OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments made between **1 January** and **31 March 2023**

Coroners’ recommendations and comments

Coroners perform essential functions within our society. They inquire into a range of unexpected deaths to establish the identity of the person who has died and the cause and circumstances of their death.

While inquiring into a death, a Coroner may make recommendations or comments for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred.

The Office of the Chief Coroner maintains a public register of these recommendations and comments and publishes summaries of those which are not prohibited from being published by order of court or law. Recommendations Recap includes all those recommendations and comments which have been summarised and published. This edition includes 39 findings with recommendations and/or comments issued by Coroners between 1 January and 31 March 2023.

DISCLAIMER The summaries of Coroners’ findings included in this publication have been produced by Legal and Research Counsel. The best effort to accurately summarise those findings has been made; however, they are not exact replications of the original finding. If formal reference of a finding is intended, the original finding should be accessed.

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Recommendations and comments

1 January to 31 March 2023

All summaries included below, and those issued previously, may be accessed on the public register of Coroners' recommendations and comments at:

http://www.nzlii.org/nz/cases/NZCorC/

Drugs and Alcohol

Akau'ola [2023] NZCorC 14 (23 February 2023)

CIRCUMSTANCES

Edgar Robertson Akau'ola, aged 23, died on 15 December 2019 at a construction site at 29 Union Street, Auckland due to multiple blunt trauma, having fell or jumped from a crane while under the influence of LSD.

On 13 December 2019, Edgar arrived at an address in Karangahape Road, Auckland to spend the weekend with his friend. At about 4:30pm on 14 December 2019, Edgar and two friends took an LSD tab each. Throughout that evening, Edgar exhibited multiple signs of being drug affected, including screaming while walking on Karangahape Road.

The following day, Edgar appeared unsettled and at 3pm left his friend's house, leaving his vehicle and personal items behind. Shortly after, he was spoken to at a bus stop on Karangahape Road by some friends. At 4:30pm Edgar was seen on CCTV walking northbound down Union Street, Auckland Central. He proceeded to enter the building site adjacent to 29 Union Street and climbed up an unsecured staircase to the top of the crane where he entered the cabin and listened to music on the radio. At about 4:45pm a loud bang was heard by two security officers who were on site. Upon checking they located Edgar on a stairway near the base of the crane in a lifeless state. Emergency services were called and Edgar was pronounced deceased at the scene.

The Coroner found that Edgar either fell or jumped from the crane while under the influence of LSD but that his death was not suicide.

COMMENTS OF CORONER FITZGIBBON

I. The NZ Drug Foundation (https://www.drugfoundation.org.nz/) has information and advice which is easy to access. If you are planning on taking LSD, the Drug Foundation recommends:

    - Taking it to a free, legal, and confidential drug checking clinic (https://knowyourstuff.nz/)

- Alternatively, check it at home using an Ehrlich's reagent test.
- Remember: 'If it's bitter, it's a spitter.' LSD generally does not have a bitter taste, however drugs in the NBOMe[1] family can.
- Start low and go slow. Take a small amount of the tab and wait at least an hour to see how you feel.
- Know the signs of an overdose and get help if needed. These may include: Severe agitation, anxiety, or psychosis, vomiting, abnormal heart rate, having a fever, having seizures, or passing out.
- If you or someone around you has taken a tab and experiences any of these symptoms, or other worrying symptoms, call 111 or get medical help as soon as possible.

II. I encourage people intending to take LSD or any other drugs, to have them checked and to ensure they follow these safe guidelines.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Edgar taken by Police, in the interests of decency or personal privacy.

Boreham [2023] NZCorC 2 (12 January 2023)

CIRCUMSTANCES

Manson Peter Boreham, aged 45, died on 22 August 2020 at Dunedin Hospital as a result of central nervous system depression following an overdose of etizolam taken for recreational purposes. His death was an accident.

Manson had a long history of drug use. He used cannabis, methamphetamine, MDMA, psychedelics, and "abused" prescription drugs such as the benzodiazepines lorazepam and valium. In addition, Manson had been purchasing "questionable" substances from overseas, in the six months prior to his death. These purchases were made via the Chinese e-commerce site Alibaba. Manson said that the powders he was buying were not illegal.

Manson was unwell in the days before his death and on 20 August 2020 was found unconscious on the couch at his home, with his young son sleeping beside him. He was admitted to Dunedin Hospital where a brain scan showed evidence of an ischemic brain injury due to hypoxia (lack of oxygen). Manson died in the Intensive Care Unit on 22 August 2020. Blood samples taken from Manson showed toxic levels of the benzodiazepine etizolam (approximately 0.9mg/L).

After Manson was taken to hospital a bag with white powder was found in his room. This was no longer in Manson's flat when Police searched it.

A post-mortem examination subsequently established that Manson had died as a result of an overdose of the benzodiazepine etizolam. The pathologist reported that if Manson had taken etizolam tablets it would have required about 100 0.5mg tablets to reach a blood concentration of 0.9mg/L. If he had taken powder rather than tablets, on the assumption

[1] NBOMe (25I-nbome, n-bomb, smiles) is a potent group of synthetic hallucinogenic drugs that mimic LSD and have been linked to many deaths overseas. NBOMe can cause hallucinations, distorted reality, euphoria, strong empathy, panic or nausea. It can also cause dizziness, hot and/or cold flushes, increased perspiration, and numbness in the arms and legs.

that less than 10% of a tablet is active, it would have taken about 50mg of pure powder to have the same effect as 100 tablets.

The Police National Drug Intelligence Bureau reported that etizolam is a novel benzodiazepine which is not approved for medical use in New Zealand, and is much stronger than any benzodiazepines legally prescribed here. It has been found in New Zealand in powder, tablet, liquid and paper blotter form. It is cheap when ordered online and highly potent. It is often sold as counterfeit Xanax. In 2018 etizolam was implicated in the deaths of 548 people in Scotland, accounting for more than 80% of "street benzodiazepine" deaths.

The Coroner was satisfied that on 20 August 2020, Manson ingested etizolam. It is likely that this was in powder form, and that it was the substance found in his flat.

As to how an experienced drug user could accidentally overdose, Manson may have thought that he was in possession of another benzodiazepine which he was used to, and did not know that he had a more powerful substance. Alternatively, if he did know that he was in possession of etizolam, he may have miscalculated the dose, the pathologist's evidence being that a very small amount will result in harm. I also note the pathologist's evidence that Manson's anabolic steroid use could have increased his susceptibility to an overdose. The evidence does not provide a definitive answer as to why Manson overdosed, but either of these two scenarios is plausible.

COMMENTS OF CORONER CUNNINGHAME

I. Manson's death illustrates the dangers inherent in recreational drug use. Not using drugs is always the safest choice.

II. The New Zealand Drug Foundation's website contains information for recreational users of benzodiazepines and warns of the risks involved in using these drugs.[2] I endorse the Foundation's efforts to promote harm reduction in the community.

III. I encourage people who use recreational drugs to avail themselves of drug harm reduction resources from reliable sources such as the New Zealand Drug Foundation, Know Your Stuff,[3] and High Alert.[4] I also encourage the use of drug checking services where they are available.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs that show Manson, entered into evidence in this inquiry, in the interests of decency and personal privacy.

[2] www.drugfoundation.org.nz
[3] www.knowyourstuff.nz
[4] www.highalert.org.nz

Makikiriti, Peirce, Taneao, Taurarii and Wright [2023] NZCorC 1 (15 December 2022)[5]

CIRCUMSTANCES

The Coroner held a joint inquiry into five deaths caused by the synthetic cannabinoids, described in more detail below. On 7 April 2022, the Coroner convened an "expert hui" to discuss a range of issues identified as pertinent to this inquiry. The hui was, and the comments and recommendations are, largely forward focused and look at what can be learnt from the events in 2017. The comments and recommendations apply to each of the five deaths.

In her finding, the Coroner noted that between July and September 2017 there was a dramatic increase in deaths associated with the consumption of synthetic cannabinoids in the Auckland area. Between May 2017 and February 2019 synthetic cannabinoids were identified as the cause of death in at least 64 cases.[6] Countless other people experienced non-fatal harm with over 137 synthetic cannabinoid associated presentations at healthcare services across the Auckland region between 1 July 2017 and 17 September 2017.[7]

In 2017 the most common chemical structures of synthetic cannabinoids were AMB-FUBINACA and 5F-ADB.[8] Studies have found that AMB-FUBINACA in 2017 was 85 times more potent than tetrahydrocannabinol (THC) found in natural cannabis plant.[9]

Due to the enactment of the Psychoactive Substances Act 2013, by 2014 synthetic cannabinoids were no longer able to be legally sold, supplied, or possessed. However, regulation under the Psychoactive Substances Act 2013 carried significantly lesser penalties[10] and contained more limited Police powers[11] than regulation under the Misuse of Drugs Act 1975. In 2019 AMB-FUBINACA and 5F-ADB were classified as Class A drugs under the Misuse of Drugs Act 1975.

The Coroner discussed a number of improvements made since 2017 in the fight against synthetic cannabinoids. One was the Ministry of Health's National drug policy 2015-2020, which included the creation of a multiagency early warning system for the purposes of monitoring emerging trends and informing both enforcement and harm reduction strategies. In December 2018 the government announced provisional funding for an early warning system, known as Drug Information and Alerts Aotearoa New Zealand (DIANZ), which was formally launched in June 2020. Another new initiative was the introduction of Drug and Substance Checking Legislation Act 2021 that aims to minimise drug and substance harm by allowing drug and substance checking services to operate legally in New Zealand. That has had little effect in the synthetic cannabinoid context, however, as it was used mainly by recreational users, rather than those with addictions. Yet another improvement was the acute drug harm response discretionary fund, introduced in 2018. Its aim was to assist regions to

[5] This was a joint inquiry into five synthetic cannabis deaths. The Coroner issued five findings, one for each death, as well as the joint finding containing recommendations applicable to all five deaths. As a result, only one summary has been prepared. While the findings were issued on 15 December 2022, the certificate of findings for each deceased was issued in January 2023. The summary is thus included in this edition of Recommendation Recap.
[6] P L Morrow et al; "An Outbreak of Deaths Associated With AMB-FUBINACA, in Auckland NZ", EClinicalMedicine 25 (2020) 100460. Paul Morrow "Consultation for coroner" 30 October 2021.
[7] Dr Mariam Parwaiz, Public Health Medicine Registrar, "The 2017 Synthetic Cannabis Incident Report", Auckland Regional Public Health Service, February 2018
[8] Diana Kappatos, Forensic Toxicologist ESR "Report request- Coroner McDowell Joint inquiry into synthetic drug deaths" 29 June 2018
[9] Ibid
[10] For example, the penalty for the supply or selling of an unapproved Psychoactive Substances Act to synthetic cannabis under Psychoactive Substances Act 2013 s 70 was two years maximum.
[11] Police had no power of arrest for simple possession which carried a fine only. There were limited Police powers for search and seizure as this the Search and Surveillance Act did not extend to the Psychoactive Substances Act.

develop their capability and implement appropriate services to address sudden or serious increases in synthetic related acute drug harm in the community. Finally, ESR worked with the Capital and Coast DHB for some years on a pilot project called USED (Unidentified Substances in Emergency Departments), the aim of which was to identify unknown recreational drugs in patients presenting at hospital emergency departments with toxic delirium, altered level of consciousness or adverse side effects from drug consumption. The pilot project concluded in 2019 but was useful in providing accurate drug identification to emergency medicine specialists and clinical toxicologists.

Having noted the improvements, the Coroner also discussed a number of problems relating to testing of synthetic cannabinoids and subsequent reporting of the related harm. She referred to presentations at hospitals, noting that they are coded into a database using ICD-10 codes,[12] entered after the patient is discharged. There is, however, no specific code for synthetic cannabinoid presentations. There is also a three-month time lag between a patient being discharged, the code being entered, and the data being received by the Ministry of Health which limits the ability to identify potential harmful or new substances in a timely manner. Additionally, there is currently no formal process for clinicians to report instances of drug harm; access to anonymised hospitalisation records by DIANZ is also impeded by time delay. Further, the testing for synthetic cannabinoids in hospitals is not routinely done.

