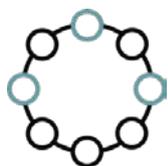




Coronial Recommendations: Fatal Facts

A summary of cases and recommendations made
between 1 October and 31 December 2013

Edition 39



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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 October and 31 December 2013.

Previous summaries and recommendations are available

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

AUSTRALIAN CAPITAL TERRITORY

FALLS

ACT.2012.244

Additional tag(s): Older persons

The deceased was an older adult female who died during surgery to repair a fractured hip sustained in a fall.

The coroner found that the death was accidental with major contributory natural causes.

The coroner's recommendation related to the coronial process in light of the uncontroversial and unchallenged evidence of this death.

Recommendations:

- I recommend a review of the requirements of section 34A of the *Coroners Act 1997* limiting the power of a Coroner to dispense with a hearing.

NEW SOUTH WALES

ADVERSE MEDICAL EFFECTS

NSW.2008.2558

The deceased was a middle aged female who was diagnosed with cerebral palsy as a child and had a cerebral shunt. She died from complications of infection and brain damage.

The deceased had been unwell for several days before admission and was brought to hospital after a medication error which caused her to become drowsy. Investigations revealed the cerebral shunt was blocked causing fluid on the brain. Her condition deteriorated and she died a few days later.

Recommendations:

To Ageing, Disability and Home Care, Department of Family and Community Services:

- That staff at the [location] group home be trained on an ongoing basis to enable them to provide adequate background information for medical professionals treating clients by ensuring that the Professional Services Report contains a complete picture of the physical and cognitive changes in a client over the preceding seven days.

FALLS

NSW.2009.3507

Additional tag(s): Aged care

The deceased was an older adult female who died from complications following a fall.

The deceased was a resident in an aged care facility. On the day of the incident, she fell whilst being transferred from her bed to a chair using a mechanical lifter. She was transferred to hospital before being returned to the aged care facility where she died a few days later.

The coronial investigation revealed areas for improvement regarding the facility's record keeping.

Recommendations:

To [aged care service provider]:

- That [aged care service provider] review clinical record keeping and training at [facility] to make sure records can be easily maintained and updated by staff and doctors with a view to ensuring legibility, transparency and accountability.

NSW.2010.5258

Additional tag(s): Aged care

The deceased was an older adult female who resided in an aged care facility. She sustained a fatal head injury when she fell whilst unsupervised in the bathroom. Instruction manuals stored above the deceased's bed and in the wardrobe outlined that she should not be left unsupervised whilst in the bathroom.

Staff summoned a non-urgent ambulance but upon arrival, paramedics indicated that an urgent ambulance should have been requested due to the severity of the deceased's injuries. She died a few days later.

Recommendations:

To: General Manager, [service provider] and the General Manager [aged care facility].

- That steps be taken to review the training of all staff in relation to where information regarding the care and treatment of residents is maintained and located, in particular, the location of the "Activities of Daily Living" sheets; and
- That the policy in relation to the care and treatment of head injuries be reviewed as a matter of urgency.

HOMICIDE AND ASSAULT

NSW.2006.6077

The deceased was a young adult female at the time of her disappearance. The case was reported to the coroner eight years after her disappearance as it was suspected she was no longer alive.

The coroner found it more than likely she died as a consequence of the action of a third party.

Recommendations:

To: The Commissioner of Police:

- That, consistent with the NSWPF [New South Wales Police Force] policy that during the first 72 hours of an investigation into a homicide or suspicious death the Homicide Squad is the leading investigator, consideration be given to the amendment of the NSWPF 'Missing Persons – Standard Operating Procedures' so as to require that where the risk assessment undertaken identifies that there is a high, or very high, risk that the missing person has been the victim of a homicide or otherwise suspicious death, the Homicide Squad is to be immediately advised of the circumstances of the disappearance.
- That the investigation of the death of [the deceased] be referred to the Unsolved Homicide Unit of the NSW Homicide Squad for further investigation in accordance with the protocols and procedures of that unit.

NSW.2008.4527

The deceased was an adult male at the time of his disappearance. The coroner found he died at an unknown location on the same day he disappeared.

The coroner made an open finding as to the cause or manner of death.

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 Homicide Squad for further investigation in accordance with the protocols and procedures of that unit.

NSW.2009.4912

Additional tag(s): Child and infant death

The deceased was a male child who was brought to hospital by a parent in a nonresponsive state. Despite medical staff efforts, he failed to recover and died a week later.

The coroner found the deceased was shaken with such force that he suffered significant injuries leading to his death. The coroner was unable to determine who was responsible for

the deceased's care at the time of the incident. The coroner also found evidence of previous injuries.

Recommendations:

To: The Attorney General

- That the attention of the Attorney General be drawn to the findings and recommendations of The Law Commission in its report entitled *Children: Their Non-Accidental Death or Serious Injury (Criminal Trials)* dated 6 August 2003 and that consistent with the findings and recommendations of that report consideration be given to the enactment of a new criminal offence in New South Wales similar to that of *Causing or allowing the death of a child or vulnerable adult* as was created by Section 5, Domestic Violence, Crime and Victims Act 2004 (UK).

To: The Minister of Family and Community Services

- That the attention of the Minister for Family and Community Services be drawn to these findings and the reasons therefore and that such action as is considered necessary to be taken to ensure the continued health, safety and siblings of [the deceased].

INTENTIONAL SELF-HARM

NSW.2012.4905

Additional tag(s): Law enforcement

The deceased was an adult male and serving prisoner who took his own life by hanging. He resided in a private cell, otherwise known as a "one-out cell", after having his request for this cell type granted by the correctional facility.

In an observational check of the deceased during the night, he was seen to be sitting on the floor in his cell. In another check a few hours later, the deceased was observed to be in the same position but a prison officer saw a ligature around his neck. It was clear he was deceased.

Recommendations:

To the Attorney-General & Minister for Justice:

- I recommend that [service provider] be required to follow Department of Corrective Services policy and practice in relation to the allocation of one-out or two-out cells at

[location] Correctional Centre. In particular, the formal process of reassessment of inmates should be followed before a change to a one-out cell is made.

- I recommend that the Department of Corrective Services review [service provider]'s practice in relation to allocation of one-out and two-out cells at [location] Correctional Centre.
- I recommend that the Department of Corrective Services and [service provider] review the investigation report of [police officer] dated 18 February 2013 and implement his recommendations or take action as appropriate in respect of them.

