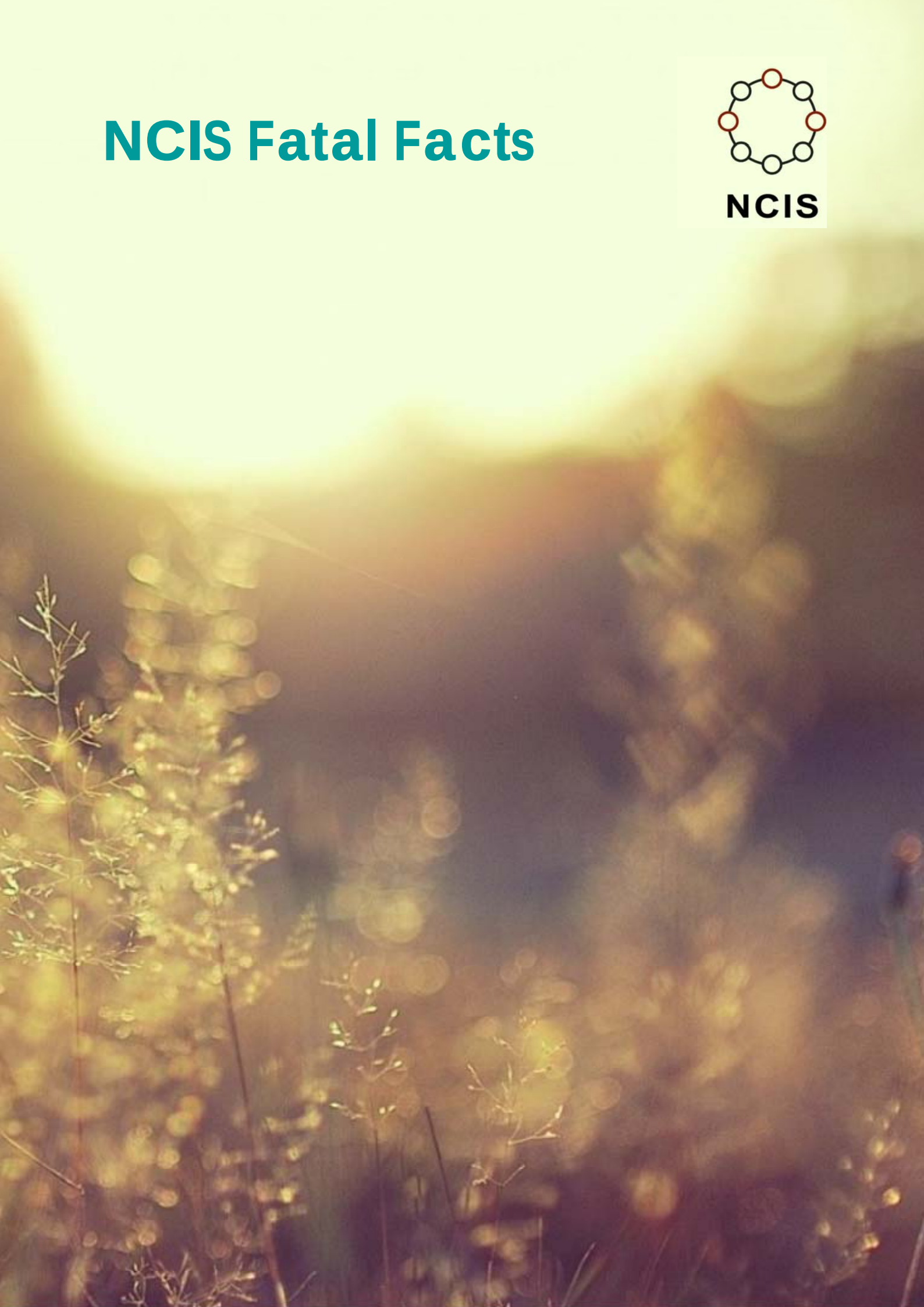
NCIS Fatal Facts



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 1 May 2007 and 31 December 2012. The NCIS have populated the tool with all past issues of *Fatal Facts* as well as including all recent issues and cases.

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

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

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.

NCIS Fatal Facts

NCIS

Edition 36 June 2018

In this Edition

Fatal Facts Edition 36 includes cases where the coronial investigation is complete and where the Coronial Finding contains recommendations. Edition 36 includes cases that were closed between 1 January and 31 March 2013. *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 36 contains summaries of 78 cases where recommendations were made as part of the formal coronial finding. Of these cases, 40 are Australian cases and 38 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.2008.3281 Adverse Medical Effects/ Child & Infant Death

The deceased was a male child who died following dental surgery. Shortly after the procedure, the deceased developed hypoxia as a result of airway obstruction following anaesthesia and could not be resuscitated.

Recommendations

I recommend to the Commissioner, Health Care Complaints Commission:

- That the anaesthetic care provided by [doctor] to [deceased] at the [hospital] on [date of death] be reviewed so as to determine whether or not the Commission should take any action as a consequence thereof.

NZ.2012.1157 Adverse Medical Effects/ Older Persons

The deceased was an older adult male who passed away following major heart surgery.

Recommendations

- A copy of this Finding be forwarded to [district] Health Board in order not only that clinicians at [district] Health Board learn from the lessons created by the death of [the deceased] but also that [district] Health Board take a role in disseminating the Finding to ensure that the complication identified during the procedure is drawn to the attention of the appropriate clinicians so that the circumstances do not occur again.

TAS.2010.52 Adverse Medical Effects

The deceased was an adult female who died due to sepsis as a consequence of a gastric banding procedure. The Coroner found that the deceased's medical practitioner contributed to the cause of death by failing to identify the sepsis at an earlier stage.

Recommendations

On this subject [the deceased]'s family has made some helpful suggestions. They are set out in a letter and are in these terms:

- The [location] Private Hospital is to have in place a system which ensures:
  - ◊ The treating surgeon or if for any reason he or she is unavailable another suitable surgeon see his or her patient who presents at the Hospital following surgery with apparent complications as soon as practicable;
  - ◊ Doctors who visit their patients in the hospital record details of the visit in the patient's medical notes;
  - ◊ That nursing staff are adequately trained and experienced to recognise signs or symptoms indicating a patient's deteriorating condition;
  - ◊ That those patients receive immediate medical attention either by the treating doctor or, if he or she is unavailable, by another suitable medical practitioner;
  - ◊ That the nursing handover take place at the patient's bedside and details of it be recorded in the patient's notes;
  - ◊ The vital signs of a patient be taken and recorded shortly prior to his or her discharge;
  - ◊ A patient not be discharged without first seeing his or her treating doctor or if for any reason he or she is unavailable another suitable doctor unless the patient signs an appropriate waiver form;
  - ◊ The treating nurse fully appraise the treating doctor prior to discharge of the current health status of the patient including his or her current vital signs and that this process be documented in the patient's notes at the time.

TAS.2010.52 continued.

- I adopt and support the standards for care set out in the family's letter. However, it is not enough to prescribe standards and for them to be incorporated in a hospital's policy documentation. More critical is to ensure that those persons to whom the policies apply are familiar with their content and comply with it. It is my recommendation that the [hospital] takes steps to ensure that this occurs and that it regularly audits compliance by its own staff and those other health professionals including surgeons who utilise their facilities.

WA.2008.654 Adverse Medical Effects

The deceased was a middle aged adult female who died from complications of elective bariatric surgery. Following the procedure, the deceased became increasingly unwell and opportunities to provide effective treatment to the deceased were missed by medical staff.

Recommendations

- Communication about abnormal vital signs:
  - ◊ In the event that vital signs of a patient are significantly outside the normal range, the nurse taking the observations should be required to advise the senior nurse of the shift of those changes.
  - ◊ At the time of the next handover information about any significantly outside the normal range vital signs detected during the shift should be communicated to the next nursing shift; and
  - ◊ There should be an entry in the Integrated Progress Notes relating to those vital signs indicating why it was considered that the vital signs were out of range, whether they were improving or getting worse and what action was being taken in respect of those signs.
  - ◊ When observations record vital signs outside the normal range, the next observations should be taken within a short period of time, not left until the next routine observations are required.
- I Recommend that [hospital, location] put in place a system of audits to ensure that when MET calling criteria are met, MET calls are in fact being instigated and appropriate action is being taken.

WA.2010.1551 Adverse Medical Effects

The deceased was a middle aged adult female who died following complications of a coronary angiogram. Following the procedure, the deceased was discharged from hospital and later presented to her general practitioner with worsening symptoms. The deceased was not referred to hospital and her condition continued to deteriorate until she passed away.

Recommendations

- All private and public hospitals at which angiograms are performed provide patients with a discharge summary which would preferably contain a diagram of the body on which the extent of any haematoma could be marked and which would provide reliable information as to the extent of any bleeding, pain levels and medications at the time of discharge.
- Any such discharge summary given to a patient should encourage the patient to retain that document and take it to any doctor seen in the event of complications, such as ongoing bleeding.
- The discharge summary provided to the patient should also be provided electronically, or otherwise as quickly as practicable, to the patient's general practitioner.