There are also problems with testing in the customs, Police and coronial settings. Evidence showed that while new substances are commonly detected at the border first, synthetic cannabinoid samples seized by customs are typically analysed by handheld devices which have limitations and often do not have updated drug libraries. As a result, DIANZ recommended greater use of the customs/ESR (CESL) laboratory at Auckland airport to conduct further testing. Similarly, due to financial constraints Police do not routinely send synthetic cannabinoid samples for analytical testing unless required to do so in the context of criminal prosecutions. Finally, the evidence suggested that coroners are not aware of the rapid speed in which synthetic cannabinoids may metabolise in blood and of the consequent limitations of the toxicological analysis of the blood sample alone. All of the above leads to inconsistent reporting and coding, which means that there is no comprehensive national picture of the synthetic cannabinoid harm.

The Coroner also discussed issues concerning clinical responses to the synthetic cannabinoid problem. When assessing patients, clinicians record information according to the DSM-V (a system of psychiatric coding). However, the Ministry of Health's system that collects mental health and addiction service activity and outcomes (known as PRIMHD) uses the old DSM-IV version of psychiatric coding which is not as nuanced in relation to substance abuse. This results in inaccurate diagnostic reporting and data sets for all alcohol and drug use. Additionally, clinical treatment guidelines specific to synthetic cannabinoid toxicity presentations are not yet available. The New Zealand Drug Foundation noted that there had been an improvement in knowledge of synthetic cannabinoids since 2017 but a lack of in-depth understanding and knowledge in this area from some clinicians and service providers continue to be a barrier to health and social services to adequately respond to this issue.

Finally, the Coroner noted concerning statistics in her finding, namely that Māori and Pasifika peoples and those living on the margins of New Zealand society are overrepresented both as users of synthetic cannabinoids and in deaths from its use. Of the 106 individuals who presented at health care services between 1 July 2017 and 17 September 2017 with synthetic cannabinoid toxicity, three quarters were men and over two thirds were of Māori or Pacific Island ethnicity. Their age range was 12 years to 62 years. During the 2017 outbreak, 40% of presentations at the Auckland DHB were identified

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[12] ICD-10 are the International to Statistical Classification of Diseases and Related Health Problems.

as homeless or living in a boarding house, or of no fixed abode. In 27% of cases, the person had had previous contact with mental health services or alcohol and drug services.

Darryn Wright

Darryn Bryan Russell Wright, aged 51, died on 9 July 2017 at Fort Street, Auckland of mixed alcohol and synthetic cannabinoid toxicity. Significant coronary artery atherosclerosis is likely to have contributed to his death. Darryn was of Māori descent. He was unemployed, often homeless and was a known "rough sleeper" in central Auckland. He had a significant history of alcohol dependency and depression.

On 8 July 2017, Police located Darryn on Fort Street and noted he was very intoxicated. He was taken to the Police cells for detoxification and released in the early hours of 9 July 2017. He then met with friends on the street and started drinking again. Later that afternoon, Darryn was given two lots of synthetic cannabis by his associates which he consumed, before he slumped forwards and fell asleep on Fort Street. An employee from a nearby business tried to wake Darryn to see if he was okay. The employee asked one of the other people sitting nearby if Darryn was alright and that person said he was just sleeping. The employee rang Police to move Darryn, and he noticed Darryn's face was purple. A doctor approached the scene and tried to revive Darryn. He asked someone to go in search of a defibrillator at a nearby pharmacy, but none were available. CPR was initiated, but Darryn was pronounced deceased at the scene.

The post-mortem examination did not identify any injuries that contributed to Darryn's death but did reveal significant coronary artery atherosclerosis which the pathologist advised was contributory to his death. Toxicology analysis of Darryn's post-mortem blood sample confirmed the presence of the synthetic cannabis AMB-FUBINACA acid metabolite and quetiapine, an antipsychotic psychiatric medication. Alcohol was detected at a level of 324 milligrams of alcohol per 100 millilitres of blood. For comparison purposes, the legal blood alcohol limit for a driver aged 20 years or over is 50 milligrams of alcohol per 100 millilitres of blood.

Expert advice suggested that Darryn's level of intoxication can be contributory to positional asphyxia. Positional asphyxia occurs when a person is lying face down (prone) and the weight of their own chest prevents them from taking deep breaths.

Devonte Peirce

Devonte Xaivier Montel Peirce, aged 17, died on 16 July 2017 at 2/52 Triangle Road, Massey, Auckland of AMB-FUBINACA toxicity, a synthetic cannabinoid. Devonte was a Māori rangatahi who lived in Rānui, West Auckland with his mother and other members of his whānau. Devonte had been using cannabis on a daily basis for three to four years prior to his death. When he was unable to source cannabis, he would use synthetic cannabis as a last resort.

On 15 July 2017, Devonte spent the afternoon with his cousin. In the evening, they watched a movie and Devonte smoked half a cone of cannabis, though his cousin was unaware it was synthetic cannabis. Devonte and his cousin went to sleep. In the early hours of 16 July 2017, Devonte's cousin checked on him and realised he was not breathing. Despite resuscitation efforts, Devonte was unable to be revived.

The post-mortem examination did not identify any injuries or natural disease that may have contributed to Devonte's death. Toxicology testing on samples of Devonte's blood was carried out. The testing showed the presence of the synthetic cannabinoid, AMB-FUBINACA, and tetrahydrocannabinol (THC). However, the THC was not a direct cause of Devonte's death.

Adah Taurarii

Adah Taurarii, aged 31, died on 27 July 2017 at Kelston, Auckland of synthetic cannabinoid toxicity (AMB-FUBINACA). Morbid obesity was also a contributing factor to her death.

Adah was of Cook Island Māori descent and lived in a boarding house in Kelston. She was unemployed and in receipt of a benefit. She had long standing history of mental illness and cannabis and alcohol use. She had significant health concerns including diabetes type II, schizo-affective disorder, asthma, severe obstructive sleep apnoea, type II respiratory failure, hypertension, and morbid obesity. Adah started smoking synthetic cannabis in February 2017. A supplier would come to the boarding house every Tuesday and she and her stepmother would purchase three or five bags of synthetic cannabis.

On 27 July 2017, Adah smoked synthetic cannabis with another resident at the boarding house. Adah then fell over onto the ground face first. The resident thought Adah had just passed out. When the resident tried to wake Adah later, he was unable to get a response and rang emergency services. On arrival of the paramedics, Adah was pronounced deceased. At the time of Adah's death synthetic cannabinoids (including AMB-FUBINACA) were not classified under the Misuse of Drugs Act 1975 and the person who supplied the synthetic cannabis to Adah was not able to be charged for supplying the substance under this legislation.

Post-mortem toxicology testing of Adah's blood showed the presence of the synthetic cannabinoid AMB-FUBINACA, the antipsychotic medication zuclopenthixol, and THC in the blood suggesting past use. Expert advice suggested that Adah's significant premorbid health conditions, particularly severe obstructive sleep apnoea, would have significantly increased her risk of progression to death whilst unconscious. This would give Adah a significant risk of respiratory arrest and positional asphyxia when unconscious and lying prone.

Ngaeinangaro Makikiriti

Ngaeinangaro Marilyn Ngatamaine Makikiriti, aged 26, died on 11 September 2017 at her home in New Lynn, Auckland of synthetic cannabinoid toxicity (AMB-FUBINACA). Obesity and an enlarged heart may also have contributed to her death.

Ngaeinangaro was known to her friends and family as Marilyn. She was a Cook Island Māori woman who lived at her auntie's home with her mother and several family members. Marilyn had a complex and difficult mental health and addiction background. She had been diagnosed with schizophrenia, cannabis use and cluster B personality traits. She was known to use cannabis daily but had stopped consuming it while pregnant. Although her mother suggested Marilyn had been smoking synthetic cannabis a couple of times per week while she was pregnant, Marilyn did not confirm or deny this. She gave birth to her child two weeks before her death.

On the evening of 11 September 2017, Marilyn asked her brother, Isitolo Uritua, if he could buy some synthetic cannabis for her. Isitolo purchased synthetic cannabis and gave some to Marilyn, but he did not see her smoke it. Marilyn was found by her family collapsed in the shower later that evening. Her family thought that she had passed out and that they would be able to wake her. When her partner arrived, he noticed her lips were purple and her eyes were rolled back. She did not respond to water being splashed on her face and her partner could not feel a pulse. Despite efforts to revive Marilyn, she was pronounced deceased at the scene.

Police found a white bottlecap with a silver "cone" on it on top of the set of drawers in the bathroom. This type of modified bottlecap is consistent with that used for smoking synthetic cannabis. In the pocket of the hoodie Marilyn was wearing Police found a small bag which contained plant material. This was forwarded to ESR for testing.

The ESR analysis confirmed that the plant material contained the synthetic cannabinoid AMB-FUBINACA. ESR also advised that it contained pFPP (para-flurophenylpiperazine) which has mildly psychedelic and euphoriant effects. A post-mortem examination revealed that Marilyn had a high BMI of 39 and had an enlarged heart (430 grams).

Isitolo was subsequently convicted of supplying a non-approved psychoactive substance to Marilyn. He was also convicted of supplying this substance to his cousin (Junior Taneao) three days later who also tragically died as a result. At the time of these events, synthetic cannabinoids and, in particular AMB-FUBINACA were not a scheduled illegal drug under the Misuse of Drugs Act 1975 and the prosecution was taken under the Psychoactive Substance Act 2013.

Marilyn was prescribed risperidone which is an atypical antipsychotic medication. Expert advice showed that these medications can increase the ECG QT interval and lead to arrhythmia. The expert advice also highlighted the lack of alarm or concern exhibited when users of synthetic cannabinoids collapse and become unconscious as this is often regarded as a normal response. The lack of alarm therefore led to some delay in providing assistance to Marilyn, such as CPR, as her family assumed she would "wake up".

Junior Taneao

Junior Taneao, aged 37, died between 13 and 14 September 2017 at his home in Henderson, Auckland of synthetic cannabinoids (AMB-FUBINACA) toxicity. Junior was of Cook Island Māori descent. He worked as a digger operator and lived with his partner and his extended whānau in Henderson, West Auckland.

On the evening of 13 September 2017, Junior drank a couple of Woodstock cans when he returned home from work and then went to visit the family of his cousin, Ngaeinangaro Makikiriti (Marilyn) who had recently died as a result of synthetic cannabinoid toxicity. While there, he asked Marilyn's brother, Isitolo Uritua, for some synthetic cannabis for him. Isitolo took Junior to an associate's address and purchased synthetic cannabis on Junior's behalf and gave it to him.

When Junior returned home, he spoke with his partner, before she went to bed. When his partner woke up in the early hours of 14 September 2017, she noticed Junior was not in bed and went to look for him. She was unable to open the bathroom door and went outside to look through the window. She saw Junior slumped against the door. Junior was unable to be revived by attending paramedics.

Police found a bag containing plant material which they suspected was synthetic cannabis. A green lighter was also found, and a home-made "bong" made out of a plastic drink bottle.

At the time of these events, synthetic cannabinoids and, in particular AMB-FUBINACA were not a scheduled illegal drug under the Misuse of Drugs Act 1975 and the prosecution was taken under the Psychoactive Substance Act 2013. Isitolo was subsequently convicted of supplying a non-approved psychoactive substance to both Junior and Marilyn.

Toxicological analysis undertaken by ESR confirmed the presence of synthetic cannabis metabolite AMB-FUBINACA in Junior's blood. The plant material located next to Junior was tested and was confirmed to be the synthetic cannabinoid AMB-FUBINACA. Testing also revealed the presence of pFPP (also known as para-flurophenylpiperazine) which has mildly psychedelic and euphoriant effects. The post-mortem examination revealed Junior had an enlarged heart and had

mild to moderate coronary atherosclerosis. This was probably a result of obesity (Junior had a BMI of 33.8) and this may have contributed to his death.

