives following the initial incident.

Recommendations

As a result of the circumstances of the death of the deceased, and as a result that current land based cardiovascular testing is unable to identify individuals who are at risk of recurrent episodes, the evidence now indicates that those who have previously suffered an episodes or episodes of Immersion Pulmonary Oedema are at high risk of another episode which could be fatal. Accordingly, I recommend education and further research into such risks.

NZ.2011.2643 Leisure Activity/ Water Related

A tourist fell from a kayak in a lake and is suspected to have drowned.

Recommendations

- I recommend a copy of this Finding be forwarded to Maritime New Zealand with my request that the organisation take further action to ensure the need for persons in small boats to wear life jackets at all times, receives further publicity.
- I further recommend that a copy of this Finding be forwarded to the Minister for Transport. The Government should take action to ensure that the wearing of life jackets by all persons using small boats in New Zealand be made compulsory and that there ought to be compulsory policing and enforcement of the necessary legislation.

VIC.2010.2819 Leisure Activity/ Youth

A young person died from complications of a cerebral arterial gas embolism due to a scuba diving incident overseas.

Recommendations

- That the Commonwealth Department of Foreign Affairs and Trade seek to partner with the Divers Alert Network Asia-Pacific to develop sufficiently detailed advice on the Smart Traveller website to allow Australians to undertake appropriate safety assessments and preparations when considering recreational diving overseas. This should be undertaken to ensure that Australians who experience diving emergencies overseas can promptly access the appropriate first aid and medical care to minimise the risk of debilitating illness or death.
- The Department of Foreign Affairs and Trade should also seek to notify the recreational diving training and certification organisations operating in Australia of the presence of this information, encouraging recreational divers who intend to dive overseas to review the Smart Traveller website in order to appropriately and safely prepare for their trip.

VIC.2010.3105 Leisure Activity/ Youth

A young person died when they collided with a concrete retaining wall whilst skiing. The deceased was not wearing a helmet at the time of the incident.

Recommendations

That the Minister for Sport and Recreation and the Minister for Environment and Climate Change consider the introduction of a regulation requiring that ski lift operators, ski school operators and ski equipment hire operators post clear notices in hire and lift areas advising that skiers and snowboarders wear helmets.

NZ.2010.2727 Mental Illness & Health/ Intentional Self-Harm/ Weapon

A person suffering from a mental illness took their own life. At the time of their death, they were on leave from the mental health ward of a hospital.

Recommendations

- I recommend that a copy of this Finding be forwarded to the [location] District Health Board. The 'circumstances of death' of the deceased had identified issues relating to communication by the [location] District Health Board clinicians with the families of the patients. Psychiatrists tasked with the care of patients presenting to them must be encouraged to take positive and active steps to engage with appropriate family members in order that such engagement enhances the clinical care given.

NZ.2010.3199 Mental Illness & Health/ Intentional Self-Harm

A person suffering from mental health issues took their own life. It was alleged that the deceased was sexually assaulted by a nurse during an earlier hospital admission. The deceased's parents were consequently reluctant to admit the deceased to hospital again despite her previous non-fatal attempt at suicide.

Recommendations

I recommend that [location] District Health Board review its procedures where a formal complaint of alleged impropriety on the part of a health professional has been made to an outside agency to ensure there is a robust process for providing support to a patient (such as the provision of an advocate to assist in dealing with the police), additional to support provided in relation to mental wellbeing.

NZ.2011.3025 Mental Illness & Health/ Intentional Self-Harm

A person suffering from a mental illness took their own life after a lengthy involvement in Family Court proceedings.

Recommendations

- That consideration be given to implementing a system of providing mental health support to people engaged in Family Court proceedings similar to the pilot program operated by the Family Court of Australia.
- That a review be undertaken of current measures in place within Family Court to ensure that there are no unnecessary delays in relationship property proceedings, for the purpose of strengthening those measures.
- That consideration be given to enable persons suffering mental health issues who are parties to Family Court Proceedings to fast-track those proceedings to minimise the detrimental effect of the litigation on their mental health.

These recommendations are directed to the New Zealand Law Society and to the Ministry of Justice.

VIC.2007.1722 Mental Illness & Health/ Intentional Self-Harm

A patient from the psychiatric unit of a hospital absconded and died by suicide.

