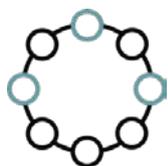




Coronial Recommendations: Fatal Facts

A summary of cases and recommendations made
between 1 July and 30 September 2013

Edition 38



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.



CONTENTS

CORONERS' RECOMMENDATIONS	4
NEW SOUTH WALES	5
Drugs and alcohol	5
Homicide and assault	5
Natural cause death	7
Transport and traffic related	7
NORTHERN TERRITORY	9
Indigenous	9
QUEENSLAND	10
Intentional self-harm	10
TASMANIA	11
Adverse medical effects	11
Aged care	12
Animal related	13
Child and infant death	14
Transport and traffic related	15
VICTORIA	17
Adverse medical effects	17
Child and infant death	19
Drugs and alcohol	23
Falls	25
Intentional self-harm	25
Natural cause death	30
Transport and traffic related	30
WESTERN AUSTRALIA	33
Adverse medical effects	33
Child and infant death	33
Drugs and alcohol	34
Natural cause death	35
Transport and traffic related	36
Water related	38
APPENDIX A: FATAL FACTS WEB TOOL CATEGORY TAGS	40

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 July and 30 September 2013.

Previous summaries and recommendations are available

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

NEW SOUTH WALES

DRUGS AND ALCOHOL

NSW.2011.1868

Additional tag(s): Law enforcement

The deceased was an adult male prisoner who died as a result of an unintentional heroin overdose. The deceased was located unresponsive in his bed and was unable to be revived. According to his cellmate, the deceased stated he had consumed drugs and also appeared affected by drugs. A bag containing a brown substance was found with the deceased's possessions.

Recommendations:

To the [organisation] and Corrective Services NSW:

- To review and audit the current training received by Correctional Officers for identifying the signs and symptoms of intoxication of inmates, including intoxication caused by inmates engaging in illicit drug use.
- To consider increasing the number of Drug Detection Dog Units at the [location] Correctional Centre to enable a more proactive approach to the screening of visitors attending the [location] Correctional Centre, to ensure that inmates leaving the C-Unit visits area after receiving a visit are screened and to enable regular patrols by the Drug Dog Detection Unit of the C-Unit visits area during and following visiting hours.
- To review the number and placement of CCTV cameras in the C-Unit visits area with the view to deterring the introduction of contraband into the Centre and to increasing the detection of contraband passing between visitors and inmates

HOMICIDE AND ASSAULT

NSW.2007.289

Additional tag(s): Youth

The deceased was a young adult female who was reported as a missing person. The deceased and her friend failed to return home one evening and were never found.

The coroner found that the deceased died sometime after her disappearance and made an open finding as to her cause of death.

Recommendations:

That this file be referred to the Unsolved Homicide Squad, NSW Police.

NSW.2007.290

Additional tag(s): Youth

The deceased was a young adult female who was reported as a missing person. The deceased and her friend failed to return home one evening and were never found.

The coroner found that the deceased died sometime after her disappearance and made an open finding as to her cause of death.

Recommendations:

That this file be referred to the Unsolved Homicide Squad, NSW Police.

NSW.2010.5548

Additional tag(s): Youth

The deceased was a young adult female and was reported as a missing person. The coroner found that on the balance of probabilities, the deceased died on the day of her disappearance. The coroner was unable to determine the location, cause or manner of death.

Recommendations:

Pursuant to S.82 of the *Coroners Act 2009* I recommend that the death of [the deceased] be referred to the NSW Police Unsolved Homicide Squad for further investigation in accordance with police procedures and protocols.

NSW.2011.5553

The deceased was an adult male and a reported missing person. The coroner found that the deceased was abducted by unknown persons and on the balance of probabilities, is deceased. The coroner was unable to determine the location, cause or manner of death.

Recommendations:

- Pursuant to S82(2)(b) of the *Coroner's Act 2009* I recommend that the matter be referred to the NSW Police Unsolved Homicide Squad.

NATURAL CAUSE DEATH

NSW.2010.3362

Additional tag(s): Physical health

The deceased was an adult male with quadriplegia who died from urinary tract sepsis. The pathologist stated that quadriplegia is a strong risk factor for urinary tract sepsis and can mask the signs and symptoms of the condition.

Recommendations:

I recommend to Disability Care Australia that it consider adopting this matter as a case study for future disability care programs.

TRANSPORT AND TRAFFIC RELATED

NOTE: The New South Wales 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.

NSW.2008.4607

Additional tag(s): Weather related

The deceased was an adult male who suffered fatal injuries in an aircraft crash. The deceased was piloting the aircraft with two other passengers on board. The aircraft encountered poor weather and collided with forest canopy before crashing into the ground. All three occupants were deceased at the scene.

NSW.2008.4608

Additional tag(s): Weather related

The deceased was an adult female who suffered fatal injuries in an aircraft crash in which she was a passenger. The aircraft encountered poor weather and collided with forest canopy before crashing into the ground. All three occupants were deceased at the scene.

NSW.2008.4609

Additional tag(s): Weather related / Child and infant death

The deceased was a male child who suffered fatal injuries in an aircraft crash in which he was a passenger. The aircraft encountered poor weather and collided with forest canopy before crashing into the ground. All three occupants were deceased at the scene.

Recommendations:

To: The Commissioner of Police

That negotiations be entered into with organisations involved in search and rescue operations so as to develop a protocol requiring that photographic and other media items obtained during search and rescue operations are not released to the general media unless and until consent is obtained from the NSW Police officer in charge of the operation or other designated NSW Police officer.

NORTHERN TERRITORY

INDIGENOUS

NT.2012.228

Additional tag(s): Natural cause death/ Law enforcement

The deceased was an older adult male of aboriginal origin and a sentenced prisoner at the time of his death. The deceased had smoked cigarettes on a regular basis since his youth and subsequently died due to complications of lung cancer.

The deceased was diagnosed with incurable cancer after a lump was noticed to be protruding over his sternum. Over the coming months, the deceased received palliative treatment before being admitted to a hospice where he died.

The coroner found there was no reasonable basis for a diagnosis of the deceased's cancer any earlier than when it occurred. The cancer was rare in someone of the deceased's age and was aggressive and rapidly moving.

Recommendations:

Given that no criticism is made of the medical care that [the deceased] received as a prisoner both before and after his diagnosis of lung cancer the sole recommendation that I make addresses the reality that the death of [the deceased] at such a young age serves as a timely reminder of the dangers inherent in cigarette smoking. I commend all efforts made to publicise through community educational programmes, particularly in Aboriginal communities, the inherent dangers of cigarette smoking.

