
From: SMHS - CEO **On Behalf Of** Crawshaw, John A
Sent: Friday, 11 June 2010 4:01 PM
To: Community Affairs, Committee (SEN)
Subject: FW: Request for corrections to proof Hansard - Community Affairs public hearing 20 May 2010

Dear Ms Bleeser

During the hearing (p63) I agreed to provide the Committee with a link to a suite of documents that make up Tasmania's strategic framework *Building the Foundations for Mental Health and Wellbeing*. Hyperlinks to each these documents are provided below.

Building the Foundations: Policy Review
(http://www.dhhs.tas.gov.au/mentalhealth/publications/strategic_documents/PPEI_Review.pdf)

Building The Foundations: Strategic Framework
(http://www.dhhs.tas.gov.au/mentalhealth/publications/strategic_documents/PPEI_Strategic_Framework.pdf)

Building the Foundations: Summary Document
(http://www.dhhs.tas.gov.au/mentalhealth/publications/strategic_documents/PPEI_summary_document.pdf)

Other strategic documents can be accessed at the following address:
http://www.dhhs.tas.gov.au/mentalhealth/publications/strategic_documents

The Committee requested that a copy of the Tasmania Police Report of Death for the Coroner form (p67) this document is attached.

The Committee also queried whether the title of an organisation may have a bearing on their success in a grants process (p67). Attached is a PDF copy of Treasurers Instruction 709 which provides the Tasmanian Government's framework for the management of grant payments.

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TASMANIA POLICE

POLICE REPORT OF DEATH FOR THE CORONER

Coroners Act 1995
Coroners Rules 2006
Rule 4

SECTION 1 – DECEASED'S DETAILS

Deceased's Demographics

Coroner's Case No:

Family Name:		Given Name(s):	
Aliases (if known):		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	
Date of Death (between):		Date of Birth:	Age:
Marital Status: <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced		<input type="checkbox"/> Married (including defacto) <input type="checkbox"/> Separated	<input type="checkbox"/> Widowed <input type="checkbox"/> Unknown
Usual Address:		Suburb/Town:	
Postcode:	State:	Country:	
Residency: <input type="checkbox"/> Permanent <input type="checkbox"/> Interstate Visitor		<input type="checkbox"/> Itinerant <input type="checkbox"/> Overseas Visitor	<input type="checkbox"/> Homeless <input type="checkbox"/> Unknown
Country of Birth:		Town, City:	
Usual Occupation (During working life):		Employment Status:	
Was deceased from non-English speaking background? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes If 'YES' specify			
Was the deceased of Aboriginal or Torres Strait Islander origin? <i>(if both tick 'yes' to both) (NB. This question is worded to be consistent with Australian Bureau of Statistics requirements)</i> <input type="checkbox"/> No <input type="checkbox"/> Yes, Aboriginal origin <input type="checkbox"/> Yes, Torres Strait Islander Origin			
Were there other deaths associated with this incident? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes (specify how many) If 'YES' specify			

Medical Information

Did an ambulance attend the scene?	<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Was the deceased treated by ambulance officers?	<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Were drugs administered by medic / paramedic prior to death?	<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes
If 'YES' specify:			
Date last visited doctor:	Can doctor certify cause of death <input type="checkbox"/> No <input type="checkbox"/> Yes		
Known medical history: <input type="checkbox"/> Unknown	<input type="checkbox"/> No known history	<input type="checkbox"/> Yes (specify)	
If 'YES' specify			
Was deceased known to be on medication? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes		Doctor's Name & Address:	
If 'YES' specify			
Was deceased suspected of having an infectious disease at time of death? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes			
If 'YES' specify			

History

Did the deceased have a known history of any of the following? <i>(Source of information may include medical record, police record, other official record, family/friends).</i>			
<input type="checkbox"/> Criminal Record	<input type="checkbox"/> Intellectual Disability		
<input type="checkbox"/> Time in Custody	<input type="checkbox"/> Depression	Source:	
<input type="checkbox"/> Time in a Mental Health Institution	<input type="checkbox"/> Psychiatric Illness	Source:	
<input type="checkbox"/> Release from an institution within the last week	Type:		

SECTION 2 – LOCATION OF DEATH (tick one box only)