NZ.2010.2908 Aged Care/ Older Persons

The deceased was an older adult female who died when they choked on food whilst eating at their aged care facility.

Recommendations

- I recommend to the [company] that it reviews the contents of its soft diet in the light of [the deceased]'s death.

VIC.2010.1284 Aged Care/ Falls/ Adverse Medical Effects/ Older Persons

The deceased was an older adult male who suffered a fall with head injury whilst in their nursing home, and died soon after. The deceased was taking Warfarin at the time of the incident.

Recommendations

- That [company] add to their head injury post fall management checklist, 'for INR [international normalization ratio] review', when the resident is on anticoagulation medication.
- That [company] have available both observation charts and neurological charts for staff to record their post fall findings and to put in place protocols to ensure the findings are recorded.
- For residents on anticoagulation, [company] to put in place a mechanism for reporting falls and/or a resident's change of medication regime, to the INR pathology service in order that consideration can be given to rescheduling testing.
- That [company] gives consideration to developing a means by which an alert is raised if a resident's INR testing routine is not followed, or appears to fall outside the established pattern.

NZ.2012.1439 Aged Care/ Older Persons

The deceased was an older adult male who suffered from Alzheimer's disease, and choked on food when left unsupervised by their caregiver for a brief period. There was a delay in the commencement of resuscitation attempts.

Recommendations

- Whilst I received no evidence to the effect that it was unreasonable for [the deceased] to have been left alone whilst eating, I draw to the attention of the [organisation] and to all other Rest Home operators and carers, the dangers of leaving a frail elderly patient, with compromised health, eating a food item which have the potential to choke.
- I draw to the attention of the [organisation] the need for it to continue to monitor, and upgrade as necessary, the emergency call systems operating at [location].
- A protocol must be established by [organisation] to ensure that patients in distress are attended by suitably qualified nursing staff more immediately than was the case with [the deceased].
- I recommend that [organisation] conduct a more intensive training regime for its caregivers. Those looking after vulnerable elderly and frail patients must be instructed on immediate steps to take should such patients require assistance. Training should be given in techniques to clear mouth and throat of food obstructions, how to affect a Heimlich manoeuvre and how to commence CPR resuscitation pending the arrival or other support and more experienced nursing staff.

NZ.2010.2995 Child & Infant Death/ Transport & Traffic Related

The deceased was a female child who died after being struck by a vehicle being reversed down the driveway.

Recommendations

- A key message from Safekids and the Child & Youth Mortality Review Committee (CYMRC), which I endorse, is that public education/awareness strategies regarding driveway safety should be increased and directed both to the public and to the decision makers.
- In December 2011 the Child and Youth Mortality Review Committee published a paper entitled "Low Speed Run Over Mortality". It stated that recent Auckland based research has found Housing New Zealand to be the landlord in a disproportionately high percentage of properties where drive way run over injuries occurred. The CYMRC has therefore recommended that Housing New Zealand modify over time all of its current stock so that driveways are separated and children have safe play areas, and that it should also ensure that all new developments are constructed so that driveways are separated and children have safe play areas. I endorse this recommendation.
- I also recommend to the Chief Executive of Housing New Zealand Corporation that, noting the particular circumstances of this case, Housing New Zealand gives consideration to erecting fences to ensure that the driveway at [the address] (and at other similarly configured HNZ properties) is separated from the steps to the front door and the grassed area beside the driveway.

NSW.2011.4835 Drugs & Alcohol/ Intentional Self-Harm/ Mental Illness & Health

The deceased was an adult female who suffered from mental illness and died by suicide. The cause of death was cyanide poisoning.

Recommendations

To the NSW Minister for Health:

- That the Act and Regulation be reviewed either to require supplies of schedule 7 drugs and poisons to inform the Department of any supply or order of those drugs or in any other way to ensure close checking of both supplies and purchases of schedule 7 drugs and poisons upon order and prior to supply.
- That the Minister consider all efforts to expedite finalization of the review intending to create national standards for the selling and purchasing of dangerous chemicals and poisons.

NZ.2010.2781 Drugs & Alcohol/ Natural Cause Death

The deceased was an adult female who died spontaneously of natural causes after an ongoing period of consuming excessive amounts of caffeinated soft drink.

Recommendations

- I will arrange for a copy of this Finding to be sent to the Ministry of Health. Whilst [company] have complied with all present regulatory obligations insofar as the manufacture and labelling of its product is concerned, I request that the Ministry of Health, in consultation with the Institute of Environmental Science & Research and other appropriate experts, consider whether, in light of the evidence given to the Inquest Hearing, that the warning labels on carbonated beverages give sufficient protection to consumers. The hazards to the health of the consumers of excessive quantities of sugar and caffeine contained in carbonated beverages could be more clearly emphasised.

NZ.2010.2781 continued.

- It is noted that the caffeine content for "formulated caffeine beverages" defined as those containing 145 milligrams/L or more (Standard 2.6.4), is regulated. Consideration could be given by The Ministry of Health to either the lowering of the caffeine percentage limit or creating a more specific warning such as those printed on cans containing "formulated caffeine beverages," produced and marketed by [company]. The Ministry of Health may also consider it appropriate to review standard 2.6.4 to reduce the caffeine content threshold to enable more specific advice to consumers to be given.
- I recommend that [company] give consideration to the inclusion of advice as to the quantity of caffeine on the labels to its products and of the adding to the labels appropriate warnings related to the dangers of consuming excessive quantities of the products.
- I am advised that the Legislative and Governance Forum on food regulations is considering further action on labelling. I recommend that a copy of this Finding be forwarded to this organisation.
- This Finding was issued on a provisional basis because I said that I would adopt this course of action in closing the Inquest hearing.
- The issue of a provisional Finding is a method, adopted by Coroners, to address the obligations imposed on a Coroner when making 'adverse comment' (s 58 of the Act).

NZ.2011.2541 Drugs & Alcohol

The deceased was a middle aged male who died due to an accidental overdose of recreational drugs.

Recommendations

- I recommend that a copy of this Finding be forwarded to the Centre for Adverse Medicine Reactions (CARM) for the information of that organisation.
- I recommend that the media, to which a copy of this Finding is to be forwarded, give publicity to the fact that drugs designed to be used for recreational purposes rather than medical purposes are not manufactured to any legal, or enforceable, quality or quantity standard and that the drugs themselves may be contaminated. The quantity of the active ingredient of the drug may not be able to be predicted from the amount of the drug ingested. The public must be warned to consume only drugs prescribed for them by appropriately qualified medical practitioners and to take these drugs solely as directed in the prescription.

NZ.2012.1259 Drugs & Alcohol

The deceased was a middle aged female who died after accidentally ingesting a fatal quantity of codeine in conjunction with other prescription drugs and alcohol.

Recommendations

- I recommend that a copy of this Finding be forwarded to the Ministry of Health in order that the Ministry consider an enhancement to existing publicity programmes drawing to public attention the dangers of taking prescribed drugs in quantities which exceed those specified in the prescription and of mixing prescribed drugs and of taking prescribed drugs, which have a central nervous system depressant effect, in conjunction with alcohol which has a similar effect.

NZ.2012.767 Drugs & Alcohol

The deceased was a middle aged female who died of an accidental overdose of prescription medication.

Recommendations

- The media give publicity to the dangers associated with the taking of drugs in excess of the prescribed quantities. A copy of this Finding has been forwarded to CARM [Centre for Adverse Reactions Monitoring] to add to its database.

NOTE: The Tasmanian Coroner held a joint inquest into the following three deaths, which resulted from the same incident. The recommendations made for all cases are listed after the third case.

TAS.2012.94 Drugs & Alcohol/ Location

The deceased was an adult male who died of accidental carbon monoxide poisoning while sleeping in a caravan in which a portable gas-operated refrigerator was in operation. The caravan had been refurbished and did not have adequate ventilation.

TAS.2012.96 Drugs & Alcohol/ Location

The deceased was an adult male who died of accidental carbon monoxide poisoning while sleeping in a caravan in which a portable gas-operated refrigerator was in operation. The caravan had been refurbished and did not have adequate ventilation.

TAS.2012.98 Drugs & Alcohol/ Location

The deceased was a middle aged male who died of accidental carbon monoxide poisoning while sleeping in a caravan in which a portable gas-operated refrigerator was in operation. The caravan had been refurbished and did not have adequate ventilation.

Recommendations

- This tragedy gives rise to a timely reminder to all do-it-yourself builders or renovators (not limited to caravans) to properly follow all legislative requirements including necessary safety standards and guidelines. To do so will limit as much as possible dangers to those persons or others who may come into contact with the items being built or renovated.
- That all persons use appropriately qualified gas fitters and these gas fitters comply with all relevant legislation and guidelines to prevent such incidents occurring in the future.
- […The] SCER [Standing Council on Energy and Resources] found that […increasing] public awareness of the situations in which those riskier appliances may cause CO poisoning. It decided that State and Territory governments would examine their existing public awareness initiatives for carbon monoxide poisoning and identify opportunities for improvement. The Director of Gas Safety, Tasmania has endorsed the recommendation.