COMMENTS AND RECOMMENDATIONS OF CORONER MILLS

Who uses synthetic cannabinoids

I. The statistics above are reflected in the five deaths included in this joint inquiry. Three of the deceased had a history of mental health and addiction difficulties; two were homeless or were living in emergency houses while another had a history of homelessness; two identified as Māori, three as Pasifika (Cook Island); and all, but one, were unemployed.

II. It is well recognised that drug abuse is a complex societal and community problem. The socio-economic factors identified in the research reflect issues of inequity, racism, and underlying poverty in Aotearoa society and in our health services. Sadly, this is not new, and the over representation of Māori and Pasifika reflects the entrenched social and economic marginalisation experienced across generations.

III. The concept of minimising harm from drugs (and therefore deaths) at strategic level is often conceptualised under a triple framework of supply reduction; demand reduction; and harm reduction. Whilst outside the scope of a Coroner's inquiry, the need to reduce demand for synthetic cannabinoids by addressing the underlying drivers of drug abuse, cannot be overstated. Addressing poverty, homelessness, institutional racism and social inequality remain key to addressing the underlying causes of drug harm and deaths.

Brief legal history of synthetic cannabinoids in Aotearoa/New Zealand

IV. There were a number of calls for law reform from experts attending the hui. There is an obvious difficulty in regulating new substances which are continually changing at a rapid pace. The general consensus at the expert hui was that the classification of AMB-FUBINCA and 5F-ADB as Class A drugs under the Misuse of Drugs Act 1975 led to a dramatic decrease in general use, however, anecdotally it may have led to an increase in "dirty drugs" and possibly poorer manufacturing processes. As the Ministry of Health observed, it is likely that manufacturers and importers are much more focused on avoiding detection, than on ensuring their products can be consumed safely.[13] One DHB also commented on the inherent tension between trying to control supply by policing and implementing an effective public health campaign when harmful batches are on the streets.

V. The National Drug Intelligence Bureau also has reported enforcement difficulties particularly with regards to proving a substance is an analogue for the purposes of criminal prosecutions. They advise that the nuances and complexity of the analogue provisions and the need for evidential testing even if a guilty plea has been entered often impacts on charging decisions. Police and others also identified short comings with the Psychoactive Substances Act.

VI. The Misuse of Drugs Act 1975 is nearly fifty years old. In 2011 the Law Commission undertook an extensive review of the Misuse of Drugs Act and recommended:[14].

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[13] Ministry of Health Submission to synthetic cannabinoid deaths inquiry 15 October 2021.
[14] https://www.lawcom.govt.nz/our-projects/misuse-drugs-act-1975 last accessed 19 August 2022.

a. repealing the Misuse of Drugs Act 1975 and replacing it with a new Act administered by the Ministry of Health.

b. creating a new regime with its own criteria and approval process for regulating new psychoactive substances. The regime should empower the regulator to impose additional conditions on individual substances, strictly limit the advertising of approved substances, and provide means for regulators to monitor compliance through search and surveillance powers and strong penalties;

c. New Zealand continues to have a vigorous law enforcement focus on large-scale commercial dealing in all convention drugs, backed up by strong penalties; and

d. there should be a more flexible response, in line with New Zealand's international commitments to small-scale dealing and personal possession and use, particularly where these activities are linked to addiction.

VII. The Law Commission report is now over 10 years old and while some of its recommendations have been implemented, the evidence provided to my inquiry suggests that the Psychoactive Substances Act 2013 and the Misuse of Drugs Act 1975 are not effective in regulating synthetic cannabinoids. Drug law reform involves complex social and legal considerations, which are beyond the scope of this inquiry. Given the time that has elapsed since the Law Commission report, and the issues identified in this inquiry, it may be appropriate for the government to consider undertaking a further review of this legislation.

VIII. In response to the above comments, the Ministry of Justice (MOJ) advised that the Ministry of Health administers the Misuse of Drugs Act 1975 although confirmed that MOJ had a strong interest in drug policy particularly as it relates to drug crime. MOJ advised that they work closely with the Ministry of Health and Police to support them with the responsibilities under the Act and continue to draw on the Law Commission's 2011 report to inform their advice.

IX. Ministry of Health advised that the Pae Ora (Healthy Futures) Act 2022 and the Misuse of Drugs Act Amendment Act 2019 were key pieces of legislation aimed at reducing drug harm since 2017.

Factors that contribute to deaths from synthetic cannabinoids

X. During discussions with experts, the complex interrelationship between obesity, heart disease, psychosis and drug use was discussed. It was noted that many antipsychotics also contribute to an increased risk of heart disease. Antipsychotics and psychosis are also known to contribute to weight gain.

XI. The high detection rate of atypical antipsychotic medications in deaths from synthetic cannabinoids likely reflects the prevalence of mental illness in the user population. Overall, 50% of the deaths reviewed by Dr Morrow had a known mental health diagnosis with 41% having a history of experiencing psychosis. At least 40% had an atypical antipsychotic medication detected in the post-mortem blood. These general figures are reflected in the deaths in this inquiry with three out of the five deaths being prescribed atypical antipsychotics.

XII. The correlation between psychosis, the decision to use a synthetic cannabinoid and fatal harm is unclear. Perhaps the desire to alleviate ones' reality may explain the high prevalence of schizophrenia amongst the synthetic cannabinoid user population but it is unclear whether a diagnosis such as schizophrenia itself is a factor directly predisposing users to fatal events. It is well known that those with schizophrenia generally have increased risk of

sudden death and this has often been attributed to the effects of antipsychotic medication such as clozapine. However, the association of schizophrenia with synthetic cannabinoid related deaths is nevertheless significant as, at a minimum, it helps identify a population at risk. It also identifies those who may play key roles in prevention programs such as psychiatrists and other mental health workers.

XIII. Discussions at the hui, also indicated that the possible adverse drug interaction between atypical antipsychotics and synthetic cannabinoid use is not widely known amongst prescribing medical practitioners. While the correlation is not yet proven, and further research is required, a precautionary approach would suggest that those prescribing these medications should inform all patients of the potential risk associated with using synthetic cannabinoids and these types of mediation. Prescribers should also make the appropriate inquiries with their patients about their synthetic cannabinoid use and, if necessary, discuss with other clinicians involved in the patient care to ascertain any known use. If there is an indication that synthetic cannabinoids may be being used, then a review of their medication would be warranted.

XIV. Given the prevalence of atypical antipsychotic use amongst those who have died from synthetic cannabinoid use, it would also be desirable for further research to be undertaken into the interaction between the two.

XV. Medical practitioners access information on prescribing from a range of sources. Medsafe NZ is the government agency that approves and regulates medicines in New Zealand. The New Zealand Formulary is an independent resource that provides healthcare professionals with best practice guidance.[15] SafeRx is another such service that promotes safe and effective use of medicines.[16] Including information about possible adverse drug interaction between atypical antipsychotics and synthetic cannabinoids in the guidance provided by these organisations may reduce the risk of further deaths and increase awareness about these risks amongst health professionals. I therefore direct the recommendation below at these organisations.

Recommendation 1

1. That Medsafe, NZ Formulary and SafeRx:

    a. Review the advice they provide on the prescribing of atypical antipsychotic and consider whether the risks associated with the use of synthetic cannabis and atypical antipsychotic medications should be included.

XVI. In response to this recommendation, Medsafe advised that datasheets published on Medsafe website are reviewed by Medsafe as part of the approval process, but are produced, owned and maintained by the pharmaceutical companies that market the medicine in New Zealand. Medsafe publishes the datasheets on their website to ensure the datasheets are available for healthcare professionals.

XVII. Medsafe advised it had reviewed the information on QT prolongation in the datasheets for atypical antipsychotic medicines. All datasheets have a warning and a precaution statement around the prescribing of antipsychotic medicines with drugs that could prolong the QT interval. Medsafe noted that the datasheets for antipsychotic medicines do not list individual medicines that may contribute to a drug interaction and prolong the QT interval.

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[15] https://nzformulary.org/
[16] http://www.saferx.co.nz/

Medsafe acknowledged that such a list could be helpful, but it would be impractical given the extensive list of potentially interacting medicines and the need to continuously update the list over time. Medsafe noted it was for prescribers to screen and manage potential drug interactions. They suggested it may be more appropriate if other agencies communicate the risks of harm associated with the use of synthetic cannabinoids to prescribers.

XVIII. Medsafe however agreed there was a need for further research on the interaction of chemical compounds in synthetic cannabinoids and atypical antipsychotic medicines. It acknowledged that the datasheets do not contain any information on the use of synthetic cannabinoids and suggested this was likely to reflect the limited evidence and following complexities:

a. Synthetic cannabinoids are used recreationally, they are not regulated like approved medicines and therefore no clinical safety data is available;

b. Stating an interaction with "synthetic cannabinoids" may not be appropriate given the term covers a broad range of different chemical compounds. Preparations of synthetic cannabinoids may contain various compositions and doses of these chemicals. It would be difficult to identify which chemical compound (if any) is indicated in a drug interaction.

c. There are several mechanisms in which drug interactions can occur. Various synthetic cannabinoid chemical compounds will react differently in the body and therefore quantifying the risk of an interaction is difficult.

d. To date over 200 different synthetic cannabinoid compounds have been identified. Research on the current predominant chemical compounds will be relevant today, however will be of questionable relevance in the future as a chemical composition of synthetic cannabinoids changes rapidly over time. Ongoing research is needed to determine whether future compounds will carry the risk of Q2 prolongation

XIX. Notwithstanding the complexities set out above, Medsafe stated it would make the pharmaceutical companies aware of these Findings. It noted that although section 36 of the Medicines Act effectively allows Medsafe to take action if there is reason to believe a medicine may have a very significant safety concern or be ineffective for the purpose for which it is sold, there is no legal obligation for a sponsor to update the datasheet at the request of Medsafe.

XX. I would like to acknowledge and thank Medsafe for their response to my recommendations and engagement with these Findings.

XXI. These Findings will be provided to the Royal College of Psychiatrists, the College of General Practitioners, Te Whatu Ora - Health NZ and Te Aka Whai Ora - the Māori Health Authority for dissemination to members and appropriate staff for educational purposes.

Positional asphyxia

XXII. Coroners have previously commented on the need for greater community awareness about how to respond to a person who has collapsed following synthetic cannabinoid use and the risks associated with positional asphyxia.[17] Assuming that the user will simply "wake up" increases the risk of death.

XXIII. As the cases in the inquiry show, those who consume synthetic cannabinoids often consume with others, who also collapse or are too "out of it" to realise that their companion is in danger. The New Zealand Drug Foundation has previously done some educational work around this issue and the "it's not ok to drop" campaign was noted as an example. It has also prepared a help guide but further work in this area needs to be done.

XXIV. A further concern raised at the Hui is that there is prejudice amongst many members of the public and those who work with synthetic cannabinoid users to intervene when users have collapsed for fear of an angry or violent backlash from someone "coming out of" their comatose state. How best to engage with a user who is comatose and who may react aggressively therefore needs to be part of any educational campaign. The messaging also needs to reach those in a position to respond including whānau, those working with the homeless, health professionals as well as synthetic cannabinoid users themselves.

Recommendation 2 – Education campaign re positional asphyxia

That Te Hiringa Hauora (now part of the National Public Health Service within Te Whatu Ora), DIANZ and the New Zealand Drug Foundation: consider implementing an education campaign on positional asphyxia in the context of synthetic cannabis use and the steps that can be taken to avoid harm and or death from this. The campaign should be aimed at those who provide support to at risk populations and their whānau and include strategies and techniques on how to respond to behaviours exhibited following a collapse from synthetic cannabinoid consumption. This campaign should be produced in consultation with appropriate Māori stakeholders to ensure that it targets the right audience in an appropriate manner.

AED devices -comment

XXV. The lifesaving benefits of having AED devices available, and having confident users of these devices, should not be underestimated. I note that in one of the deaths in this joint inquiry, an off-duty doctor responding to a collapse sent a witness to look for an AED, but one could not be found.