INTENTIONAL SELF-HARM

QLD.2009.4079

Additional tag(s): Mental illness and health

The deceased was an adult male who intentionally took his own life by choking on a bar of soap. The deceased was first diagnosed with a mental health condition a few years prior and had a history of suicide attempts. The deceased was an inpatient at a mental health unit. In line with standard practice, the deceased was observed periodically by nursing staff on the morning of the incident.

A root cause analysis report identified an opportunity to improve the manner of conducting observations by requiring the documentation of clinical wellbeing rather than merely the status of awake or asleep. The report also identified the size of the soap as a contributing factor, recommending the Unit purchase smaller bars of soap to reduce risk.

Recommendations:

The Director of Mental Health in Qld Health (or Chief Psychiatrist) develop and implement an Environmental Risk Management System for the identification of hazards and assessment of associated risk for inpatient suicide and suicide attempts within Psychiatric Intensive Care Units. The starting point might be the development of checklists to guide staff conducting routine inspections to identify environmental hazards and to take appropriate corrective action. Periodic auditing of the outcome of inspections will facilitate the capture and dissemination of lessons to be learnt.

TASMANIA

ADVERSE MEDICAL EFFECTS

TAS.2009.510

The deceased was a middle aged female who died of complications following neurosurgery. The deceased was extubated following surgery and was noted to be breathing well.

The deceased was transferred to the recovery room. A short while later, staff realised her airway was obstructed and that she was unresponsive. Despite attempts to recover the situation, she suffered a cardiac arrest and failed to regain consciousness. Palliative care was maintained until her death a few days later.

During the coronial investigation, a consulting specialist questioned why end tidal CO₂ monitoring equipment was not available. This non-invasive device measures expired carbon dioxide and provides an indication of ventilation status.

Recommendations:

In his report to me [medical adviser] has advised that end tidal CO₂ monitoring equipment should be available in theatre recovery rooms for use on patients at high risk of post-operative airway complications. [The deceased] was one such patient. I accept [medical adviser]'s advice upon this issue and recommend that such equipment be acquired by [the hospital] and be readily available in its Recovery Rooms.

TAS.2012.419

The deceased was an older adult male who died following complications of abdominal surgery to treat cancer.

The deceased's procedure was complicated by internal bleeding. Following surgery, the deceased displayed features of sepsis and was given antibiotics. The deceased's condition began to deteriorate and a few weeks later, he died.

The coroner was unable to determine the cause of the deceased's post-operative sepsis but was satisfied that the care provided by the hospital was proper and appropriate. Despite having no bearing on the deceased's death, the coroner made recommendations relating to the hospital's record keeping.

Recommendations:

- That the [hospital] review its protocols and practices with respect to medical records with a view to:
 - i. Ensuring that its medical staff is familiar with the relevant national standards and
 - ii. Ensuring that its medical staff comply with those standards.
- That the [hospital] review its current use of a secondary medical record system including daily handover sheets with a view to ensuring that all medical events including handover, critical results and consultations are recorded in a single medical record which is retained.

AGED CARE

TAS.2010.108

Additional tags: Natural cause death / Drugs and alcohol

The deceased was an older adult male and resident at an aged care facility, where he was receiving palliative care only.

The deceased died a short while after nursing staff administered an incorrect dosage of morphine sulphate. The Coroner was not satisfied that the morphine caused or contributed to the deceased's death so the death was considered of natural causes.

The resident nurse-in-charge, who administered the incorrect dosage, was particularly inexperienced having only recently become a registered nurse.

Recommendations:

I am advised that following a review of the circumstances of [the deceased's] death [the facility] has taken these steps:

- Conducted one-on-one education with its extended care workers at [aged care facility] on checking medications as a witness if a second registered nurse or enrolled nurse is unavailable to perform this role.
- Amended the staff induction (orientation) programme policy at [aged care facility] to ensure that the process and periods for differing staff are more clearly defined. Relevant to this case the policy provides for a registered nurse with less than one year acute or aged care experience to receive five days of orientation as a 'buddie' shift.

It is my understanding that Standards and Accreditation Agency Ltd ('the Agency') is the body responsible for the formulation of standards of best practice in the aged-care sector.

Counsel assisting has proposed that I recommend for the Agency to review the circumstances of this matter with a view to:

- Assessing the adequacy of the form and content of the orientation and induction process for registered nurses who commence employment at an aged care facility in Tasmania.
- Considering the qualifications and experience that a registered nurse should have as a minimum before being placed in charge of an aged-care facility and whether they should be mandated.
- A review and assessment of the training and level of competence required of 'responsible persons' (including extended care assistants) for the purpose of checking the preparation and administration of all narcotic substances, and a scheme for the validation of that competency at regular intervals.
- A review of the medication administration competency tool and assessment process and its suitability as a competency tool.

I agree with the proposed recommendations and adopt them.

ANIMAL RELATED

TAS.2011.182

Additional tag(s): Sport related / Work related

The deceased was a middle aged male who was involved in training pacing horses.

The deceased and a colleague were training two horses in sulkies alongside each other around a track. The other sulky lost control and veered into the path of the deceased's sulky, causing the two to come into contact. The collision caused the deceased to be thrown from his sulky and he suffered a fatal brain injury.

The sulky being driven by the deceased was found to be poorly maintained and failed to meet the level required by Harness Racing Australia's (HRA) Sulky Standard.

Recommendations:

The HRA Sulky Standard relates only to sulkies being used in competitive racing conditions and the Standard is therefore not applicable to use of sulkies during training. However, the Sulky Standard provides an overall standard of safety levels in relation to the construction and maintenance of sulkies, and whilst it is accepted that it would not be feasible to have the Sulky Standard apply to all sulkies wherever they are being used, including during training on private tracks, I would recommend that HRA give consideration to an increased level of education to all trainers to recommend that they only use sulkies that are in a condition

which meets the criteria set out in the Sulky Standard to ensure a high level of safety applies at all times for themselves and for any others training with them.

CHILD AND INFANT DEATH

TAS.2007.196

The deceased was a male child who died of positional asphyxia whilst sleeping in his pram.

The deceased's family had purchased a second-hand stroller online, from eBay. The pram arrived in good condition but with no accompanying documentation, such as operating instructions. A harness was supplied with the pram.

The deceased was having trouble sleeping and was placed in his pram to settle him. The deceased was left in the pram so as not to disturb him and the harness was not used.

The following morning the deceased was located on his tummy with his head wedged between the wall and mattress of the pram. It was apparent he had been deceased for some time.