  […] In light of this triple fatality I adopt and endorse the recommendation of the Director of Gas Safety, Tasmania to expand the scope of any "public awareness" campaign to include portable gas appliances and warnings to users of gas in confined spaces to ensure that gas appliances are safe, properly installed and maintained. I go further and recommend this be done urgently together with urgent consideration in Tasmania of the mandatory installation of CO detection alarms in any residences, boats or caravans where gas appliances are either permanently fixed or where portable gas appliances might likely be used.

TAS.2012.94, TAS.2012.96 & TAS.2012.98 continued.

- That consideration is given to empowering regular inspection of caravans or boat gas installations to ensure safety of occupants and to monitor appropriate installation and maintenance of gas appliances and the appropriate ventilation thereof.
- The Director of Gas Safety, Tasmania alert insurance companies involved in providing protection for licensed gas fitters and the owners of caravans or boats about the risks associated with non-compliance with relevant regulations and Australian Standards surrounding the installation or use of gas appliances in those environments.
- The Director of Gas Safety, Tasmania alert any plumbing apprentice courses and TAFE and Polytechnic courses required for the registration of gas fitters, to include reference to and testing about the requirement to check for flue operation and appropriate ventilation operation when performing routine maintenance on gas appliances in caravans or boats; to give warnings to owners and to notify the Director of Gas Safety and the Registrar of Motor Vehicles when the unit does not comply with current regulations and standards.

TAS.2011.136 Drugs & Alcohol/ Mental Illness & Health

The deceased was an adult female who suffered from mental illness and unintentionally overdosed on medication.

Recommendations

- Lithium has been widely studied as a treatment for bipolar disorder and its efficacy as a treatment is strong however I recommend that medical practitioners, through major prescribers, be provided guidelines for the monitoring of lithium dosing, its side effects and its interaction with other drugs and lifestyles.

WA.2009.162 Drugs & Alcohol/ Misadventure/ Youth

The deceased was a young adult female who died after consuming a fatal amount of recreational drugs whilst at a large public event. In compliance with standard law and regulation, the medical services available at the event did not include tertiary qualified practitioners (paramedics, nurses or doctors), but only volunteer first-aiders.

Recommendations

- The Director General of Health consider revising the current Guidelines for Concerts, Events and Organised Gatherings 2009, so that organisers of future similar large-scale public events are required to provide the standard of medical care achieved at the [event].
- The Director General of Health consider creating a definition of 'paramedic' and that he considers a form of registration that will ensure that only appropriately qualified people are entitled to use the title of paramedic and to be able to practise in Western Australia as a paramedic.

NZ.2011.2594 Drugs & Alcohol/ Falls

The deceased was an adult female who fell in her home while intoxicated and sustained a fatal head injury.

Recommendations

To the Health Promotion Agency:

- 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.2012.430 Falls/ Drugs & Alcohol/ Physical Health/ Mental Illness and Health

The deceased was a middle aged male who died as a result of a fall in his home while affected by alcohol. The deceased had recently been discharged from mental health treatment a few months earlier.

Recommendations

I Recommend to the DHB [District Health Board] and to others that:

- A protocol be developed, therein at the onset of treatment, or at the first reasonable opportunity thereafter a patient's consent is obtained – if at all possible – to the sharing of information with specified family members. Unless later revoked – and my thinking is that this would be a rarity – that would enable the DHB to properly inform nominated family members of significant events. I realise that not all patients would give authority – some would be very much opposed to doing so. However, I strongly suspect that such consent would be available more often than not. This seems to be an obvious and very simple process to put into effect that would overcome the "privacy dilemma" in most cases. I hope that this DHB and others will seriously consider my recommendation and attempt to implement it.

VIC.2011.580 Falls/ Physical Health

The deceased was a middle aged female who sustained fatal injuries in a fall at home.

Recommendations

- The Royal Australian College of General Practioners further promote the use of the existing Medicare items in providing falls prevention plans for patients at risk of falls and if barriers currently exist which limit the uptake of these items to consult with the Commonwealth Department of Health and Aging to determine how these barriers may be overcome.
- A copy of the finding be distributed to the Australian Competition and Consumer Commission to inform their product safety surveillance system and to assist them in their regulation of consumer products in Australia.

NZ.2012.2228 Fire Related/ Adverse Medical Effects

The deceased was a middle aged male who sustained fatal injuries when their supplementary oxygen supply caught alight when they attempted to ignite a cigarette.

Recommendations

- I recommend that a copy of this Finding be forwarded to the New Zealand Fire Service for its information. There is an obvious lesson to be drawn to public attention.
- I recommend that a copy of this finding be forwarded to [district health board]. I have made no criticism of [district health board] and merely enlist their support in drawing to the attention of all respiratory physicians and support staff the serious consequences created for patients by their smoking whilst using the supplemental oxygen.

NZ.2012.1359 Fire Related/ Drugs & Alcohol

The deceased was an adult female who died in house fire while heavily intoxicated. The smoke alarms installed within the property had been disabled when the batteries were removed.

Recommendations

- I endorse the concerns expressed by [National Manager of Fire Investigation and Arson Reduction] of the Fire Service with regard to the removal of batteries from smoke alarms in Housing Corporation properties. I consider that the recommendation contained in his statement is worthy of being repeated in the hope that some action will be taken to prevent further deaths occurring in similar circumstances.
- I recommend that Housing New Zealand Corporation ensure that properties owned by them and used for residential purposes be fitted with hardwired interconnected smoke alarms.

WA.2010.181 Geographic/ Indigenous/ Natural Cause Death/ Physical Health/ Older Persons

The deceased was an Indigenous older male who died of natural causes whilst stranded in a remote location. The deceased had been suffering from ill health and ventured alone into a remote area, where he became stranded and subsequently succumbed to illness.

Recommendations

- Any telephone call requiring police action be logged in the occurrence book. Recording information with contact details on a piece of paper alone is not effective communication.
- The occurrence book needs to be used to effectively note details relevant to handover and be positioned where it is accessible to provide continuity of information through shift changes.
- Once there is a concern a person has not been sighted by a time an appropriately informed person believes is critical the police officer/staff member to whom the concern is expressed record relevant information by asking appropriate questions to ensure the circumstances of the failure to appear are appreciated. That information will always be relevant to identification issues.
- Where a police officer is aware of an incident which may relate to a missing person the police officer take an appropriate missing person report, regardless of the incident. The information can always be used to exclude an identity if it does not relate to the incident in question, and also serves to ensure an appropriate assessment of the circumstances of the missing person.

WA.2011.636 Geographic/ Leisure Activity/ Older Persons

The deceased was an older male who is presumed dead after they went missing in a remote location when hiking.

Recommendations

- The Department of Environment and Conservation should consider providing information on its website and in its brochure relating to the [location] to address specifically the hazards associated with the use of the [location] and to advise persons who wish to use that walk how to obtain more detailed information.

NSW.2005.1288 Homicide & Assault

The deceased was an adult male who died due to injuries sustained as a result of being shot by an unknown person(s).

Recommendations

To the Commissioner of Police, I recommend:

- That the investigation of the death of [deceased] be referred to the Unsolved Homicide Unit of the NSW Homicide Squad for further investigation in accordance with the protocols and procedures of that unit.

NSW.2005.1291 Homicide & Assault/ Youth

The deceased was a young adult male who died due to injuries sustained as a result of being shot by an unknown person(s).

Recommendations

To the Commissioner of Police, I recommend:

- That the investigation of the death of [deceased] be referred to the Unsolved Homicide Unit of the NSW Homicide Squad for further investigation in accordance with the protocols and procedures of that unit.

NSW.2010.4207 Law Enforcement

The deceased was an adult male who was involved in a physical altercation at a public event. During the altercation, the deceased was restrained on the ground by police. Shortly after, the deceased was found to be unresponsive and was unable to be revived.

Recommendations

To the Commissioner of Police:

- That training provided to OSG [Operation Support Group], and other officers involved in crowd control situations, be reviewed to ensure that the risks of restraining a person in the prone position, with or without weight, particularly where the person is obese, as well as the need for careful and constant monitoring of such persons, is given appropriate emphasis and if necessary be amended to ensure that this is the case.
- That OSG teams be led by officers who have received appropriate leadership training emphasising the importance of communication and the co-ordination of an approach in crowd control situations.
- That OSG officer's receive training as to co-ordination and communication so as to ensure that appropriate procedures are adopted particularly in crowd control situations.

WA.2011.50 Law Enforcement/ Indigenous/ Natural Cause Death/ Physical Health

The deceased was a middle aged Indigenous male who died of natural causes whilst in police custody. The deceased's medical records did not reflect any health problems related to his sudden death.