XXVI. Having an AED (Automated External Defibrillator) in your workplace or community can make the difference between life and death. An AED can increase someone's survival chances by up to 44 percent.[18] Without an AED the chance of survival decreases by 10 percent for each minute that passes without a defibrillator.[19]

XXVII. AED devices are not publicly funded, however there are numerous organisations and groups that support and promote their installation.[20] There is also a difficulty in knowing where AED devices are kept. There is a website (https://aedlocations.co.nz/) that aims to make it easier for people to locate AED devices, however equity of access remains an issue for those who are homeless, living in boarding houses or on the margins of our society.

[17] See for example An Inquiry into the death of Asiata [2022] NZCorC 62 (14 April 2022) and An Inquiry into the death of Waara [2021] NZCorC 96 (15 June 2021).
[18] https://www.stjohn.org.nz/first-aid/about-aeds/
[19] Ibid
[20] Such as the Heart Foundation, St Johns, or Red Cross.

XXVIII. It is difficult to make a specific recommendation about AED devices. However, I draw the attention of the general public, and specifically those that provide services to vulnerable people, to the benefits of installing AED devices. I also encourage the general public to find out where in your neighbourhood or work place an AED device is kept and refer people to the website https://aedlocations.co.nz/. If an AED device is not readily available in your neighbourhood, I encourage people to consider contacting an organisation that promotes their installation, such as St Johns or Red Cross, for guidance on how to have one installed.

What improvements have been made since 2017?

XXIX. The new drug checking legislation has been effective in reducing drug harm in the recreational setting. While currently the technology requires further development, drug checking has the protentional to help reduce synthetic cannabinoid harm.

XXX. It is hoped that the developing technology will improve the ability to check for dangerous “batches or baggies” and be able to be used at locations and in a manner that meets the needs of synthetic cannabinoid users. This could include training organisations that work with homeless and other vulnerable population to test substances and provide harm reduction advice as part of their day-to-day service.

XXXI. I therefore support and encourage the ongoing development and resourcing of drug checking technology.

XXXII. In response to this comment the Ministry of Health advised that in May 2022, following the passing of regulations under the Drug and Substance Checking Legislation Act (No 2) the Drug Checking Licensing scheme was launched to enable a permanent licensing system for drug checking services. The Ministry of Health also confirmed that in October 2021 the government announced $800,000 towards the operating costs of drug checking for the national co-ordination of service, training of drug checkers, and provision of harm reduction information through to June 2022. Drug checking services received sustainable funding in budget 2022.

XXXIII. The acute drug harm response discretionary fund has been a good initiative which aims to provide a flexible and rapid response to localised outbreaks and incidents. The disadvantage is that it is time limited and does not provide for sustained intervention and programmes.

What needs to be improved?

XXXIV. I accept the evidence that early identification of synthetic cannabinoids, particularly new or novel formulations or “bad batches” is essential for harm minimisation and reducing further deaths. Currently there is no consistent process or guidelines across our hospital system for doing this. I note the success of the USED programme that was initiated in Wellington emergency department may provide a model for future. The creation of a unitary health authority, Te Whatu Ora provides an opportunity to review the USED programme and develop a consistent national process for testing toxicological samples and samples in hospitals.

Recommendation 3 Testing of synthetic cannabinoids in the hospital setting

I recommend that *Te Whatu Ora - Health NZ* review the USED programme with a view to preparing guidelines that will apply across all hospitals to ensure a consistent national process for toxicological analysis and testing of unknown substances and drugs, such as synthetic cannabinoids, taking into consideration any consent and privacy concerns.

XXXV. Response to this recommendation was received from the National Drug Intelligence Bureau, clinicians and ESR who strongly supported the recommendation.

XXXVI. Dr Sinclair, a public health physician and Medical Officer of Health for the Auckland Regional Public Health Service supported the recommendation. He confirmed it would be good to have broadly consistent identification and reporting of emerging situations across the health service backed up by regular and automatic data analysis so that unusual situations can be identified early enough for intervention. He commented that what gets noticed often depends on the situation and the people involved. The 2017 cannabinoid outbreak in Auckland essentially was noticed because of its impact on emergency and ED services but the smaller increase in presentations at Middlemore Hospital early in the year had not drawn much attention. He noted that had this earlier outbreak been noticed, it could potentially have provided an early warning.

XXXVII. Dr Sinclair also noted that clinicians' priority is gathering information and doing tests for an individual's current clinical management, with much lower attention given to related purposes like improving services and prevention. He noted that in the synthetic cannabinoid situation, some tests, such as toxicology testing of urine and the material being consumed, might not be of high priority at the time for the clinical management of people who present to the ED, but could be useful for regional or national surveillance, analysis, identification of trends and new drugs, and inform preventive programmes. He noted that it could be beneficial if the standard privacy and consent process included something to the effect that some (anonymised/de-identified) health information could be used to improve health services and contribute to preventing illness and improving health for the community.

XXXVIII. In its response to this draft recommendation, Te Whatu Ora – Health New Zealand confirmed that the USED pilot initiative demonstrated the potential merit of establishing a consistent national process for toxicological analysis and testing of unknown substances and drugs, such as synthetic cannabinoids in order to strengthen data surveillance capability and enable faster responses by health, Police and community agencies in identifying new synthetic recreational drugs. Te Whatu Ora advised that the lessons from the USED programme pilot will inform ongoing efforts in this area.

XXXIX. Maintaining an up-to-date data base or library of synthetic cannabinoids currently circulating in the community is an important tool in preventing deaths. It forms part of an early warning system and provides an opportunity for early public health messaging. Knowledge of what substances are present in the community improves first responder and community responsiveness and increases awareness of potential harm. It also contributes to reducing supply through detection and prosecution of new substances.

XL. The inquiry has identified a range of areas where testing of samples could be improved. ESR and DIANZ have made good process in establishing a data base but its success is dependent on substances being tested at all links in the chain – the border, in the community, by Police or following a death of a user. This inquiry has identified a number of areas where improved testing could be achieved, mainly through greater awareness of its importance and of how it can be done.

XLI. I note ESR's advice to coroners that consideration should be given to the possibility of urine samples being included when a lesser post-mortem is directed particularly in cases where synthetic cannabinoid toxicity is considered a possible cause of death. ESR also advise that coroners should also ensure that evidence, such as

plant materials or smoking devices, is seized and submitted to ESR for testing. These Findings will be specifically brought to the attention of the Chief Coroner.

XLII. These Findings will be provided to the Commissioner of Police to draw attention to need to provide greater education to Police about synthetic cannabinoids and the need to test plant material and implements associated with its use in order to identify the specific formula.

XLIII. These Findings will also be provided to the Chief Executive of Customs NZ and Comptroller of Customs to draw their attention to the need to increase custom officers' awareness of the limitations of the handheld device and synthetic cannabinoids generally and encouraging greater use of the CESL testing capacity and training.

Hospital and medical issues

XLIV. What is apparent from the evidence before me is that the ICD-10 coding is not sufficiently precise to provide accurate data on synthetic cannabinoid presentations. Nor does it assist in the early detection of harmful products or of specific products due to the reporting time lag. Some form of national automated real-time monitoring of acute harm and drug-related trends is clearly needed.

XLV. As already discussed, a key component of any harm minimisation strategy is the ability to identify new and harmful substances or batches in a timely manner. The hospital setting is a key setting for data collection and analysis. The emergency department also has a pivotal role in minimising harm and death to those presenting with synthetic cannabinoid toxicity or harm.

XLVI. In 2017 Auckland District Health Board, through the interagency committee, developed a reporting form that aided the identification of harmful substances, but this has not continued. There has been no consistent nationwide process for data collection. While acknowledging there are ethical and privacy concerns that need to be addressed, the collection of real-time data could reduce harm and deaths.

XLVII. This inquiry identified a number of issues in the way presentations were coded and data collected, which limits the usefulness of that data. The lack of clear clinical treatment and testing guidelines was also identified as problematic.

XLVIII. The recent changes in the health system and the establishment of a unitary health authority, Te Whatu Ora, provides an opportunity for improvement in data collection and for the development of a national treatment pathway for those presenting with synthetic cannabinoid toxicity which could help prevent further deaths from synthetic cannabinoids. This recommendation is therefore directed at Te Whatu Ora – Health NZ.

Recommendation 4

1. That Te Whatu Ora - Health New Zealand:

    a. review the current data-gathering systems and consider developing a reporting system that allows for prompt identification of "spikes" or trends in synthetic cannabis related harm.

    b. work with a team of experienced emergency department clinicians and drug and alcohol practitioners together with DIANZ to consider the development of clinical guidance which could include reporting

processes, as well as clinical pathways to improve outcomes for those presenting with synthetic cannabinoid toxicity.

c. update the PRIMHD to enable reporting using the current DSM rather than the outdated version.

XLIX. In response to this recommendation, Ministry of Health acknowledged that the PRIMHD only permitted recording of diagnosis by DSM-IV and accepted that this can result in inaccurate diagnostic and reporting data sets. The Ministry did advise there was an alternative system, SNOMED-CT, being used for reporting in some areas of the health system including 15 hospital emergency departments. They commented that SNOMED-CT had several advantages over DSM in that it allowed for the addition of new terms including Aotearoa-specific terms and it is the endorsed Health Information Standards Organisation standard clinical terminology for use in NZ health information systems. The Ministry of Health also noted that to upgrade or replace PRIMHD across the health system and the associated changes to agreed clinical coding would have significant resource implications including helping clinician and administrators consistently capture clinical notes and agreed key words.

Education/public awareness campaigns and improved treatment services

L. The need for increased and varied addiction services is well known. The 2018 He Ara Oranga report (The Government Inquiry into Mental Health and Addiction) report explicitly recommended increasing funding and access to mental health and addiction services. That report also emphasised the need for a diverse and broad range of services that are easily accessible. The report also emphasised the need for increased Māori workforce development and leadership at all levels of the mental health and addiction sector.

LI. It is acknowledged that the government has taken steps to increase funding, and already has a focus on health workforce development. However there remains minimal services that fall into the scope of kaupapa Māori or Māori centred substance use treatment programs based on communities.

LII. This inquiry into deaths caused by synthetic cannabinoid use has identified a particular vulnerable group of our society. This is a group which are generally hard to reach and whose needs are complex. I consider it is beyond the scope of this inquiry or my expertise to make specific recommendations about the services required, however I endorse the calls made for more diverse services and interventions as suggested by Te Rau Ora, the Drug Foundation and the Ministry of Health above.

LIII. I consider it appropriate to emphasise the need for a specific focus on the development of more community-based interventions to address the harm caused by synthetic cannabinoids. Services focusing on harm reduction rather than just abstinence are needed. Funding of these services needs to be longer term than the discretionary fund currently permits and should aim to anticipate rather than just respond to harms.

LIV. I also accept that the particular challenges Māori face from substance use requires a national direction for the reduction of alcohol and drug harm specifically for Māori which compliments the existing national health and action plans. The focus should be on building community, whānau/hapū/iwi resilience, capacity knowledge and strength. This requires both addressing the social determinants of drug use but also increasing Māori workforce capacity, and kaupapa Māori services which place whānau and community at the centre of the recovery process.

LV. These comments are directed at the Ministry of Health, Te Aka Whai Ora (Māori Health Authority) and Te Whatu Ora - Health NZ for their consideration.

LVI. In response to my draft Findings, the Ministry of Health advised that it would continue to ensure alcohol and other drug (AOD) services support as many people who are affected by AOD harm as possible. It noted that “Kia Manawanui Aotearoa - Long-term pathway to mental wellbeing”, the government’s 10-year strategy and action plan for mental well-being, as well as the current development of the “Mental Health and Addiction System and Services Framework” by Manatū Hauora provide opportunities to reduce drug harm. These focus on improving both population mental well-being and Aotearoa’s mental health and addiction services.

LVII. The Ministry of Health also advised that an acute drug harm community of practice was now funded by Te Whatu Ora and delivered by the New Zealand Drug Foundation. It currently has a network of 195 people across 77 organisations. Its aim is to look at insights, trends and innovative responses to acute drug harm by unique communities and nationwide.