- | | |
|--|--|
| <input type="checkbox"/> Home | <input type="checkbox"/> School / Other Institution / Public Administration Area |
| <input type="checkbox"/> Recreation Area | <input type="checkbox"/> Correctional Facility <small>(eg prison, youth training centre)</small> |
| <input type="checkbox"/> Sports or Athletics Area | <input type="checkbox"/> Residential Facility <small>(eg retirement village)</small> |
| <input type="checkbox"/> Farm <small>(not incl farm house)</small> | <input type="checkbox"/> Street or Highway |
| <input type="checkbox"/> Hospital or other Health Service | <input type="checkbox"/> Trade or Service Area |
| <input type="checkbox"/> Mine or Quarry | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Industrial or Construction Area | <input type="checkbox"/> Other <small>(specify)</small> |

SECTION 3 – ACTIVITY AT TIME OF INCIDENT (tick one box only)

- | | | |
|--|---|---|
| <input type="checkbox"/> Sports and Active Recreation | <input type="checkbox"/> Leisure Activity | <input type="checkbox"/> Working for Income |
| <input type="checkbox"/> Engaged in Formal Education (Student) | <input type="checkbox"/> Domestic Duties | <input type="checkbox"/> Volunteer Work |
| <input type="checkbox"/> Resting / Sleeping / Eating / Personal Activity | <input type="checkbox"/> Unknown | <input type="checkbox"/> Nursed / Cared For |
| <input type="checkbox"/> Other <small>(specify)</small> | | |

SECTION 4 – CAUSE OF DEATH DETAILS

- Apparent Case Type: Suspected Suicide Homicide Accident
 Natural Unknown

Apparent Cause of Death:

INCIDENT CIRCUMSTANCES: (tick one or more boxes & ensure you also complete additional section specified)

- | | |
|---|---|
| <input type="checkbox"/> Natural | <input type="checkbox"/> Drowning / Water-Related Death <small>(section 15)</small> |
| <input type="checkbox"/> Work Related Death <small>(section 8)</small> | <input type="checkbox"/> Unexpected Infant / Child Death <small>(section 16)</small> |
| <input type="checkbox"/> Consumer Product Related Death <small>(section 9)</small> | <input type="checkbox"/> Hospital Death |
| <input type="checkbox"/> Death Involving a Weapon / Firearm <small>(section 10)</small> | <input type="checkbox"/> Death Involving an Anaesthetic |
| <input type="checkbox"/> Fire / Burn Related Death <small>(section 11)</small> | <input type="checkbox"/> Hanging Death |
| <input type="checkbox"/> Transport Related Death <small>(section 12)</small> | <input type="checkbox"/> Homicide |
| <input type="checkbox"/> Suspected Suicide <small>(section 13)</small> | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Drug/Alcohol/Poison Related Death <small>(section 14)</small> | <input type="checkbox"/> Other <small>(eg. electrocution, fall, sporting) (specify)</small> |

SECTION 5 – INCIDENT DETAILS

Incident

Coroner's Case No:

Police Event / Reference No.:		
Incident Date <small>(dd/mm/yyyy)</small> :	Approximate Incident Time <small>(24hr format)</small> :	
Location Address:		
Suburb/Town:	State:	Postcode:

Found Dead / Dying

Date <small>(dd/mm/yyyy)</small> :	Approximate Time <small>(24hr format)</small> :	
Location Address:		
Suburb/Town:	State:	Postcode:
Found By:	Phone No:	
Address:	Postcode:	

Last Seen Alive

Date <small>(dd/mm/yyyy)</small> :	Approximate Time <small>(24hr format)</small> :	
Location Address:		
Suburb/Town:	State:	Postcode:
Last Seen By:	Relationship:	Phone No:
Address:	Postcode:	

Next Of Kin Details

Senior Next of Kin:		Relationship:	
Phone Numbers:	Address:	Postcode:	
Home:			
Work:			
Mobile:			
Does the Senior Next of Kin Object to Post Mortem: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If yes a written objection is required)</i>			
Does the Senior Next of Kin authorise disposal of clothing worn by deceased: <input type="checkbox"/> No <input type="checkbox"/> Yes			

Identification Details

Has deceased been identified: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If 'YES', By Whom:	
Address:	Phone No:
Post Code:	Relationship:
If 'NO', have arrangements been made for Identification: <input type="checkbox"/> No <input type="checkbox"/> Yes	
If 'YES', By Whom:	
Address:	Phone No:
Post Code:	Relationship:

Section 6 – SUMMARY OF INCIDENT

Have or will charges be laid in relation to the death:	<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes
If 'YES' specify			
Summary of Circumstances:			
Items Taken Possession of:			

Section 7 – REPORTING INFORMATION

Death Reported To Police By

Name:	Date:	Time (24hr):
Address:	Postcode:	Phone No:

Reporting Police Member Details

Surname and Initials:		
Rank and Number:	Station:	
Phone No:	Fax:	Signature:

Investigating Police Officer

Surname and Initials:		
Rank and Number:	Station:	
Phone No.:	Fax:	Signature:

PLEASE SAVE THIS DOCUMENT PRIOR TO SENDING IT AS AN 'EMAIL' TO:

**Coroner's Associate
Hobart or Launceston**

Section 8 – WORK-RELATED DEATH

at work, travelling to / from work or travelling as part of work

Did death occur while:

working (*incl. travelling for work*) travelling to / from work (*commuting*) not known if working or commuting

Occupation at time of death (if different from usual occupation):

Industry:

Section 9 – CONSUMER PRODUCT-RELATED DEATH

Did the death involve any of the following in relation to a product or safety device?

Defect Malfunction Misuse
 Design Fault Inherent Safety Problem Other Problem, specify

Type and description of product:

Make and model of product:

Approx age of product:

Place of purchase:

Section 10 – DEATH INVOLVING A WEAPON / FIREARM

Type of weapon: Firearm (complete 10.1) Other weapon (*specify*):

Who inflicted fatal wound? Deceased Other person Unknown

10.1 Firearm

Type of firearm (eg. make, model, type, action, calibre, category)

Was the firearm registered? Unknown No Yes

If 'YES', to whom? Deceased User (*if not deceased*) Other Unknown

Was the user licensed to use that category of firearm? Unknown No Yes

Section 11 – FIRE / BURN RELATED DEATH

Setting of Incident

Private Building Public Building Outdoor Area Other (*specify*):

If building:

Were smoke alarms present? Unknown No Yes

If 'YES' were they activated? Unknown No Yes

Was a sprinkler system present? Unknown No Yes

If 'YES' was it activated? Unknown No Yes

Were there barriers to escape? Unknown No Yes

If 'YES' specify: Locked exits Barred windows Other (*specify*):

Section 12 – TRANSPORT-RELATED DEATH

(Does not include water-vessel. Describe road/rail and weather conditions in summary of incident)

Types of vehicles involved in incident: (*tick all relevant boxes*)

Motor Vehicle Motor Cycle Tram / light rail Train Aircraft
 Bicycle Other, specify:

No. of vehicles involved:

Area Speed Limit:

Role of the deceased at time of incident?

Driver / Rider or Pilot Passenger Pedestrian Cyclist Other (*specify*)

Is drug/alcohol involvement suspected? No Yes Unknown

Vehicle / Aircraft Descriptions:					
Vehicle	Type (eg. car, plane, motorcycle)	Make/Model/Description	Year	Speed Category	
Deceased's Vehicle:				<input type="checkbox"/> within limit <input type="checkbox"/> possibly over <input type="checkbox"/> likely over <input type="checkbox"/> definitely over <input type="checkbox"/> N/A	
Vehicle 2:				<input type="checkbox"/> within limit <input type="checkbox"/> possibly over <input type="checkbox"/> likely over <input type="checkbox"/> definitely over <input type="checkbox"/> N/A	
Vehicle 3:				<input type="checkbox"/> within limit <input type="checkbox"/> possibly over <input type="checkbox"/> likely over <input type="checkbox"/> definitely over <input type="checkbox"/> N/A	
Vehicle 4:				<input type="checkbox"/> within limit <input type="checkbox"/> possibly over <input type="checkbox"/> likely over <input type="checkbox"/> definitely over <input type="checkbox"/> N/A	
Was the deceased wearing a seat belt?		<input type="checkbox"/> N/A	<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Were airbags installed and activated?		<input type="checkbox"/> N/A	<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes (specify below)
Airbags	Driver	Front passenger	Right side	Left side	Other (specify)
Installed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Activated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
If cycle rider, was helmet being worn?		<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Section 13 – SUSPECTED SUICIDE