Recommendations

With a view to consistency with the National Mental Health Care Plan 2009-2014, 'Priority area 3: Service access, coordination and continuity of care'- I recommend that [location] Mental Health Services review its model of delivery of psychiatric care with a view to implementing one that provides greater continuity of care by the psychiatrists, such as described by [doctor] in his evidence. The review should incorporate a comparison of other regions/jurisdictions that have adopted similar models.

VIC.2008.4985 Mental Illness & Health/ Intentional Self-Harm/ Physical Health

A person with a past history of HIV positivity died by suicide whilst an inpatient at a hospital. The deceased had requested psychiatric assistance during their admission, however it was not provided by the hospital.

Recommendations

- To improve the safety of patients with HIV/AIDS in the Infectious Diseases Unit at [location] hospital, it review the process for the formal follow-up to a referral to the HIV Psychiatric Liaison Service, to establish a clear pathway of accountability for action and communication of outcome.
- To increase the safety of patients with HIV/AIDS in the Infectious Diseases Unit at [location] hospital, the nursing staff on the Infectious Diseases Unit should undertake training in the assessment of patient's mental states and of the out-of-hours referral process to the HIV Psychiatric Liaison Service.

VIC.2010.3926 Mental Illness & Health/ Intentional Self-Harm/ Physical Health

A person diagnosed with multiple sclerosis and suffering from depression took their own life after their employment was terminated.

Recommendations

That, in order to ensure that employees who are terminated are supported in accordance with best practice, as the lead organisation in the promotion and enforcement of health and safety in Victorian workplaces, WorkSafe Victoria ensures that the Fair Work Ombudsmen's guidelines relating to best practice in managing underperformance and termination of employment, are brought to the attention of employers and individuals in management positions as soon as practicable, and are readily accessible.

ACT.2012.29 & 30 Misadventure

Two tourists died from fungal poisoning after consuming death cap mushrooms they found in a park. The deceased persons believed the mushrooms were edible straw mushrooms found in parts of Asia.

Recommendations

In view of the deaths of three Chinese nationals in two years, the fact that in the past couple of years Chinese Nationals have comprised the largest group of migrants intending to visit or live in the Australian Capital Territory and the high risk that Chinese nationals will mistake death cap mushrooms for edible straw mushrooms, I strongly recommend that all signage posted in the Australian Capital Territory warning of the danger of ingesting death cap mushrooms including a statement in the most appropriate form of Chinese writing warning that death cap mushrooms are poisonous and can kill if ingested.

There are two areas in the Australian Capital Territory where, although it is known that death cap mushrooms grown, no warning signage is posted. They are [location] and [location]. I recommend that death cap mushroom warning signage, which includes a warning in the Chinese language, be posted in these two areas.

NZ.2009.3950 Natural Causes

A person collapsed in an airport after disembarking from a flight and suffered a fatal cardiac event. Despite being attended to by passers-by, no CPR was attempted until Airport Fire Service personnel arrived at the scene.

Recommendations

To: The Chief Executive Offices of the Aerodrome Certification Holders (all airports in NZ)

That in the event the Airport Authority has not already done so, it purchase and install in appropriate places within the airport complex sufficient publicly accessible automatic external defibrillator units to enable response to medical emergencies.

And that all airport staff should have basic CPR training, including the use of automatic external defibrillator units.

NZ.2010.2595 Older Person

An elderly person died from unintentional carbon monoxide poisoning in their caravan. The refrigerator was emitting abnormally high levels of carbon monoxide and the deceased had a portable LPG heater in the caravan. A lack of adequate ventilation also contributed to the death.

Recommendations

Energy Safety on its website promotes awareness of the need for regular maintenance of gas appliances, safety with LPG equipment in caravans and the avoidance of carbon monoxide hazards. In light of the circumstances of this event, [name] recommends a review of the safety messages. I endorse this recommendation with particular reference to his evidence that PPG heating appliances are not designed for and should not be used in confined spaces such as caravans, campervans or tents.

This recommendation is directed to Energy Safety, Ministry of Economic Development.

NZ.2011.3042 Physical Health/ Adverse Medical Effects

A person with Crohn's disease died from sepsis after a series of surgical interventions. The deceased's condition could not be managed by medication or further surgery.

Recommendations

I recommend that a copy of this Finding be forwarded to the District Health Board for the information of its clinicians and for training purposes.