The coroner noted that the initial police investigation was not comprehensive, including a lack of evidence gathering and failure to reconstruct scenes. The coroner found that whilst no persons contributed to the death, the pram as an unsafe sleeping environment that did contribute.

Recommendations:

- I recommend consideration be given to introducing legislation designed to limit the on-sale of second hand nursery furniture only to accredited and licensed second hand dealers and precluding the import, whether via the agency of eBay or similar agencies, from overseas of such second hand equipment not complying with current Australian safety standards.
- I recommend in future that police officers involved in the initial investigation involving the death of a child should, as a matter of course, seek consent to obtain a blood sample for analysis from any relevant person who was in close proximity to the deceased at the relevant time.
- I also recommend that any person charged with the care of a very young child should not be under the influence of any alcohol or drug to any extent whereby their capacities may be compromised.
- I recommend there be further training for police officers who may be involved in the investigation of any paediatric death including a recommendation that all such investigations should be fully investigated by the Criminal Investigation Branch or an experienced senior investigator.

- I recommend that in all paediatric deaths there should be early and numerous family meetings to try and give immediate answers to the questions for the distressed family. To expedite that, the State Forensic Pathologist should be invited to attend such meetings so that clear explanations of causes might be provided and elaborated

TRANSPORT AND TRAFFIC RELATED

TAS.2012.487

The deceased was a middle aged female who died from injuries sustained in a motor vehicle incident. At the time of the incident, the deceased was a tourist from overseas.

The deceased and other family members hired a large passenger car from the airport. The driver of the vehicle was inexperienced in driving a car of this size, or driving on windy roads with fast speed limits.

The driver of the vehicle lost control whilst negotiating a bend and struck a tree head-on. The deceased was a rear seat passenger and not wearing a seatbelt. The deceased was thrown forward, striking the front row of seats and died prior to the arrival of ambulance personnel.

Recommendations:

I recommend that consideration be given to requiring hire cars to display a label inside the cabin of the vehicles stating clearly the legal obligation for all persons to wear seatbelts whilst the vehicle is in motion.

TAS.2013.82

Additional tag(s): Older persons

The deceased was an older adult female who died in a motor vehicle incident. Despite her age, the deceased maintained an independent and active lifestyle, including holding a drivers licence.

On the day of the incident, witnesses report the deceased to be her normal self and in good spirits. The coroner found that in all likelihood the deceased suffered a cardiac incident which rendered her unable to control her motor vehicle as it entered a bend. The vehicle has then continued forwarded, colliding with a tree stump and causing fatal injuries.

Recommendations:

I therefore recommend that the appropriate authorities consider restricting the speed limit at that point or alternatively erecting arrowed signs to highlight the nature and extent of the curve.

VIC.2008.1883

The deceased was an older adult female who died due to complications of a hernia. The deceased was admitted to hospital after feeling unwell and died a few days later.

The coroner found that the care provided to the deceased fell short of the required standard. The deceased's treating doctors failed to appropriately assess and investigate the deceased's symptoms and accurately diagnose her condition.

Recommendations:

- That a copy of these findings be sent, by way of notification to the Australian Health Practitioner Regulation Agency (AHPRA) with a view to investigation, by the Medical Board of Australia (Victoria) of [doctor's] involvement in the assessment and treatment of [the deceased].
- That [health service] ensure that all patient records, including where practicable, GP records, be sourced and available for treating medical practitioners for the purposes of reviewing a patient's medical history.
- That [health service] ensure that all Ambulance records are reviewed by treating medical practitioners and nursing staff from the time of arrival at the hospital, in order to ensure that all relevant observations, information and records are communicated to the treating professionals.
- That [health service] ensure that staff are aware of the necessity to incorporate the records of Ambulance Service members into their initial notes and assessment of patients.
- That [health service] ensure that all medical practitioners take a full and comprehensive history in relation to patients seen at the hospital, with notes that incorporate all observations and examinations, not just those where there has been a positive finding.
- That [health service] ensure that notes made by medical practitioners and nursing staff be initialled at all times, to ensure that authorship can be established.
- That [health service] ensure that record keeping in relation to patients follows best practice principles, particularly in relation to the notation of all tests requested and results obtained. This includes investigating whether electronic methods of compiling information would be preferable to the current paper based method.
- That [health service] ensure that further training is provided to its medical practitioners in relation to the range of interpretation of blood test results.

- That [health service] establish protocols for communicating with other hospitals, in relation to patients who are referred for services not available at [health service], to ensure that all relevant observations, examinations and results are communicated back to treating practitioners at [health service].

VIC.2008.5587

The deceased was an older adult male who died due to complications following heart surgery. Shortly after surgery, the deceased became unstable and his condition deteriorated. A few days later, active management of the deceased's condition was withdrawn and he died.

The deceased's family expressed concern over the lack of communication between treating surgeons and the deceased and his family. The coroner found this claim to be supported by evidence, including a miscommunication between the surgeons as to who would liaise with the family.

Recommendations:

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation connected to the death.

- [Hospital] ensure, (either by developing and maintaining an education program, or some other means) that doctors with admitting rights, and hospital medical officers, keep family informed of the medical progress and outcomes of patients under their care.

VIC.2010.4475

Additional tag(s): Natural cause death

The deceased was a young adult male who died due to bacterial meningitis. He had been unwell for a few days before visiting a doctor, who diagnosed him with gastroenteritis and sent him home with a script. The following afternoon, the deceased's mother located him deceased in his bed.

The deceased's mother and treating doctor dispute whether all of the deceased's symptoms were fully disclosed by the family. The coroner found that the practice's internal communication and progress notes of the deceased's condition were insufficient and the symptoms were such that a diagnosis of bacterial meningitis could not be ruled out.

Recommendations:

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation(s) connected with the death:

- That the Department of Health conduct a public awareness campaign to all areas of the community as to the signs and indicia of bacterial meningitis (particularly when affecting children) emphasizing the need to seek urgent medical advice if the presence of those symptoms are noticed or reasonably suspected.

CHILD AND INFANT DEATH

VIC.2010.756

Additional tag(s): Domestic incident

The deceased was a female child who sustained fatal injuries when she was crushed by a piece of furniture. The deceased was put to bed in her own room whilst her parents watched television in the lounge. It appears that she climbed up the chest of drawers to reach ornaments on top when the drawers overbalanced and tipped over, pinning her against the foot of her bed and suffocating her. A few hours later, she was discovered by her parents. Despite resuscitative efforts, she was unable to be revived.