What evidence is there to indicate that the deceased intended suicide? (tick the relevant box(es))					
<input type="checkbox"/> Statement to Family/Friends		<input type="checkbox"/> Statement to Health Professional			
<input type="checkbox"/> Note / Letter		<input type="checkbox"/> Other (specify):			
Has the deceased previously attempted suicide?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
If 'YES' , approx number of times:					
Has the deceased previously been hospitalised for self harm?			<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown
If 'YES' , approx number of times:					
Is there any possible motive / trigger for the suicide? (tick the relevant box(es))					
<input type="checkbox"/> Relationship Breakdown		<input type="checkbox"/> Sexual Abuse		<input type="checkbox"/> Financial Problems	
<input type="checkbox"/> Loss of a Loved One		<input type="checkbox"/> Illness		<input type="checkbox"/> Prospect of Criminal Sanction	
<input type="checkbox"/> Alcohol / Drug Dependency		<input type="checkbox"/> Unknown		<input type="checkbox"/> Other (specify)	
Was deceased being treated / seen by any of the following professionals? (tick relevant box(es))					
<input type="checkbox"/> General Practitioner		<input type="checkbox"/> Psychiatrist		<input type="checkbox"/> Psychologist	
				<input type="checkbox"/> Case Manager	
Was the death accompanied by the murder / suicide of other person(s)?				<input type="checkbox"/> No	<input type="checkbox"/> Yes
If 'YES' , what was the relationship between the deceased and the person(s)?					

Section 14 – SUSPECTED DRUG / ALCOHOL / POISON RELATED DEATH

Was there evidence of drug / alcohol / substance use? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If 'YES' , tick the relevant box(es):	
<input type="checkbox"/> Alcohol or empty containers Describe:	<input type="checkbox"/> Prescription or over-the-counter drugs Describe:
<input type="checkbox"/> Illicit / prohibited drugs Describe:	<input type="checkbox"/> Poisons or gases (<i>including carbon monoxide</i>) Describe:
<input type="checkbox"/> Injecting or other drug paraphernalia (<i>eg. needle, syringe, tourniquet, bong, straw</i>) Describe:	<input type="checkbox"/> Statement by deceased prior to death or by witness Describe:
<input type="checkbox"/> Items related to volatile substance abuse (<i>eg. petrol, paint, glue</i>) Describe:	<input type="checkbox"/> Other (specify)

Suspected Drug / Substance Abuse (*Excluding Alcohol*)

Apparent substance(s) used (<i>if known</i>):	
Date of last use:	Time of last use:
Administered By: <input type="checkbox"/> Unknown <input type="checkbox"/> Self <input type="checkbox"/> Other	
Location of last use:	
Symptoms of drug use:	
When symptoms first appeared:	
Was there evidence of drug/substance administration on the body of the deceased? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes	
If 'YES' , what? (<i>eg injection marks, powder on nose</i>)	
Route of administration (<i>tick one or more</i>) <input type="checkbox"/> Unknown <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Inhalation <input type="checkbox"/> Other:	

History

Did the deceased have a history of any of the following? (<i>tick the relevant boxes</i>)			
Source of information may include medical records, police records, other official records, family/friends			
<input type="checkbox"/> Abuse of alcohol Source:		Abuse of other drugs: Source:	
<input type="checkbox"/> Abuse of prescription of over-the-counter drugs Source:		<input type="checkbox"/> heroin or other opiates <input type="checkbox"/> amphetamines <input type="checkbox"/> cocaine <input type="checkbox"/> marijuana <input type="checkbox"/> type unknown <input type="checkbox"/> other (<i>specify</i>)	
<input type="checkbox"/> Abuse of volatile substances (<i>eg. petrol, glue, paint</i>) Source:			
<input type="checkbox"/> Exposure to poisons or gases: Type:	Source:		
<input type="checkbox"/> Drug treatment program(s): Type:	Source:		

Prescription Medication

Was the deceased recently prescribed any medication? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes		
If 'YES' date:	b) Prescribing doctor:	Phone:
Address:	Suburb:	Postcode:
List the drug(s) and quantities prescribed and amount remaining:		