Recommendations

- A reference to previous admissions to ascertain whether there are likely welfare needs, such as routine medications, which need to be addressed.
- There be follow-up when circumstances have changed, or the detainee has settled, to re-address the issue of specific current concerns, especially where a detainee has made a vague reference to being a 'sick man'.
- There is a clear indication at shift handover as to the specific reason for a detainee's high risk status, and a request a lack of information be followed-up with the detainee if no welfare information has been provided for that admission.

NSW.2011.595 Law Enforcement/ Transport & Traffic Related

The deceased was a middle aged female who died whilst driving a motor vehicle that collided with a police vehicle. At the time of the incident, the police vehicle entered the intersection from the wrong direction causing a collision with the deceased's vehicle.

Recommendations

To the Minister for Transport, I recommend strongly that:

- Roads and Maritime Service accept the recommendation of the [location] Council that stop signs replace give way at the intersection of [location] and implement as quickly as possible.

TAS.2010.446 Law Enforcement / Youth/ Natural Cause Death

The deceased was a young adult male in custody at the time of his death. Despite being unwell in the period preceding his death, prison staff had not referred the deceased for medical treatment. The Coroner ruled the cause of the death to be most likely of natural origin.

Recommendations

- Two investigations were undertaken at the instigation of the Department of Health and Human Services following [the deceased]'s death. One was Clinical Assessment of the [prison] Current Policy and protocols of Health Issues dated […] which is (Exhibit […]). The other was a Confidential Serious Incident Investigation Review – [prison] Death of a Youth in Custody which is Exhibit […]. The materials relied on in that report are in (Exhibit […]). The reports, and the material relied on to compile them, form part of the evidence in this inquest.
    - ◊ Those reports make a number of recommendations. Steps have been taken to implement some of the recommendations. Some have been substantially implemented and others have not yet been implemented at all.
    - ◊ I consider they are all appropriate and can be adopted as recommendations of this inquest to the extent they have not yet been fully implemented.
    - ◊ There is one further matter about the implementation of the new arrangements for dealing with residents who are unwell which warrants comment and recommendation. It is important that the judgment as to health matters which an unqualified staff member has to exercise is kept to a minimum. The memoranda in [exhibit] and the new Standard Operating Procedure […], if complied with, will achieve an appropriate result in that regard.

TAS.2010.446 continued.

- […] There is a risk that if senior staff do not appreciate the importance of adopting and following the new procedures, other staff may adopt the same attitude. I therefore recommend appropriate training and other steps to ensure rigorous compliance with the requirement to obtain medical review of residents who complain of being, or who appear to be, unwell should be undertaken.
- In addition it is desirable that all matters relevant to the health of a resident be recorded in a way that ensures they are available for the staff responsible for the care ad supervision of residents and for medical personnel reviewing a resident. […]
- I therefore recommend consideration be given to implementing a practice of exchanging such information, at least where there is no legally binding obligation of confidentiality, good medical reason or other appropriate reason to maintain the confidentiality.
- […] The evidence also suggested that it may have been convenient for staff to have access to a portable phone in the course of the 000 call on [date]. I therefore recommend consideration be given to providing such phones if appropriate.
- I previously observed that observation of the residents in their rooms was made difficult by the damage to the material through which the observations are to be made. I therefore recommend investigation be made into an improved manner to check on a resident either by using a different material in the viewing panel or removal of the panel, leaving an opening which could be covered by a sliding panel.

  Finally the evidence demonstrated that steps had been taken to ensure that staff comply with the observation policies. That is done by a review of the CCTV now installed in the Centre and checking it against the observation sheets. Some occasions of non-compliance have been discovered. Nonetheless the audit procedure does not appear to be particularly rigorous. I therefore recommend a review of the audit procedure be undertaken and any other appropriate steps be taken to ensure compliance with the observation policies.

NOTE: The New Zealand Coroner held a joint inquest into the following two deaths, which resulted from the same incident. The recommendations made for both cases are listed after the second case.

NZ.2009.3973 Law Enforcement/ Homicide & Assault/ Work Related/ Weapon

The deceased was a middle aged male and police officer. He was fatally shot by an armed assailant during a search for illicit substances at the assailant's property.

NZ.2009.3960 Law Enforcement/ Intentional Self-Harm/ Weapon

The deceased was a middle aged male who died due to a self-inflicted gunshot wound. At the time of the incident, the deceased's property was under police siege.

Recommendations

I recommend that a copy of this Finding be forwarded to the Commissioner of Police and to the Minister of Police with a request:

- That the Arms Act be reviewed.
  - ◊ I have had drawn to my attention the decision of Mallon J in Lincoln v Police. The evidence I received at the Inquest hearing and this decision identify deficiencies in the legislation and in the enforcement of it. The policy of tracking MSSA's and confirming the type of firearm that is a MSSA must be looked at again. The Thorpe Report may have to be revisited. At present the Arms Act is only complied with by honest people.

NZ.2009.3973 & NZ.2009.3960 continued.

- That the roll-out of Police digital radios be expedited. Now that appropriate technology exists our Police ought never to be put in the situation of hesitating to use an unsecure channel.
- That the programme of review and simplification of Police "General Instructions" [GI] ought to receive prompt attention. No serving Police Officer can be expected to have instant recall to each, and every, GI.
- That procedures for the execution of all Search Warrants by the Police be upgraded to ensure that:
  - ◊ All supervisors are aware of Warrants being executed by their staff
  - ◊ Adequate numbers of Police Officers attend the execution of Search Warrants.
  - ◊ There are improved tools and equipment available to staff and that appropriate training in risk assessment and other tasks is given.
  - ◊ There is a continuing monitoring of staff in their use of personal protection equipment.

NSW.2012.841 Law Enforcement/ Intentional Self-Harm/ Transport & Traffic Related

The deceased was a middle aged male who died when they intentionally caused a motor vehicle collision whilst being pursued by police.

Recommendations

To the Commissioner of the NSW Police Force:

- That the relevant protocols, policies and training be reviewed so as to include a direction to police officers that where:
  - ◊ A police officer becomes aware that a person has attempted self-harm; or
  - ◊ A police officer conducts a "concern for welfare" check in relation to a threat of self-harm by a person, a warning is required to be placed on the COPS system.

TAS.2010.250 Law Enforcement/ Natural Cause Death

An adult male died of natural causes whilst in prison. The prison was not aware of the deceased's full medical history.

Recommendations

- The Tasmanian Faculty of The Royal Australian College of General Practitioners liaise with the prison's medical staff with a view to putting in place processes to better ensure that its members' patient records for prisoners are made promptly available to authorised personnel at the prison upon request.

NZ.2010.2747 Mental Illness & Health/ Intentional Self-Harm

The deceased was a middle aged female who suffered from mental illness and died from self-inflicted wounds.

Recommendations

To the Chief Executive Officer, [mental health unit]:

NZ.2010.2747 continued.

- That upon the discharge of a patient from [mental health unit], especially patients who remain the subject of a community treatment order, the terms and conditions of such discharge, the nature and extent of any risks to which the patient remains subject, the early warning signs and all necessary interventions (including monitoring) shall be documented in the Multi-Disciplinary Team Plan AND a copy of such plan shall be given to the family members/whanau/caregivers or friends into whose care the patient is discharged.

NZ.2011.2562 Mental Illness & Health/ Intentional Self-Harm/ Youth

The deceased was a young adult female who died by suicide. Prior to her death, the deceased had a heated exchange with a family member and had written pre-prepared notes to family members.

Recommendations

I recommend to the Ministry of Health:

- That it provides strong advice to the public about the sorts of behaviours, gestures and comments by children and young people that could indicate they might kill themselves.
- That this advice includes launching an advertising campaign through News Media that shows parents ways to respond to such behaviours, comments and gestures.

NZ.2010.3160 Mental Illness & Health/ Intentional SelfHarm

The deceased was a middle aged female who suffered from mental illness and died by suicide.

Recommendations

Recommendations to the [district] Health Board:

- That a review be undertaken to support the report of [doctor], in that the multiple layers of service delivery as it applies to mental health patients be undertaken to eliminate possible delays with patient care and to provide a simple pathway for the patient and their families to deal with.
- To ensure that in cases such as indicative bipolar affective disorder the face-to-face clinical assessment be completed by a specialist psychiatrist or psychiatry registrar in a first instance.

NZ.2010.2994 Mental Illness & Health/ Intentional Self-Harm/ Drugs & Alcohol

The deceased was an adult male who had a history of drug use, mental illness and self-harm, and was under the care of multiple health services. The deceased died by suicide.

Recommendations

To [mental health liaison team] and to [district] Health Board:

- That [mental health liaison team] and to [district] Health Board read this Finding and consider whether they need to review their current communication arrangements about their mutual clients in the light of it.

NZ.2010.2613 Mental Illness & Health/ Intentional Self-Harm

The deceased was an adult male who suffered from mental illness and died by suicide. In the weeks prior to his death, the deceased had had contact with police services regarding an urgent mental health crisis. A communication error meant that this incident was not reported to his personal mental health services.