Recommendations:

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected to the death:

- That the ACCC [Australian Competition and Consumer Commission] give due consideration to the voluntary Australian Standard Domestic furniture - freestanding chests of drawers, wardrobes and bookshelves/bookcases (AS/NZS4935:2009) for the introduction of a mandatory standard under the Australian Consumer Law.
- Further, and in the alternative, in the event that the ACCC determines that AS/NZS 4935:2009 is not appropriate to be applied as a mandatory standard, I recommend that the ACCC consider alternative product safety measures to reduce the risk of furniture/appliance tip-over.
- While there is existing safety information regarding domestic furniture and the risk of tip-over, it is primarily available on the internet. I endorse [another Coroner's] conclusion that, information that is only available online, would mainly be accessed by those already attuned to infant safety, rather than raising awareness amongst parents and carers generally. I also endorse [another Coroner's] observation that retailers could do much more to alert consumers to the potential for apparently stable items to become unstable.

- I therefore recommend that the ACCC consider the mandatory labelling of safety information for furniture and appliances that pose a tip-over risk to children, and/or mandatory provision of safety information by retailers regarding tip-over risks at the point of sale of these products. Examples of safety labels are contained within the voluntary Australian Standard AS/NZS 4935:2009.
- More intensive efforts could be made to enhance community awareness of tip-over risks to children, and practical measures that can be taken to reduce those risks. I recommend that the ACCC develop a public awareness campaign, aimed at the parents and carers of young children, with the goal of raising awareness of the risks of furniture tip-overs. The Western Australian tip-over campaign involved collaboration between the State government and child-safety groups, and such collaboration in this case would also be appropriate.

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

VIC.2010.2034

Additional tag(s): Drugs and alcohol

The deceased was a male child who died due to carbon monoxide poisoning. The deceased, his brother and mother slept in the same bed. When the deceased's mother awoke in the morning, she located both her sons deceased.

Throughout the night, the gas wall furnace (open flued) located in the kitchen/dining area down the hallway from the bedrooms was operating. Both the heater and the fan were switched to the highest level. The heater had not been serviced or cleaned for at least four years at the time of the incident.

VIC.2010.2035

Additional tag(s): Drugs and alcohol

The deceased was a male child who died due to carbon monoxide poisoning. The deceased, his brother and mother slept in the same bed. When the deceased's mother awoke in the morning, she located both her sons deceased.

Throughout the night, the gas wall furnace (open flued) located in the kitchen/dining area down the hallway from the bedrooms was operating. Both the heater and the fan were switched to the highest level. The heater had not been serviced or cleaned for at least four years at the time of the incident.

Recommendations:

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation(s) connected with the death:

(A) IN RELATION TO ENERGY SAFE VICTORIA [ESV]

- THAT ESV continue its public awareness campaign to alert the public to the risks associated with failure to regularly service gas heating appliances and the need to have this servicing performed by licensed gas fitters. In this regard, I want to highlight the tremendous contribution that has been made to this campaign by [name] and [name]. By selflessly and publicly displaying their grief and advocating for safer monitoring and maintenance of domestic gas appliances they have reached many people in a poignant way that has been memorable and, therefore, extremely effective.
- THAT ESV - whose publications are widely distributed to many trade organizations specifically target the electrical trade to ensure that exhaust fans are not retro-fitted in homes with gas heaters without first getting a clearance from a properly qualified and licenced gas fitter who can conduct the necessary tests and analyses.
- THAT ESV- in its public awareness campaign alert the public to the dangers of DIY exhaust fan retro-fitting insofar as this may impact on the safe operation of gas furnaces.
- THAT ESV- investigate the sorts of ventilation options available in five and six star energy rated homes that could be fitted in circumstances in which open flued furnaces have been or are to be installed and distribute any recommendations that arise from such an investigation to relevant parties.
- THAT ESV in its public awareness campaign stress the difference between carbon monoxide alarms and smoke detectors to dispel any perception in the community that each is the equal of the other giving equal re-assurance. This could be simply done by expressing it in the way [Executive Manager, ESV] did in his evidence (see paragraph 23 above).
- THAT ESV continue to train gas fitters to test for spillage of CO from open-flued appliances and continue to conduct presentations and continuing education on this issue.
- THAT ESV as a member of the Australian Standards Association continue to use its offices to persuade manufacturers of gas heating appliances to nominate within their Owners Manuals the appropriate periodic checking and servicing of such appliances. Whilst the foregoing addresses the public awareness of the issues and of the appropriate precautions to be taken I consider that specific reference should be made to the position of tenants.

(B) IN RELATION TO REAL ESTATE INSTITUTE OF VICTORIA (REIV)

I was impressed by the actions taken by Estate Agent [name] in response to this tragedy. (Refer paragraph 12 above). I note with some dismay that a small number of landlords she approached were not prepared to delegate to her agency the power to undertake two yearly checks of gas appliances as they were not legally obliged to do so. I note that in the UK, pursuant to the Gas Safety (Installation and Use) Regulations 1998, a landlord is required to service gas appliances in accordance with the manufacturers' instructions and, in the absence of these, it is recommended that they are serviced annually. A gas safety check *must* be carried out annually on every gas appliance/flue to make sure gas fittings and appliances are safe. I have no information as to how effectively these requirements are policed. Certainly if enforcement is not occurring, the option of a public awareness is to be preferred to legislative change.

I have already referred to the steps pro-actively taken by [Director, real estate agency] in her agency. Given the fact that the safe operation of these appliances is not always able to be ascertained visually (save, perhaps when the pilot flame can be visualised) and that CO is not detectable by the senses, it does not fall within a category that behoves the tenant to report any malfunction and require repairs to be carried out under the provisions of the Residential Tenancies Act. The only way defects can be detected is by regular checking by a licenced gas-fitter. I consider that the steps taken by [Director, real estate agency] could be encouraged by the Real Estate Institute of Victoria in the material disseminated to managing agents. Having listened to all the evidence about time frames, I consider that two yearly checks is a realistic goal in this respect. [Director, real estate agency] told the court that they have licenced gas fitters on their books that are willing to undertake the work and she has not found it burdensome to offer this service to landlords.

ACCORDINGLY I RECOMMEND:

- THAT the REIV take steps to encourage managing real estate agents, by implementing information and/or training packages, to build into the arrangements made between landlords and tenants in respect of domestic dwellings an undertaking that any gas appliances be checked and, if necessary, serviced and cleaned, on a two yearly basis at the expense of the landlord. Such could be incorporated as an additional clause in the relevant tenancy agreement. It follows from the foregoing discussion that such should be performed by a suitably qualified gas fitter and the landlord should be prepared to make any alterations in relation to negative pressures created by exhaust fans as is necessary to obviate the risk of CO being emitted into the living space of the residence.