Section 15 - DROWNING / WATER-RELATED DEATH

Type Of Aquatic Environment

Place	<input type="checkbox"/> Public	<input type="checkbox"/> Private		
Location				
<input type="checkbox"/> Bathtub	<input type="checkbox"/> Beach (<i>non-surf</i>)	<input type="checkbox"/> Beach (<i>surf</i>)	<input type="checkbox"/> Bucket / Container	
<input type="checkbox"/> Dam	<input type="checkbox"/> Lake	<input type="checkbox"/> Harbour / Bay	<input type="checkbox"/> Pond / Ornamental Lake	
<input type="checkbox"/> Ocean	<input type="checkbox"/> Spa (<i>external</i>)	<input type="checkbox"/> Spa (<i>internal</i>)	<input type="checkbox"/> Swimming Pool (<i>in ground</i>)	
<input type="checkbox"/> Swimming Pool (<i>above ground</i>)	<input type="checkbox"/> Irrigation Channel		<input type="checkbox"/> River	
<input type="checkbox"/> Other (<i>specify</i>)				

Activity at Time of Incident (tick the relevant box(es))

<input type="checkbox"/> Fishing (<i>including spear fishing</i>)	<input type="checkbox"/> Skin Diving / Snorkelling
<input type="checkbox"/> Attempting a Rescue	<input type="checkbox"/> Diving (<i>eg. Scuba / SSBA / Platform</i>)
<input type="checkbox"/> Swimming, Paddling or Wading	<input type="checkbox"/> Walking / Playing Near Water
<input type="checkbox"/> Incident Involving a Water Vessel	<input type="checkbox"/> Board Riding (<i>eg. Surfing, Body Boarding</i>)
<input type="checkbox"/> Water-skiing	<input type="checkbox"/> Bathing
<input type="checkbox"/> Unknown, no witness	<input type="checkbox"/> Other (<i>specify</i>)

Did the activity involve any of the following? (*tick the relevant box(es)*)

- | | |
|---|--|
| <input type="checkbox"/> Fell / Wandered / Jumped into water | <input type="checkbox"/> Injury / accident |
| <input type="checkbox"/> Swept away by water (<i>eg. off rocks, by rip</i>) | <input type="checkbox"/> Hypothermia |

Deceased's Swimming Ability

<input type="checkbox"/> Strong	<input type="checkbox"/> Competent	<input type="checkbox"/> Weak	<input type="checkbox"/> Non-Swimmer	<input type="checkbox"/> Unknown
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Death Involving a Water Vessel

Did the death involve a water vessel?	<input type="checkbox"/> Yes	<input type="checkbox"/> No (<i>go to 'supervision'</i>)	
If 'YES', was the vessel:			
<input type="checkbox"/> Motorised Personal Watervessel(PWV) (<i>eg. Jet Ski</i>)	<input type="checkbox"/> Motorised Water Vessel		
<input type="checkbox"/> Non-Motorised Water Vessel			
Type of Vessel:	<input type="checkbox"/> Commercial	<input type="checkbox"/> Recreational	<input type="checkbox"/> Unknown
Number of people on board the vessel?			
Were life jackets / personal flotation devices available on the vessel?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If 'YES', was a life jacket / personal flotation device worn by the deceased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Supervision

Was the deceased under supervision?	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes (<i>go to (a)</i>)	<input type="checkbox"/> No (<i>go to (b)</i>)
If 'YES', by whom?			
(a) Describe the extent and level of the supervision:			
(b) Was the area being patrolled by life guards at the time? <input type="checkbox"/> N/A <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes			

Conditions at Time of the Incident

What were the prevailing environmental conditions where the death occurred?				
Weather:	<input type="checkbox"/> Unknown	<input type="checkbox"/> Clear	<input type="checkbox"/> Hazy	<input type="checkbox"/> Cloudy
	<input type="checkbox"/> Rain	<input type="checkbox"/> Flood	<input type="checkbox"/> Fog	
Wind:	<input type="checkbox"/> Unknown	<input type="checkbox"/> None	<input type="checkbox"/> Light	
	<input type="checkbox"/> Moderate	<input type="checkbox"/> Strong	<input type="checkbox"/> Gale	
Tide:	<input type="checkbox"/> Unknown	<input type="checkbox"/> In	<input type="checkbox"/> Out	
Waves:	<input type="checkbox"/> Unknown	<input type="checkbox"/> < 1metre	<input type="checkbox"/> 1 – 2 metres	<input type="checkbox"/> > 2 metres

Rescue & Resuscitation

Was any attempt made to rescue the deceased?

Unknown No Yes (*by whom*)

What equipment was used to assist in this rescue?

Was any attempt made to resuscitate the deceased?