Recommendations

- The [location] District Health Board's Mental Health Service give consideration to implementing a system which ensures that the sender of a facsimile requiring any follow-up action in relation to clinical care, checks that such facsimile has been received by the intended recipient. This may also encourage verbal dialogue regarding the acute event, and any actions required.
- The computerised 'red flagging' of patients who may have been seen after hours is a sensible back-up system to ensure that follow-up actions are undertaken. In this respect I recommend that the Service given consideration to formalising that system; for example, by ensuring that acute, crisis services consistently 'red flag' in all appropriate cases, and that clinicians be encouraged to log into the caseload screen (where the red flags would appear) on a consistent, daily basis.

QLD.2010.389 Mental Illness & Health/ Intentional Self-Harm/ Youth

The deceased was a young adult male who died by suicide whilst under an Involuntary Treatment Order (ITO). The deceased was an inpatient in a psychiatric facility on a strict observation regime when he absconded from the facility and took his own life.

Recommendations

It is therefore recommended that [location] Mental Health Services:

- Communicate with the Chief Psychiatrist in relation to the current policy for missing consumers (unauthorised absence) seeking advice as to whether this policy should be altered (anticipating that any change to the current policy may be linked to a review of the *Mental Health Act 2000*). In the meantime [health service] is to undertake a review of its current procedures in relation to implementing this policy with particular reference to strategies to assist in the management of repeat absconders, the management of the no smoking procedures within the service and the current escalation processes.
- Conduct a three month trial of the provision of a leave book or register to be signed by each patient who is leaving the ward to ascertain whether any such changes modify patient behaviour and the capacity of staff to monitor and support the missing persons procedure.
- Undertake a review into possible technological aides which could be used to assist staff in managing repeat absconders in an open ward environment (that is, providing some form of intermediate supervision between AOA [Acute Observation Area]/constant observations and an open ward environment).
- Continue the clinical transformation process which is committed to the development and implementation of strategies to identify and manage the deteriorating patient with respect to their mental and physical health. I note that this process is well advanced and it is expected that a report will be provided to [health service] in early 2013. I welcome the offer of being provided a copy of the report and regular advice as to its implementation and training of staff.
- It is noted that [health service] is awaiting the implementation of a journey board system providing online details with respect to a patient's admission status, expected date of discharge, Mental Health Act status and frequency of visual observations. Pending implementation the Director of Nursing will be requested to utilise a photographic identification process for patients with the requirement that this be connected to the handover sheet for each nurse, which document is also to include leave entitlements.

QLD.2010.389 continued.

- Ensure any scheduled MHRT [Mental Health Review Tribunal] reviews are entered on the current whiteboard system and ultimately on the proposed journey board.
- Review the practicality of providing reception staff with a copy of the visual observation photo board so they are aware of which patients can or cannot leave the ward.
- Ensure there are specific individual behavioural management plans for excessive alcohol and drug use by those patients, who cannot be discharged. Such individual plans may include the clinical team Implementing a structured program of searches, regular breathalysing, and limiting the patient's access to money (where there is a legal entitlement to do so). […]
- Queensland Health is conducting in 2013 a review of the Mental Health Mortality Report. During that process Queensland Health, as well as [health service] should review the practical and legal implications for the inclusion of written statements from medical and nursing staff caring for the patient at the time of the death (to assist the RCA [Root Cause Analysis] process and any subsequent investigations such as a coronial inquest).

Stage 2 Queensland Plan for Mental Health 2007 – 2017

- It is recommended the Queensland Government progress Stage 2 of the Mental Health Plan to provide a Medium Secure Unit for [location] Mental Health Services; […]

[Company] Car park

- It is recommended [company] install appropriate barriers to the [car park] in attempt to prevent future suicides from the car park.
- A copy of these findings will be provided to the chief executive of Workplace Health and Safety Queensland pursuant to section 48(2)(b) by way of information in which I reasonably suspect a person has committed an offence.

VIC.2007.3357 Mental Illness & Health

The person was a middle aged male with a history of mental illness who died by drowning. The investigating Coroner was unable to determine the intent of the deceased. In the months prior to his death, the deceased had lost contact with mental health services and ceased taking his medications.

Recommendations

- That the President of the Mental Health Review Board review the way in which they obtain information relevant to mental health patients' involuntary status to ensure that they have adequate evidence on which to make a determination.
- That the Royal Australian and New Zealand College of General Practitioners encourage its members who administer regular depot antipsychotic medication to maintain active communication with their patients' mental health treating team, particularly when they fail to keep appointments.
- That the Office of Housing review the criteria for provision of public housing to mentally ill people who, despite having adequate income, are unlikely to obtain long-term, private, rental accommodation because of their illness and circumstances.

NOTE: The Victorian Coroner held a joint inquest into the following two deaths, which resulted from similar incidents. The recommendations made for both cases are listed after the second case.

VIC.2007.1467 Mental Illness & Health/ Location

The deceased was an adult male who suffered from mental illness and died whilst being restrained by hospital staff.

VIC.2007.4273 Mental Illness & Health/ Location

The deceased was an adult male who suffered from mental illness and died following a period of physical restraint by hospital security.

Recommendations

- That the current review of the Mental Health Act considers the inclusion of regulation, which endorses the following seven principles for safe physical restraint, with a view to reducing the possibility that death or serious injury may result from psychiatric patient restraint.

General approach to psychiatric patient restraint

◊ Physical restraint is only to be employed after a consideration of all available options and as a last resort, to prevent immediate harm to the patient or others.

Training

◊ Approved physical restraint techniques should not include the putting of any pressure at all on the trunk of the patient's body; that is the taking of a patient to the floor in a prone position, or the pressing of his or her abdomen from above, while a patient is on the floor.

◊ All staff members who could potentially be involved in restraining a patient, including clinical staff, security staff and patient services assistants, should be trained insofar as is practicable together, by Hospital contracted personnel (in approved restraint techniques).

◊ All such staff training to include specific direction concerning the dangers of positional asphyxia during physical restraint, how to recognise the condition and what to do if a patient appears to be succumbing to the condition, or to any related condition or syndrome.

Management

◊ Aggression management in an inpatient unit is a clinical issue, and as such, a senior clinical staff member should always lead any physical restraint

◊ While a patient is being physically restrained, a clinical staff member must be and remain present to manage the staff engaged in the restraint, while also monitoring the patient's breathing and general well being, this for the duration of the physical restraint.

◊ As per principle 2 above, an approved physical restraint should not involve the taking of the patient to the floor, unless such a course is unavoidable. In the event that it is determined prior to the restraint, that a patient must be taken to the floor, or where a patient is unintentionally forced to the floor during restraint, this should only be permitted to continue for the minimum amount of time required to achieve restraint, and concurrently, only while the patient's respiratory condition remains uncompromised. Determination of these matters, both before and during restraint, is the exclusive responsibility and is to remain at all times under the control and direction of the senior clinician present.

- Following a review of all relevant practise and having regard to existing contractual obligations, a practise guideline should also issue from the Office of the Chief Psychiatrist, which guideline should broadly direct the adoption of a single manner of physical restraint guideline, for the consideration of respective hospitals and their training managers.
- Of those now in place at [location] and [location] Hospitals and those additionally reviewed below in Attachment 1 [not available here], it appears to this Coroner that the MOVAIT Techniques Manual, deserves particular consideration.

TAS.2011.203 Natural Cause Death

The deceased was an adult female who died following a seizure. In the months prior to her death, the deceased presented to hospital following a similar incident but a diagnosis was not made.

Recommendations

[Professor] has suggested these recommendations be made:

- That the [hospital] formulate guidelines for the evaluation of syncope for use in its Emergency Department.
- That the reporting of radiological investigations where the abnormality may be an artefact should indicate an abnormality is present (that is that the scan is not normal) but that the abnormality may be an artefact.

I support both of these recommendations.

TAS.2010.388 Natural Cause Death/ Older Persons

The deceased was an older adult female who died at home. On the night of her death, the deceased had been discharged from hospital despite advise from another doctor that she be admitted to the ward.

Recommendations

- In this case a patient was discharged by a medical registrar in the emergency department without reference to or contact with the staff specialist consultant who had recommended admission to a coronary care unit. I would recommend consideration and implementation of a system whereby patients referred by the emergency department to another medical practitioner for admission to hospital should not be discharged without reference to or discussion with the referring practitioner and a consultant.

NSW.2009.6311 Natural Cause Death/ Child & Infant Death

The deceased was a female child who presented multiple times over a period of one to two weeks to various medical services with worsening symptoms. On the day of her death, the deceased was eventually diagnosed and plans were arranged for her to be transferred to another hospital. However, the deceased's condition deteriorated and she suffered a fatal cardiac arrest before the transfer was able to occur.