To the Managing Director, [service provider]:

- I recommend that [service provider] and the Superintendent of the [location] Correctional Centre consider implementing a policy that, if during nightly security checks an inmate is observed to be sitting or lying beside cell door vent, or in proximity to any other potential hanging points in his cell, the officer(s) check to ensure that the prisoner has not hanged himself.
- I recommend that [service provider] follow Department of Corrective Services policy and practice in relation to the allocation of one-out or two-out cells at [location] Correctional Centre. In particular, the formal process of reassessment of inmates should be followed before a change to a one-out cell is made.
- I recommend that the Department of Corrective Services and [service provider] review the investigation report of [police officer] dated 18 February 2013 and implement his recommendations or take action as appropriate in respect of them.

LAW ENFORCEMENT

NSW.2012.1375

Additional tag(s): Natural cause death

The deceased was a middle aged male who died as a result of a heart-related condition.

The deceased had an argument with a relative and police were called to the scene. The police spoke to the deceased who then collapsed and became unresponsive. Paramedics were called and police placed him in the recovery position. He was transferred to hospital where he was pronounced life extinct.

Recommendations:

The Commissioner of NSW Police:

- That the current education and training programs for Police relating to first aid and CPR be reviewed and amended in light of the current accepted industry standard, and to that end, the appropriate persons within the NSW Police force consult with the Australian Resuscitation Council with respect to improving and updating the training of all police officers with respect to the provision of CPR.

NSW.2012.1449

Additional tag(s): Weapon

The deceased was an adult male who died when he was shot by police.

Police were called to the scene where the deceased was armed with a knife and threatening members of the public. A police officer discharged their service pistol when the deceased threatened police. Despite first aid attempts, the deceased died at the scene.

Recommendations:

To Commissioner of Police:

- I recommend that [police sergeant] and [police sergeant] be nominated for appropriate bravery awards.

SPORTS-RELATED

NSW.2011.3490

The deceased was an adult male who died due to a head injury sustained in a boxing match. He had competed professionally as a boxer for the past ten years.

During the match, the deceased sustained kicks and punches to the head and became unconscious. He was conveyed to hospital and underwent surgery but his condition did not improve and life support measures were withdrawn.

Recommendations:

To the Minister of Sport and Recreation and the Australian College of Sports Physicians:

- I recommend that the College and the Combat Sports Authority consult and develop protocols for pre-match and post-match medical screening of combat sports

combatants.

NSW.2011.4527

The deceased was an adult male who died due to a head injury sustained in karate training.

The deceased was sparring with another person when he collapsed. He was taken to hospital by ambulance but died a couple of days later.

The sparring training was not captured by *Combat Sports Act 2013* so there were no relevant statutory requirements in place with respect to safety standards.

Recommendations:

To the Minister for Sport

- That the Office of Sport consider working with [sports organisation] (and possibly other martial arts organisations) to develop a general head injury/concussion protocol or policy for the use of karate organisations at gradings and training. This process should take place with expert medical advice. Once developed, the policy could be published and promoted on [sports organisation]'s website and made available more widely.
- That the Office of Sport, through funding contracts with State Sporting Organisations, mandate the adoption of appropriate head injury/concussion protocols or policies.
- That the Office of Sport consider working with [sports organisation] (and possibly other martial arts organisations) to develop a guideline on best practice for grading days. Once developed this guideline could be published and promoted on [sports organisation]'s website and made available more widely.

NORTHERN TERRITORY

ADVERSE MEDICAL EFFECTS

NT.2011.217

Additional tag(s): Natural cause death

The deceased was a young adult female who died from sepsis.

The deceased had recently given birth and had been discharged from hospital. A few days later, she fell, injuring her knee. She was transported to hospital via ambulance later that evening due to extreme pain.

Hospital staff were unable to diagnose the deceased so arrangements were made to transfer her care to another hospital. During the transfer, her condition deteriorated and she suffered a cardiac arrest and died.

The coroner found that the delay in diagnosing the deceased and transferring her care to another hospital reduced her chance of survival.

Recommendations:

- I have referred previously to the sepsis recognition protocol for [hospital]. There is one key matter in respect of which I make a recommendation. We now know that when [the deceased] arrived at the [the hospital] at 6.00am she was very sick and already in the early stages of severe sepsis. [Physician] says that her pulse rate at shortly after 6.00am was 110 (95 when settled), her blood pressure was normal at 110/60, her temperature was 36.8. She didn't specify the respiratory rate. Therefore at this point stage two of the [hospital] sepsis protocol (if it existed back then) would not have been activated. The observation charts for the day commence with results taken at 8.00am. At that time the observation charts reveal that [the deceased] had a respiratory rate of 21, a heart rate of 116 and a systolic blood pressure of 120. On the present [hospital] protocol, stage two would not have been satisfied as the respiratory rate requires 25 at least, and the heart rate requires 110bpm. The systolic blood pressure had to be less than 100mmHg. The [hospital] protocol would have been satisfied at 8am (subject to appropriate blood gas results) if the sepsis protocol respiratory rate was lowered to 20. I recommend that this occur. I note that the Mayo Clinic in the United States, which is an esteemed medical organisation of many years standing, has respiratory rate of 20 breaths per minute under its 56 sepsis diagnosis protocol. It would seem to me that this, of itself, is a strong basis for lowering it. Fundamentally, it would be nonsensical if a lady who we now know was in

the early stages of severe sepsis does not have this recognised as soon as possible. I also recommend that [another hospital's] sepsis protocol heart rate figure be lowered to 110 from 120 for the same reason. I can see no reason for the difference with [hospital] and prudence would dictate that the lower number be used. The Mayo Clinic uses a heart rate figure of 90 beats per minute.

- The second recommendation that I make is that medical doctors when making a statement for an Inquest should make it as soon as possible; refer to clinical notes, if possible; date the statement; and not refer to the statements of any others when in the process of making the statement.

ANIMAL

NT.2012.274

Additional tag(s): Location/ Youth/ Indigenous

The deceased was a female child of aboriginal origin who died when she was attacked by a crocodile whilst swimming in a water hole.

The coronial investigation established that there was no crocodile warning signs near the billabong and surrounding area.

Recommendations:

I recommend that Parks and Wildlife Commission NT give consideration to erecting crocodile warning signage in the vicinity of and surrounding the billabong.