Unknown No Yes (*by whom*)

Was the person trained in resuscitation?

Unknown Yes No

Signage

Were there warning signs in the area where the death occurred?

N/A No Yes (*specify*)

Marine Animals

Was the death caused by a water animal? (*eg. shark, crocodile, box jelly fish*)

N/A Unknown No Yes (*specify*)

Swimming Pools / Spas / Dam / Pond

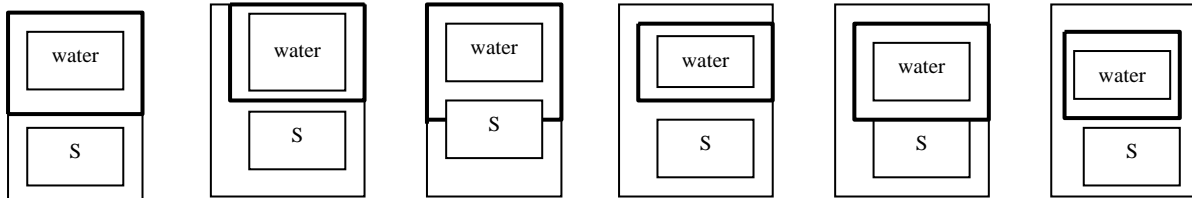
Was the pool/spa/dam/pond fenced? No (*go next question*) Yes (*specify and go to **diagram***)

If '**NO**', were there any other barriers between the pool/spa/dam/pond and other structures? (*eg. Door and window locks*)

Unknown No Yes (*specify*)

If '**YES**', which diagram best represents fence installation? (S = Structure eg. house)

1 2 3 4 5 6 7 (other)



If 'other', describe fence or other barrier separating pool/spa/dam/pond from structure.

Describe type of fence (eg. height, material, horizontal bars)

Using the diagram, indicate the position of gate in reference to the pool/spa/dam/pond.

Top Bottom Left Right

Was the fence or gate defective?

Unknown No Yes (*describe defect*)

Was gate self-latching?

Unknown No Yes

Was gate open or closed at the time of the incident?

Unknown Open Closed

Section 16 – UNEXPECTED INFANT / CHILD DEATH

Scene

Where was the infant found?			
<input type="checkbox"/> Infant's Bedroom	<input type="checkbox"/> Parent's Bedroom	<input type="checkbox"/> Other (<i>specify</i>)	
Was the infant sleeping alone? <input type="checkbox"/> Yes <input type="checkbox"/> No (explain) <input type="checkbox"/> Unknown			
If No, with whom?			
Position of infant when found (<i>tick all relevant</i>)			
<input type="checkbox"/> On Back	<input type="checkbox"/> On Stomach	<input type="checkbox"/> Side	
<input type="checkbox"/> Head to right side	<input type="checkbox"/> Head to left side	<input type="checkbox"/> Head face down	<input type="checkbox"/> Unknown
Were any items covering the infant's head/face?			
<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes (<i>specify</i>)	
Were there signs of mechanical causes of strangulation or suffocation?			
<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes (<i>specify</i>)	
Was there debris/object in the infant's mouth?			
<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes (<i>specify</i>)	

Medical Information

Was the infant born prematurely? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Did the infant have any of the following in the 2 weeks prior to death? (<i>tick all relevant</i>)			
<input type="checkbox"/> Cold	<input type="checkbox"/> Fever	<input type="checkbox"/> Recent injury or other illness	
<input type="checkbox"/> Sniffles	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Diarrhoea	
<input type="checkbox"/> Cough	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Recent Inoculation	
Was the child known to have any of the following?			
<input type="checkbox"/> Abnormal Development	<input type="checkbox"/> Recent Exposure to Contagious Disease	<input type="checkbox"/> Medical Equipment in Use	
<input type="checkbox"/> Known Allergies	<input type="checkbox"/> Recent Hospital visit(s)	<input type="checkbox"/> Any known medical problems	
Has there been any other child die in the immediate family? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes			
If 'YES' , what was the cause of death?			