I recommend that a copy of this Finding be forwarded to the Medical Council of New Zealand.

NSW.2009.813 Sports Related/ Water Related

A powerboat driver died when they were ejected from the cockpit after the boat became airborne whilst travelling at high speeds.

Recommendations

To the Australian Power Boat Association:

That the Australian Power Boat Association (APBA) adopt and implement the steps identified in the letters of its solicitor, [name] to the Crown's Solicitor's Office of [date] and [date] as follows:

- That the APBA amend its Rule Book to include a rule that no APBA sanctioned race is to start until the starting official is satisfied that all boats are in their allocated pole position.
- That the Australian Power Boat Association consult with the NSW Water Police or another police service concerning the establishment of procedures for preserving vessels and other evidence where a power boat has been involved in an accident at an APBA sanctioned event.
- That the APBA consult with the NSW Ambulance Service or another ambulance service to compile a checklist of the necessary medical and emergency equipment to be carried by all suitably qualified paramedical personnel engaged at any APBA sanctioned event.
- That the APBA amend its Rule Book to include a rule that the trim system of a boat be examined to ensure that it is correctly operating as part of the scrutineering checklist conducted at APBA sanctioned events.
- That the APBA amend its rules in respect of requirements for safety capsules and safety harnesses in racing vessels in accordance with its proposals that:
    - ◊ The APBA rules will require that a reinforced cockpit and safety harness, approved under its rules, are to be mandatory on all inboard hydroplanes fitted with an engine of 4301 capacity or greater, including newly constructed and existing vessels, and will encourage the fitting of reinforced cockpits and safety harnesses in any vessel with an engine capacity below 4301cc.
    - ◊ The APBA rules will require that an approved reinforced cockpit and safety harness be mandatory on all inboard displacement vessels fitted with an engine capacity of 5201cc or greater, including newly constructed and existing vessels, and will encourage the fitting of a reinforced cockpit and safety harness in any vessels with an engine capacity below 5201cc. Pro Stock Class vessels and/or other vessels fitted with engines with a capacity in excess of 5201cc but which are fitted with modified engines limiting their speeds to less than 105 mph are exempt from this rule. The APBA will, however, encourage the fitting of both reinforced cockpits and safety harnesses in such vessels.
    - ◊ The APBA rules will require that all classes of boats with engine capacity less than those referred to above be limited to a maximum racing speed of 105 mph. The APBA will give consideration to the placement of GPS equipment in all vessels of any class where they wish to participate in a limited speed class event, for the purpose of the scrutineering of race speeds.

NSW.2009.813 continued

◊ The APBA rules will require clubs organising events under its auspices meet a minimum standard set by it for first aid equipment available at those events, either by clubs purchasing/ hiring the relevant equipment or by requiring that paramedics hired to attend events bring a standard kit including defibrillators, oxygen and bag valve masks and any other equipment listed by the APBA. The APBA's safety officers or committee should compile a list of such equipment in consultation with the NSW Ambulance Service.

I also recommend that:

- The APBA will conduct detailed and ongoing reviews of all inboard and outboard racing classes with a view to ensuring that racing classes will be established to cater to the speed capabilities of vessels rather than engine capacity, to ensure the safety requirements of each class are reflective of vessel speed and resultant risk.
- The APBA will continue its review of racing classes in order to monitor and manage the speeds of individual classes and, where it considers necessary, will introduce additional safety measures such as reinforced cockpits to any class where it is considered in the interests of safety. The APBA will continue to seek and receive information from local and overseas experts with a view to adopting additional safety equipment and racing practices as they become available.

To NSW Roads and Maritime Services:

That NSW Roads and Maritime Services takes action to amend the conditions of licenses for powerboat races under its jurisdiction to require that licensees be required to conduct and manage the event in accordance with the rules of the APBA (as amended from time to time and including requirements concerning the specifications of competing vessels and safety equipment of crews) or, alternatively, (upon the request of the applicant for an aquatic license) under rules verified by an independent expert appointed by the RMS as being of an equivalent or higher safety and technical standard to the APBA rules.

To the Minister for Transport and NSW Roads and Maritimes Services (or whichever is most appropriate):

That the Minister or Roads and Maritime Services (whichever is most appropriate) explore the question of setting national safety standards for powerboat racing with their interstate equivalents through either the National Maritime Safety Committee or another more appropriate intergovernmental body with a view to establishing such standards in appropriate regulatory form.