HOMICIDE AND ASSAULT

NT.2011.254

Additional tag(s): Mental illness and health/ Weapon

The deceased was an adult female who died when she was stabbed by her flatmate. The flatmate suffered from paranoid schizophrenia and was acutely psychotic at the time of the incident.

The deceased and her flatmate were under the care of a mental health service. The flatmate had not been effectively treated or medicated in the previous months leading up to the incident.

The coronial inquest found a lack of effective leadership and management of the health service contributed to inadequacies in the treatment of clients, including the deceased's flatmate. Whilst some reforms had already been implemented by the time of the inquest, the coroner made recommendations aimed to ensure long-term reform.

Recommendations:

To the Minister for Health:

- That the role of Clinical Director of [health service] be maintained, and that in the event of the current Director leaving the role, steps be put in place to ensure [they are] replaced as expeditiously as is feasible.
- That a quality assurance mechanism be set up to monitor implementation of the recommendations that were made in the "Critical Incident Review (Confidential report to the Directors of [another mental health service] and Mental Health)" and the "RM Critical Incident Review - Report to the Director of Mental Health" commissioned following the death [the deceased].
- That the Office of the Northern Territory Coroner be advised of the mechanism referred to in 2 above within three (3) months of the date these findings are published.

NATURAL CAUSE DEATH

NT.2012.35

Additional tag(s): Physical health/ Indigenous/ Geographic

The deceased was a middle aged female of aboriginal origin who died as a result of a chronic renal condition.

The deceased had a history of kidney disease and was experiencing pain in her right leg and blood in her urine. She was scheduled to fly to another hospital for treatment but her flight was delayed due to bad weather. During this time, her condition deteriorated and she died soon after.

The coroner found that the deceased was provided appropriate care but a point-of-care blood test - a blood test administered at the time and place of patient care - may have improved the safe management of the deceased.

Recommendations:

I recommend that the Department of Health give consideration to point-of-care testing technology in remote health clinics in the Territory.

QUEENSLAND

INTENTIONAL SELF-HARM

QLD.2011.2168

Additional tag(s): Work related/ Drugs and alcohol

The deceased was a middle aged male who took his own life by inhaling exhaust fumes. He was a school teacher with a long-term diagnosis of depression that was treated with medication.

He experienced difficulties at his workplace in the lead up to his death,. The coroner highlighted a number of events that negatively affected him and contributed to his mental health deteriorating.

Recommendations:

I RECOMMEND that the Department in consultation with appropriate stakeholders (such as the QTU [Queensland Teachers Union]), develop an appropriate policy, procedure or guideline that provides staff with clear direction on information concerning their medical, mental health, rehabilitation and grievance history that should and can be communicated or which can be communicated with their consent (and if relevant, information that should not be communicated), when staff are being considered for transfer or relocation, to enable regional staff (either at a HR level and/or other sections of the administration and/or the Vacancy Review Panel) to better place employees to best fit the needs of the employee and the school and to determine if any particular level of support is required.

TRANSPORT AND TRAFFIC RELATED

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

QLD.2008.5109

QLD.2008.5111

The deceased were two men on a joy flight in a two-seater aircraft when it crashed into the ocean. The evidence suggests that the pilot failed to recover after performing a particular manoeuvre, either by suffering from a medical indisposition or having committed a pilot error.

The pilot was well-known with many years' experience. He had an extensive history of offences and breaches under aviation regulation and the law and his commercial piloting licences had been cancelled. None of this information was known to the other passenger and no mandatory reporting regimes existed at the time.

Recommendations:

Recommendations Re CASA [Civil Aviation Safety Authority]

- That CASA consider immediately disseminating the names of pilots to the industry who have had conditions imposed upon their licence or had their licence suspended or cancelled. As it is a matter of some urgency, the dissemination should be by way of emails.
- That CASA consider immediately introducing a Register of Pilots which includes reference to licence suspensions and cancellations. That further dissemination should be by way of, a readily available entry on the CASA website in the form of the Register of Pilots, in the CASA briefing newsletter and the bi-monthly electronic magazine 'Flight Safety Australia'.
 - i. The fact that the Register exists should be published as widely as possible and on an urgent basis so that all pilots, airports and related aviation industry members are alerted to its existence.
 - ii. In the event that concerns are raised by CASA with respect to privacy or confidentiality requirements CASA should be referred to a range of entities which have long published such Registers.
- That when investigating a pilot's medical fitness CASA should consider adopting the practice, in the event of becoming aware of an ambulance/paramedic attendance upon the pilot, of obtaining the ambulance/paramedic report and related hospital reports. Where relevant they should also speak to the author of such reports. Those reports should also be forwarded to that pilot's Aviation Medical Examiner.
- That CASA give consideration to a review of the 'culture' within its Medical Unit of accepting medical information provided by pilots rather than being cautious, in particular with respect to pilots who are at risk of losing their licence.

Commonwealth centralised medical treatment system

- That the Queensland government give consideration to participating in the Commonwealth centralised medical treatment system (eHealth). That systems records medical data including personal health records, Medicare data, Australian Organ Donor Registration data and Australia Childhood Immunisation Registry data which can only be

accessed by medical practitioners. Further consideration should be given to a requirement that Queensland Ambulance Service reports also be included.

TASMANIA

ADVERSE MEDICAL EFFECTS

TAS.2012.127

Additional tag(s): Physical health

The deceased was a middle aged male who died from complications of heart disease.

He presented to a community health centre with chest pains but was discharged. Later that day, he became unwell and was transported back to the health centre via ambulance. His condition deteriorated rapidly; he suffered a cardiac arrest and died shortly after.

The coroner found the deceased should not have been discharged. The results of his electrocardiogram (ECG) were misinterpreted and he had several risk factors for heart disease.

Recommendations:

- The electrocardiogram remains a critical tool in medical practice and continued refresher courses in the interpretation and use of the ECG is recommended. The continued use of the ECG and review with experts is the best method of maintaining interpretation standards.

TAS.2012.127

Additional tag(s): Older persons

The deceased was an older adult female who died of complications following multiple abdominal surgeries.

She underwent abdominal surgery and was discharged from hospital. About a week later, she was unwell and was re-admitted to hospital for further surgeries. She suffered ongoing and severe pain and required an emergency laparotomy. After surgery, her condition deteriorated and she died the following day.

The coroner found that a breakdown in communication between theatre co-ordinating staff caused a delay in the emergency surgery and reduced the deceased's optimal chance of survival.