Other Information (observations)

Were there any signs of habitual smoking in the household?			
<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes (<i>describe</i>)	
Was there any evidence of alcohol or drug use around the infant?			
<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes (<i>describe</i>)	
Is there any history of family violence?			
<input type="checkbox"/> Unknown	<input type="checkbox"/> No	<input type="checkbox"/> Yes (<i>describe</i>)	

**PLEASE SAVE THIS DOCUMENT PRIOR TO SENDING IT AS AN 'E-Mail' BY 7am TO:
Coroner's Associate
Hobart or Launceston**

Life Extinct Report etc are to be forwarded as per normal

Treasurer's Instruction No	709
Title	Grant Management Framework
Effective date	1 August 2008
Objective and Background	To provide a framework for the management of grant payments
Last Reviewed Date	30 June 2008

This Instruction supersedes Treasurer's Instructions 709 and 710

Black letter (or bold) items within these Instructions are mandatory and other plain font items are instructional or for the purpose of providing guidance only.

Background

This Instruction sets out the minimum conditions which agencies need to meet when offering a one off grant or an ongoing grant program. When designing a grant scheme, legal advice should be obtained from the Crown Solicitor on how best to protect the interests of the Agency. The Funding Agreement will determine the legal remedies that are available. Useful references in relation to the Best Practice Administration of Grants are located on web sites of the Department of Treasury and Finance and the Australian National Audit Office.

Definitions

(1) For the purposes of this Treasurer's Instruction (TI):

"Grant" means any assistance by way of a sum of money or other resource provided to an organisation or individual by the Government on the condition that the assistance is used for a specified purpose, and where the grantor receives no direct economic benefits in return for the assistance provided.

A grant does not include a loan, whether repayable or not, nor payments by the Agency to a third party. The term "grant" also does not include funding of activities relating primarily to the provision of goods and services directly to a government agency.

A grant is assistance, which may or may not have conditions imposed, other than the condition that the grant be used for a specified purpose, by the agency and agreed to by the grantee. These conditions are set out in the Funding Agreement. If the conditions of a grant are breached, the only remedial action may be that the grant money is repaid or future payments withheld.

"Grant Program" determines the processes by which individual grants are allocated. It allocates responsibility to plan and manage grants, establishes and manages individual funding agreements and provides for effective review or evaluation of the allocation. The grant program will ensure that all grants are administered and expended in accordance with approved Government objectives and outcomes.

"Funding Agreement" is a legally enforceable Agreement in writing, setting out the terms and conditions regarding the establishment and administration of grants. These terms and conditions are determined by the grantor.

The form of agreement will vary depending on the intent of the grant and the degree of control required. It can be a deed, contract or exchange of letters.

“Grant Resources” is an interchangeable term along with, “grant funds”, “grant monies” and “grant money”, indicating the sum of money or other resources allocated by the agency as part of a grant or grant program.

Administration

- (2) The Head of Agency must ensure that grants are allocated in accordance with the purpose for which the grant funding was provided by the Government.**
- (3) The Head of Agency must develop and maintain appropriate documentation for each grant program and its administration in accordance with current Agency processes.**

The documentation and relevant records should be maintained in the same manner as other financial records. The Agency must comply with the Government’s anticipated outcomes and objectives from the grant or grant program. Grant allocation, where possible, should be linked to an Agency’s core business and goals. The outcomes and objectives should be clear and non-conflicting, based on meeting government priorities.

- (4) The Head of Agency is to ensure that an appropriate risk assessment and management plan is completed for each grant or grant program before its commencement.**

By identifying the risks associated with each grant program or significant one off grants, an Agency can take precautionary measures to mitigate the risks, and avoid adverse outcomes. In addition to minimising the financial risk of non-performance by the grantee, a robust risk assessment will assist to reduce negative non-financial impacts, such as adverse publicity or a loss of public confidence in the agency’s financial management. Some risks associated with grant management include funding inappropriate or lower priority community projects, inappropriate use of grant funds, projects not being completed or completed after agreed target dates and loss of Agency credibility.

Risk assessment will identify uncertainties that may impact on grant funds being utilised as intended. Once identified, each potential risk should be able to be addressed by a specific course of action to minimise the potential for damage. Varying degrees of risk require varying levels of required action.

- (5) The Head of Agency must ensure that:**
 - (a) grants are properly differentiated from the acquisition of goods and services;**
 - (b) all applications for grants are assessed in an open, transparent and consistent manner;**
 - (c) the Agency meets all taxation obligations, including any Goods and Services Tax obligations, in accordance with [TI 1001 Taxation Management Framework](#);**
 - (d) grant funds are allocated in accordance with publicly available eligibility and selection criteria, which align with relevant Government policies; and**
 - (e) grantees are reasonably capable of meeting the objectives and outcomes of the grant program.**

Goods and services are defined in the Glossary at the Resources section of Buying for Government on the Procurement website www.purchasing.tas.gov.au.