(C) IN RELATION TO CONSUMER AFFAIRS VICTORIA

Exhibits E and EI tendered in the inquest were booklets issued by Consumer Affairs Victoria. Pursuant to Section 66 of the Residential Tenancies Act 1997, the landlords and agents must give a copy of Exhibit E "Renting a home. A guide for tenants and landlords" to residents moving into rented premises on or before the day they move in or face a fine of up to \$500.

- IT IS RECOMMENDED THAT the booklet be re-drafted in such a way as bring to the attention of prospective tenants, perhaps on page 8, the need to be satisfied as to the safety of any gas heating appliances by suggesting that the landlord be asked to provide evidence of the appliances having been checked within the past two years. It could also be recommended that the tenant ask that a clause be inserted in the tenancy agreement pursuant to which the landlord would undertake to have the appliances checked within that time frame and every two years thereafter.

DRUGS AND ALCOHOL

VIC.2006.4582

Additional tag(s): Mental illness and health

The deceased was an adult male who died due to quetiapine toxicity. The deceased had a long history of psychological disorders treated with medication and was subject to a Community Treatment Order administered through a health organisation.

In the month leading up to his death, the deceased's mental state deteriorated. His doctors adjusted his medication regime in an attempt to reduce the effect of his mental illness.

The deceased was located unresponsive in his bedroom. Toxicological analysis indicated concentrations of quetiapine and sertraline at potentially excessive levels. The Coroner was unable to determine the intent of the deceased.

Recommendations:

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation(s) connected with the death:

- That [health organisation] review their procedures for monitoring mental health clients' compliance with the requirements of their Community Treatment Orders to encourage early collateral monitoring of their blood medication levels when they present with otherwise unexplained or continuing deterioration in their mental state.
- That the Chief Psychiatrist advise authorised psychiatrists of the approved mental health services in Victoria of the circumstances of [the deceased's] death and encourage early collateral monitoring of blood medication levels when clients on Community Treatment Orders present with otherwise unexplained or continuing deterioration in their mental state.
- That the Royal Australian and New Zealand College of Psychiatrists advise its members of the circumstances of [the deceased's] death and the importance of collateral evidence of compliance with treatment conditions in the context of otherwise unexplained or

continuing deterioration inpatients' mental state.

VIC.2007.4122

Additional tag(s): Mental illness and health

The deceased was an adult male who collapsed in the street after consuming a large amount of clozapine and later died in hospital.

The deceased had a long history of mental health conditions and non-compliance with his medications. In the months leading up to his death, the deceased's care was transferred between different health organisations.

A few weeks prior to this death, the deceased presented to the Emergency Department requesting scripts for various medications. According to the Victoria Mental Health Triage Project, the deceased should have been referred to mental health services, but was not.

The coroner was unable to determine the intent of the deceased.

Recommendations:

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected to the death:

- In order to improve the safety of patients and their continuity of access to Clozapine, I recommend that [health organisation] and [health organisation] review their existing policies and procedures related to Clozapine to address what is required in relation to patients' own supplies of medications at the point of transfer, and the change from one brand of Clozapine to another.
- In order to improve the safety of all patients, I recommend that [health organisation] includes information on the restrictions of Clozapine prescribing in the training and/or orientation of all medical officers, to decrease the risk of inappropriate and unsafe patient access to Clozapine.
- In order to improve the safety of patients who are prescribed Clozapine, I recommend that [health organisation] reviews its guideline to increase frequency of review of such patients in the initial weeks following transfer from another mental health service on the basis that this is a recognised high-risk period.

FALLS

VIC.2011.3396

Additional tag(s): Aged care / Older persons

The deceased was an older adult female who died following a fall in her nursing home. Whilst being transferred from her bed to a commode with the assistance of two nurses, she suffered a fall and fractured her neck of femur. She underwent surgery to repair the fracture but passed away a few weeks later.

Recommendations:

- That [nursing home] review their procedures in relation to the transfer of mobility/fall risk information to external agencies to ensure information that is provided is clear, comprehensive and accurate.
- That the [location] Hospital ensure that not only are there documented systems for mobility management and fall prevention but that steps are taken, such as spot auditing, to ensure that these systems are being fully implemented in practice

INTENTIONAL SELF-HARM

VIC.2009.1771

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

The deceased was an adult female who intentionally took her own life by ingesting an excessive quantity of prescription drugs. The deceased was suffering from acute symptoms of borderline personality disorder (BPD) and depression.

The deceased experienced suicidal thoughts and associated distress. The consulting clinician referred her to a crisis assessment and treatment team (CATT) to provide additional clinical support. In the days leading up to her death, the CATT team were unable to make contact with her and she was located deceased at home.

Recommendations:

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death of [deceased]:

- BPD is a complex psychiatric illness that poses challenges for treatment within the existing public mental health system.
- In common with other situations where there is a shared care arrangement or transition from one health care practitioner or institution to another, the circumstances surrounding [the deceased's] death highlight the need for rigour and clarity at the point of transfer of a patient with BPD from the public mental health system back to the private practitioner. Ideally, decision-making around transfer should involve multidisciplinary review, clear communication with the private practitioner, and a clearly articulated plan. At a minimum, that plan should stipulate how and when the transfer will occur, what the future roles of the private practitioner and the CATT team will be, and the extent to which the patient is involved in planning for disengagement and recommencement of treatment with the private practitioner.
- [Health service] provided the Coroners Court of Victoria with a statement regarding the availability of BPD specific training for CATT staff. [Health service] does not provide specific training for CATT. The available training provides the necessary information clinicians need, although there is no evidence of evaluation that this meets the needs of this cohort of staff. Between 2009 and 2012, only 5-13 % of attendees at the available [health service] training were CATT staff. In light of the fact that CATT staff provide most of the crisis and short-term assertive community based care for clients who are referred by private practitioners when a crisis is identified, this figure seems low. The current system relies on a CATT clinician recognising they require training specific to BPD.

Pursuant to section 72(2) 'of the Coroners Act 2008, I make the following recommendation(s) connected with the death of [the deceased]:

- That in order to improve the safety of people with a Borderline Personality Disorder (BPD) who are in crisis and referred to CATT /ECATT [emergency crisis assessment and treatment team], [Health service] should assess whether the available BPD specific training meets the needs of CATT/ECATT clinicians, whose focus is on short-term assertive follow-up, and transfer of care back to private practitioners, rather than ongoing treatment and support of people with BPD.
- If found wanting, that [health service] work with the CATT/ECATT teams in public mental health services in Victoria, to develop BPD specific training suitable to the needs of CATT/ECATT clinicians, in order to improve the safety of people with BPD who are referred to them in crisis.
- That all public Mental Health Services encourage CATT/ECATT team member to participate in BPD specific training.