Recommendations:

- It is apparent that for whatever reason there was a communication breakdown between [physician] and [hospital]'s theatre co-ordinating staff so that the surgery proceeded at least two hours later than it should have done thus denying [the deceased] the optimal chance of survival. However, the evidence does not permit me to make a positive finding that the outcome for [the deceased] would have been different if the delay in surgery had been avoided. Nevertheless, this case does serve as an opportunity to recommend to [hospital] that it review its procedures to ensure that all critically ill patients requiring emergency surgery are treated without delay.
- In the course of investigating this matter [hospital] provided a copy of its emergency team calling and response protocols. I am advised by [professor] that these protocols do not employ the multi-observational scoring systems which have been proven to be better at detecting the deteriorating patient and are recommended by the Australian Commission on Safety and Quality in Health Care. In light of this advice it is my further recommendation that [hospital] review its protocols on this subject and give consideration to adopting a multi-observational scoring system.

CHILD AND INFANT DEATH

TAS.2009.510

Additional tag(s): Law enforcement

The remains of a female child were located in a suburban park. Police and the coroner were unable to determine the identity of the deceased infant or her mother.

Recommendations:

- I recommend that investigating police officers continue the search for the parents of the infant by regularly reviewing all state and national DNA databases.
- I recommend that investigating police officers liaise annually with Forensic Science Service Tasmania to ensure the infant's DNA profile is compared with all new profiles recorded.
- I recommend that investigating police officers investigate any new information that may come to light.

VIC.2012.3903

The deceased was a female child who died of positional asphyxia when her head became trapped between the mattress and a horizontal rail in the bed frame.

The deceased's mother heard a noise from the deceased's room shortly after she was put to bed. She later checked on the deceased and located her trapped and unresponsive. Despite resuscitative attempts, she was unable to be revived.

The deceased's bed was a cot that had been recently converted into a toddler's bed. The bed was marketed in a way that suggested it was suitable for toddlers.

Recommendations:

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

- That the Minister for Consumer Affairs through the Department of Consumer Affairs immediately issue a warning to parents that in making purchasing decisions or using adult sized beds and bed ends for toddlers and young children that entrapment may be an issue.
- That at point of sale all single beds ought be required to carry a warning as to suitability for use by toddlers and young children with particular reference to entrapment hazard and that the responsible authorities at Federal and State level take immediate steps to institute such a requirement.
- That the same product safety design standards applicable to bunk beds and cots be required to be applied in the manufacture and design of any bed designed or marketed or sold for use by toddlers or young children.

VIC.2009.5646

The deceased was an adult male who died when he accidentally overdosed on his prescription methadone. He was on a 'take away' methadone program, where he was dispensed methadone from a local pharmacist.

The day before his death, the deceased told his partner he had incorrectly taken an additional dose of his methadone. The couple fell asleep and in the morning, the deceased's partner located him cold and not breathing. Ambulance services arrived but he was unable to be revived.

It was reported that the deceased had been revived several times within the last two weeks following other incidents.

Recommendations:

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

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

VIC.2010.1621

Additional tag(s): Youth

The deceased was a young adult female who died of an accidental mixed drug overdose involving methadone. She was under the care of the Department of Health and Human Services at the time of her death.

The deceased purchased methadone from a supplier who was reselling the takeaway methadone of other people. The coroner found a lack of regulation in the prescribing and delivery of takeaway dosing programs.

Recommendations:

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

- That the Victorian Department of Health urgently review its policy with respect to the takeaway dosing component of the Opioid Replacement Therapy [ORT] programme, taking into account the number of deaths that have occurred due to the widespread availability of methadone in the community and the lack of any real safeguards to protect vulnerable third parties from the risks associated therewith.

At Page 21 of the 2013 Policy it is stated:

"Pharmacotherapy in Victoria is based on the principle of supervised dosing".

However, in response to a recommendation made by [another coroner] in the matter of [another deceased person] in which [they] recommended that supervised dosing only be implemented and takeaway dosing be prohibited, the Department of Health stated:

"The overall long-term success of maintenance therapy and patient retention in treatment is contingent on providing patients the opportunity to normalise their lives through the provision of takeaway dose. Takeaway doses facilitate a patient's reintegration into the community and enable stable patients to meet work and family commitments with minimal disruption."

On the face of it, this response seems to be at odds with the principal policy position that clearly states that *supervised dosing* should be the norm.

I am not advocating that takeaway dosing cease to be available. However, the statistics that have come to light in the course of this investigation in my view warrant an urgent rethinking of the way in which the ORT programme is operating in practice, the way in which eligibility for takeaway doses is assessed. The apparent expectation in the minds of ORT clients that they will automatically be entitled to takeaway doses seems to be contrary to the overriding policy as set out above. Given the reliance of prescribers on self-reporting by the patients in a number of areas that relate primarily to the safety of third parties, unless the safety of other members of the public can be objectively ascertained in some way (and I accept that this is difficult in a practical sense) and/or the other recommendations listed below are implemented, it is certain that there will be more tragic deaths like this one.

- That the Victorian Department of Health initiate a process whereby data is required to be generated in the following areas:
 - a. The number of patients on takeaway dosing;
 - b. Period of time between initial presentation to GP and commencement on takeaway dosing;

- c. The weekly number of takeaway doses allowed those patients;
- d. The dosage ranges of those takeaway doses;
- e. Any reductions in numbers of takeaway doses due to suspicion of diversion;
- f. Any reasons provided in support of permission to take away doses.

The abovementioned data relate to quantifying risks of *diversion* only. Other items that were listed by [physician] as desirable relate to the methadone programme generally (as opposed to takeaway doses) and do not fall within the scope of this inquest.