LVIII. The Ministry of Health also advised that Te Whatu Ora had recently announced funding for eight “addiction special projects” overseen by a cross agency and cross sector expert advisory group. These projects aim to lay a strong foundation to enable consistent, high-quality evidence, informed and culturally safe addiction service delivery in Aotearoa and to strengthen the AOD workforce and workforce leadership. The topics include one covering best practice guidance that supports embedding harm reduction principles into practice, specific to settings, drugs and populations across the continuum of care. The Ministry of Health advised that this particular “Special project” will be relevant to harm from synthetic cannabis and the final document is due in June 2023.

Note: Orders under section 74 of the Coroners Act 2006 prohibit the making public of any photographs of Darryn Wright, Devonte Peirce, Adah Taurarii, Ngaeinangaro Makikiriti and Junior Taneao taken during this inquiry, in the interests of decency.

Fire

Holley [2023] NZCorC 18 (8 March 2023)

CIRCUMSTANCES

Graham Stanley Holley, aged 75, died on 16 August 2022 from asphyxia in a fire at his home.

At the time of his death, Mr Holley lived with his nephew. On 15 August 2022, the two of them had some drinks with friends, after which they had dinner together and went to bed at around 10:30pm. The nephew last saw Mr Holley on one of the chairs in front of the wood burner fire, which he said was out at this time. At around 12:30am on 16 August 2022, the nephew got up to use the bathroom and on opening his bedroom door saw thick smoke. He left the property and alerted some neighbours. He and the neighbour returned to the house and observed flames coming from the kitchen area. They tried to re-enter the house but were unable to do so due to smoke. Fire and Emergency NZ (FENZ) attended and the fire was extinguished after extensive efforts. Mr Holley’s body was later recovered from the scene.

FENZ investigated the fire and identified the rear of the building as its origin. However, the cause and the exact point of origin could not be determined given the extensive fire damage.

RECOMMENDATIONS OF CORONER TELFORD

I. As the cause of the fire has not been established, I do not consider it appropriate to make speculative recommendations.

II. However, I do have evidence that Mr Holley did not have any smoke alarms in his home. FENZ advice is widely known – that they recommend installing a smoke alarm in every bedroom, hallway and living area. The installation of a heat alarm in the kitchen, laundry, bathroom or garage is also suggested.

III. It may well be the case that an activated smoke alarm could have alerted Mr Holley to the fire and saved his life. Therefore, at the very least, this tragedy could serve as a reminder to us all of the critical importance of fire alarms in our homes.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Mr Holley entered into evidence, in the interests of personal privacy and decency.

Leisure Activities

Adler and Herzog [2023] NZCorC 31 (28 March 2023)

CIRCUMSTANCES

Peter John Adler, aged 25, Mark Benjamin Herzog, aged 27, both died on 31 January 2020 at Sabre Peak in the Darran Mountains of Fiordland National Park due to a lethal injury to their heads with associated haemorrhage.

Messrs Adler and Herzog arrived at the Homer Hut in Fiordland National Park on the evening of 24 January 2020, excited to climb Mount Sabre. They told another climber that they were concerned about finding the traverse around Barrier Knob and discussed the options of leaving the route to go into more serious terrain or going over the knob which is easier but adds to the elevation.

Messrs Adler and Herzog left the hut around mid-morning on 26 January 2020. The weather was slightly overcast and raining in the higher mountains.

Police flew by helicopter into the Darran Mountains on 31 January 2020 and observed two bodies on the North Buttress of Sabre Peak. A ground team later located Messrs Adler and Herzog. It was clear they had both fallen some distance and were wedged in a waterfall system at the base of the buttress. Both men were entangled in ropes.

Following their deaths, the New Zealand Mountain Safety Council (NZMSC) reviewed the evidence and provided a report. They were able to identify what took place on 26 and 27 January 2020. The account of events from this point is based upon the report.

It appears that Messrs Adler and Herzog either stayed at Phill's Bivvy on the night of 26 January 2020 or progressed further and spent the night closer to the climb. At some point on 27 January 2020, they attempted to climb the north face of Sabre Peak. It started raining which would have made the climb difficult and dangerous. It appears that they decided to retreat

from this attempt before they made the summit. However, the distance they needed to descend was further than the length of their rope and meant that their retreat would have required a series of abseil pitches. They chose to employ a single rope descent method. The NZMSC report writers said that, in general, this is acceptable practice and can be done safely however it meant they would have to make shorter and more frequent abseils than if they had used a twin rope method.

The NZMSC report writers said that the single rope descent is more time consuming and increases the workload for both climbers. In addition, this method requires the climbers to create anchors to use for their descent and, as there were no fixed anchors in this area, Messrs Adler and Herzog relied on the gear they were carrying to safely descend. This meant that they had to ration the material used for anchors and likely leave gear behind.

Messrs Adler and Herzog used an anchor made with a cut section of accessory cord, which is normal practice for such a descent. Shortly after Mr Herzog started descending, with Mr Adler waiting to descend, an anchor failed. The report writers noted that it is not known where this anchor was set and whether they were able to load test it before descending. However, the cord remained intact but the rock feature to which the cord was attached failed. When the anchor failed both men fell a considerable distance and sustained fatal injuries.

The NZMSC report considered possible factors that contributed to the fall. It concluded:

> Mr Adler and Mr Herzog died while retreating from their route up Sabre Peak almost certainly due to a failing natural anchor that they constructed. The factor that likely contributed most to this outcome is the pair's lack of experience climbing alpine routes, in particular in the Fiordland area, as well as their lack of experience climbing together (based on the information available). This, combined with some choices around gear (use of a single rope), the weather, and the characteristics of the route would have made for a stressful and challenging retreat, despite it probably being the correct choice under the circumstances. They appear to have resorted to using a marginal anchor to abseil off, and ultimately this has led to their death when that anchor failed, and no backup was in place. Depending on whether they were aware of the MetService weather forecast or not, the commitment heuristic and/or confirmation bias may have also been significant factors.
>
> Like many outdoor incidents, there was not one specific factor or decision that led to this accident, but rather several smaller factors and decisions that all contributed.

COMMENTS OF CORONER ELLIOTT

I. The Mountain Safety Council said:

- Mountaineering is an inherently risky recreational pursuit, and it is often this balance between risk and reward that attracts and motivates climbers, or if not, climbers are at least aware of this fine balance. It is impossible to remove all the risks from mountaineering. The MSC encourages those with the relevant skills, experience, and knowledge to undertake outdoor recreation activities, including mountaineering and in no way suggests people should not get involved in the pursuit.
- MSC wishes to pass on the following recommendations for alpine climbers in New Zealand, with certain recommendations holding emphasis for those climbing in Fiordland.
- When exploring a rock-climbing area for the first time, give yourself time to adjust to the feel of the rock, nature of anchor building and gear placement, and other environmental conditions such as weather

before tackling harder objectives. This will mean you'll be more familiar with your environment should you face unexpected challenges or stress on your route. This is especially important in unique environments like Fiordland that experience extreme weather.

- Likewise, when climbing with a new partner for the first time, stick to a route or climbing area that at least one of you is very familiar with or has climbed before, or one that is well within your experience and skill level. This assessment should not be limited to the climbing grade of the route, but also environmental factors such as rock type/condition, weather, etc. This will give you both time to get to know each other's strengths and weaknesses as well as understanding each other's risk tolerance.
- For the above two points, if you are in those scenarios consider a shorter objective rather than a long, highly committing route to allow for more straightforward bail out options.
- When alpine climbing (and particularly in areas like Fiordland), look beyond the climbing grade of your intended route to assess whether you are experienced enough for the objective. Consider other factors such as experience in alpine terrain, weather, remoteness, anchor and gear placement issues, as well as differences in rock types compared to your background.
- Wherever possible, employ the use of backup anchors to allow for testing the primary anchor when abseiling on natural protection for the first descender, and/or properly load test the anchor prior to use. The NZAT article on the subject[21] goes through one process for this and some of the reasons why it is good practice.
- When alpine climbing, consider the use of twin ropes vs. single ropes carefully based on your objectives and the nature of the route. If you have long or challenging retreats or descents potentially involved, twin ropes may be a better option to allow for more anchor flexibility and a reduced workload.
- Always check the forecast carefully and have a plan for various possible weather scenarios that you may encounter. Understand how these conditions will affect your route and your plan. The weather in New Zealand can change fast and is relatively unpredictable compared to many overseas climbing destinations. Have backup trip options should the weather at your first choice not be suitable.

II. I endorse these comments. A copy of these findings will be sent to the New Zealand Alpine Club.

Campbell [2023] NZCorC 22 (14 March 2023)

CIRCUMSTANCES

Koyren Lee Campbell, aged 22, went fishing from his kayak in Tarakena Bay, Wellington on 17 January 2021. For reasons that cannot be established, he entered the water and accidentally drowned. His body has never been recovered.

Early on the morning of 17 January 2021, Koyren told his family that he intended to go kayak fishing– something he had been doing most days over the preceding few weeks.

[21] https://alpineteam.co.nz/2014/how-descend-safely-abseiling

At around 11:00am, a group of divers saw a man fishing in Tarakena Bay about 300m offshore from a moored orange kayak, which was later identified as belonging to Koyren. At about 2:00pm, the divers returned to Tarakena Bay and noted that the kayak was still anchored but was now unmanned. After completing a dive at around 3:00pm, they checked the kayak and saw a fishing rod still in a holder on the side of the kayak, with a fish bin and a tackle box inside it. There was no kayak paddle on board the kayak. Concerned, the divers radioed the Coastguard before searching the surrounding water. Shortly afterwards, the weather began to deteriorate significantly. As winds of around 40 knots were causing the kayak to drift out to sea, the divers were advised to cut its anchor line and tow it back to shore.

At around 3:30pm, a search and rescue operation commenced. The keys to Koyren's car were found stored inside his kayak. The weather continued to deteriorate that night, with strong winds and a rough sea swell with white caps. Searching was suspended at 9:40pm, and resumed over the following three days. Clothing recovered from the sea floor on 19 January 2021, near to where Koyren's kayak had been moored, matched the clothing he had been wearing. It was unclear whether Koyren was wearing a lifejacket or if he had one with him at the time.

Koyren was described by his father as physically fit but "probably a very average swimmer". Expert advice provided to Police was that Koyren would likely not have survived more than 24 hours in the water.

On 27 January 2021, Police reported Koyren as missing presumed dead to the Coroner. The Coroner was satisfied that it was more probable than not that Koyren was dead, and that he had drowned on or about 17 January 2021 after coming off his kayak into the water.

It was not clear from the evidence how or why Koyren ended up in the water or how his clothes came to be off. The Coroner noted a number of possible theories, such as Koyren falling out of the kayak or intentionally entering the water to retrieve his dropped paddle and then getting into difficulty, and not being able to get back on the kayak or return to shore.

COMMENTS OF CORONER GREIG

I. Given the many uncertainties about the circumstances of Koyren Campbell's death I make no recommendations (which must be related to the circumstances of a death).

II. However, as a general comment for those contemplating sea kayaking, I note that Maritime New Zealand ("MNZ") has issued safety guidance in the "Paddle Craft Guide",[22] a resource produced by MNZ in conjunction with the Safer Boating Forum. I encourage everyone who intends to use a kayak to review the Paddle Craft Guide.

III. The Kiwi Association of Sea Kayakers Inc. also provides guidance for sea kayakers to consider before setting off.[23]

[22] https://www.maritimenz.govt.nz/content/recreational/kayaks-and-canoes.asp,
[23] https://kask.co.nz/presidents-blog/safety/

Kino [2023] NZCorC 9 (24 January 2023)

CIRCUMSTANCES

Clinton Mathew Te Puea Hamiora Kino, aged 47, died on 21 December 2019 at Cape Saunders of drowning, having been swept from coastal rocks while fishing.