Recommendations

To the Minister of Health:

- That attention be given to the continuing education of ED and paediatric staff on the recognition of the critically unwell child.
- Maintenance of APLS [Advanced Paediatric Life Support] skills and certification for senior ED and paediatric staff, broadening this to include senior nursing staff where possible.
- Incorporation of paediatric MET-type guidelines in non-paediatric hospital EDs to ensure prompt senior review of critically unwell children.
- Enhanced familiarity with intraosseous devices for vascular access, e.g. EZ-10 device.
- Improved standards of documentation for communication by paediatric registrars with on-call consultants.
- Direct documentation by consultant paediatricians in the file notes of critically ill children.
- Involvement of on-call anaesthetic staff in the management of critically ill children.
- Stipulation of review times for critically ill children and improved documentation of plans in the event of treatment failure.

NOTE: The New Zealand Coroner held a joint inquest into the following two deaths, which resulted from the same incident. The recommendations made for both cases are listed after the second case.

NZ.2009.3968 Sports Related

The deceased was an adult male who sustained fatal injuries during a hang gliding incident in which they were a passenger.

NZ.2009.3969 Sports Related/ Work Related

The deceased was an adult male who sustained fatal injuries during a hang gliding incident in which they were the pilot.

Recommendations

- A copy of this Finding be forwarded to:
  - ◊ The Director, Civil Aviation Authority, [address];
  - ◊ The Minister of Transport, with my request that Part 115 be finalised at the earliest possible date;
  - ◊ The NZHGPA [New Zealand Hang Gliding and Paragliding Association] for the information of the Association.

I endorse the safety actions in CAA Report 09/923; that consideration be given to the inclusion of the following items as part of Part 115:

- Fitment of a means of accurately measuring air speed of commercial tandem hang gliders;
- A requirement for commercial operators to have a means of accurately weighing passengers to ensure maximum hook-in weights are not exceeded;
- Carriage of reserve parachutes in all tandem flights;
- Definition of minimum requirements for parachutes;
- Training of pilots in use of emergency equipment;
- Annual competency tests on commercial tandem hang glider pilots;
- Annual auditing of commercial operations.

I similarly endorse the recommendations in the report of [professional skydiver]:

- Pilots are reminded of their responsibility to operate their glider within manufacturers' recommendations;
- NZHGP A to include information on the meaning and importance of flying within stated limits into their Operations and Training Manual. Particular emphasis to be given to tandem pilots. Pilots need to have an understanding of VNE (Velocity Never Exceed) and VA (Design manoeuvring speed);
- Reserve parachutes for tandem use must be of a suitable size and design to carry the entire load of pilot, passenger, harness and hand glider;
- NZHGPA adopt and acceptable international standard for tandem reserves and harnesses;
- Accurate weight measurement for pilots and passengers

NSW.2012.1397 Transport & Traffic Related/ Older Persons

The deceased was an older male who was struck by a motor vehicle when attempting to cross a road at a point without a pedestrian crossing.

Recommendations

To the General Manager, [local council]:

- Having considered all the evidence with respect to the death of [the deceased], the number of accidents at this location together with the location of [a shopping centre] and local schools, serious consideration be given to installing a pedestrian crossing in or about the location ([location address]) to prevent further pedestrian accidents on this stretch of road.

NOTE: The Northern Territory Coroner held a joint inquest into the following two deaths which resulted from the same incident. The recommendations made for both cases are listed after the second case.

NT.2012.80 Transport & Traffic Related/ Law Enforcement/ Drugs & Alcohol

The deceased was an adult female who died in a motor vehicle incident. At the time of the incident, the vehicle was being pursued by police and the driver was intoxicated.

NT.2012.81 Transport & Traffic Related/ Law Enforcement/ Drugs & Alcohol

The deceased was an adult male who died when the vehicle he was driving crashed whilst being pursued by police. The driver was intoxicated at the time of the incident.

Recommendations

I recommend that timely consideration be given to:

- Providing police with new tools of investigation which would assist them to follow up offenders (and offending vehicles) in a safer and more considered fashion "after the event". Some of the possible investigation tools, suggested by Counsel Assisting and supported by Counsel for Police, included:
  - ◊ Automatic number plate recognition cameras and the introduction of in-car data capability,
  - ◊ The use of emergent video technology in police cars such as "Go-Pro", and
  - ◊ The exploration of technologies which permit the remote disabling of vehicles.
- Introducing expanded vehicle seizure and impounding laws, as has been done in Victoria, for vehicles that:
  - ◊ Fail to stop or which are used to evade police, or
  - ◊ Have attached registration plates belonging to another vehicle.
- Introducing tougher penalties for offenders who:
  - ◊ Speed or drive recklessly or dangerously when evading police (see for examples, section 51B *Crimes Act* NSW and section 319AA *Crimes Act* 1958 Vic), or
  - ◊ Fail to stop.

NOTE: The New Zealand Coroner held a joint inquest into the following two deaths, which resulted from the same incident. The recommendations made for both cases are listed after the second case.

NZ.2012.1554 Transport & Traffic Related

The deceased was an adult male who died in a motor vehicle incident in which he was the driver of the vehicle. At the time of the incident, the deceased was an international tourist in New Zealand on a working visa and driver fatigue was considered to be a contributing factor.

NZ.2012.2110 Transport & Traffic Related

The deceased was an adult female who died in a motor vehicle incident. The driver of the vehicle was an international tourist in New Zealand on a working visa and driver fatigue was considered to be a contributing factor.

NZ.2012.1554 & NZ.2012.2110 continued.

Recommendations

- It is noted that, at the time of the crash, the area of the intersection of [state highway] and [state highway] was the subject of a 100-kilometre-per-hour speed limit. Since the crash, a temporary speed limit of 80 kilometres per hour was instituted. It is my recommendation that NZTA [New Zealand Transport Agency], to whom a copy of this Finding is to be forwarded, again review the speed limit to ensure that appropriate safe speed limits for the intersection is continued.
- NZTA have, again since the crash, created safety enhancements for the site. An upgrade, including the acquisition by NZTA of land from adjoining owners to open up visibility, is noted and commended.
- I observe that the intersection is in an area of [location] which is frequently travelled by visitors to New Zealand who may not always be alert to the hazards created by others who may approach intersections at high speeds. Such drivers may not always be familiar with the signage provided at intersections in New Zealand. NZTA are requested to continue monitoring the crash site to ensure that the safety enhancements remain appropriate.

NT.2011.198 Transport & Traffic Related/ Water Related/ Location

The deceased was a middle aged female who drowned in a motor vehicle incident. The evidence suggests that the deceased attempted to cross a river at a designated crossing when her car was swept away and was submerged.

Recommendations

- That the Minister for Local Government conduct or commission a review on the safety of the river crossings at [location], including consideration of effective strategies to ensure the safety of motorists using that road area during the wet season.

NZ.2012.1151 Transport & Traffic Related

The deceased was an older male who died when the bicycle he was riding was struck by a car. The deceased was wearing a high visibility vest at the time of the incident.

Recommendations

- That a copy of this Finding be forwarded to New Zealand Transport Authority. Although the wearing of a high visibility vest by [the deceased] did not result in the collision being avoided, in my view it is always appropriate for those riding cycles on roads carrying other vehicular traffic to do all that they can to ensure they make themselves visible to other road users.

NZ.2008.4234 Transport & Traffic Related/ Work Related

The deceased was a middle aged male who was cycling in heavy traffic and entering a roundabout when he was struck by the trailer unit of a truck travelling in the same direction. At the time of the incident, the deceased was wearing reflective stripes on his clothing and backpack and his bicycle lights were operating.

NZ.2008.4234 continued.

Recommendations

To the Honourable Minister of Transport. The following recommendations are made with respect to the road user rules applicable to cyclists:

- That just in the same manner that it is compulsory for a cyclist to wear a safety helmet when cycling on public roads, all cyclists (with the exception of those partaking in a controlled event, such as a road race) should wear high-vis clothing.
- That the road user rules (road code) include that where a motor vehicle is passing a cyclist that a 1 metre gap be provided between the cyclist and the vehicle.
- That an enhanced cyclist education (primary schools) and driver licence education with respect to cyclists be incorporated to a high degree.
- That the rules as they apply with respect to cycle lanes be clarified, making it compulsory for cyclists to utilise those lanes where they are in existence and to clearly determine where cyclists can intermingle with motorised vehicles.

To the Chief Executive, [location]:

- That a complete review of the cycle/traffic lanes be undertaken at the [location] so as to provide an adequate separation between cyclists and other forms of traffic utilising that area. It is clear that while attempts have been made to provide a separate cycleway, the quality and limited connectedness fails to meet a level that cyclists are likely to use.

NZ.2012.1375 Transport & Traffic Related/ Animal/ Older Persons/ Work Related

The deceased was an older adult female who suffered fatal injuries when their vehicle struck a cow on a country road at night. Police investigations revealed that the cow had escaped from a nearby farm with inadequate fencing.

