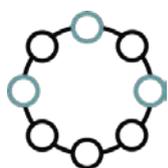




Coronial Recommendations: Fatal Facts

A summary of cases and recommendations made
between 1 April and 30 June 2013

Edition 37



NATIONAL CORONIAL INFORMATION SYSTEM

65 Kavanagh Street, Southbank VIC 3006

+61 3 9684 4442

ncis@ncis.org.au

ncis.org.au

© National Coronial Information System. Reproduction requires written permission from the NCIS.

DISCLAIMER

Released 2019. While every effort is made to ensure information is accurate, the NCIS does not provide any warranty regarding the accuracy, currency and completeness of the information in this publication. The NCIS and the Victorian Department of Justice and Community Safety accept no responsibility for any loss or damage that may arise from any use of or reliance on the data in this report.

ACKNOWLEDGMENTS

The NCIS is funded by all State/Territory Justice Departments, New Zealand Ministry of Health, Commonwealth Department of Health, Commonwealth Department of Infrastructure, Regional Development and Cities, Australian Competition and Consumer Commission, the Australian Institute of Criminology and Safe Work Australia. Coronial data has been provided by each State and Territory Coroner's Office in Australia and New Zealand. Additional codes are provided by the Australian Bureau of Statistics (ABS) and Safe Work Australia. We gratefully acknowledge their support.



Coroners Court
of Victoria



QUEENSLAND
COURTS



CORONIAL SERVICES
OF NEW ZEALAND
Parangō O te Aotearoa



Coroner's Court
of New South Wales



Coroners Court of
Western Australia



MAGISTRATES COURT
OF THE AUSTRALIAN CAPITAL TERRITORY



MAGISTRATES COURT of TASMANIA
CORONIAL DIVISION



NORTHERN TERRITORY OF AUSTRALIA
Office of the Coroner



Courts Administration Authority
of South Australia

CONTENTS

CORONERS' RECOMMENDATIONS	5
AUSTRALIAN CAPITAL TERRITORY	6
Animal	6
NEW SOUTH WALES	7
Adverse Medical Effects	7
Child and infant death	7
Drugs and alcohol	8
Homicide and assault	9
Intentional self-harm	9
Law enforcement	11
Mental illness and health	15
Older persons	16
NORTHERN TERRITORY	17
Homicide and assault	17
Intentional self-harm	17
Transport and traffic related	18
QUEENSLAND	20
Law enforcement	20
TASMANIA	22
Adverse medical effects	22
Natural cause death	22
Sports related	23
Transport and traffic related	24
Water related	25
VICTORIA	27
Child and infant death	27
Drugs and alcohol	28
Intentional self-harm	28
Natural cause death	29
Sports related	30
WESTERN AUSTRALIA	31
Adverse medical effects	31
Intentional self-harm	31

Law enforcement	32
Natural cause death	33
Transport and traffic related	33
Water related	34
Youth	35
APPENDIX A: FATAL FACTS WEB TOOL CATEGORY TAGS	36

CORONERS' RECOMMENDATIONS

A coroner may make recommendations as part of their inquiry into a death.

Recommendations are made to help prevent similar deaths from occurring in the future.

The National Coronial Information System (NCIS) maintains a repository of information on deaths reported to a coroner in Australia and New Zealand. Subject to coronial approval, the NCIS publish summaries of Australian cases in which a coroner has made a recommendation.

Coronial Recommendations: Fatal Facts includes case summaries and recommendations for cases closed between 1 April and 30 June 2013.

Previous summaries and recommendations are available

at: <https://www.ncis.org.au/publications/fatal-facts/>

AUSTRALIAN CAPITAL TERRITORY

ANIMAL

ACT.2012.255

Additional tag(s): Location/ Transport and traffic related/ Older persons

The deceased was an older adult male who was trampled by two horses and an attached stage coach whilst attending a charity event. The horses were spooked when being hitched to the stage coach by their handlers and were unable to be restrained. The deceased was a bystander who was thrown to the ground when he attempted to intercept the horses.

Recommendations:

It is recommended that the Australian Carriage Driving Society Rules in relation to coupling of animals to horse drawn vehicles be adopted at public events. Specifically that all coupling of horses to a coach or carriage should be done with the horses facing and close to an immovable object.

NEW SOUTH WALES

ADVERSE MEDICAL EFFECTS

NSW.2011.3538

The deceased was a middle aged male who died when he failed to regain consciousness after being anaesthetised for surgery. The surgery was performed with the deceased in a seated position.

Recommendations:

To the Minister for Health and the Australian and New Zealand College of Anaesthetists:

I recommend that NSW Health and the College:

- Bring the [hospital] guidelines for anaesthetics in "beach-chair" position surgery to the attention of all anaesthetics departments in NSW hospitals and to all anaesthetists;
- Request or recommend (whichever is more appropriate) that all anaesthetic departments in NSW hospitals develop guidelines for the appropriate adjustment for the hydrostatic gradient by anaesthetists when calculating mean arterial pressure for "beach-chair" surgery.

CHILD AND INFANT DEATH

NSW.2011.3859

The deceased was a female infant who died of unascertained causes. On the balance of probability, the coroner determined that the likely cause of death was accidental overlay.

Recommendations:

To the Minister of Family and Community Services (FACS):

Having heard all the evidence in relation to the death of [the deceased] in particular the drug use of [the parents] that FACS take all necessary steps to ensure the welfare of their current child [name] or any other future children. Such steps to include random drug testing.

NSW.2011.1566

Additional tag(s): Water related/ Indigenous

The deceased was a male infant of aboriginal origin who drowned whilst in the care of a foster family. The deceased's body was discovered in the backyard swimming pool. It is believed he gained access to the pool area through a gate that had been left ajar.