On 21 December 2019 Mr Kino finished work early to go fishing at Cape Saunders with his workmates, Mr Moata'ane, Mr O'Connor, and Mr Duval. Mr Kino was fishing from a ledge separate from his workmates. As the swell got bigger, Mr Moata'ane tried to tell Mr Kino not to turn his back on the ocean. However, Mr Kino was wearing headphones and may not have heard the warning. Mr Kino turned away from the ocean to fix his broken fishing line, at which point a wave washed up over the ledge and knocked him off of his feet. The water then took him down across the rocks into the ocean.

Toxicological analysis found methamphetamine in Mr Kino's blood at a level of 0.19 milligrams per litre, a level associated with both recreational use and methamphetamine related toxicity. Mr Kino's blood tested positive for cannabis and presence of THC.

COMMENTS AND RECOMMENDATIONS OF CORONER BATES

I. Pursuant to sections 57(3) and 57A of the Coroners Act 2006 I make the following comments and recommendations.

II. Mr Kino's death was an accident. Unfortunately, it is not uncommon to hear of accidental drowning deaths associated with fishing activities on or around coastal rocks, particularly in remote areas and when surf conditions are rough. It is unclear how well Mr Kino knew the area where he was fishing, but the rough conditions were apparent on the day and he had been warned not to turn his back on the ocean.

III. Water Safety New Zealand information around staying safe while fishing, particularly rock fishing, states it is important to pay particular attention to swell and tide information as well as never to turn your back on the sea.[24]

IV. Mr Kino consumed cannabis and methamphetamine prior to fishing off rocks in obviously rough and, as tragically demonstrated, dangerous conditions. Cannabis cannot easily be classified as a sedative or stimulant since it can have different effects in different people and its effects generally vary over time. Its main psychological and behavioural effects are euphoria and relaxation, an impairment of perception and cognition, and loss of motor coordination. Methamphetamine is a central nervous system stimulant that is abused for its ability to induce euphoria.

V. Consumption of cannabis and methamphetamine had the potential to impair Mr Kino's perception and cognition, and cause loss of motor coordination. His judgement may have been affected by the drugs in his system in terms of where he positioned himself on the rocks, failure to fully appreciate the danger presented by the swell and large waves, electing to turn his back on the swell when large waves had been breaking on the rocks, and his ability to resist being swept from the rocks.'

[24] Water Safety New Zealand "How to stay safe while fishing" <https://watersafety.org.nz/how%20to%20stay%20safe%20while%20fishing>.

VI. While this appears obvious, I nonetheless offer a cautionary warning and recommend that any person who has consumed substances that may affect their judgement, perception, or coordination, whether that be drugs or alcohol, avoid high risk recreational activities, such as rock fishing in dangerous conditions. Of course, I recognise that the consumption of drugs or alcohol may affect a person's ability to heed such a warning. For that reason I recommend that friends, whānau, and other associates who become aware that a person has consumed drugs or alcohol discourage them from participating in such activities. I wish to be clear, there is no suggestion in the present case that Mr Kino's associates knew he had consumed cannabis or methamphetamine.

VII. Given Mr Kino was wearing headphones while fishing, it is unclear whether he heard the warning from Mr Moata'ane who told him not to turn his back to the ocean because of occasional big waves. It is unclear whether he could hear the force of large waves breaking on the rocks. It is reasonable to infer that when someone is wearing headphones they will be unable to hear everything happening around them. Their ability to perceive risk is reduced. There are obvious dangers when fishing off rocky coastal areas in rough conditions, due to swell or weather. I encourage people to maximise their ability to perceive risk. Therefore, I recommend that headphones are not worn when engaging in high risk recreational activities such as this.

VIII. It is estimated that over a 10-year period there have been approximately five incidents at Cape Saunders of people being washed off the rocks and rescued. Two incidents there of this nature have been fatal, including Mr Kino's. The number of incidents there could be significantly higher as the above figures do not include any unreported incidents, or incidents where rescue services did not attend.

IX. I note the lifebuoy ring was installed at the site by the Coastguard in 2010 after a person was washed off the rocks. In the present case, the lifebuoy ring likely contributed to Mr Moata'ane surviving the incident. He was able to use the lifebuoy to support Mr Kino in the water rather than having to support him directly, assisting both men to stay afloat while awaiting rescue services.

X. However, there does not appear to be any signage in the area warning of the dangers of fishing off the rocks during rough conditions. Police identified that signage in the area may be helpful and could alert people to the dangers of large waves and being swept from rocks. I agree. I recommend that appropriate signage is installed in prominent locations in the area. For example, where track down to the rocks commences from the carpark, and at points along the track.

XI. An attempt was made to throw a rope to Mr Kino shortly after he was swept from the rocks and before he was too far out in the swell. Unfortunately, the rope the men had with them was too light which resulted in it being blown back onto the rocks. The addition of a rescue throw rope next to the lifebuoy ring may aid in future rescue efforts. I recommend installation of a rescue throw rope.

Response of Otago Regional Council and Coastguard to Provisional Findings

XII. Otago Regional Council (ORC) and local and South Island Coastguard were provided with a provisional copy of these Findings. They liaised, and ORC has responded on behalf of these organisations. A copy of the response is attached to these Findings.

XIII. ORC and the Coastguard adopted several of my recommendations.

XIV. A site visit to Cape Saunders was completed. Further warning signage has been developed and approved (example of signage in ORC response) and will be installed as soon as weather permits. A replacement heavier throw rope will be installed. Other rescue equipment already installed will be checked and attended to if necessary. Weather permitting, these matters will be completed during the week of 19 December 2022.

XV. 10 January 2023 update from ORC: signage has been erected at Cape Saunders by ORC as recommended.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Kino taken during the investigation into his death, in the interests of decency and personal privacy.

Nowell [2023] NZCorC 19 (8 March 2023)

CIRCUMSTANCES

Maurice Lionel Nowell, aged 73, died on 6 April 2019 at Tauranga Hospital of head, thoraco-abdominal, and limb injuries sustained in a high-energy impact following a seven-metre fall onto rocks.

On 4 April 2019, Mr Nowell attended a guided tour to Moutohorā Island, off the coast of Whakatāne. Moutohorā is managed by the Department of Conservation ("DOC") for ecological restoration of its ecosystems and access is controlled by DOC permits. The walking tracks on Moutohorā are designed for use by Day Visitors, a DOC category which refers to domestic and international visitors, and local community visitors seeking an experience in a natural setting with a sense of space. The least mobile of this group are commonly families with young children, school parties, and elderly people.

Mr Nowell's walking tour was organised through White Island Tours Limited ("WIT"). Two guides from WIT were present for the duration of the trip. Before starting on the Hut to McEwans Bay Track, one of the guides gave the group a safety briefing regarding the track, which is particularly steep and can be slippery. The guide informed the group that everyone needed to walk in single file, to be careful of the edge, and to walk on the left because the track is around the volcano edge.

Approximately 200 metres from the start of the track, Mr Nowell stopped to talk with two other members of the group. He stood with his back to the outer edge of the track as they were talking. During this time, he stepped back, slipped, and fell over the edge onto the rocks seven metres below. He was transported to Tauranga Hospital and treated but died two days later from his injuries.

Following Mr Nowell's death, DOC staff undertook on-going work on Moutohorā, engaged in considerable discussions with WIT, visited the island with Police, and had a discussion with WorkSafe. The following safety measures were implemented:

(a) Visits to the island are now controlled by an entry permit process, and there is opportunity to fully standardise the safety briefing for all visitors.

(b) The concessionaires are now undertaking a visitor capability assessment prior to travelling to the island. This process is intended to ensure the standard of the track and the capabilities of the predominant visitors are well-matched.

(c) Any new hazards (e.g. landslips, treefalls, increased activity in the hot spring) are recorded by all concessionaries as they visit the island, and they exchange up-to-date information.

(d) Management of the tracks and facilities on the island is prioritised across all sites using feedback from all visits (e.g. vegetation clearance on track edges, removing treefalls across the track, etc).

(e) Signage has been installed on the island at locations where the track narrows, as an indicator to team leaders and concessionaire guides to keep their party members aware of hazards and to keep moving. Two new signs have been installed by DOC at either end of the Hut to McEwans Bay Track. These new signs read "warning, steep drop-off, keep left, kia tūpato! Be careful!".

RECOMMENDATIONS OF CORONER BATES

I. What occurred was a tragic accident and the result of momentary inattention on the part of Mr Nowell. Section 57A of the Coroners Act permits me to make recommendations or comments for the purpose of reducing the chances of further deaths in similar circumstances.

II. On 20 January 2021, I raised with DOC and WIT the possibility of signage being placed at appropriate points on Moutohorā where the track becomes particularly narrow and/or is next to a steep drop. I indicated the proposed signage should contain advice to travel the track in single file where indicated, not to stop or congregate in groups on the track unless advised by a guide that it is safe to do so, and not to turn your back to the edge of the track where it drops away.

Responses to proposed recommendations

III. Section 57B of the Coroners Act requires that I notify proposed recommendations to organisations at whom the recommendations are directed. A copy of my recommendation was provided to WIT who responded:

> WIT supports the proposed recommendation about additional signage to be installed on Moutohora Island. After Mr Nowell's death WIT consulted with the Department of Conservation, which is responsible for the island, about potential improvements and two new signs were installed by the Department of Conservation at either end of the track (in addition to signage already in place on the island) … WIT sees value in the signage being extended and enhanced, to support the safety measures its guides provide to tourists undertaking the excursion to the island.

IV. WIT also suggested installation of an anchored rope safety handrail on the inside of the track at points where it narrows. This would provide a means of support and balance for anybody who wishes to place a hand on it while traversing the track.

V. DOC responded to my proposed recommendation as follows:

> The installation of signage at hazardous sites could lead to a significant proliferation of signage on public conservation land. Motuohora [sic] is a site where public access is tightly controlled, other measures such as track design, maintenance programme, assessing capability and gear of group members, and actively monitoring and managing new hazards, are likely to have more success in improving visitor safety outcomes. The Department has concerns about signage fatigue by visitors – i.e. ignoring signs due to their widespread use.

There have been suggestions that an anchored rope handrail may provide stability for visitors on some track sections. Continuing to manage the width of the track, as well as ensuring visitors have the capability and are actively briefed and managed would be more advantageous for risk management. Signage that acts as a prompt to the group leader or guides to move the group through the next section of track without pausing has also been implemented.

VI. Although access to Moutohorā is controlled by DOC permits, DOC does not have direct control over which people take tours to the island. DOC advised that concessionaries now undertake a visitor capability assessment before departing for the island. I note however that the walking tracks on Moutohorā are designed for Day Visitors, which includes parents with young children, groups of school children, and elderly people. It therefore seems to be a high threshold for excluding potential visitors based on a lack of capability. It is possible that people who pass the capability assessment are still at risk of falling if momentarily distracted. Mr Nowell's death was due to a moment of inattention.

VII. Despite DOC's concern regarding signage fatigue, I am satisfied on balance that signage with the warnings indicated at [paragraph II above] is likely to prevent further deaths in similar circumstances. I recommend to the Department of Conservation that signage is installed at both ends of the Hut to McEwans Bay Track on Moutohorā containing advice to travel the track in single file, not to stop or congregate in groups on the track unless advised by a guide that it is safe to do so, and not to turn your back to the outer edge of the track which drops away, due to the risk of falling.

VIII. Further, although Mr Nowell slipped off the outer edge of the track, a rope safety handrail where he slipped, and other narrow sections of the track, as suggested by WIT, would provide a visible reminder for the need to take particular care (as well as a means of support). Rope safety handrails would reduce the likelihood of individuals positioning themselves near the outer edge or the track, particularly with their back to it. I therefore recommend implementation of WIT's suggestion at [IV above].

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Nowell taken during the investigation into his death, in the interests of decency and personal privacy.

Pattinson [2023] NZCorC 32 (28 March 2023)

CIRCUMSTANCES

Woodrow Jules Pattinson, aged 36, died on 15 March 2020 in the waters above the wreck of the *RMS Niagara* near the Hen and Chicken Islands, Northland of drowning.