VIC.2010.234

Additional tag(s): Mental illness and health

The deceased was an adult female who intentionally took her own life by hanging. At the time of her death, the deceased was an inpatient at a psychiatric facility and was on unsupervised day leave. The deceased's family was not informed that she had not returned to the facility for several hours.

The coroner found significant issues with the documentation kept by the psychiatric facility, including correspondence relating to the circumstances of [the deceased's] leave.

Recommendations:

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation(s) connected with the death:

- To prevent suicides from patients granted leave from Acute Inpatients Units, I recommend:
 - a) The Department of Health and Human Services ensure there is clear and consistent process, documentation and communication for Leave Plans. Any changes are to be made only after suitable discussion and consideration and such variations recorded and communicated.
 - b) In addition to Recommendation 1A, the process and documentation of Leave Plans should incorporate supervision and accountability to ensure compliance by all mental health professionals involved in the granting and implementation of leave plans.
 - c) That there be a process for ensuring the accuracy of information provided to the Chief Psychiatrist.
 - d) Implement Recommendation 15 made in the report titled "Chief Psychiatrist's investigation of inpatient deaths 2008-210" that "That the Chief Psychiatrist convene a panel every three years to inquire into inpatient deaths over that time to consider overall practice improvements and issues relevant to the mental health system".

VIC.2010.601

Additional tag(s): Domestic incident

The deceased was an adult female who intentionally took her own life by hanging. On the day of the incident, the deceased was involved in an argument with her partner. The

deceased's partner and children left the property and on their return located the deceased hanging in the garage. Despite resuscitative efforts, the deceased was unable to be revived.

The coroner found that the deceased experienced a number of stressors that likely caused or contributed to her decision to end her life. The deceased's relationship was characterised by violence and she was expecting another child.

Recommendations:

Pursuant to Section 72(2) of the *Coroners Act 2008*, I make the following recommendation(s) in connection with the death:

- That the Royal Australian College of General Practitioners develop a strategy to reinforce the presence of current resources and guidelines which recommend general practitioners routinely ask pregnant women about intimate partner violence, as described in the following publications:
 - Guidelines for Preventive Activities in General Practice 7th Edition (2009), published by the Royal Australian College of General Practitioners;
 - Abuse and Violence: Working with Our Patients in General Practice (2008), published by the Royal Australian College of General Practitioners; and
 - Management of the Whole Family When Intimate Partner Violence is Present: Guidelines for Primary Care Physicians (2006), published by the Victorian Government Department of Justice.

VIC.2010.3666

Additional tag(s): Mental illness and health

The deceased was an adult female who took her own life by incised injury. The deceased had planned to take a holiday. On the day of her scheduled departure, she was located by police after a welfare check was requested by her neighbour.

The deceased had a complex psychiatric history, including schizophrenia, treated with medications. She had recently been prescribed the antidepressant, Escitalopam, but it appears she may not have commenced taking it. She was also under the care of a mobile support and treatment service that included home visits, mental state examinations and risk assessments.

Recommendations:

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation connected with the death:

- That to increase the safety of patients with an emerging depressive illness, [organisation name] Mental Health Services review its policy and clinical guidelines to ensure

monitoring of therapeutic effectiveness in the high-risk commencement period for antidepressants is assessed according to best practice principles.

VIC.2011.291

Additional tag(s): Mental illness and health

The deceased was an adult male who intentionally took his own life by hanging. The deceased was an involuntary patient at a mental health facility when he absconded. Several days later, he was located hanging in the garage of his own home.

The deceased's absence was not noticed for a significant period of time and there was a breakdown in the procedure for notifying police. The facility also had no procedure for following up on police inquiries to locate him.

Recommendations:

- That the [location] Mental Health Service [MHS] review the security arrangements relating to exiting the [location] in patient facility, in the context of admission of involuntary patients to the low dependency unit at that facility.
- That the [location] Mental Health Service review its procedures relating to notifications to police of absconding patients and documentation on patient file and follow up of same with police by the Mental Health Service staff.
- In view of the review and new procedures adopted by the [location] Hospital MHS in relation to the follow up of absconding patients and improvements in the effectiveness of the liaison between inpatient services and the Community Treatment Team, I make no recommendation as to this matter.
- The Secretary of the Department of Health and/or the Chief Psychiatrist should ensure that a state-wide co-ordinated procedure for notification of and locating absconding mental health patients is adopted in order to ensure that a coordinated approach is adopted and follow up occurs. This procedure may appropriately be advised by way of the existing procedures published by the Department of Health in relation to accessing services.
- In the absence of a state-wide procedure the responsibility for follow up of an absconding patient ought to rest primarily with the facility from which the unauthorised absence occurred. There should be no administrative transfer of care to another facility until the patient has been located. This approach would appear to be supported by existing Departmental directives referred to in the footnote to Recommendation 4 herein.
- During the course of the Inquest it became apparent that there were limitations upon access by responsible clinicians to the RAPID database in a context of an absconding involuntary patient. Access arrangements to absconding patient details ought to be reviewed in order that all information on that database is available to any mental health

clinician state-wide with responsibility for follow up of an absconding patient.

NATURAL CAUSE DEATH

VIC.2004.4606

The deceased was an adult female who died shortly after giving birth. The deceased was transferred to the operating theatre for manual removal of the placenta when she suffered a cardiac arrest. Circulation was returned following resuscitation but the deceased had suffered irreversible brain injury. Medical treatment was eventually withdrawn and the deceased pronounced life extinct.

Recommendations:

I acknowledge the divergence of views between the pathologists and the clinicians about the evidence required to diagnose AFE [amniotic fluid embolism], nevertheless, it was clear on the evidence that it is considered one of the leading causes of maternal death of which not enough is understood. In an attempt to capture the incidents of AFE, including both where death and survival has occurred, with the aim of improving the knowledge base and potentially the management of women diagnosed with AFE, I accept [clinician's] comments and I recommend that The Royal Australian and New Zealand College of Obstetricians and Gynaecologists explore the utility of sharing this knowledge through the development, administration and maintenance of an Amniotic Fluid Embolism register.