- (6) The Head of Agency must ensure that the terms and conditions of each grant provided by the Agency are set out in a legally enforceable written Funding Agreement.**

The Funding Agreement must be between the grantee and the Agency and it must clearly state that grant funds are not to be paid to a third party. That is, a contractual arrangement should always be established between the grantor and grantee.

- (7) The Head of Agency must ensure that the Funding Agreement includes conditions that address:**

- (a) the Agency's risk management and monitoring requirements;**
- (b) the repayment or withholding of grant money in cases where the grantee fails to meet the terms and conditions of the contract; and**
- (c) the repayment of any unspent grant funds.**

Terms and conditions should utilise performance measures to indicate appropriateness, efficiency, effectiveness and economy of the grant. They can be both qualitative and quantitative.

The Funding Agreement agreed upon by all parties, must set out arrangements under which grants are provided, received, managed and acquitted. Accordingly, the contract should contain appropriate controls and accountability mechanisms to ensure that the grant funds are utilised for the intended purpose. Actions that will be taken for breaches of the grant conditions should be clearly stated in the Funding Agreement.

Monitoring

- (8) The Head of Agency must ensure that an appropriate monitoring strategy is established for each grant or grant program to ensure compliance with grant conditions.**

Monitoring is the process of collecting, recording and analysing information on a regular basis to ensure that funds are being spent correctly and measured against identified outcomes and objectives. It is important that an appropriate level of monitoring is established. The following should be taken into account:

- the amount of the funding, nature of the funding and the nature of the funded organisation (or activity/individual);
- the administrative costs of monitoring, reporting and data collection for both the Agency and funded organisation; and
- the Agency's risk management policy.

The performance of the grantee in meeting the Funding Agreement conditions can be monitored in a number of ways, through the application of a combination of:

- written updates;
- site visits;
- performance information reports regarding the achievement of specified outcomes;
- the review of the grantee's audited financial statements; and/or

- other monitoring tools, as identified in the grant program's risk management plan and approved by the Head of Agency.

The amount and type of the grant, and the risk assessment completed at commencement of the grant, will determine the level of monitoring. For example, a small project may only require a report at the end of a Project, while a more complex project would have a more regular and rigorous review completed to measure performance against agreed measures.

For grants of more than \$50 000, or considered of high risk according to the agency's risk management assessment, audited financial statements should be obtained. Audited financial statements showing the receipt and manner of disbursement of each grant, together with an audit certificate, will provide the best assurance to an agency on the adherence to grant conditions. Where audited financial statements are obtained, and the grantee has received a qualified audit opinion, the Head of Agency shall, except where that opinion has been provided by the Auditor-General, advise the Auditor-General of the qualification as soon as possible.

- (9) The Head of Agency must ensure that any significant breaches in grant terms and conditions are appropriately and promptly dealt with to maximise the recovery of public monies. Any losses are to be dealt with in accordance with [TI 302 Recording of Losses](#). If the grant is partially completed, no further payments are to be made to the grantee where significant breaches have been identified.**
- (10) In accordance with [TI 206 Presentation of Annual Financial Statements](#), an Agency must provide details, including purpose and intended outcomes, of each significant grant or grant program in its Annual Report. All other grant or grant program details must be recorded and reported in accordance with prudent accounting practice and in accordance with the requirements of the initial risk management assessment.**

Grant Program Review

- (11) The Head of Agency must ensure that each grant program is reviewed at least annually to ensure that intended outcomes are being realised. The review findings must be reported in the Agency's Annual Report.**

Reviews are to be conducted to assess the success of grant programs as well as the efficiency and effectiveness of grant programs and processes. A review of a grants process is important to determine many factors, such as whether the grant program:

- should continue;
- is still achieving desired outcomes;
- being managed in the most efficient and effective manner;
- can be changed or improvements made; and
- the plan to implement these identified improvements.

Reviews should be completed by an objective and, where possible, an independent party from the allocation and decisions making regarding grant applicants. Performance measures should be utilised to monitor the grant throughout its lifecycle and to evaluate the grant program process as a whole. These measures should be clear and based on the identified outcomes of the grant. They should be comprehensive and tested from time to time.