- That the Department of Health make ORT permit information accessible to hospital emergency departments 24 hours per day.
- That the Victorian Department of Health require all hospital emergency departments to record all admissions of patients suffering from methadone toxicity who are not on the ORT programme as evidenced by a search of the data base referred to in C above and forward such documentation to the Department of Health.
- That the Victorian Department of Health require ambulance paramedics to record attendances on all patients presenting with methadone overdose and forward such information to the Department who can then establish and record in a data base whether the patient is or is not currently registered on the ORT programme.
(In cases D and E, this will require some effort on the part of personnel to satisfy themselves as to the true identity of the patient, if necessary asking for proof of identity-name and date of birth. In the event that no satisfactory proof is supplied, this fact should also be recorded and the reasons why. Whilst privacy arguments may be advanced in opposition to this Recommendation, it is arguable that, given the number of deaths due to diverted dosing and the greater public health concerns, patients enrolled in the programme should be prepared to sacrifice some privacy for the greater good.)
- That the Victorian Department of Health embark on an investigation to determine the extent of trading in takeaway methadone such as, for example, requesting ORT programme clients to complete an anonymous survey in which they are asked about their knowledge of the practice.
- That the Secretary to the Commonwealth Department of Health amend the current Poisons Standard to require that containers of methadone dispensed as takeaway doses for opioid pharmacotherapy are adequately labelled with the caution: *“Never leave a person who has taken methadone to sleep it off. Call an ambulance immediately. Dial 000”*.
- That the Victorian Department of Health investigate the viability and safety of doctors supplying Narcan in injectable form or, should it become available, as a nasal spray to all clients on the ORT who are eligible for takeaway doses. The idea would be that the general practitioner strongly encourage, in the event of an overdose of a third person, the calling of an ambulance as a first response but, failing that, the administration of the Narcan, with appropriate demonstration of how to administer the drug. The shelf life of Narcan is two years. Some form of alert system could be instituted to warn the patient of

the need to replace the supply after that time has elapsed. Whilst it is appreciated that the half life of Narcan is short, it may save a life in time and enable transfer to hospital for further treatment.

- That General Practice Victoria include in its pharmacotherapy GP Training Program a component in which prescribing doctors are trained to teach patients on the ORT programme who are eligible for takeaway doses and their families and friends how to recognise signs of opioid overdose in the event that a third person accesses the takeaway dose. (I am concerned that the “targeted methadone consumer safety education campaign” outlined in the submission of Harm Reduction Victoria, whilst laudable in its intention, nevertheless suffers from the subtle difficulty that in providing so much information publicly and generally about how to respond to a third person suffering effects from ingesting a takeaway dose, it may tend to suggest to ORT clients that diversion is a recognised, even if unacceptable, practice. For this reason, I limit my recommendations in this regard to doctors providing this information on a private doctor/patient basis to the patient and his/her family).
- That the Victorian Department of Health consider requiring patients on the ORT programme to return their bottles with labels intact when attending to obtain takeaway doses. Whilst it is appreciated that there may be health concerns in relation to the adequate cleansing of the used bottles for future use, the pros and cons of such a requirement should be part of the risk-benefit evaluation process in relation to the current takeaway programme policy.

The following recommendations relate to **new patients** entering the ORT programme.

- That the Victorian Department of Health policy should recommend that when a patient expresses the desire to commence opioid replacement therapy that the doctor encourage the patient to commence on the buprenorphine/naloxone (Suboxone) course of therapy, which, after an initial trial period of two weeks could, if appropriate, become automatically a takeaway option gradually increasing the number of takeaway doses to 6 per week. This may represent an incentive to select this programme rather than methadone, particularly if entitlement to takeaway doses in the latter programme is restricted.
- That the Department of Health policy recommend that *methadone* therapy be offered only as dosage *under supervision*-unless compelling reasons (which are officially recorded) warrant a takeaway dose. Such takeaway doses should be limited to the number necessary to address the “compelling reasons” provided by the patient and be reviewed from time to time to determine whether those reasons still exist. This is in line with the general policy situation as outlined in the Victorian Policy of 2013 at Page 21: “Pharmacotherapy in Victoria is based on the principle of supervised dosing”.
- That the Department of Health policy recommend that as a condition of accepting a patient into either programme, the doctor require the patient to participate in drug counselling and such other therapy as may be appropriate to address the underlying

reasons for their addiction problems. This should be monitored by the doctor from time to time and the patient encouraged to persevere with it.

- That the Department of Health require doctors to maintain and, if necessary, furnish to the Department of Health, a ledger listing all new patients on ORT, stipulating which programme they are on and, in the case of patients assigned to the methadone programme and allowed takeaway doses, a summary of the “compelling reasons” on the basis of which such doses were allowed.
- That the Department of Health require that if a doctor identifies that a patient is exchanging, trading and/or selling methadone to a third person, this should result in automatic ineligibility for continued *takeaway doses*, and patients, both new and current, should be told this at the commencement of their participation in the program and also the fact that diversion is a criminal offence under the Drugs Poisons and Controlled Substances Act.

VIC.2012.2496

The deceased was a middle aged female who died of an accidental mixed drug overdose involving methadone. She resided with her partner who was on the methadone program.

The deceased’s partner collected takeaway methadone from a local pharmacist. He stored the methadone in the spare room. He became aware that one dose was missing but did not discuss the matter with the deceased.

The deceased was sleeping on the couch and observed to be snoring. The following morning, her partner located her unresponsive and paramedics were unable to revive her.

Recommendations:

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

- That regulatory authorities establish a clear mechanism of supervision of the safety arrangements for storage of take away dosage of methadone.
- That there be a prohibition upon take away methadone dosage unless a responsible regulatory authority is satisfied that safe storage arrangements are in place in the premises in which the drug is to be stored.

FIRE RELATED

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

VIC.2012.1070

VIC.2012.1071

Additional tag(s): Child and infant death

The deceased were two children who died when their house was destroyed by fire.

During the night, the children's parents awoke and became aware of the fire burning in the house. They were unable to access the children's room due to the intensity of the fire. The house was completely destroyed in the blaze and the children were unable to be saved.

Investigations revealed that the fire likely started from combustible material in the chimney cavity and that the source of ignition was the hot flue. The coroner found that the flue was inadequately installed and failed to comply with Australian/New Zealand standards.

Recommendations:

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

In all of the circumstances I recommend:

- That the Victorian Building Authority produce a consumer information brochure on the importance of regular heater and flue maintenance for households where a wood heater is installed. The brochure should offer specific advice on the importance of checking chimney spaces around flues for detritus that might accumulate and cause a fire hazard.
- That the Victorian Building Authority produce a practice note offering detailed guidance to plumbers on appropriate installation and maintenance of wood heaters and associated flue systems. The practice note should offer specific guidance on processes such as inspecting chimneys to ensure they are appropriate for fitting single-skin flues, and checking whether detritus is accumulating around a flue installed in an existing chimney.

HOMICIDE AND ASSAULT

VIC.2005.3694

Additional tag(s): Weapon

The deceased was an adult male who was fatally shot by an acquaintance. His body was never recovered.

The assault occurred in the presence of two witnesses who were coerced into assisting the perpetrator to dispose of the body. The coroner was unable to determine the rationale for the murder.