Recommendations:

To the Minister for Family and Community Services and the Office of the Children Guardian:

- That all care agencies be required to create & implement a policy ensuring that all cares are given and accept respite care and support at regular set intervals.
- That action be taken to ensure all care agencies in New South Wales implement policies and procedures requiring;
 - that new foster cares at residences with swimming pools provide a certificate of compliance under the Swimming Pool Act 1992 before being authorised as a carer and;
 - that home visits conducted by providers involve monthly observation of the state of any swimming pool and its safety.

DRUGS AND ALCOHOL

NSW.2012.121

Additional tag(s): Homicide and assault

The deceased was an adult male who died due to a drug overdose of a combination of licit and illicit substances. The coroner was unable to determine the manner in which the drugs were administered to the deceased.

Recommendations:

Refer matter to unsolved homicide to see if any further evidence can be obtained in relation to the manner of his death.

HOMICIDE AND ASSAULT

NSW.2011.4459

Additional tag(s): Youth

The deceased was a young adult female who disappeared some years prior. Her body has never been recovered. The coroner concluded that on the balance of probabilities, the deceased's death occurred at the hands of some unknown third party or parties.

Recommendations:

To The Commissioner of Police:

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

INTENTIONAL SELF-HARM

NSW.2011.3424

Additional tag(s): Law enforcement/ Weapon

The deceased was an adult male who died by suicide whilst in police custody. The deceased shot himself in the rear of a police transport van with a weapon he had concealed. The deceased was not searched by police prior to being placed in the van.

Recommendations:

To the Commissioner of Police:

- I recommend that the NSW Police Force should consider adopting a policy that, pursuant to their power under s 24 of the Law Enforcement (Powers and Responsibilities) Act 2002 police officers should search all persons taken into police custody before placing those persons in police vehicles or transporting them to a place of custody, unless there are sound reasons not to do so.
- I recommend that the Police Force should consider adopting a policy that if, pursuant to s 23 of the *Law Enforcement (Powers and Responsibilities) Act 2002*, arresting police

officers have reasonable grounds to suspect that it would be prudent to search arrested persons, they should do so unless there are sound reasons not to do so.

- I recommend that the Police Commissioner review the policy or practice of police officers securing their firearms before unloading persons in custody from police vehicles at police stations. In particular, I recommend that consideration be given to situations in which police transport persons who have not been searched to police stations or other places of custody. In such cases, I recommend that the Commissioner consider issuing a guideline that one or more officers should, at a safe distance from the vehicle, retain their firearms to provide protection while unsearched prisoners are unloaded.
- I recommend that the NSW Police Education and Training Command consider using this case and the [name] incident as case studies for training officers in appropriate search procedures including the desirability of ascertaining an arrested person's identity and considering COPS warnings if reasonably practicable.
- I recommend that the NSW Police Education and Training Command review its training curriculum in the light of these incidents.
- I recommend that the roll-out of CCTV cameras in NSW Police Force caged vehicles be expedited as fast as resources, funding and competing priorities allow.
- I recommend that in addition to and following the thorough investigation that follows a Critical Incident, I propose that the NSW Police Force conduct a policy and procedure analysis, similar to NSW Health's "Root Cause Analysis" process, to determine whether or not latent systems defects have been revealed by the incident and, if so, what measures ought be taken to rectify them.

To the Attorney-General and Minister for Police:

- I recommend that the *Law Enforcement (Powers and Responsibilities) Act 2002* be amended so as to define with precision the meaning to be given to the phrase "lawful custody" in s 24 of the Act.

NSW.2011.4732

Additional tag(s): Law enforcement/ Weapon

The deceased was a middle aged male who died due to a large incised wound deliberately self-inflicted with the intention of taking his own life. The incident occurred in the presence of police, who used a taser in an effort to stop the deceased from inflicting further injury. Despite their efforts, the deceased passed away at the scene.

Recommendations:

To the Commissioner of Police:

- I recommend that the August 2012 Critical Incident Guidelines (PSO) be amended to suggest that involved officers be asked questions relating to separation of officers and other measures taken to ensure non-contamination of evidence.

LAW ENFORCEMENT

NSW.2011.2158

Additional tag(s): Drugs and alcohol

The deceased was an adult male who died whilst in police custody overnight. The cause of death was undetermined however toxicology results show multiple pharmaceutical substances in the deceased's blood, including methadone. Throughout the night, corrective services officers performed periodic visual inspections of the cell and reported the prisoner to be sleeping on each occasion.

Recommendations:

To the Minister for Police:

- That the Commissioner of Police give consideration to ensuring that all Police Officers undertaking the role of custody managers and or custody assistants be trained in the identification of risks to health of persons in custody who have consumed alcohol, prescription drugs or prohibited drugs.
- That information as to the services available from and the contact details of the clinical forensic unit of the NSW Police be displayed prominently in the custody reception areas of all NSW Police Stations.

To the Minister for Corrective Services:

- Any faults noted by correctional officers in electronic security equipment in a correctional centre are to be immediately reported in writing to the officer in charge of that centre.
- That all correctional officers responsible for the reception into custody of prisoners at the [location] Court Cell Complex located in the [location] Police Centre should have access to all alerts (including those entered by officers of Justice Health) and be required to check those alerts upon receipt of a person into custody.
- That when a death in custody occurs in the [location] Court Cells Complex the officer in charge of that centre should be responsible to ensure that
- All CCTV or other video footage in which the deceased person appears in the 48 hours prior to their death is immediately retained, secured and made available to investigating Police.

- All records available from electronic security equipment such as cell records and "Guard Tower" records relating to the deceased's custody for the 48 hours prior to the death is immediately retained, secured and made available to investigating Police.
- That the Commissioner request Justice Health to consider a 6 month trial of a 24 hour nursing presence at the [location] Court Cell Complex at least on Friday and Saturday nights.