To the NSW Minister for Transport and the National Maritime Safety Committee:

That they consider the issue of license conditions for aquatic events and the question of safety capsules and harnesses and establish a short, economical but reasonable consultation process open to relevant bodies and individuals.

NZ.2011.2098 Transport & Traffic Related/ Older Person

An elderly person lost control of their vehicle in wet conditions and collided with another car.

Recommendations

I recommend that this finding, and the Serious Crash Report, be sent to the State Highway Manager at the New Zealand Transport Agency to investigate the issue of the surface adhesion of the stretch of road where this accident occurred and determine whether improvements are needed.

QLD.2011.4180, 4183 & 4188 Transport & Traffic Related/ Child & Infant Death

Three people, including a newborn, died when the driver lost control of the vehicle due to excessive speed and collided with a tree. The newborn was not appropriately restrained in the baby capsule and was ejected from the car.

Recommendations

It is evident that Standards Australia is open to putting before its technical committee any suggestions for changes to the relevant standard and it is opportune to do so now given the draft standards is being considered.

QLD.2011.4180, 4183 & 4188 continued

On that basis I recommend that Standards Australia submit to Technical Committee CS-085 for further technical consideration that AS/NZS 1754 include:

- Clause 6.4.1 include that the product be engineered such that provision shall be made for the instruction booklet to remain permanently with the child restraint;
- Table 6.2 include with respect to child restraints for infants up to 6 months old a warning with words to the effect of 'Fit the harness firmly to the child. Do not wrap the child in a blanket when placing in restraint.'

Given the Australian Standard is likely to be upgraded in the near future, it may be opportune to consider further public awareness of the issues concerning child restraints. It is therefore recommended that the State Government, through the Department of Transport and Main Roads, consider contributing towards and/or conducting public awareness campaigns on the importance of the correct selection, use or installation of child restraints.

VIC.2011.2207 Transport & Traffic Related

A fruit picker died when the mini van they were travelling in rolled. The deceased was not wearing a seatbelt at the time of the incident and was ejected from the vehicle.

Recommendations

- That [location] City Council engage with VicRoads and the local horticultural industry to review the need for road infrastructure upgrades in areas adjoining large horticultural developments to appropriately manage the potential conflict between freight vehicles and passenger vehicles transporting workers.
- That the Commonwealth Department of Education, Employment and Workplace Relations provides information through the Harvest Labour Service to participating workers, labour hire companies and host employers regarding basic road safety in Australia, particularly the need to wear seatbelts.

WA.2008.13 Transport & Traffic Related/ Youth

A young person died when the vehicle they were travelling in rolled on an unsealed road. The driver was advised of the route at a Visitors Centre as a fire had led to the closure of the sealed highway.

Recommendations

- I recommend brochures outlining tourist attractions along scenic, unsealed tracks include a warning to travellers that long distance travel on unsealed roads is something which needs to be approached with caution.
- It needs to cover in words, and with examples, the information conveyed by the stylised diagram apparent on the sign in 'exhibit 9' so that tourists unfamiliar with unsealed surfaces have some comprehension of the meaning of these stylised diagrams.
- I recommend all unsealed roads directed towards a known tourist attraction carry the sorts of stylised depiction of a sliding motor vehicle as exhibit '9'.
- Police fax or deliver cautionary notices to relevant local facilities instead of advice by telephone where practicable. This provides some tangible documentation where there may be staff changes or events become so busy simple messages may be overlooked.

NZ.2010.3090 Water Related/ Youth

A young person drowned when they attempted to swim across a river with a strong current.

Recommendations

[Name] of ECan states that water safety campaigns continue to be promoted and supported especially for young people now that many schools can no longer afford pools. I commend these campaigns but go further and recommend to ECan, the [location] District Council, [location] District Council that they continue by education to the public, to promote the dangers of swimming specifically in this part of the [location] River and the importance of taking notice of the advisory signs.

As the hot weather approaches and people want to swim outdoors, the [location] River can look flat and calm and very inviting, when in fact it is very dangerous. I ask The Press, to whom I will send a copy of this Finding, to publicise this- that the [location] is not a safe swimming river, especially by its bridges and that people should not ignore the signs advising not to swim there.