TRANSPORT AND TRAFFIC RELATED

VIC.2007.3890

Additional tag(s): Work related

The deceased was a middle aged male driving a ride-on mower in a reserve near a freeway exit. A prime mover was travelling along the freeway at speed when the wheel, hub and axle broke away from the vehicle. The detached parts collided with the deceased causing fatal injuries.

Investigations revealed that the separation of the wheel, hub and axle was caused by the development of cracks in the right forward drive axle of the prime mover. The coroner found

that the death could have been prevented had the cracks been identified and remediated at an earlier stage.

Recommendations:

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation(s) connected with the death:

- That VicRoads provide greater incentive for registered vehicle operators to report modifications that require re-registration by making the failure to do so within the relevant timeframe an indictable offence and by increasing the penalty. This would have the additional benefit of removing the 12 month time limit for prosecution.
- That VicRoads, in addition to the ongoing requirement of notification pursuant to Regulation 225(3) of the Road Safety (Vehicles) Regulations 2009, require registered heavy vehicle operators to declare any repairs or modifications that change or may change the heavy vehicle's compliance with Australian Design Rules and road worthiness requirements.
- That VicRoads provide greater incentive for registered vehicle operators to prevent drivers using vehicles that do not comply with the regulations. To do this, it should be an indictable offence for a registered vehicle operator to direct a driver to drive a non-compliant vehicle. The penalty attached to the offence should also be increased accordingly.
- That the National Heavy Vehicle Regulator ensure that the National Heavy Vehicle Accreditation Scheme is expanded to include all Victorian heavy vehicle operators who perform their own maintenance in-house.
- That the National Heavy Vehicle Regulator ensure that the Code of Practice adopted by the National Heavy Vehicle Accreditation Scheme also ensures that mechanics performing maintenance work on heavy vehicles have access to and comply with manufacturers' maintenance instructions.
- That VicRoads review and re-publish their advice to heavy vehicle repairers in Victoria in the context of new arrangements involving the National Heavy Vehicle Regulator using [the deceased's] death as an example of the long-term consequences of inappropriate repairs.
- That WorkSafe distribute an Industry Alert to heavy vehicle operators, using [the deceased's] death as an example, to promote industry awareness about the long-term consequences of performing inappropriate repairs on heavy vehicles and inadequately maintaining fleets.
- That the Insurance Council of Australia ensures that their new Code of Practice encourages heavy vehicle repairers to become aware that they must comply with manufacturers' advice when they repair damaged drive axles on prime movers under an insurance contract.
- That VicRoads require registered owners, operators and drivers of commercial heavy vehicles to undertake training in basic vehicle maintenance to enhance their

understanding and appreciation of regular maintenance in an effort to improve safety awareness.

- That VicRoads undertake or authorise a prevention study to provide insight into motivational factors behind heavy vehicle operators use their vehicles when they have not been properly maintained.

VIC.2010.4004

Additional tag(s): Work related

The deceased was an adult male who died in a motor vehicle incident on a freeway. The incident involved the deceased, who was riding a motorcycle (vehicle 1), a heavy rigid truck (vehicle 2), and a prime mover/trailer combination (vehicle 3) displaying a 'Long Vehicle' sign. The 'Long Vehicle' sign detached from vehicle 3, crossing the lane in front of vehicle 2 and into the path of vehicle 1. The deceased lost control, fell from his motorcycle and was pronounced deceased at the scene.

Recommendations:

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation(s) connected with the death:

- I recommend that VicRoads and the Victorian Transport Association, through their respective industry networks, communicate to the broader transport industry, about the need to ensure that 'Long Vehicle' (and other) warning signs are correctly positioned and securely attached to heavy vehicles, in the interests of the safety of all road users.

VIC.2012.154

Additional tag(s): Location / Older persons

The deceased was an older adult female who sustained fatal injuries when she was struck by a passenger car whilst crossing the road. The deceased was trapped underneath the vehicle until the arrival of emergency services. She was transported to hospital but later died.

Recommendations:

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

That VicRoads consider the installation of a designated pedestrian crossing allowing patrons of [location] Centre to safely cross [road] from the [...] car park, opposite the Centre.

WESTERN AUSTRALIA

ADVERSE MEDICAL EFFECTS

WA.2008.313

Additional tag(s): Older persons

The deceased was an older adult female who died following an anaphylactic reaction to a drug administered in hospital. She had recently undergone eye surgery and the drug was administered to reduce post-operative intraocular pressure.

Prior to the surgery, the deceased's allergy to *sulphas*, or sulphonamides, was well known and well recorded in the hospital medical file. Despite this, the treating doctor prescribed a drug containing *sulphas*.

Recommendations:

- I recommend the Director-General of Health circulate a directive to all nurses, doctors and surgeons employed by the Department of Health at [hospital] to remind and require them to appropriately record the precise nature of each patient's known allergy to medications, in order to ensure the precise nature of the allergy is known to the prescriber of any subsequent medication.
- I recommend the Director-General of Health develop a protocol which mandates the minimum acceptable standards of practice which doctors and surgeons, not employed by the Department of Health, agree to adopt before being allowed to practice in [hospital]. These protocols should highlight, to the physician, the existence of any protective procedures or systems such as the wearing of a red identity wristband which signify the wearer as suffering from a known allergy including an allergy to a medication.

CHILD AND INFANT DEATH

WA.2010.1325

The deceased was a male child who died when he became entrapped in a washing machine in the house he lived in with his mother and her partner. According to the deceased's

mother, she located him in the washing machine before immediately contacting emergency services. Despite resuscitative efforts, he was unable to be revived.

The coroner was unable to determine how the child came to be trapped in the washing machine.

Recommendations:

- I RECOMMEND that the Electrical Safety Committee consider the possibility of amending the relevant Australian Standards so that all front loader washing machines have a two-way latch mechanism regardless of dimensions. In the event that this is found to be impracticable;
- I RECOMMEND that the Electrical Safety Committee consider the possibility of amending the relevant Australian Standards so that for machines to which a two-way latch is not fitted, there is a safety catch on the door which would be difficult for a young child to open.
- I RECOMMEND that Standards Australia arrange for the relevant technical committee to review AS/NZS 60335.2.7 [(the relevant standard)] in the context of the concerns expressed in these comments.

WA.2010.773

The deceased was an adult male who died when he accidentally self-injected an excessive amount of propofol. His body was located at home by police conducting a welfare check after he failed to show up for his shift. The deceased worked at a hospital and had unrestricted access to propofol.

Under the *Poisons Act 1964*, there is no requirement for hospitals to keep a register or make regular inventories of Schedule 4 drugs, such as propofol.