NSW.2010.4938

Additional tag(s): Weapon/ Youth

The deceased was a young adult male who was fatally shot by police during an armed robbery. At the time of the incident, police were undertaking a surveillance operation investigating a series of armed robberies in the area. The Coroner found that the police operation was insufficiently planned and that the officers involved did not adhere to standard police guidelines of containment and negotiation.

Recommendations:

To the Minister and Commissioner of Police:

- That consideration should be given to requiring that the chain of command be clearly stated, with means of communication and officers identified, in all Robbery and Serious Crime Squad operational orders.
- That, as far as is reasonably possible, when different units are combined or work together for the purposes of a high-risk operation or an operation with the potential to become high-risk, the operational planning should involve senior members of each of the units, and the members of all teams should receive a joint briefing before the commencement of the operation.
- That consideration should be given to amending the Robbery and Serious Crime Squad Standard Operating Procedures to include a requirement that operational orders in respect of an operation that may lead to the arrest of a person of interest include operational orders:
 - setting out contingency planning;
 - requiring an assessment of resources and consideration of what additional resources may be required and/or accessed should the operation move to an arrest phase;
 - setting out certain predetermined actions that may be appropriate should the operation move to an arrest phase;
 - setting out as guiding principles, to be departed from only if necessary in the particular circumstances,;

- that if physical or electronic surveillance leads to a reasonable belief that an offence involving violence is imminent, the Field Commander will take all reasonable steps to prevent that offence occurring and, if possible, arrest the target and secure any weapons;
 - that if the threat of imminent violence or an offence involving violence cannot be neutralised by the apprehension of the target(s) the Field Commander will take all reasonable steps to prevent the commission of the offence by using overt strategies such as securing the target location and/or causing High Visibility Policing in the vicinity of the target location if known. If the target location is unknown the Field Commander will cause the description of the target(s), any vehicle involved and relevant warnings to be broadcast via VKG for information of police generally;
 - that if armed targets enter premises with an apparent intention to commit a serious offence, and it is not possible to prevent that offence being attempted or committed, priority should be given to containment, negotiation and the deployment of the Tactical Operations Unit if possible;
 - that if armed targets enter premises in which members of the public are present and commit an offence of violence prior to interception, they ought not be approached whilst in the premises or in the process of committing an armed robbery unless this is the only reasonable way to prevent further harm or risk of harm to members of the public within the premises;
 - that where reasonably possible, an arrest will only be effected once all targets have left premises or there is no immediate danger to potential victims including other police officers;
 - that armed offenders who are contained ought be given a reasonable opportunity to comprehend this and to surrender before police resort to the use of force, especially deadly force.
- To simplify planning for potentially high-risk police operations in exigent circumstances, that the Robbery and Serious Crime Squad develop and append to its Standard Operating Procedures a simple checklist (like the Australian Army's "Military Appreciation Process) for developing an appreciation of the situation and a second simple checklist (like the Australian Army's "SMEAC") for operational orders.
 - That consideration should be given to amending the Standard Operating Procedures to emphasise that during the conduct of operations the following general principles should be adhered to by members of the Robbery and Serious Crime Squad, and that these should be inserted into any written operational orders instructions:
 - that if a high-risk police operation may be required the Tactical Operations Unit should be requested to assist at a point in time when they are likely to be able to

- deploy in the field before the point at which it is envisaged that a high-risk police operation may be required;
- that if the Tactical Operations Unit responds by indicating that it does not intend to deploy immediately, any significant additional information potentially affecting that decision should be communicated to the Tactical Operations Unit;
 - that interoperability of communications and sharing of communications is a priority during high-risk police operations;
 - that effective communications should be established as a priority, with an officer being responsible for communications, for any high-risk police operation;
 - that the priority should generally be prevention of offences of violence even at the expense of arrest of the targets and/or securing any weapons;
 - that other than in exceptional circumstances, high-risk arrests should not be attempted except on an immediate order from the Field Commander or in accordance with operational orders;
 - that the preferred option for controlling any high-risk situation is containment and negotiation, and non-violent means shall be used as far as is reasonable before resorting to the use of force;
 - that in a high-risk operation police should first consider their options to contain and negotiate. Containment and negotiation should be the primary option considered;
 - that after high-risk incident has been confirmed, where possible control should be gained by containing the threat within an inner perimeter, without compromising the point of exit for offenders, and isolating the threat by establishing an outer perimeter; and
 - that officers should if possible avoid any action which would place hostages, uninvolved civilians, other emergency personnel or police officers in any further danger.
- That, in addition to and following the thorough investigation into the conduct of involved police officers that follows a Critical Incident, the NSW Police Force conduct a policy and procedure analysis, similar to NSW Health's "Root Cause Analysis" process, to determine whether or not latent systems defects have been revealed by the incident and, if so, what measures ought be taken to rectify them.

NSW.2012.164

Additional tag(s): Natural cause death/ Older persons

The deceased was an older adult male and serving prisoner who died of natural causes. The deceased was a resident in a section of the prison where inmates can live and move freely

around the wing. On the night of the incident, the inmate sharing a cell with the deceased spent the night in a different cell, meaning the deceased was alone in his cell all night.

Recommendations:

To the Minister for Corrective Services:

- I recommend that the Standard Operating Procedures for the [correctional facility] be amended to ensure that empty cells are secured, that all empty cells are checked at every evening muster and that all reasonable steps be taken to ensure that inmates sleep every night in their allocated cells.

MENTAL ILLNESS AND HEALTH

NSW.2009.4859

Additional tag(s): Falls

The deceased was an adult male who sustained fatal injuries following a fall from height. At the time of the incident, the deceased was a patient at a psychiatric unit from which he absconded. The Coroner was unable to determine whether the death was intentional or accidental.