Recommendations

- The SCU report concludes that a contributing factor to the crash which ultimately resulted in [the deceased's] death was the escape of the cow from a farm at night through a fence that was probably inadequate. This highlights the need for all landowners with property adjoining roads to ensure that their boundary fences comply with the requirements of the Fencing Act 1978.
- I recommend that [organisation] and all other organisations involved in promoting good farming practices or road safety continue to remind landowners whose properties border state highways that they must construct and maintain adequate boundary fences along those highways.
- I recommend that the NZTA [New Zealand Transport Agency] consider entering into an agreement with [district] in relation to the monitoring of fencing along the major highways running through the [district], as provided for under the NZTA State Highway Control Manual SM012.

These comments and recommendations are directed to the Chief Executive Officers of the New Zealand Transport Agency and the [district] Council.

- This crash also highlights the danger to motorists of travelling at night on country roads with headlights on low-beam. I trust that the lesson learned from this crash by all motorists is that they should utilise the full power of their headlights at all times when travelling at provided that doing so will not adversely affect other drivers.

NZ.2012.1728 Transport & Traffic Related/ Drugs & Alcohol

The deceased was an adult male who died when the vehicle they were driving collided with a pole. Driver intoxication and lack of street lighting in the crash area were found to be contributory factors.

Recommendations

- [Police officer] recommends that reflective roadside marker posts be installed on the outside of the relevant bend. I agree with that recommendation as such markers will indicate the bend for drivers approaching [state highway] at night along [road] and may reduce the changes of the occurrence of other deaths in similar circumstances to that of [the deceased].

NZ.2012.1040 Transport & Traffic Related/ Work Related/ Older Persons

The deceased was an older adult male who died when the vehicle they were driving collided with a power pole. At the time of the incident, the deceased was working as a courier. The Coroner found that driver fatigue may have been a contributing factor.

Recommendations

- I recommend that a copy of this Finding be forwarded to New Zealand Transport Authority and to the Police in order that the issues identified relating to driving hours be re-appraised.

NOTE: The New Zealand Coroner held a joint inquest into the following three deaths which resulted from the same incident. The recommendations made for all cases are listed after the third case.

NZ.2012.1299 Transport & Traffic Related/ Drugs & Alcohol/ Youth

The deceased was a young adult male who died when the vehicle he was driving lost control and collided with a tree. The deceased was intoxicated at the time of the incident.

NZ.2012.1518 Transport & Traffic Related/ Drugs & Alcohol/ Youth

The deceased was a young adult male who died when the vehicle he was travelling in lost control and collided with a tree. The driver of the vehicle was intoxicated at the time of the incident.

NZ.2012.1855 Transport & Traffic Related/ Drugs & Alcohol/ Youth

The deceased was a young adult male who died when the vehicle he was travelling in lost control and collided with a tree. The driver of the vehicle was intoxicated at the time of the incident.

Recommendations

- That all relevant agencies continue their efforts to educate young people of the dangers of driving while under the influence of alcohol and while sleep deprived, and to impress upon them the tragic consequences that can flow from breaking the law.
- That the [district council], or the relevant roading authority responsible for the site where the crash occurred, remove the mature gum tree that the vehicle crashed into, as soon as possible. Alternatively, that the Council erect a barrier around the tree that would deflect a vehicle which struck it rather than allow a front-on impact.

NOTE: The Queensland Coroner held a joint inquest into the following two deaths which resulted from similar incidents. The recommendations made for both cases are listed after the second case.

QLD.2010.4080 Transport & Traffic Related/ Law Enforcement/ Work Related

The deceased was an adult male who died when his motorcycle impacted with the trailer of a prime-mover travelling in the opposite direction. The deceased was a police officer and was escorting an oversize load along a highway at the time of the incident .

QLD.2011.1796 Transport & Traffic Related/ Work Related

The deceased was an older adult male who died when the vehicle he was driving impacted with an oversize load being transported by a prime-mover. The logistics of the transporting prime-mover, including dimensions and lighting of the oversize load, were found to adhere to current guidelines.

Recommendations

- In view of the risk to other road users and the damage done to the road network by oversize loads, I recommend that permits not be granted to carry such loads if other forms of transport are available.
- To ensure permits are not granted for the carriage of excess dimension loads that could in fact be made smaller and therefore safer; I recommend the Heavy Vehicle Road Operations Program Office (HVROPO) review the basis on which it accepts loads are indivisible.
- In view of the obvious dangers of transporting loads that protrude into adjacent lanes on single lane highways in the dark, I recommend that the practice generally be limited to the metropolitan areas and dual lane carriageways.
- I am of the view that the reduced visibility of motorcycles and the increased risk of death or serious injury to the rider should a crash occur make them unsuitable for use as wide load escorts. Accordingly, I recommend that the HVROPO review their continued use.
- In view of the dangers inherent in moving some over sized loads and the increasing frequency with which this will be happening in many parts of Queensland in coming years, it is essential the activity is well managed. The evidence to this inquest indicates there is substantial room for improvements. The National Heavy Vehicle Regulator is the appropriate body to consider how this could best be achieved. Accordingly, I recommend it has regard to the evidence put before this inquest when developing regulations or guidelines for the management of wide loads by escorts.
- I recommend that wording on wide load warning signs be reviewed to ensure they more effectively communicate to other road users the size of the load and what is required of them.
- I recommend that in conjunction with the development of more useful and communicative signs, a public awareness campaign be undertaken to explain the new regime of signs to motorists and make them aware of their obligations when confronted by a wide load.

NOTE: The VIC Coroner held a joint inquest into the following three deaths which resulted from the same incident. The recommendations made for all cases are listed after the third case.

VIC.2007.1118 Transport & Traffic Related/ Fire Related/ Work Related

The deceased was a middle aged male who died in a motor vehicle incident and subsequent fire within a major city tunnel. The incident occurred when a heavy vehicle failed to avoid a broken-down vehicle that was stopped within the tunnel and subsequently collided with three other vehicles, causing the deaths of each of the other drivers.

VIC.2007.1119 Transport & Traffic Related/ Fire Related/ Work Related

The deceased was an adult male who died in a motor vehicle incident and subsequent fire within a major city tunnel. The incident occurred when a heavy vehicle failed to avoid a broken-down vehicle that was stopped within the tunnel and subsequently collided with three other vehicles, causing the deaths of each of the other drivers.

VIC.2007.1120 Transport & Traffic Related/ Fire Related/ Work Related

The deceased was an adult male who died in a motor vehicle incident and subsequent fire within a major city tunnel. The incident occurred when a heavy vehicle failed to avoid a broken-down vehicle that was stopped within the tunnel and subsequently collided with three other vehicles, causing the deaths of each of the other drivers.

Recommendations

- That VicRoads consider including in the next reprint of the New Drivers Handbook more advice and information about safety in tunnels, especially with regard to safe distances, lane changing, driver distraction, special dangers in tunnels, emergency behaviour, self rescue and emergency response.
- That VicRoads reconsider and request AustRoads to re-consider its position on banning lane changing in all future road tunnels to minimise the possibility of collisions as a result of lane changing in tunnels.
- That VicRoads ensure that it maintain regular promotion and delivery of public safe driving in tunnels campaigns including the importance of keeping a safe distance in tunnels.
- That VicRoads ensure that at the design approval stage of all new tunnels, (i) promotion of consistency of vehicle speed is incorporated into the design and (ii) the proposed plan of operation of the tunnel promotes consistency of vehicle speed.
- That VicRoads ensure that as far as is possible, approval for the construction of future road tunnels requires a design that incorporates an emergency lay-by or equivalent for stranded or disabled vehicles inside the tunnel.
- That VicRoads ensure that in the design, construction, operation and management of road tunnels that the risks inherent in underground intersections both from diverging and converging traffic flows be actively managed.
- That VicRoads ensure that in the design and construction of road tunnels the number of horizontal curves be minimised and/ or engineered so as to maximise the sight distances available to motorists.
- That VicRoads request AustRoads to consider incorporating into its current Guide to Road Tunnels the best and most up to date information as to the design of road tunnels to assist drivers to maintain safe speeds and vehicle separation.
- That VicRoads ensure that in the design of approved road tunnels, emphasis be placed on the design of emergency egress pathways to ensure that evacuees are assisted to make appropriate choices for emergency escape routes.
- That VicRoads ensure that in the design, construction and operation of tunnels the placement of driver information signs is done to ensure minimising the risk of driver distraction and maximising driver safety.
- That CityLink in conjunction with all other relevant agencies regularly assess the CityLink emergency control computer systems to ensure that in emergency conditions, all emergency systems and operators are able to command the emergency in a safe, effective and timely manner.
- That CityLink and MFB [Melbourne Fire Brigade] (i) review the deluge system generally to ensure it is operating at its maximum in terms of speed and efficiency and (ii) develop an agreed plan to investigate and respond to the impact on hydrant pressure and volume, of three or more deluge zones operating simultaneously, to assist in preparing response plans for multiple incident (multiple deluge) events.
- That CityLink and VicRoads review the current directions as to messages to be broadcast in the event of an emergency in the Tunnel to ensure clear and simple directions are given to minimise confusion and maximise safe and orderly evacuation.