NZ.2011.1999 Water Related/ Leisure Activity/ Older Person/ Transport & Traffic Related

An elderly person drowned after falling from their yacht whilst sailing. The deceased was unable to deploy their life jacket due to a malfunction of the CO_2 inflation canister.

Recommendations

I recommend that Maritime New Zealand (MNZ), to whom a copy of this Finding is, of course, being circulated, continue with its efforts to ensure that the wearing of appropriate Personal Floatation Devices (PFDs) by all of those involved in activities on the water is made compulsory.

I recommend that a copy of this Finding be forwarded to Survitec, which company will, I hope, send it to RFD (manufacturers). I hope that all will cooperate with an education programme, both nationally and internationally, to draw the dangers with the failure in the CO_2 cylinder, this inquiry has discovered, to public attention.

NZ.2012.1255 & 2453 Water Related/ Leisure Activity/ Transport & Traffic Related

Two fishermen died from hypothermia due to cold water immersion after their boat was struck by a wave and overturned.

Recommendations

- I recommend that a copy of this Finding be forwarded to Maritime New Zealand (MNZ). I agree with [name] that the reason the three surviving passengers are still alive is directly attributable to the insistence by [name] that lifejackets be worn. All too often a Coroner will draw to the attention of MNZ the need for the wearing of lifejackets to be made compulsory occurs in respect of drowning where lifejackets are not worn. The fact that the use of lifejackets, in these circumstances, saved lives, adds weight to the call for MNZ to continue to press for the wearing of life jackets on small boats to be made mandatory.
- MNZ have programmes stating 'water and alcohol don't mix'. To this programme should be added an education programme warning those on boats not to smoke cannabis. The effects of cannabis can decrease survivability in cold water.
- MNZ is to be commended for its education programmes relating to communication and I recommend that these be continued.
- The 'safety feature' extracts in the Maritime New Zealand publications:
    - ◊ 'If you need help, can you call for it'
    - ◊ 'Distress beacons save lives'
    - ◊ 'Are you ready?'

  are appropriate and deserve wider publication.

NZ.2012.1571 Water Related

A swimmer at a beach became caught in a rip and drowned.

Recommendations

The recommendations of Surf Life Saving New Zealand, as set out above are endorsed by the Court. In particular, it recommends to the Chief Executive Officer of the [location] City Council that a sign be erected as soon as possible at the northern and southern ends of [location] beach warning the public of the presence and dangers of the rips.

WA.2009.1545 Water Related/ Transport & Traffic Related

A person drowned following the sinking of a Suspected Illegal Entry Vessel (SIEV).

Recommendations

I recommend that WA Police, other state police forces, the Australian Federal Police, Australian Maritime Safety Authority (AMSA) and all organisations and agencies involved in responding to 000 distress calls work together with a view to identifying mechanisms for accessing a high quality pool of interpreters to assist with foreign language distress calls. Ideally procedures should be in place to enable early identification of foreign languages being used with speedy ability to patch in interpreters capable of interpreting a wide range of languages while 000 distress calls are ongoing.

NSW.2009.5634 Weather Related/ Work Related

A person died from complications of hyperthermia after working in very high temperatures as a roofing insulator.

Recommendations

- I recommend that the WorkCover Autority of NSW ('the WorkCover Authority') consider undertaking publicity campaigns from time to time directed to industry bodies, industry training organisations, businesses and individuals emphasising the risks of heat stress and heat stroke, and the importance of regular consumption of water instead of, or in addition to, any other drinks, as a primary means of preventing heat stress or heat stroke. The publicity materials should include specific reference to the danger of hydrating solely with soft drinks and caffeinated drinks.
- I recommend that the Australian Construction Training Service (ACTS) consider conducting random audits of registered trainers and training organisations using its materials for certificate courses to assess that training is being delivered appropriately and effectively.
- I recommend that the ACTS consider requiring registered trainers and training organisations to certify that courses they conduct have included a practical component and assessment in accordance with an appropriate standard set by the ACTS. The trainers and training organisations ought be required to describe the activities or competencies and method of assessment applied.
- I recommend that the ACTS consider requiring that, in respect of individual participants in their courses, registered trainers and training organisations certify they have either passed or not passed the practical component and assessment.
- I recommend that the ACTS amend its insulation industry training materials to include a specific reference to the topic of heat exhaustion and heat stroke and the need for regular hydration with water. The materials should include specific reference to the danger of hydrating with soft drinks and caffeinated drinks.
- I recommend that the ACTS consider having its insulation industry materials reviewed by a specialist adult educationist to ensure that they meet 'best practice' educational standards and consider modifying the course design in accordance with the findings of such a specialist.
- I recommend that ComSec Global Training PTY LTD ('ComSec') modify its insulation industry training materials to include a specific reference to the topic of heat exhaustion and heat stroke and the need for regular hydration with water. The materials should include specific reference to the danger of hydrating with soft drinks and caffeinated drinks.
- I recommend that Standards Australia consider amending the Australian Standard AS3999-1992 to include a reference to managing hot conditions.
- I recommend to the Commonwealth Minister for Finance that guidelines for Australian Government programs include a standard reference to the requirement for compliance with State and Federal occupational health and safety legislation in so far as they are relevant to particular programs.