Recommendations:

To the Minister for Health:

- That the [hospital] develop a specific document, which is readily identifiable and easily found on a patient's file, outlining:
 - Approved leave;
 - The name of the person who authorised that leave; and
 - Listing any breaches of the leave protocol.
- That a review of the [hospital]'s procedures concerning leave be undertaken to ensure that legislation and protocols concerning leave and conditional release of forensic patients are adhered to and that its documentation clearly conforms with the relevant protocols.
- That the [hospital]'s "Mental Health" form be amended to include a section for collateral sources of information concerning a patient's mental state (such as observations of relatives, carers, police, ambulance officers, other service providers) and that a new section entitled "Carer's Issues" be included in the form to encourage staff actively to seek collateral information from carers.

- That, following the return of a patient to the [hospital] [especially if this is an early return from leave due to a deterioration in the patient's mental state), a clearly delineated and documented formal process of review be undertaken.
- That the Ministry for Health consider whether these recommendations ought be adopted in all NSW Health psychiatric units (insofar as they are relevant in individual facilities).

To the Minister for Health and Commissioner of Police:

- That, for the safety of absconding psychiatric patients (and the conservation of police and NSW Health resources), NSW Health and the NSW Police Force consider how best to develop optimal liaison between psychiatric units and the Local Area Commands concerning such patients.
- Alternatively, if the Minister and the Commissioner consider that it is more appropriate for local solutions to be developed, I recommend that the [hospital] and the [location] Local Area Commander develop an arrangement to manage issues of mutual concern relating to absconding patients between them.

OLDER PERSONS

NSW.2012.61

The deceased was an older adult female who died of blunt force head injury. The coroner was unable to determine whether the injury was sustained as a result of a fall or some other means.

Recommendations:

This matter be referred to 'cold cases' for further investigation in accordance with police procedure and protocol.

NORTHERN TERRITORY

NOTE: The Northern Territory Coroner held a joint inquest into the following three deaths, which resulted from the same incident.

HOMICIDE AND ASSAULT

NT.2012.117

NT.2012.118

Additional tag(s): Child and infant death/ Law enforcement

The deceased were two children who were suffocated by their father. The coroner found that the deaths were premeditated and planned. Prior to the incident, the mother of the children had expressed concern to the police regarding the children's welfare.

INTENTIONAL SELF-HARM

NT.2012.117

Additional tag(s): Youth

The deceased was a young adult male who died by suicide after he suffocated his child and step child. The coroner found that the deaths were premeditated and planned. Prior to the incident, the mother of the children had expressed concern to the police regarding the children's welfare.

Recommendations:

- I recommend that consideration be given to amending section 126(2A) of the Police Administration Act by inserting paragraph (ba) as follows:
 - (2A) A member of the Police Force may, by reasonable force if necessary, enter a place if he believes, on reasonable grounds, that:

- (ba) it is necessary to do so in order to evaluate whether there is a serious imminent risk to the welfare of a child,
- I recommend that consideration be given to the employment of a dedicated Grief Counsellor to be available to assist families whose loss is subject to a coronial investigation. Consideration should also be given to such a position having a broader role in respect of other deaths under police investigation.

TRANSPORT AND TRAFFIC RELATED

NOTE: The Northern Territory Coroner held a joint inquest into the following three deaths, which resulted from the same incident.

NT.2011.167

NT.2011.168

NT.2011.173

Additional tag(s): Work related

The deceased were three passengers in a motor vehicle that collided with a specialised fire truck after it ran a red light. The fire truck was rarely driven on public roads. The coroner found that the driver of the fire truck was ill-equipped to be operating the vehicle in these conditions and that the vehicle was not immediately recognisable as an emergency services vehicle to the general public.

Recommendations:

To the NT Department for Roads/Department of Infrastructure:

- That the Department reduce the speed limit for vehicles travelling on [the road] in the area near the approach to the [intersection], from 100 kilometres per hour to 80 kilometres, near the approach to the intersection.

To [the company]:

- That changes be made to the appearance of the lime green Mark-8/9 Fire Tender to ensure that they are more obvious as emergency services vehicles, for example, by the addition of a red band across the middle of the vehicle.

- That [the company] initiate an education campaign to alert members of the public that their Fire Tenders are emergency services vehicles exempt from Traffic Regulations if operating "Lights and Sirens".
- That the proposed changes to the ARFF "Standard Operating Procedure" currently set out in the draft that appears as appendix 14 to the statement of [Chief Fire Officer] are introduced as soon as [the company] resume the policy of responding to emergencies with "lights and sirens", in particular with regard to the proposed policy setting a speed limit for drivers proceeding through red lights.
- That when driving "lights and sirens" outside the airport boundary, a passenger be positioned in the seat behind the driver to assist them to identify obstacles caught in the right blind spot.

To the Government of the Northern Territory:

- That resources be allocated for a dedicated grief counsellor available to assist the office of the NT Coroner.

QLD.2012.1310

Additional tag(s): Weapon

The deceased was an adult male who was shot and killed by police at a residential property. Following a search of the property, the deceased had produced a replica firearm, pointing it at one of the officers. When the officer ran, the deceased followed with the replica firearm and the officer shot the deceased causing his death. Following the incident, a representative of the police union made several media statements and interviews in which he unintentionally disclosed inaccurate details of the circumstances of the shooting.