Recommendations:

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

- That the Chief Commissioner of Police direct the Homicide Squad to review their investigation of the death of [the deceased] with a view to identifying who assisted [perpetrator] in disposal of [the deceased's] body and ascertaining its whereabouts.

LAW ENFORCEMENT

VIC.2005.582

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

The deceased was an adult male who died when he was shot by police.

The deceased had a Naltrexone implant inserted to stop his heroin use. The coroner found that the side effects of the Naltrexone implant and the deceased's mental state may have contributed to his death.

At the time of the incident, police were attempting to arrest the deceased in relation to his suspected involvement in a homicide. The police operation involved the Special Operations Group as the deceased was believed to be a risk to himself and the community.

The coronial investigation critically reviewed tactical operation of arresting police and made recommendations accordingly.

Recommendations:

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

- The Department of Health and the College of General Practitioners should review its advice to addiction physicians in relation to Naltrexone implants to emphasise the social dangers associated with changed mental state and diversion to stimulants which, in the absence of adequate follow-up, can be associated with the procedure.
- The Chief Commissioner review the way in which Special Operations Group operations are reviewed after a critical incident occurs with a view to identifying how the incident occurred and ways in which it can be prevented in the future.
- The Chief Commissioner of Police provide the Special Operations Group with specialist training in the factors that can influence the success of the operation when the target has a mental illness and/or is under the influence of drugs.
- The Chief Commissioner of Police require the Special Operations Group Tactical Commander and Team Leaders to formally review the known characteristics of targets in appropriate circumstances with a view to identifying the possibility that they either do not expect to survive or intend to die during the planned arrest.
- The Chief Commissioner of Police require the Special Operations Group Team Leader and the Tactical Commander to specifically address the risks to each vehicle occupant in determining how best to effect the arrest they seek using a mobile intercept operation.
- The Chief Commissioner of Police direct the Special Operations Group to review their tactical arrest options to ensure that the Team Leader does not place himself in the main arrest role when he is allocating tasks during determination of an arrest plan for violent offenders.
- The Chief Commissioner direct re-examination of all the evidence to ensure that this incident is treated and seen to be treated in the same way as it would have been treated if a civilian had been involved in causing [the deceased's] death.

PHYSICAL HEALTH

VIC.2012.2340

The deceased was a young adult male who died when he aspirated on a latex glove he had ingested. He suffered from severe mental and physical disabilities, required full time care and was prone to placing objects in his mouth.

The deceased was in the care of a day care centre for adults with disabilities when he was located lying on the ground, blue in the face. Whilst attempting to perform CPR, staff found a latex glove in his mouth that had been blocking his airway. He was transferred to hospital via ambulance but was unable to be revived.

The coroner found the facility failed to ensure potential choking hazards were securely disposed.

Recommendations:

- Recommendation 1: That [service provider] undertake an independent risk analysis of the premises by a qualified risk assessor in order to seek to identify hazards to clients at the facility and in particular programs.
- Recommendation 2: That [service provider] revisit the option of placing a defibrillator machine at the facility.
- Recommendation 3: That [service provider] revisit the option of applying for one on one funding from the Department of Human Services for clients with similar to those exhibited by [the deceased].

TRANSPORT AND TRAFFIC RELATED

VIC.2012.1468

The deceased was an adult male who died when he was struck by a train whilst running along the shoulder of the train track.

The driver of the train was unable to see the deceased as the incident occurred in low light conditions and the deceased was wearing dark coloured clothing. He was also wearing earphones and likely listening to music at or around the time of the collision.

Recommendations:

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

- That rail authorities consider the development of a campaign similar to that developed by Tram operators to remind pedestrians about dangers of rail track environs and in particular, the danger to pedestrians of distraction from earphones and other devices which may impede the ability to perceive or identify that a train is approaching.

VIC.2012.2271

The deceased was a young adult female who was fatally injured in a motor vehicle collision.

The deceased performed a U-turn over a continuous white line and into the path of the oncoming vehicle. The vehicles collided and the deceased sustained fatal injuries. Her vehicle did not have airbags.

Conditions were poor on the day of the incident,. The other vehicle did not have any head lights or parkers illuminated. This driver sustained less serious injuries as a result of the airbags in their vehicle deploying upon impact.

Recommendations:

The Coroner's brief for this matter was prepared by [police officer] of the [location] Highway Patrol. [Police officer] made two pertinent observations relating to this unfortunate accident:

It is likely that side and curtain airbags would have reduced the severity of [the deceased's] injury. It has previously been observed that parents often hand their older vehicles to their children, whereas it is the novice driver who is more likely to need modern safety features. Further education surrounding vehicle selection for novice drivers could be beneficial.

[Other driver's] vehicle would have been more visible with its headlights operating. Victorian Road Rule 215 already requires headlights to be used in "hazardous weather conditions causing reduced visibility". Further education surrounding vehicle colour selection could be beneficial. [...]

I would recommend that these issues be referred to VicRoads for its consideration.

WATER RELATED

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

VIC.2009.4786

VIC.2009.4787

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

The deceased were two men who drowned whilst on a recreational boating trip.

The men attempted to contact the Coast Guard when their vessel started taking on water but the phone signal kept cutting out. The bodies of both men were located the following day.

The vessel was not fitted with a compass or emergency position indicating radio beacon and neither men were wearing personal flotation devices.

Recommendations:

Pursuant to section 72(2) of the *Coroners Act 2008*, I recommend that the Maritime Safety Division of Transport Safety Victoria:

- Research the use of marine radios and EPIRBs [Emergency Position Indicating Radio Beacons] in [location] and other designated enclosed waters to explore the merit and feasibility of mandating these devices. This research could include, for example, determining current usage rates among recreational vessels, and the public's view towards a potential requirement to carry these items in certain recreational vessels.
- Continue to undertake boating education campaigns addressing:
 - i. The importance of going beyond the minimum safety equipment requirements when operating vessels in Victorian waters. In particular, boaters should be encouraged to carry marine radios and EPIRBs when venturing into enclosed waters such as [location].
 - ii. The fundamental steps to take in the event of a marine emergency, including the need to wear a personal flotation device (PFD) and to raise the alarm through whatever means available.
 - iii. If using a mobile telephone to raise the alarm, the importance of dialling triple zero in the first instance.

VIC.2012.681

The deceased was an adult male who drowned whilst swimming at an ocean beach.

The deceased and some friends were fishing on the beach and decided to go for a swim. According to a witness, the deceased did not appear to be in distress but he raised the alarm when he noticed the deceased being swept further out to sea. The deceased's body was located later that day by the Coast Guard.