Woodrow (known as Woody) had completed his PADI[25] Dive Master course in November 2019. He was trained and qualified to dive to 40 metres. Woody's friend, Daniel Smythe, described Woody as an experienced diver. Daniel had been on several dives with Woody where Woody would deviate from the agreed dive plan to explore different places, especially when diving at shipwrecks. Woody had set himself the goal of reaching the wreck of the *RMS Niagara* which lies off the coast of Northland at a depth of approximately 100 metres.

[25] Professional Association of Diving Instructors.

On the morning of 15 March 2020, Woody and Daniel made plans to scope the *RMS Niagara* and dive for crayfish on the way back. They each had a glass of wine before setting out for the marina. That afternoon, they left Marsden Marina in Daniel's boat and each consumed two or three beers en route. Woody suggested that they dive 50 metres down to the *RMS Niagara*.

Daniel had a dive computer, but Woody did not as he had borrowed diving gear from Daniel. Daniel monitored the depth on his dive computer. When they got to 50 metres, a large school of kingfish swam by. Because kingfish swim up and down in schools, it can be hard for divers in amongst kingfish and with no other reference point to distinguish between up and down.

After the kingfish passed, Daniel looked down and saw Woody below him holding the anchor line. Daniel followed because he did not want to get too far away from him. However, when Daniel was at 64 metres, Woody was about five to ten metres below him still holding the anchor line. Daniel did not continue further as the regular air on which they were diving would become toxic at 60 metres. Daniel decided to surface and wait for Woody on the boat. Once back on board the boat, Daniel conducted a surface search. Woody did not surface, and Daniel called emergency services.

Woody's body was located by the Police Dive Squad on 25 March 2020, lying on the *RMS Niagara*. He was still wearing his dive gear except for his fins which were lost. He had not inflated his buoyancy control device to control or stop his descent past 50 metres, nor had he jettisoned his weight belt. Woody's failure to take either of these actions suggest that a sudden event had overcome him, including but not limited to panic, inexperience to recognise the trouble he was in and/or some sort of event such as nitrogen narcosis or oxygen toxicity.

A post-mortem examination was conducted and the pathologist observed decompositional changes and injuries consistent with post-mortem marine activity. Toxicology analysis identified the presence of doxylamine, an antihistamine, and alcohol at a concentration of 101 milligrams per 100 millilitres. However, given the decomposition it could not be certain that this alcohol concentration was the same as at the time of death.

The Coroner concluded that the most likely scenario was that Woody became disoriented by the school of kingfish, possibly due to preliminary symptoms caused by nitrogen narcosis and/or oxygen toxicity exacerbated by recent consumption of alcohol. This was then compounded by his relative inexperience in diving at that depth and resulted in him descending further and failing to take appropriate steps to stop or control his descent.

The Police dive squad investigated Woody's death and noted that when diving on air, the partial pressure of the oxygen in the breathable air increases as the depth increases. Oxygen toxicity can begin to affect divers at about 56 metres. Typical signs and symptoms of oxygen toxicity include convulsions, tunnel vision, ringing in the ears, nausea, twitching and dizziness. Diving at depth with air can also cause the nitrogen in the breathable air to have a narcotic effect and which is known as nitrogen narcosis. Typical signs and symptoms of nitrogen narcosis include slurred speech, irresponsibility and inability to concentrate. The effects can be exacerbated by alcohol.

The dive squad also noted that Daniel and Woody needed to consult diving tables for that depth and plan how long they could dive down and remain at 50 metres before ascending. They would also have had to consult a decompression table different to that used for PADI recreational diving, which only went down to a depth of 42 metres.

The dive squad concluded the following factors contributed to Woody's death:

a. Woody consumed alcohol before the dive.

b. Woody did not inflate his buoyancy control device.

c. Woody did not jettison his weight belt.

d. Woody's lack of fins to the extent they were lost or removed at the end of his dive rather than posthumously.

e. Woody was not wearing a timing device or dive computer meaning he could not calculate his dive time.

f. Woody did not complete pre-dive planning due to the impromptu change of plan.

g. Woody dived deeper than he had been trained or qualified to dive.

COMMENTS OF CORONER HO

I. There are several resources which provide guidance about safe recreational diving. The dive squad also summarised a list of this guidance:

   a. Divers should abandon their weights when in difficulty.

   b. Every diver should dive with a dive buddy and remain with the buddy including during the ascent and descent.

   c. Dive within dive experience and qualifications. Divers should complete recognised training courses.

   d. Divers must have a dive plan of which all divers and any boat person in the party are aware. The plan should include procedures in event of emergency.

   e. Divers need to follow their dive plan.

   f. Never dive within eight to ten hours of consuming alcohol.

   g. Dive watches should be worn to ensure divers do not exceed their allowable dive time.

   h. Follow industry standard diving tables.

   i. Wear fins with the appropriate booties whilst diving.

   j. A non-diving boatperson to remain in the vessel and monitor the divers' activity and position.

   k. Divers should seek advice from a qualified diving doctor if existing medical conditions exist or medication is being taken.

   l. Divers should provide honest answers to medical questions.

II. As the above guidance is already in the public domain, I do not consider it necessary to make further recommendations under s 57A of the Act.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Woodrow Pattinson taken during the investigation into his death, in the interests of decency and personal privacy.

Shi [2023] NZCorC 24 (15 March 2023)

CIRCUMSTANCES

Wei Shi, aged 56, died on 17 November 2019 at Ninepin Rock, Whatipu Beach, Waitakere, Auckland. The cause of his death was undetermined after autopsy but occurred in the context of being unexpectedly swept out to sea from rocks.

Mr Shi was a property developer who lived in Mt Roskill, Auckland, with his wife and son. At about 10:00am on 17 November 2019, Mr Shi began fishing alone at Ninepin Rock on the side facing the sea. He was not wearing a life jacket.

Jeremiah Alonso was also fishing in the same area that day. At around 1:45pm, Mr Alonso saw a large wave come in over the rocks where he and Mr Shi were standing. As the wave went out, he realised that Mr Shi had been swept off the rocks and was now in the water. Mr Alonso ran to retrieve a life-ring (angel ring) located nearby and threw it out to Mr Shi, but Mr Shi was too far for the ring to reach him. Mr Alonso could see Mr Shi trying to swim back towards the rock, but after about 8 to 10 minutes Mr Shi disappeared and did not resurface.

After another person fishing in the vicinity called 111, Police co-ordinated a search of the area including the Coastguard and Airport Marine Control. At approximately 2:00pm, Eagle helicopter personnel saw the body of a deceased male floating in the water about one kilometre off shore, near the mouth of the Manukau Harbour. However, the body was only visible for a short time before slipping below the surface.

Mr Shi's body was found 11 days later after being washed to shore. Due to the level of decomposition, the cause of death was unable to be determined at autopsy. Although it appeared likely that Mr Shi had drowned, it could not be discounted that he may have had a sudden medical event which was fatal.

COMMENTS OF CORONER GREIG

I. Rock-based fishing is a high risk activity. It has been characterised as one of the deadliest recreational pursuits in New Zealand:[26] over the ten years from 2010 – 2020 twenty eight people in New Zealand have lost their lives fishing from rocky foreshores and surf beaches.[27] Most were males with fishers of Asian ethnicity the most frequent victims. A buoyancy aid was being used by only one victim. The Auckland region accounted for 35% of the deaths.[28]

II. Since 2006, Auckland Council, Drowning Prevention Auckland (DPA) (formerly Watersafe Auckland Inc) and Surf Life Saving Northern Region have collaborated on a project called the West Coast Rock-based Fisher Safety Project. The purpose of this project is to increase the safety of rock-based fishers and increase their awareness of risk related to tock-based fishing activities on Auckland West Coast beaches.

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[26] https://www.dpanz.org.nz/wp-content/uploads/2020/09/2020-Rock-Fishing-report.pdf
[27] Dangers of rock fishing | Have an enjoyable long weekend but stay safe. Over the last ten years (2010 - 2020) 28 people have lost their lives fishing from rocky foreshores and... | By Water Safety New Zealand | Facebook
[28] Ibid, footnote 26 above.

III. As part of the project the Council has installed angel rings (with signage) in high-use, high-risk rock fishing spots along the West Coast. There are eleven angel rings in the Piha area, and the duty ranger carries out routine checks to ensure they are in good condition.

IV. Through the West Coast Rock-based Fisher Safety Project, Auckland Council has over the last sixteen years, engaged in a number of safety activities related to promoting awareness of the dangers associated with rock fishing on the coastline in Auckland Council's purview and how it can be undertaken more safely. In 2020-2021 safety initiatives included:

- Hiring a Rock Fishing Advisor.
- Preparing e-learning rock fishing resources on the Drowning Prevention Auckland website,[29] with translations in Korean and Chinese.
- Publishing safety warnings on Auckland Council's websites, including a section with information on Hī ika – Fishing, with specific information on coastal fishing safety for both Anawhata and Piha, and links where the viewer can read more.
- Holding workshops at Muriwai beach with at-risk community groups.
- Holding a land-based fishing safety talk at Pakiri with at-risk community groups.
- Facilitating media coverage regarding rock fishing safety.
- Completing over 20 community presentations in relation to land-based fishing safety; and
- Maintaining angel rings and safety signage at high-risk sites.

V. Not wearing a lifejacket when fishing from rocks has been identified as a persistent high-risk behaviour amongst rock fishers. The importance of doing so is highlighted as a key message on the websites of organisations such as the Drowning Prevention Auckland and Water Safety New Zealand.

VI. Water Safety New Zealand's Facebook page contains key safety messages about Rock Fishing safety[30] which are relevant to this inquiry:

- Always wear a lifejacket.
- Pay particular attention to swell and tide information.
- Never fish in exposed areas during rough or large seas.
- Spend at least ten minutes observing the sea conditions before approaching the rock ledge.
- Never turn your back on the sea.

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[29] https://www.dpanz.org.nz/courses/safer-rock-fishing/

[30] Dangers of rock fishing | Have an enjoyable long weekend but stay safe. Over the last ten years (2010 - 2020) 28 people have lost their lives fishing from rocky foreshores and... | By Water Safety New Zealand | Facebook

- Pay attention to warning signs.
- Never fish from wet rocks where waves and spray have obviously been sweeping over them.

VII. I endorse these key messages which are also highlighted in an online course on Safer Rock Fishing available on Drowning Prevention Auckland's website.[31]

VIII. It is apparent that there is a need for continued education and reinforcement of the message that lifejackets save lives when rock fishing. In view of the ongoing proactive work being done by Auckland Council, Drowning Prevention Auckland (DPA), Surf Life Saving and Water Safety New Zealand to raise awareness of the dangers of rock fishing and key safety measures, as well as the clear signage and the location of an angel ring at Whatipū, I do not make recommendations in this matter.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Mr Shi entered into evidence, upon the grounds of personal privacy and decency.

Medical Care

Ali [2023] NZCorC 27 (22 March 2023)

CIRCUMSTANCES

Galib Nur Ali, aged 63, died at Auckland City Hospital on 4 November 2020. The cause of death was complications of liver failure following an operation for squamous cell carcinoma on the left side of his jawbone. An underlying condition was his non-alcoholic fatty liver disease with cirrhosis (categorised as child-Pugh C chronic liver disease).

Mr Ali was initially seen for concerns about skin lesions including one that had developed on his tongue. This led to a diagnosis of cancer and subsequent surgery on 26 October 2020. Mr Ali underwent the major free flap and mandibulectomy operation, involving dissection of both sides of his neck, placement of a breathing tube into his trachea (tracheostomy), removal of much of his jawbone and reconstruction with a skin and bone flap from his leg.

Over the days following the surgery Mr Ali became progressively agitated and confused. His blood tests indicated that his liver had decompensated (failed to compensate for the functional overload resulting from disease) as a result of the operation.

Dr Benjamin Griffiths was responsible for preoperative optimisation and medical management of Mr Ali's operation. Two days after the operation, Dr Griffiths learned that Mr Ali was under the care of a hepatologist. It was made clear that his liver disease was a good deal worse than Mr Ali had disclosed or was known, including endoscopies that had indicated portal hypertension. Dr Griffiths discussed these matters with one of the operating surgeons, and was advised that prior to the surgery, Mr Ali had disclosed after direct questioning that he had seen a hepatologist in the past. The surgeon had

[31] Safer Rock Fishing | Drowning Prevention Auckland (dpanz.org.nz).

included this fact in an email sent to multiple correspondents, including Dr Griffiths, on 22 October 2020. Unfortunately, Dr Griffiths did not receive this email.