Recommendations:

- Recommendation 1 -Security of critical incident scenes
In order to avoid the uncontrolled and unintended release of information and the adverse impact that can have on the integrity of an investigation, I recommend the QPS [Queensland Police Service] review its policies and procedures to ensure access is only granted to the outer cordon of critical incident scenes to those needed to investigate and/or respond to the incident. Union officials and employees should of course be given ready access to their members to support them but that should happen away from the incident scene whenever possible.
- Recommendation 2 -Initial family liaison
I am aware the QPS has a family liaison policy that provides for the allocation of a specific family contact person in all cases of homicide. In deaths in custody, the investigators from the Ethical Standards Command discharge this role. That happened in this case. However, as this case demonstrates, in some instances, family or 'secondary victims' will be at the scene at the time of the incident or very soon after. QPS procedures which stipulate how the incident scene is to be managed should stipulate that those with a special interest in the incident, such as family members of the deceased, are to be treated appropriately and, as soon as possible, given as much information as can be released to them without compromising the investigation.
- Recommendation 3 - Union officials' competing responsibilities
The president of the QPUE has responsibilities to the union and its members but he or she remains a member of the QPS and is subject to and must comply with its policies and

procedures. There currently seems some uncertainty as to how these roles are to be accommodated if they conflict, for example, in relation to accessing and disseminating confidential information held by the QPS. Accordingly, I recommend the QPS in conjunction with the union review those aspects of the union's areas of activity that may cause this conflict to arise to ensure both parties have in place appropriate policies and protocols so they can be managed without compromising the functions of the QPS, while allowing for the legitimate and necessary industrial activities of the union's officials.

- Recommendation 4- Responsible media comment

Public comment concerning a critical incident involving police officers can negatively impact on the integrity of the investigation of the incident, the reputation of the officers involved, the reputation of the QPS and the public confidence in those investigations. It is therefore essential the comments be limited to the release of sufficient information to satisfy the public's right to know in very general terms what has occurred and to engender confidence the incident is under rigorous and impartial investigation, the results of which will be made public at the appropriate time. I recommend the QPS review its policies in relation to such matters and have regard to the report of the Office of Police Integrity's suggestions as to the limit of matters that should be included in such public comments. The resulting policies should be binding on all police officers, including union officials.

TASMANIA

ADVERSE MEDICAL EFFECTS

TAS.2013.114

The deceased was a middle aged male who died of an infection following multiple major surgeries. During one major surgery, one large pack was deliberately left in situ to assist with intra-abdominal bleeding. Usually packs are removed after two to three days due to the risk of infection; however, the pack in the deceased's abdomen was not removed for 12 days. During this period, the deceased was transferred to a different hospital and it is unclear whether the patient notes regarding the remaining pack were copied and transferred.

Recommendations:

[The deceased] died of complications relating to attempted curative surgery for his cancer. The surgery he undertook is difficult and complications are common and his death occurred despite the exercise of considerable care and skill and effort on the part of his surgeons and the staff of both hospitals.

Nevertheless I would recommend that both the [Hospital 1] and the [Hospital 2] review their respective procedures in regard to retained packs, if such a review is not already underway. To the extent that counting packs is to be used as a means of controlling risk then particular care should be taken to ensure accuracy of recording, consistency of recording between nursing and medical staff and clear and easily accessible communication of information between practitioners and hospitals, particularly on transfer between hospitals. Each hospital should also consider whether a practice of abdominal x-ray following emergency abdominal surgery to identify and reduce the risk of retained packs might be appropriate.

NATURAL CAUSE DEATH

TAS.2010.275

Additional tags: Law enforcement

The deceased was a middle aged male who died from leukaemia for which he refused treatment. At the time of his death, the deceased had been granted bail following a week in custody. After receiving bail the deceased was taken to hospital due to poor health and died the next day from complications of his cancer.

Recommendations:

I agree with [doctor's] opinion that:

- The Admission to [facility] form should be expanded to make it more flexible and provide space for more detail to be included in cases where a person has identified health issues, and
- An Incident Form should be introduced so that events such as [the deceased]'s fall, which can obviously have adverse medical implications, are properly recorded.

I would recommend that the Department of Corrective Services adopt such practices.

SPORTS RELATED

TAS.2012.68

Additional tag(s): Water related

The deceased had previous experience scuba diving but had not been diving for many years. The day prior to his death, the deceased completed three dives without any issues. On the day of the incident, the deceased descended with the rest of the dive group before experiencing problems and indicating he wished to ascend and return to the surface. The deceased experienced further difficulties whilst ascending and was located unresponsive at the surface by his dive buddy.

Recommendations:

[...]

My investigations have revealed that there is no mandated Code of Practice controlling scuba diver training in Tasmania. There is an Australian Standard 4005-1 which provides guidance upon the pre-entry requirements and training in scuba diving. The application of this Standard is not mandated in any State as a Code other than Queensland. This Standard, amongst other things, obliges a student to undergo a specific pre-diving medical assessment prior to commencing scuba diving training. I am advised that there is a move by the dive training industry to abandon AS4005-1 in favour of the

“International Standards” which do not oblige a medical examination. There is also apparent opposition from the industry concerning any move to mandate the application of AS4005-1.

[...]

I recommend that any change, be it to mandate an Australian Standard or, alternatively, to make less restrictive the current Standard, should only occur after thorough and reasoned assessment which includes consideration of the medical, community, participants and industry input. There was obviously a proper basis to justify the issue of AS4005-1 and the onus must be that any change does not materially affect the health risk status of anyone undergoing scuba diver training or as a recreational activity. Such investigation goes far beyond the scope of my investigation into the death of [the deceased]. Although it is highly probable that a pre-dive specialist medical examination may have determined that [the deceased] was not fit to dive, the obligation for such a medical examination in fact existed upon the process that was in use at the time by [dive company] based upon the answers [the deceased] provided to the medical questionnaire. [Dive company] were not applying AS4005-1 but rather the loosely described International Standards that require completion of a pre-dive medical questionnaire.

[...]