There were extremely strong tidal currents on the day of the incident,. The coroner found that nearby signage describing the conditions and associated risks could be improved.

Recommendations:

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

- That the [location] Shire Council erect signage at Car Park 1 to warn members of the public about the dangers of the tidal currents at the beach and entrance and about the dangers of swimming at the beach or at or near the entrance.
- That [organisation] review signage in Car Park 2 its accuracy, consistency and relevance.
- That the Emergency Services Telecommunications Authority, Victoria, investigate the options for the provision of communications to emergency services in case of an emergency, at points closer to the beach.

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

VIC.2012.4561

VIC.2012.4562

Additional tag(s): Older persons

Two people drowned when the vessel they were aboard capsized.

A group were on a fishing trip when they experienced difficulty starting the boat's engine. One person entered the water and swam to the shoreline to get help. Meanwhile, the boat drifted to the breakwater, capsized, and the two remaining occupants drowned.

All three people were wearing commonly available and approved inflatable type 1 personal flotation devices (PFD). The coroner found that without a crutch strap to hold them in place, these PFD's can easily slip off.

Recommendations:

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

I recommend that the Transport Safety Victoria consider seeking a modification to the Australian Standard for Type 1 inflatable PFD's to require that a crutch strap be a part of the design of these devices.

WORK RELATED

VIC.2005.354

The deceased was an adult male who worked as an engineer with a company contracted to inspect faults in sewage works. He had a history of mental ill-health.

The deceased travelled to the work site alone. A week later, his body was located a significant distance into a sewer pipe that he must have intentionally entered. The coroner was unable to determine the cause of death.

Recommendations:

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

- That South East Water upgrade their recording facilities to include the live status of sewer facilities subject to a Notice of Agreement for the provision of sewerage facilities so that it is available for electronic access to approved consultant engineers and engineers on their provider list.
- That South East Water require approved consultant engineers and engineers on their provider list to submit regular reports of the sites they have accessed and apply random audits to ensure these lists comply with their applications for permission to access live sewer assets.
- That [company] review its recruitment and training needs assessment policies and protocols to ensure new employees have adequate training, experience and peer support in the specific tasks they are required to perform.

VIC.2007.2172

The deceased was a middle aged female who died from a head injury sustained in a tractor incident. She had no experience operating the tractor.

The deceased was attempting to move an unsecured load using the tractor. She incorrectly operated the control lever and the load became unstable, fell and crushed the deceased.

According to the coroner, the death could have been avoided.

Recommendations:

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

- That the Tractor and Machinery Association and Worksafe Victoria recommend installation of a brake in front end loaders intended for agricultural operation that complies with Australian Standard AS1418.1-2002.
- That the Tractor and Machinery Association and Worksafe Victoria recommend installation of a height limiting device in front end loaders intended for agricultural operation.
- That the Tractor and Machinery Association and Worksafe Victoria cooperate to develop printed and other communication materials with basic safety information for all purchasers of tractors and front end loaders that emphasises the need to be aware of the relevant safety considerations for use and to provide this knowledge to other inexperienced and untrained users before they operate the tractor and/or front end loader.
- That the Tractor and Machinery Association amend their Industry Code of Practice for Manufacture and Supply of Front End Loaders for Use on Agricultural Tractors in Victoria to advocate installation of four post roll over protection for tractors fitted with front end loaders with a maximum lift height greater than the height of the cabin.
- That the Tractor and Machinery Association and Worksafe Victoria develop a written material and other communication devices directed at all purchasers of tractors and front end loaders which explains the importance of working within the scope of the tractor or front end loader's intended uses and the safety mechanisms in place.

WESTERN AUSTRALIA

CHILD AND INFANT DEATH

WA.2009.1463

The deceased was a male child who sustained fatal injuries when a masonry pillar collapsed on top of him.

The deceased was on a holiday with his family and some family friends. An individual from the group brought a hammock with them on the trip and secured it to a tree and a brick pillar. Several individuals of various weights used the hammock that day without incident. The deceased and two other children were swinging on the hammock when the pillar collapsed and fell onto the children. The deceased sustained significant head injuries and despite medical treatment, he failed to recover.

The coroner found that the pillar was missing a central rod connecting it to the roof above and that the death would have been avoided had the pillar been correctly constructed.

Recommendations:

- I recommend that Government consider making it a requirement for local governments responsible for issuing building permits under the Building Act 2011 (WA) to require the details of all tie down connections for residential buildings to be submitted on plans provided to local government as part of the approval process preceding the construction of a residential building.
- I recommend that the Government consider making it a requirement for local governments responsible for issuing building permits under the Building Act 2011 (WA) to undertake inspections during the construction of a residential building to ensure roof tie downs are adequately constructed, placed and fitted.
- I recommend the Government act to ensure that copies of all architectural drawings commissioned by a government body be archived with one government organisation so that in future they will be available to those in need of referring to them.

WA.2010.962

Additional tag(s): Natural cause death

The deceased was a female child who died of Pneumococcal Meningitis.

The deceased was unwell and her mother sought medical advice over the phone from a government health service. A registered nurse advised the deceased's mother that the deceased likely had a stomach virus and to monitor her condition and call back if her temperature increased.

The following morning, the deceased was blue around the mouth, her skin had a yellow tinge and she had a rash. She was transported to hospital via ambulance and diagnosed with Pneumococcal Meningitis. Her condition deteriorated and she died the following day.

Recommendations:

- I recommend that [health service] require the registered nurses employed by it, who are undertaking telephone triage duties, to tell callers/patients the nature of the triage service being provided and expressly advise callers/patients that they are unable to provide a diagnosis over the telephone.
- I recommend that [health service] work to improve the content of its guidelines and the training given to registered nurses undertaking triage in order to ensure that those presenting with subtle symptoms of difficult and complex cases such as Pneumococcal Meningitis.

FALLS

WA.2009.1608

Additional tag(s): Older persons

The deceased was an older adult female who died following a fall in her own home. The deceased underwent surgery but her condition deteriorated and she died.

The surgery to repair the fracture was delayed to wait for the effects of her anticoagulants to reverse. There was also a delay in obtaining test results due to inadequate staffing levels. The deceased's family also expressed concern over the management of her care and the lack of understanding they, and the deceased, had about how her treatment plan.