Recommendations:

- I recommend that, if reasonably practicable, the Department [of Health] and all hospitals in the Western Australian health system implement a means of restricting the unauthorised use of propofol without placing patients at risk.

DRUGS AND ALCOHOL

WA.2010.858

Additional tag(s): Adverse medical effects

The deceased was an adult female who died from complications of an overdose of fentanyl. At the time of her death, the deceased was using fentanyl patches prescribed by her doctor to treat lower back pain.

The evening prior to her death, the deceased was heavily intoxicated and her son removed a fentanyl patch from the deceased's abdomen before putting her to bed with a hot water bottle. He located the deceased with no signs of life the following morning.

The coroner found it likely the effect of the already high dosage of fentanyl was exacerbated by the application of heat via the hot water bottle.

Recommendations:

- The Therapeutic Goods Administration consider changing the product information for fentanyl transdermal patches to ensure that it contains no potential anomalies.
- Medical practitioners ensure that, in prescribing fentanyl transdermal patches, they follow closely the relevant prescribing directions.

NATURAL CAUSE DEATH

WA.2011.1520

Additional tag(s): Law enforcement / Indigenous

The deceased was an older adult male of aboriginal origin and a sentenced prisoner at the time of his death. At the time of his imprisonment, he had a number of medical conditions, including heart-related issues.

During the term of his imprisonment, the deceased's status as a terminally ill prisoner was upgraded from phase one to phase two, whereby his death was considered imminent. This change in classification can influence a prisoner's sentence. The deceased and his family were not immediately made aware of this changed status.

On the day of his death, he suffered a heart attack and was conveyed to hospital but his condition deteriorated and he died a short while later.

Recommendations:

- I recommend that the Department of Corrective Services consider amending its Policy Directive 8 to require that a person classified as having a Phase 1 or Phase 2 terminal illness be notified of the classification and the ramifications thereof as soon as practicable after the classification occurs.

WA.2012.1356

Additional tag(s): Law enforcement

The deceased was an adult male and a sentenced prisoner at the time of his death. The deceased died of natural causes when an undetected aneurysm in his brain ruptured.

The deceased was lying on his stomach repairing a faulty drainpipe on the prison grounds and was unsupervised at the time of the incident. Whilst he was lying in that position, the aneurysm in the deceased's brain ruptured and he became unresponsive. The deceased was located by a prison officer a short while later and emergency services were contacted. The deceased was transferred to hospital but his condition was considered non survivable and he died the following day.

The coroner considered the care provided by the correctional facility to be appropriate.

Recommendations:

- I recommend the Commissioner of the Department of Corrective Services consider implementing changes to the healthcare arrangements of prisoners at the [correctional facility], so they can provide written permission for a hard copy of their ECHO [Electronic Health Online] file to be provided to their local, community based physician.
- I recommend the Commissioner of the Department of Corrective Services consider implementing changes to the healthcare arrangements of prisoners at the [correctional facility], so their ECHO file is regularly reviewed by a physician employed by the Department, with a view to determining whether an unwelcome pattern of ill-health has developed which invites further medical investigation or treatment.

TRANSPORT AND TRAFFIC RELATED

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

WA.2008.248

Additional tag(s): Work related

The deceased was a young adult male who died when the small plane he was piloting collided with the ground following a mid-air collision with a helicopter. At the time of the incident, the aircrafts were undertaking a feral animal culling exercise in the area.

The coroner found that pilot fatigue was a major factor in the fatal crash. At the time of the incident there were no clear protocols or procedures in place for establishing and maintaining aircraft separation in multi aircraft operations, including aerial shooting operations. Neither aircraft was fitted with electronic avoidance technology which would alert pilots to the potential for an air crash.

WA.2008.249

Additional tag(s): Work related

The deceased was a young adult male who died when the small plane in which he was a passenger collided with the ground following a mid-air collision with a helicopter. At the time of the incident, the aircrafts were undertaking a feral animal culling exercise in the area. The deceased's task was to locate goats for culling.

The coroner found that pilot fatigue was a major factor in the fatal crash. At the time of the incident there were no clear protocols or procedures in place for establishing and maintaining aircraft separation in multi aircraft operations, including aerial shooting operations. Neither aircraft was fitted with electronic avoidance technology which would alert pilots to the potential for an air crash.

Recommendations:

- I RECOMMEND that both DEC [Department of Environment and Conservation] and DAF [Department of Agriculture and Food, Western Australia] put in place guidelines in respect of aerial work which would specifically cover feral animal culling, to ensure that there is at least a 500 foot vertical buffer between spotter and shooter aircraft in addition to any horizontal buffer.
- I RECOMMEND that] take DEC and DAF action to ensure that ongoing consideration is given to possible use of available anti-collision systems and particularly the FLARM system.

WATER RELATED

NOTE: The Western Australian Coroner held a joint inquest into the following 17 deaths, which resulted from the same incident.

WA.2012.1001

WA.2012.1003

WA.2012.1004

WA.2012.1005

WA.2012.1006

WA.2012.1007

WA.2012.1008

WA.2012.1009

WA.2012.1010

WA.2012.1011

WA.2012.1012

WA.2012.1013

WA.2012.1014

WA.2012.1015

WA.2012.1016

WA.2012.1017

Additional tag(s): Transport and traffic related

17 people died by drowning when the vessel they were aboard capsized. The deceased were asylum seekers travelling from Indonesia to Christmas Island on a journey coordinated by people smugglers.

The vessel was unseaworthy, grossly overloaded, had no emergency locator devices, inadequate personal safety devices and a crew with very limited sea experience.

Both Australian and Indonesian authorities were involved in the search and rescue response. The Coroner found Australian and Indonesian authorities could have increased the quality and quantity of information sharing to improve the search and rescue operation. The

Coroner also found that the comprehensiveness of the coronial investigation was affected by Commonwealth authorities failing to share critical information.

Recommendations:

- I RECOMMEND that Australia work with Indonesia to improve the quality of communication in respect of coordination of search and rescue responses to calls for assistance made by asylum seekers on boats travelling from Indonesia to Christmas Island.
- I RECOMMEND that transfer of acceptance of search and rescue responsibility should take place at a relatively senior level.
- I RECOMMEND that when possible documents containing information about any important decisions made about search and rescue responses be translated into languages of the involved countries.
- I RECOMMEND that in any relation to any future tragedies where Commonwealth departments or organisations are involved and have access to relevant information, whether classified or not, that information is volunteered, or at least its existence is made known, to those investigating the circumstances of the deaths on behalf of the coroner.

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.