It is incumbent upon organisations and individuals who conduct scuba dive training to do so applying a recognised and accepted industrial standard. [Dive company] did so in this case using the PADI format and yet they did not comply with those standards. This case highlights the risk of non-compliance and I strongly recommend that all such operators should adopt an accepted and validated industry standard be it based upon AS4005-1 or otherwise and that they comply with such standard. It was clearly unsuitable for [the deceased] to be completing the dive medical questionnaire when, presumably, he was already in location in preparation for the course. This pre-course documentation, if it is to have any proper affect, must be completed before a person commences the scuba diving training when it is possible to delay their attendance at the course until a medical or other issue is addressed.

TRANSPORT AND TRAFFIC RELATED

TAS.2012.161

The deceased was an older adult male who died when he unintentionally drove his vehicle into the path of a train. The deceased failed to heed railway crossing warning signs and drove onto the train tracks when a train was approaching.

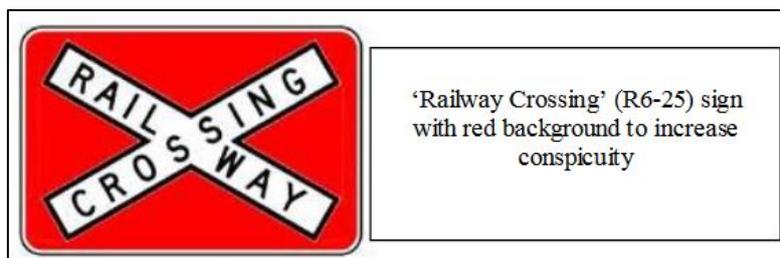
Recommendations:

[...]

I would recommend that an awareness program be produced and disseminated via the media to increase the public awareness of the need to exercise caution at level crossings, perhaps with the use of figures from the Australian Transport Safety Bureau, and those statistics compiled in the report 'A Review of Crashes at Level Crossings in Tasmania' by the Traffic Engineering Branch, Department of Infrastructure, Energy and Resources. In the event that TasRail installs cameras on the front of their trains, the pictures and videos captured could be used by the media to highlight the risks created by drivers when approaching and crossing railway lines, and creating greater awareness of the risks of not complying with the installed signs.

The Department of Infrastructure, Energy, and Resources undertook a thorough investigation of this crash scene, and I endorse the outcome of that investigation.

I recommend that the railway crossing sign currently utilised throughout Tasmania be replaced by an alternative sign that is permitted by the Australian Standard AS1742 Part 7: Railway Crossings (R6- 25), as is depicted below [image].



The replacement of the existing signs with the recommended sign would be cost-effective and would improve safety at level crossings. In arranging the replacement of signs throughout the State, priority should be given to level crossings with passive control, which without flashing lights and warning bells, rely on signs and markings to draw the attention of drivers to the presence of train crossings.

[...]

WATER RELATED

NOTE: The Tasmanian Coroner held a joint inquest into the following two deaths, which resulted from the same incident.

TAS.2012.271

TAS.2012.282

Additional tag(s): Work related

The deceased were two adult males with a long history of engagement in the fishing industry. The men went to collect their catch in a dinghy when they went missing. Their bodies were recovered several days later.

Recommendations:

[...]

I have given some consideration to whether or not the carrying by either or both of these men of a personal location device may have materially improved their chances of survival. However the majority of these devices require manual activation and their effectiveness would be significantly impaired if under any depth of water. In the circumstances that I presume these men found themselves in there may have been no opportunity to activate such a device whilst they were on the surface. However I recommend that the industry consider the safety benefits of utilising such devices especially when someone is working away from the main vessel. Although once again it may not have altered the final outcome of this matter I do recommend that when professional fishermen are working in a dinghy away from the main vessel they carry the vessel's EPIRB [Emergency Position Indicating Radio Beacon]. [Deceased person] was in the habit of carrying safety flares in the dinghy had he carried the EPIRB and it had been able to be deployed then at the very least a timely distress signal would have generated.

This tragedy highlights that no matter how experienced or competent a person is, nature in the form of the sea will, on occasions, prevail. Professional fishing along the exposed coastline of Tasmania is a dangerous activity and this incident highlights the need to fully and rationally consider the risks of any action before embarking upon it. I recommend that professional fishermen take the time to identify the risks associated with any of their activities, assess those risks and consider ways to mitigate those risks before undertaking the activity or, as a result of that consideration, delay or desist taking that activity. Complacency will always be a risk where persons have been involved in activities over a length of time and continue to perform those activities without considering specific increased risk factors that could be present on any particular occasion. Taking the time to consider the circumstances in this particular case may have avoided the tragic outcome.

VIC.2007.4482

The deceased was an infant male who died shortly after birth. The deceased's birth was complicated by the umbilical cord being wrapped around the deceased's neck.

Recommendations:

I recommend that:

- The Department of Health recommend revision of the Victorian and Australian Perinatal Data Collections for births from 1 January 2014 to include information about the status of the umbilical cord including whether it is round the neck or has a true knot and providing for free text to clarify any other abnormalities
- The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, of its own initiative, arrange for the three Level 6 Maternity Services in Victoria to commence use of their current reporting procedures to include information about the status of the umbilical cord including whether it is round the neck and/or has a true knot and to clarify any other abnormalities.
- The Secretary of the Department of Health provide the Consultative Council on Obstetric and Paediatric Mortality and Morbidity with the funding required to implement these changes in the Victorian Perinatal Data Collections for births from 1 January 2014.
- The Department of Health monitor the data produced by the new data collection to inform it about the priority it should give to procuring new radiology equipment which can identify true knots and cord around the foetus' neck so that clinical responses can be informed by the knowledge of potential cord vascular occlusion.
- The Consultative Council on Obstetric and Paediatric Mortality and Morbidity and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists publish the statistical information that becomes available from the Victorian Perinatal Data Collection as a way of encouraging obstetricians and midwives to consider how they can minimise the risks associated with true knots and other umbilical cord complications in otherwise non-concerning births.