Recommendations:

- [Health service] consider increasing the education of staff and reinforcing the need for and requirements of documentation, including timing entries, documenting family concerns, and communications between doctors and nurses.

- [Health service] to consider increasing education of staff and reinforcing the need for staff to communicate with patients and their families in relation to the patient's treatment and plan for care.
- The pathology request forms in use have a clear field for the urgency of results, and there be a protocol as to when and how results are delivered, and to whom.
- [Health service] continue with the audits already in place to ensure real time appropriate adherence to policies procedures, documentation and the relevant completion of all forms requiring action.

FIRE RELATED

WA.2012.1076

Additional tag(s): Location

The deceased was a young adult male who died following a gas explosion. The explosion was caused by an LPG leak in a residential rental property. The gas was odourless so the occupants were unaware of its presence in the house. The deceased was sitting upstairs and sustained fatal injuries when he was struck by a large piece of masonry.

The leak came from a device located under a nearby road that connected two gas mains together. Investigations found improper installation and disturbances to the surrounding soil were two factors that contributed to the leak developing.

Recommendations:

- I recommend that [regulatory body] undertake an audit of [company]'s training manuals relating to components used in the [location] Gas Network, in order to confirm whether the training provided by [company] to its employees correctly state the tolerances and limitations in which the components can be safely and properly used and that the correct methods of installing, working on and removing the component in question are taught to employees working on the [location] gas network.
- I recommend that the Government reconsider regulation 9 of the Gas Standards (Gas Supply and System Safety) Regulations 2000 with a view to clarify whether it is intended that the regulation applies in circumstances where LPG travels a significant distance from the point of discharge, through soil, and is consequently stripped of its odorant but remains at explosive concentrations.
- I recommend that the Government take prompt steps to help customers of the [location] Gas Network potentially affected by the risk of leaking un-odorised LPG making its way

undetected into or beneath their properties.

This may include, but is not limited to, publishing advice as to the desirability of adequately ventilating properties without vapour barriers so that LPG will be likely be dispersed rather than being allowed to pool, and other safety advice aimed at informing the [location] community of the risk posed by leaking LPG and the need to report it to [company] so that the repairs can be undertaken in a timely manner before it can pose a significant risk to the community.

NATURAL CAUSE DEATH

WA.2009.400

Additional tag(s): Older persons

The deceased was an older adult female who died shortly after surgery to treat a recurrent hernia.

The operation was completed without apparent complications but that evening, the deceased reported pain and later vomited. Investigations revealed her kidney function was impaired. She did not recover and died the following day.

The coroner was unable to say whether the operation was the cause of the death so found the death to be by natural causes. The coroner also found the deceased's post-operative care may have been improved by more effective recordkeeping.

Recommendations:

- All nursing staff employed in [hospital] be reminded about the importance and requirement for effective documentation.
- [Hospital] consider increasing clinical supervision to allow more real time audits of documentation, including provision of more clinical nurse co-ordinators.

WA.2009.1235

Additional tag(s): Physical health

The deceased was a young adult female who died unexpectedly of natural causes. She had a complex medical history that led to many inpatient stays in hospital.

After presenting at the emergency department of a hospital, she was transferred to another hospital where she had to wait for an assessment cubicle to become available. She was located unresponsive a short while later and was resuscitated by staff. Her condition failed to improve and life support was withdrawn.

The coroner found that the deceased's management and treatment was affected by delays between appropriate assessment and decision making, and a lack of communication.

Recommendations:

- Doctors accepting patients on doctor/hospital transfer ensure they provide [hospital] ED [emergency department] with clinical information supporting their reason for accepting transfer at the time the decision is made and request it be placed on EDIS [hospital computer information system].
- [Hospital] ED considers the use of "smart computers" to interrogate entries to EDIS where there may be an error in name spelling or date of birth to assist with effective repopulation of patient's files.
- Triage assessments be done by sighting appropriate discharge/transfer information, especially where they provide a base line for further assessments.
- While I accept transfer documents now move with a patient through ED, and not via a hydraulic system, team leaders in the ED making decisions about appropriate placement of patients awaiting assessment ensure they understand the significance of transfer documents to ensure decision-making for placement is as informed as possible.
- [Hospital] ED consider the facility of introducing some vital sign observations at triage and any following primary assessment rather than reliance on ABC [airway, breathing, and circulation] alone where there is likely to be a delay before secondary assessment and/or medical assessment due to the pressure on ED when operating over capacity.

WA.2011.1269

Additional tag(s): Older persons

The deceased was an older adult male who died of natural causes shortly after surgery. His medical history included hypertension and ischaemic heart disease.

Shortly after surgery, he had difficulty breathing and his blood pressure remained low. The following day, he was extubated but suffered cardiac arrest.

The low blood pressure was attributed at the time to the known effects of anaesthetics but the post mortem examination revealed significant atherosclerosis. The coroner found that the medical care the deceased received was appropriate given the circumstances.

Recommendations:

- I recommend that any GP referring a patient for surgery provide a detailed medical history to the surgeon and also to the hospital where the surgery is to be performed, to be distributed in advance of the surgery to the anaesthetist who is to administer the anaesthetic during the surgery and the practitioner who performs the hospital preadmission check.

WATER RELATED

WA.2012.358

Additional tag(s): Child and infant death

The deceased was a male child who drowned in a swimming pool.

The deceased resided with his parents in a rental property with in-ground swimming pool at its rear. The pool was accessible via a sliding glass door and self-closing, sliding security door. The security door was installed to ensure children could not gain access to the pool but it was broken so the deceased's father removed it from its frame.

On the day of the incident, the deceased was momentarily unsupervised and opened the sliding glass door and gained access to the pool area. Some minutes later, his father found him floating in the swimming pool and was unable to resuscitate him.

Recommendations:

- Local Governments consider implementing a regular public awareness process to remind persons responsible for children of the importance of maintaining proper supervision where the children may have access to swimming pools and for the need for proper pool safety barriers to be provided and maintained.
- The Building Commission consider adopting a proposal to phase out the use of child resistant doors as barriers between houses and swimming pools.
- The Western Australian Local Government Association consult with REIWA [Real Estate Institute of Western Australia] with a view to adopting a process whereby new tenants at properties at which there is a pool are notified of their right to notify local government as well as to the estate agent about matters relating to the safety of the pool.
- REIWA consider taking the appropriate steps to train property managers about the fundamental requirements of pool safety barriers and to encourage them to include basic assessments of such barriers when conducting property inspections.

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 assault	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.