VIC.2007.1118, VIC.2007.1119 & VIC.2007.1120 continued.

- That MFB satisfy itself, in consultation with the other relevant entities that all relevant emergency communications systems operating inside the [location] have addressed the issues raised by the Dix report at 14.2.12.

NOTE: The New Zealand Coroner held a joint inquest into the following three deaths, which resulted from the same incident. The recommendations made for all cases are listed after the third case.

NZ.2010.2802 Water Related/ Work Related

The deceased was an adult male who drowned when the international vessel they were aboard sank in New Zealand waters. The deceased was a foreign national working as a sailor on the vessel at the time of the incident.

NZ.2010.3167 Water Related/ Work Related

The deceased was an adult male who drowned when the international vessel they were aboard sank in New Zealand waters. The deceased was a foreign national working as a sailor on the vessel at the time of the incident.

NZ.2010.3168 Water Related/ Work Related

The deceased was an adult male who drowned when the international vessel they were aboard sank in New Zealand waters. The deceased was a foreign national working as a sailor on the vessel at the time of the incident.

Recommendations

- A proposed new regulatory framework, known as the Maritime Operator Safety System (MOSS) will require Foreign Charter Vessels (FCVs) to enter the MOSS system before operation in New Zealand, without the two year window available under the SSM system. The MOSS system is expected to deliver a simplified system and strengthen MNZ's regulatory control over FCVs operating in New Zealand.
- A Cabinet decision announced on 22 May 2012, if enacted, appears to substantially adopt and exceed the recommendations of the Ministerial Inquiry and will achieve fundamental change to the operation of foreign fishing vessels in New Zealand's EEZ. It will require reflagging of FCVs operating in New Zealand's EEZ. Only New Zealand registered vessels will be licensed to fish in New Zealand's EEZ. The Fisheries (Foreign Charter Vessels and Other Matters) Amendment Bill currently before parliament would ensure improved management of vessel safety, employment and fisheries management matters for FCVs operating in New Zealand waters.
- The two international instruments specific to fishing are each yet to come into force. They are the 1977 International Convention for the Safety of Fishing Vessels ("the Torremolinos Convention", superseded by the 1993 Torremolinos Protocol) and the 1995 International Convention of Standards of Training, Certification and Watchkeeping for Fishing Vessel Personnel (STCW-F). New Zealand is not a signatory to either convention. Expert witnesses urged that New Zealand becomes signatories to these conventions. Recommendation 11 of the Ministerial Inquiry is to similar effect.

To [name], Minister for Primary Industries:

- That as a matter of priority the Government proceeds in accordance with recommendation 11 of the Ministerial Inquiry relating to the international conventions referred to above and the International Labour Organisation Convention C188-Work in Fishing.

NZ.2010.2802, NZ.2010.3167 & NZ.2010.3168 continued:

To [name], Minister of transport:

- That the proposed new regulatory framework, known as the Maritime Operator Safety System (MOSS):
  - ◊ Requires instructional videos in appropriate languages for crew induction on all safety matters;
  - ◊ Addresses access to, and requirements in certain circumstances to wear, immersion suits;
  - ◊ Addresses the issue of Maritime Safety Inspectors engaging directly with the master and command crew of a vessel on safety matters rather than with, or in addition to, a New Zealand on-shore agent as occurred in this case;
  - ◊ Develops a communication strategy to demonstrate expected standards to the industry in matters such as fire drill, evacuation, man overboard, knowledge of mandatory policies, contact man ashore and roles and responsibilities of individuals.

NZ.2011.2308 Water Related

The deceased was a middle aged male who drowned when his small vessel capsized. The deceased was unable to swim and was not wearing a lifejacket at the time of the incident.

Recommendations

To Maritime New Zealand:

- I recommend that it should be compulsory for all occupants of small boats to wear lifejackets at all times while they are on the water. As to what constitutes a 'small boat', I leave that for the maritime experts to consider.

NZ.2010.3184 Water Related/ Youth

The deceased was a young adult male who drowned after jumping off a cliff into a lake. The incident occurred whilst the deceased was on a group excursion under supervision by a teacher, but the trip had not been authorised or condoned by the school.

Recommendations

- A [council feasibility study] was commissioned, and makes 12 recommendations. It recommends (among other things) placing new signage warning of the dangers, a permanent pool fence along the 6 metre cliff… and further planting to limit the visibility of, and access to the 12 metre cliff by the squash club as well as the 6 metre cliff. It also recommended improving entry and exit points to the lake.
- I accept that the findings and recommendations of the Feasibility Study may reduce the risk of future deaths occurring in similar circumstances. I therefore endorse the findings and recommendations of the Study, and specifically the efforts to restrict access to the 6 and 12 metre 'diving' points. There is inherent risk associated with the diving points - not only for the person jumping or diving, but for anyone who attempts to aid someone in trouble as a consequence of the jump/dive. To exit the lake from these points requires at least a 15 metre swim. In the context of the Council undertaking this work I do not intend to make any further comments or recommendations regarding the lake, though I encourage the Council to audit its implementation of the recommendations.
- I recommend to [the school] that it consider undertaking regular audits of staff compliance with their policies/protocols - particularly of those policies/protocols relevant to the safety of its students.

NZ.2010.3095 Water Related

The deceased was a young adult male and an international student who had recently arrived in New Zealand. The deceased drowned whilst swimming at the beach. Prior to the incident, the deceased had never swam in the ocean.

Recommendations

- On [date] a website was launched by Surf Life Saving www.findabeach.co.nz. I commend this website and the information it contains. I recommend to Surf Life Saving that if it can, it advertises this site for maximum publicity, so that more people become aware they can access it before going to the beach and see the safety messages.

TAS.2012.123 Water Related/ Weather Related

The deceased was an older adult male who drowned when the vessel he was aboard encountered adverse weather conditions. The deceased was not wearing a lifejacket at the time of the incident.

Recommendations

- Although it is not a legal requirement to wear personal floatation devices on vessels the size of the [vessel], this tragic death illustrates the need to do so in adverse weather or other conditions in which persons are at risk of entering the water. I would recommend that all persons involved in recreational boating, no matter what size the vessel is they are using, consider the safety benefit of wearing a personal floatation device, (even a "*yoke style*") in circumstances such as this where they are on deck on the vessel and the movements and actions of the vessel are being impacted by the conditions with the behaviour of the vessel being unpredictable.

NZ.2010.2638 Work Related

The deceased was a middle aged male who died whilst working on a power pole which had been erected with an insecure footing. The deceased sustained fatal injuries when the pole fell from its placement, carrying the deceased who was attached with a safety harness.

Recommendations

- I recommend that specific reference be made by [company] to the future practice of "sign-off" for a project identified in a work instruction sheet "project has been completed, checked for defects and been left a safe condition".
- The "working alone" policy applying at the time of the death of [the deceased] has also been addressed. I recommend that this continue. As I have stated, the policy must go beyond merely having two workers on site, one to give aid or to call for help for another in the event of a mishap. Two minds are better than one. Another worker may have identified the hazard the pole presented when such hazard was not noticed by [the deceased].
- I recommend that [company] adopt "red tag" identification for all suspect poles as I have outlined in my previous comments.
- In addition to the safety sign-off referred to in para 29, [company] must adopt a system whereby 'job sheets' are not created without the instruction specifically identifying hazards which may exist and of which the employee uplifting the 'job sheet' may be unaware.

NZ.2010.2638 continued.

- I recommend that a copy of this Finding be forwarded to the Electrical Engineers Association (EEA) for wider distribution through the electrical supply industry. I ask that all those engineers who have assisted me with my enquiry, as part of their role within the Association, draw the attention of their colleagues to the circumstances of the death of [the deceased] and to the enhancements identified which could, if acted upon, reduce the chances of further deaths in similar circumstances.

VIC.2004.2272 Work Related/ Transport & Traffic Related

The deceased was an adult female who was fatally injured when working as a waste collection driver. Toxicological analysis revealed the presence of cannabis in the deceased's blood.

Recommendations

- [The company] appoint a full-time supervisor to provide greater supervision of waste collection driver/operators performing recyclable waste collection tasks.
- [The company] better educate operational supervisors to increase their awareness of the effect of cannabis on skilled performance and risk and ensure appropriate responses to suspicions that cannabis is an issue in the workplace.
- [The company] continue to fit all their domestic side loader vehicles with a "Maxi brake" that engages if the driver exits the cabin while operating it in left hand drive without engaging the handbrake.
- [The company] ensure that there is an emergency stop button on their domestic side loader vehicles which is accessible from outside the cabin.
- The Government of Victoria amend the definition of "plant" in the Occupational Health & Safety (Plant) Regulations 2007 to ensure that equipment mounted on a vehicle used primarily as a means of transport on a public road is not excluded from the provisions that impose duties on the designers of that equipment.

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