DRUGS AND ALCOHOL

VIC.2012.2114

The deceased was an adult male who died of mixed drug toxicity. The unintentional overdose was caused when the deceased ingested his deceased wife's palliative medication. The deceased's wife died due to terminal illness a year prior. In the months prior to his death, the deceased's family and friends became aware that the deceased was using his wife's medications to help him relax.

Recommendations:

- The Victorian Department of Health consider consulting with relevant bodies whose members have contact with the family of the deceased after a death, such as Victoria Police, Ambulance Victoria and the Royal Australian College of General Practitioners, to identify any appropriate opportunities to retrieve medications (particularly Schedule 8 opioids) that had been prescribed to the deceased thus reducing harms associated with other people accessing and using those medications.

INTENTIONAL SELF-HARM

VIC.2008.729

Additional tag(s): Mental illness and health / Transport and traffic related / Indigenous

The deceased was an adult female of aboriginal origin who was under involuntary psychiatric treatment at the time of her death. The deceased absconded from the facility and attempted to return home. The following day, the deceased was seen sitting on a bench near a highway before suddenly running into the path of a truck and sustaining fatal injuries. At the time of the deceased's death, an Aboriginal Health Liaison Officer was employed at the psychiatric treatment facility during business hours.

Recommendations:

- It is recommended that this role [Aboriginal Health Liaison Officer] be extended to include on call duties so that all times outside of the normal working week will also be covered. This would enable a 24 hour notification and support service for Aboriginal patients admitted to psychiatric hospitals.
When an Aboriginal person is taken into police custody, police are required to inform

the Victorian Aboriginal Legal Service of that fact without delay in order to ensure that persons legal rights are protected.

- It is recommended that whenever an Aboriginal person is admitted to a mental health facility, that as part of the process, the Aboriginal Liaison Officer (or any other person holding a similar role) be notified without delay so that all necessary services can be actioned.

Whilst satisfied that [the deceased] was taken to the nearest and most appropriate mental health facility given her involuntary patient status, the importance of 'country' to Aboriginal people must be acknowledged.

- That being so, it is recommended that where circumstances permit, that Aboriginal involuntary patients always be located at a Mental Hospital as close to their country as possible.

At the time of [the deceased's] admission to the [hospital] as an involuntary patient, [they were] exhibiting homicidal/suicidal ideas. [The deceased] (and others before [them]) found it relatively easy to abscond from this facility.

- Whilst accepting that Mental Hospitals are not prisons, it is recommended that regular audits be conducted into the security environment at these facilities with a view to minimizing the risk of patients (particularly involuntary patients) absconding.

NATURAL CAUSE DEATH

VIC.2011.2045

Additional tag(s): Older persons

The deceased was an older adult male who died at home shortly after being discharged from hospital. The deceased presented to the hospital with chest pains but was discharged when various tests came back negative. However, no blood tests for the cardiac enzyme, Troponin, were ordered and the deceased died due to cardiac-related issues.

Recommendations:

That [district health body] develop/review guidelines for clinicians in the Emergency Department for the management of patients presenting with chest pain that supports the performance of Troponin measurement in circumstances where the definitive cause of the chest pain has not been identified.

VIC.2007.732

The deceased was an adult male who sustained fatal injuries during a motorcycle race. During the race, the deceased's motorcycle crashed on a jump ramp, causing him to fall. As the deceased attempted to get up from his fall, another motorcycle came down the ramp and collided with the deceased. Toxicological analysis detected cannabis in the blood of the deceased.

Recommendations:

I recommend that:

- The [motorcycle club] implement a random and targeted cannabis saliva testing programme for race participants on race days.
- The [motorcycle club] and Motorcycling Victoria re-consider the way in which motocross races are started to improve the time and/or space separation of race participants early in the race and reduce the risk of serious incidents involving following riders.
- The [motorcycle club] and Motorcycling Victoria explore the possibility of cooperating with the *Sportsinjurytracker* sports injury surveillance system.
- The [motorcycle club] ensure that the Club Application Form requires riders to belong to an Ambulance Fund and requires applicants to notify the organisers if they take prescribed substances.

WESTERN AUSTRALIA

ADVERSE MEDICAL EFFECTS

WA.2009.1512

The deceased was a middle aged female who died from complications of gastric band surgery. The surgery had occurred over one year prior without complication. The day prior to her death, the deceased became unwell but declined a visit to hospital when suggested by her general practitioner. Investigations revealed that the deceased's stomach had herniated through the gastric band.

Recommendations:

- I recommend a Specialist General Practice Group look at the development and extension of training programs to raise awareness about the common and life long concerns and complications associated with gastric banding surgery (GBS) including the significance of prolonged vomiting in a patient with prior GBS..

INTENTIONAL SELF-HARM

WA.2009.763

Additional tag(s): Drugs and alcohol/ Mental illness and health

The deceased was an adult female who suffered from a combination of personality disorders and substance abuse issues. On the night of the incident, the deceased intentionally ingested a fatal amount of prescription medications before contacting a health clinic to seek advice. Despite being advised to attend hospital, the deceased did not go and was located deceased at home the following day.

Recommendations:

- Staff likely to respond to telephone inquiries at [clinic], particularly at night, are trained to make clinical assessments on the telephone as well as normal risk assessments in their day to day work experience. There are a number of emergency telephone operators who train call receivers in appropriate assessment.

- [Ward], as the ward receiving telephone calls from the switchboard after hours always be staffed by nurses trained in telephone assessment.
- [Clinic] investigate the feasibility of a tracer call facility with the Police or more simply provide their service provider information next to telephones capable of receiving outside calls with instructions about timing the commencement and duration of calls where a concern may arise as to the safety of the caller.