WA.2011.129 Weather Related/ Geographic/ Work Related/ Transport & Traffic Related

A truck driver died as a result of exertional heat stroke whilst searching for assistance in a remote area after their truck became bogged.

Recommendations

- I recommend that [company] and [company] review their systems relating to the way they ensure that drivers are provided with potable water. This should be done with a view to improving the ways drivers are provided with drinking water when travelling to areas outside the metropolitan area.
- I recommend that [company] and [company] ensure that all drivers are provided with a route specific 'emergency breakdown card', including site specific emergency information such as, but not limited to, instructions about what to do or not to do in an emergency, what channels of the UHF could be used and whether they are monitored, who to call and what numbers to call in the event of an emergency. Instructions about locating and using any satellite phones, PLB, or GPS should also be set out on the card.
- I recommend that [company] considers ensuring that drivers travelling to areas outside the metropolitan area, especially to mine sites, are provided with a personal locator beacon (PLB) which provide an encoded GPS location (such as a SPOT device), together with written instructions on how to use it.
- I recommend that [company] reviews its current systems with a view to ensuring that all drivers travelling out of the metropolitan area, especially those travelling to any mine site, are provided with a personal locator beacon (PLB) which provides an encoded GPS location (Such as a SPOT device), and instructions as to its use. Consideration should be given to incorporating this requirement into its contractual arrangements with sub-contractors to ensure that no driver travelling out of the metropolitan area and/or mine site can leave a depot without one.
- I recommend that [company] and [company] put in place systems whereby all drivers travelling out of the metropolitan area, especially to mine sites, are provided with written directions and maps which clearly explain how to get to the expected destination. This should be done whether or not a driver asks.
- I recommend that [company] and [company] audit their procedures to ascertain the whereabouts of late running truck drivers, with a view to ensuring that account is kept of each driver's expected time of arrival so that emergency services can be notified in a timely way should no one be able to contact the driver.
- I recommend that the definition of 'remote' as currently applied by [company] be broadened to take into account communication difficulties experienced outside the metropolitan area. Drivers should be able to initiate assistance whenever required, wherever they are.

NZ.2011.2065 Work Related/ Transport & Traffic Related

A person died when the bulk fertiliser spreader they were driving overturned, crushing the deceased.

Recommendations

I recommend that a copy of this Finding be forwarded to the Department of Labour and to the New Zealand Ground-spread Fertiliser Association (NZGFA) to promote ongoing cooperation in the creation of further safety enhancements. I ask the industry and the Department of Labour work together to clarify the benefits of operators using safety belts and investigating methods to ensure that restraints are more 'user friendly' for operator/drivers in difficult situations. The New Zealand Ground Spread Association should also investigate the provision, in the vehicles of its members, of an emergency call and tracking system which are not dependent upon cell phone or radio coverage or the continuing consciousness of an operator/driver who may have been disabled in a rollover.

The NZGFA and the Department of Labour should give consideration to establishing a protocol between customers, contractors and employees, ensuring the fact that employees are not pressured to complete spreading tasks beyond safe parameters.

NZ.2011.2086 Work Related

A bushman died after he was struck by a tree that fell due to a gust of wind.

Recommendations

I recommend that a copy of this Finding be forwarded to the Department of Labour (ministry of Business, Innovation and Employment) and to the Forestry Industry Association in order that the lessons learned from the tragic death of the deceased not be lost.