LAW ENFORCEMENT

WA.2007.956

Additional tag(s): Drugs and alcohol/ Mental illness and health

The deceased was an adult male prisoner under observation in the Critical Care Unit. On the morning of his death, the deceased was found unresponsive due to an unintentional overdose on his prescription medication, clozapine. The deceased's caffeine levels were also excessively high and this contributed to his death.

Recommendations:

- Patients on clozapine who are returned to the Department have a formal handover to the treating psychiatrist at the relevant custodial facility. The handover should include a comprehensive report of the previous and current management of the patient's clozapine therapy including:
 - All dosage changes during their inpatient care;
 - All changes in relevant drug and lifestyle changes which are likely to impact on clozapine levels;
 - All clinical screening completed during this time; and
 - All clozapine blood levels;
- Clinical parameters, including physical examination findings, relevant to clozapine management at the time of their transfer to the Department.
- Department of Corrective Services educate their medical and mental health staff about specific interactions between clozapine, caffeine and the cessation of smoking not counteracted by the use of nicotine patches.
- Department of Corrective Services review care of clozapine patients and consider who can usefully ask questions of patients about their caffeine use in the same way patients are currently asked to provide information about their smoking habits.

NATURAL CAUSE DEATH

WA.2009.1182

The deceased was a middle aged male who died following an uncomplicated surgery. The deceased had travelled by long-distance coach to the hospital on the same day as the surgery.

Recommendations:

- [Health service] to facilitate a review of the VTE Risk Assessment Form to consider inclusion of the type/duration of travel of pre-operative patients.

TRANSPORT AND TRAFFIC RELATED

WA.2008.1561

The deceased was an older adult male who died when his motor vehicle collided with a road train. The deceased was navigating a bend in a highway when a road train approached from the opposite direction. The rear semi-trailer of the road train overturned and collided with the deceased's motor vehicle. The coroner was unable to conclusively determine the root cause of the incident but notes that speed was not a factor.

Recommendations:

- That the Department of Transport take steps to inform owners and drivers of heavy vehicles of the potential hazard of using vehicles equipped with poorly maintained airbag suspension systems and the need to ensure that such systems, especially including the dampers, are operating properly.
- That the Commissioner of Main Roads consider including within the accreditation process for permits for heavy vehicles a specific requirement in maintenance regimes for the regular inspection and replacement of airbag suspension components.
- That the Western Australian Police Service consider obtaining, in appropriate circumstances, the assistance of engineering expertise in relation to the investigation of heavy vehicle accidents.
- That the Western Australian Police Service investigators cause to be examined in detail the suspension systems of heavy vehicles involved in rollover incidents unless there is a compelling reason not to do so in any particular case.

- That the Main Roads Western Australia reduce the speed limit on the Hamilton River section of the Coalfield Highway from 100kph to 80kph pending completion of upgrades to that roadway.

WATER RELATED

NOTE: The Western Australian Coroner held a joint inquest into the following two deaths, which resulted from the same incident.

WA.2010.1906

WA.2010.1907

The deceased were two adult males who had recently immigrated to Australia. The men and three others were walking along a sandbar that connects an island to the mainland when the group encountered adverse weather conditions and strayed off the sandbar into deep water. They were not strong swimmers and the two men drowned despite being rescued by passers-by.

Recommendations:

- I recommend that Surf Life Saving WA, the [lifesaving club] and the relevant employee of the [city council] meet and liaise with one another with a view to determining an appropriate location for a storage facility to house the equipment needs of lifesavers. After agreeing on an appropriate location for the storage facility a proposal should be put to Council for its approval to use the location for that purpose.
- I recommend that the Department of Environment and Conservation consider engaging Surf Life Saving WA to undertake comprehensive Aquatic Coastal Risk Assessment of the area surrounding [location] and [island].
- I recommend that the Department of Environment and Conservation consider engaging Surf Life Saving WA to provide ongoing instruction to its marine rangers in the competencies required to undertake rescue and resuscitative efforts during the course of their duties.
- I recommend that the Department of Environment and Conservation provide adequate and appropriate resources, for those engaged in rescue and resuscitative efforts in the area surrounding [location] and [island], to perform their function.

WA.2007.46

Additional tag(s): Misadventure/ Indigenous

The deceased was a male child and had been a Ward of the State for most of his life. For some of this period, the Western Australian Department for Children Protection was experiencing significant issues with resourcing.

On the day of the incident, the deceased was supposed to go on a trip with family and became angry when these arrangements were changed. The deceased's brother found him hanging from the window frame a short while later. The coroner determined the death arose by way of accident.

Recommendations:

- The new Relative Carer and Assessment Training Package (the Package) currently being [developed] by the Department for Child Protection (the Department), which includes information on the psychological impact on a child being placed in care and the effects of maltreatment and neglect, be implemented as soon as possible and all relative carers be made aware of its availability.
- The Department continue to offer child care for children in the care of relatives when they participate in training related to the Packages.
- The Department's 'Circle of Security' training be made available to all case workers and carers to facilitate better provision of support and coaching for the carers of children in care.
- The Department ensure that its induction training for new case workers continues to provide information and training on appropriate ways to communicate with clients and in particular, the carers of children in care.

APPENDIX A: FATAL FACTS WEB TOOL CATEGORY TAGS

Category	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 an animal was involved in the cause of death.
Child and 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 and 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, for example remote location.
Homicide and	Includes interpersonal violence and family domestic violence.
Indigenous	Cases related to a specific demographic group.
Intentional self-harm	Cases determined intentional self-harm (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 activity that directly influence the circumstances including holiday.

Category	Description
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 and 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 and traffic related	Cases involving road, water and air vehicle incidents, motorised or naturally powered. Also includes 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.