NZ.2012.409 Work Related

A forestry worker died after a pile of logs moved and they were crushed between two logs.

Recommendations

To: Harvesting contractors, forestry owners, principals and cable harvesting employers

- That cable harvesting contractors use mechanical grapples as the preferred method of log extraction;

To: Forestry Industry Training and Education Council, Ministry of Business, Innovation and Employment- Labour

- Immediate consideration be given to including in both the Best Practice Guidelines and the Approved Code of Practice for Safety and Health in Forest Operations a recommendation that mechanical grapples be used;
- Immediate consideration be given to including in both the Best Practice Guidelines and the Approved code of Practice for Safety and Health in Forest Operations for Breaking Out, recommendations for extraction, location and height restrictions of bunched logs.

NZ.2012.1202 Work Related/ Transport & Traffic Related/ Older Person

An elderly farmer sustained a fatal head injury when they lost control of their vehicle whilst driving on a farm track.

Recommendations

I recommend that a copy of this Finding be forwarded to Federated Farmers and to New Zealand Transport Authority (NZTA). Federated Farmers should circulate the advice to its members. Even in a 'on farm' situation where the wearing of seat belts may not be legally compulsory, the use of a seat belt is still recommended and can save a driver or passenger from serious injury, or death, in certain circumstances. It needs to be drawn to public attention, by NZTA and by Federated Farmers, that in some vehicles at least, air bags fitted to the vehicle will only deploy if a seat belt is fastened.

WA.2008.1794 Work Related

A crew member sustained fatal head injuries whilst attempting to disconnect the ship from an import hose attached to a Catenary Anchor Legal Mooring (CALM) buoy.

Recommendations

I recommend that [organisation] consider the use of some form of visual recording of a disconnection from the import hose and CALM buoy as part of its induction, training and familiarisation programs for crew.

NSW.2011.2094 Youth

A young person died from complications of anaphylaxis after consuming a cookie that contained walnuts. The cookie was made by a classmate during a class at school.

NSW.2011.2094 continued

Recommendations

To the Minister for Education NSW-

- That the Department communicate to secondary students and their parents that students are actively encouraged, where known to suffer asthma and/or allergies, to carry on their persons their own Ventolin and/or auto-injections, in addition to those held by the school.
- That the Department consult immediately with the Anaphylactic Education Program Governance Group (including the Ministry of Health, Australasian Society of Clinical immunology and Allergy (ASCIA), Allergy & Anaphylaxis Australia, the Catholic Education Commission and the Association of Independent Schools) to explore the further need for improvements in the ongoing management of students at risk from anaphylaxis or asthma. In particular-
    - ◊ To improve the quality and provision of training face to face of teachers and other staff by anaphylaxis course educators
    - ◊ To improve the anaphylaxis action plans displayed in schools
    - ◊ To make clearer on auto-injections the instructions for use
- That the Department consider restricting as far as possible the availability of nuts on school premises and elimination of the use of nuts in school cooking classes.

NZ.2012.1811 Youth/ Transport & Traffic Related

A young person died when they were struck by a train. The deceased was distracted by their mobile phone and did not hear the oncoming train as it approached the unfenced area which was surrounded by trees.

Recommendations

I recommend that Kiwi Rail consider measures that can be practically implemented to make this area of the rail system safer for pedestrians. This could be done by either fencing off this section of the track, or by reducing or removing the trees bordering the track to improve visibility for both train drivers and pedestrians. In addition, the company may wish to review the applicable speed limit for trains travelling on this particular section of track.

NZ.2012.2126 Youth/ Misadventure/ Leisure Activity

A young person died from immersion hypothermia after they were pushed by a current in between two rocks at the top of a waterfall.

Recommendations

- I recommend that a copy of this Finding be forwarded to the Department of Conservation with a request that the Department review signage for the [name] Gorge to emphasise the extreme hazard presented by the steep and slippery rocks and by the swift cold water. Consideration should be given to erecting a sign of appropriate design and colouration at the point in the gorge where the swimming area ends and the waterfalls begin.
- I recommend that a copy of this Finding be forwarded to the Commissioner of Police to ensure that the courage of Police personnel involved in the rescue of the deceased be recognised.
- I recommend that a copy of this Finding be forwarded to the Royal Humane Society to arrange for recognition of the courage of rescuers in recovering the deceased from a most difficult and dangerous predicament.

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