Mr Ali was transported to Auckland City Hospital where he was treated before deteriorating and dying on 4 November 2020.

Mr Ali's family objected to a post-mortem examination, and their objection was upheld by the duty coroner. After his death, the duty coroner received a hospital record of death (HROD) from Auckland City Hospital. The HROD raised concerns that protocols for managing liver impaired patients were not followed prior to the surgery occurring at Mercy Ascot Hospital.

COMMENTS OF CORONER TETITAHA

I. I am satisfied there is need to make comments and recommendations about this death pursuant to section 57A of the Coroners Act 2006.

II. Auckland City Hospital have provided me with a copy of the guidelines for their patients with liver cirrhosis undergoing surgery. One of the perioperative recommendations include:

    a. Patients with chronic liver disease/cirrhosis should be assessed by a hepatologist prior to undergoing surgery. Patients can be reviewed in the outpatient setting before elective surgery or as an inpatient before emergency surgery. The haematology registrar can be contacted on 021XXXXXX or 021XXXXXX to facilitate patient assessment.

III. The input of hepatologist is sought at all stages including preoperative and post-operative. It does not appear that the input of a hepatologist was obtained during the critical stages leading up to Mr Ali's death.

IV. Dr Griffiths states in his report with the benefit of hindsight, he would have discussed the case with Dr Harry (Mr Ali's hepatologist) and held a multidisciplinary family discussion highlighting the significant risk of complications and death following surgery. The surgery might still have occurred at Mercy Ascot Hospital or Auckland City Hospital but with haematology input throughout.

V. This raises a further issue regarding the quality of informed consent Mr Ali gave in respect of his surgery and anaesthetic. It is speculative to state he may still have consented to surgery despite the risks.

VI. This indicates the need for further investigation regarding the standard of care Mr Ali received and the information he was given regarding the risks of undertaking the surgery that led to his death. This is a matter that requires a referral to the Health and Disability Commissioner.

VII. One of the medical practitioners also referred to the failure of the public hospital email account system to deliver critical information regarding Mr Ali's liver cirrhosis. There is no indication of the severity of this issue and whether it is ongoing. This is a matter that should be referred to Te Whatu Ora for investigation and (if required) remedy. This may also be an issue for consideration by the Health and Disability Commissioner.

VIII. I direct these comments and the below reference to the Health and Disability Commissioner that I intend making to the medical practitioners involved in Mr Ali's care between 1 October and 4 November 2020 (Dr Abu-Serriah, Dr Benjamin Griffiths and Mr Rajan Patel), Mercy Ascot Hospital, Te Whatu Ora and the Health and Disability Commissioner for further comment.

Referral to the Health and Disability Commissioner

IX. In lieu of any recommendations, this matter may be more appropriately referred to the Health and Disability Commissioner (HDC). The HDC administers the code of Health and Disability Services Consumers Rights (the Code).

X. I am satisfied that the public interest would be served by this death being investigated by the HDC pursuant to section 119 of the Coroners Act 2006. There is evidence that indicates rights under the Code may have been breached. These rights include but are not limited to the right to services of an appropriate standard (right 4) and the right to make an informed choice and give informed consent (right 7).

XI. There is merit in a specialist body reviewing the circumstances leading to this death to determine whether further action is required or not. Any recommendations can then be made by the HDC following its investigations.

Responses to comments and referral

XII. I have received responses from two of the medical practitioners involved with Mr Ali's care. Both responses state the ADHD guidelines for patients with liver cirrhosis are not universally applicable and note the information received from Mr Ali was at times incorrect and downplayed the severity of his NASH cirrhosis.

XIII. One of the practitioners does not believe a reference to the HDC is required. Another practitioner sets out steps they have done to improve practice and maximise patient safety including:

- We discussed the details of the event and our clinical governance meeting at both service level and Mercy Hospital level.
- Formal anaesthetic assessment is required prior to major head and neck surgery.
- We have added questions about liver disease specifically liver cirrhosis in preadmission questionnaire.
- Patient medical history will always be obtained from his/her GP.
- To use at least 2 methods of communication (verbal, text or email) to highlight patients with significant comorbidity who are listed for surgery.

XIV. I thank both practitioners for the responses. These responses shall be provided to the HDC for consideration as part of its investigation.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Mr Ali during this inquiry (being photographs of a deceased person), in the interests of decency.

Grace [2023] NZCorC 17 (2 March 2023)

CIRCUMSTANCES

Callum Deon Grace, aged 19, died on 19 August 2018 at Auckland City Hospital of acute oesophagitis. Callum was born with the neurodevelopmental disorder Prader-Willi Syndrome (PWS). He lived in Seabrook House, a care facility run by Spectrum Care.

At some time between 4pm and 4:30pm on 19 August 2018, Callum was admitted to Auckland City Hospital with stomach pain and vomiting. He had been vomiting repeatedly since the previous night. At about 6:30pm Callum was sitting upright on his hospital bed when he experienced a sudden massive vomiting event. He then became flaccid, slumped forward and was unresponsive. Hospital staff carried out full resuscitation efforts but this was not successful and Callum was pronounced deceased.

Spectrum Care provided a report to the Coroner produced by an external consultant who had reviewed the circumstances leading to Callum's death. The review identified that only one staff member had attended PWS training and that there was a general lack of knowledge across the organisation as to the seriousness of Callum's presenting symptoms. The report recommended that all staff involved in caring and supporting clients with PWS should receive training on the condition and potential emergency indicators.

The Coroner sought an independent expert opinion from Dr Paul Quigley who advised that the correct position to manage this situation would have been the patient lying flat on their side in the coma or recovery position. He advised that keeping Callum upright would have been a perilous position as he would not have been able to vomit strongly due to his PWS. Dr Quigley found that all other actions of medical staff were appropriate and the only significant point of contention was whether the event leading to aspiration could have been prevented by staff placing Callum on his side immediately when he started to vomit. Dr Quigley opined that nursing staff should have been advised of this.

The Coroner also contacted the Prader-Willi Syndrome Association New Zealand (PWS Association). The PWS Association advised that there is limited medical expertise and experience of PWS in New Zealand and internationally. The PWS Association was not aware of any specific published guidelines around positioning during vomiting in PWS but noted it provides training to residential care providers, stressing that vomiting may signify a serious health concern for a person with PWS. The PWS Association also reported it had assumed that the safe position for a vomiting PWS patient would be the same as for the general population, namely the recovery position as per the advice of Dr Quigley.

The Coroner found on the basis of all the reports and information provided that Callum's airway became occluded when he was in the upright position. He then became unconscious and slumped forward and was in cardiac arrest prior to being laid into the recovery position.

COMMENTS OF CORONER WOOLLEY

I. The outcome in this case is utterly tragic, and, unfortunately, despite making several attempts to locate an expert in PWS who may be able to assist with the key issue in this matter, being the position that Callum should have been placed in when he began vomiting, I have been unable to identify such an expert. Consequently, having reviewed the evidence, I am unable to make any recommendations pursuant to section 57 of the Coroners Act 2006 in this case. However, I wish to make the following observations:

a. Vomiting is rare in PWS and pain tolerance amongst PWS patients can be high, therefore it is important that medical assistance is sought as soon as possible because a vomiting event in a PWS patients can signal a very serious illness.

b. There is no detailed guidance available to assist medical practitioners with the position that a person with PWS should be placed in when vomiting. The current practice is to adopt the position that is recommended for any person suffering such an event, being the recovery position. In this case, Dr Quigley's opinion is that keeping Callum upright would have been a perilous position for him as he would not be able to vomit strongly due to his PWS.

c. I observe it would be helpful and useful for guidance to be developed addressing the position that a person with PWS should be placed in when vomiting. The Hospital may be able to work with the PWS Association New Zealand to advance such guidance, but I acknowledge that this is an area with few experts and, therefore, may not be something that is able to be easily progressed.

d. I commend the outcome of the Spectrum Care review and endorse the recommendation that its staff receive training on the conditions and potential emergency indicators of PWS and on the seriousness of presenting symptoms of vomiting and abdominal distension in PWS.

e. Lastly, I acknowledge the helpful work that the PWS Association New Zealand provides to residential care providers about the various complexities of PWS and how best to support persons living with PWS.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs that show the deceased, in the interests of decency and personal privacy.

Hedges [2023] NZCorC 28 (22 March 2023)

CIRCUMSTANCES

Daphne Louise Hedges, aged 89, died on 19 December 2016 in her room at Woburn Rest Home, 57 Wai-iti Crescent, Woburn, Lower Hutt of cardiac amyloidosis which made her susceptible to a fatal arrhythmia.

The Coroner found that Mrs Hedges' death was precipitated by the stress associated with her becoming trapped between a pressure relieving mattress sitting atop a base mattress on her bed and the adjacent wall and wall heater. She became trapped due to the insecurity of the pressure relieving mattress. This happened due to its incorrect use and due to it having smaller dimensions than the base mattress. The trapping hazard posed by the pressure relieving mattress was not appreciated by the healthcare assistants attending to Mrs Hedges despite her previously being observed in similarly trapped positions.

RECOMMENDATIONS OF CORONER WRIGLEY

I. Any recommendation or comment I make under the Act must be made only for the purpose of reducing the chances of further deaths occurring in circumstances similar to those surrounding Mrs Hedges' death. They must

also be "clearly linked" to the factors that contributed to the death.[32] In this case I have found that the stress associated with becoming trapped contributed to Mrs Hedges' death. I have further found that issues with the size, security and use of the pressure relieving mattress contributed to that trapping as did a failure to identify, notify and address that hazard prior to her death.

II. The limited information about the model of pressure relieving mattress actually being used by Mrs Hedges and likely errors with how it was being used precludes a blanket recommendation against the use of pressure relieving mattresses requiring placement upon a base mattress. I did, though, give consideration to making the following more specific recommendations to assist in addressing the issues with the features and use of Mrs Hedges' pressure relieving mattress which contributed to her becoming trapped (addressed […] above):

Proposed Recommendation 1

When a pressure relieving mattress must be used on top of a base mattress, to prevent slipping or trapping:

(a) the pressure relieving mattress used should be matched in size to the base mattress and securely fitted to the base mattress through the use of a closely fitted sheet, straps and/or other mechanisms to avoid the risk of movement of the pressure relieving mattress; and

(b) the secure fit of the pressure reliving mattress should be regularly monitored.

III. I proposed to direct Proposed Recommendation 1 to all health care workers, including healthcare assistants, responsible for fitting, and monitoring the use of, pressure relieving mattresses used atop a base mattress. I also proposed to direct Proposed Recommendation 1 to those organisations who employ, regulate and support healthcare assistants and or their employers and invite them to proactively promote the recommendation.

IV. I also considered what, if any, recommendation ought to be made to address the apparent failure of healthcare assistants to identify and notify the trapping hazard posed by the pressure relieving mattress being used for Mrs Hedges. Mrs Tlapi [on behalf on PSC Eliven], reported that since Mrs Hedges' death, healthcare assistants at Woburn Rest Home have received mandatory training in relation to hazard identification. However, this training does not specifically support the identification of the trapping hazard that I have found was overlooked for Mrs Hedges. I consider helpful lessons in hazard identification could be learnt from the circumstances of Mrs Hedges' death which may prevent further deaths like hers. For this reason, and based on the premise that effective training will improve healthcare assistants' identification of relevant trapping hazards, I proposed making the following second recommendation:

Proposed Recommendation 2

Training of healthcare assistants in relation to hazard identification should include education that will support identification of trapping hazards.

[32] Coroners Act 2006, s57A.

V. When proposing this recommendation, I observed that the use of the (anonymised) circumstances of Mrs Hedges' death as a case study may assist with such training, something which her family supports. I proposed directing this recommendation to those organisations responsible for, or interested in, the training of healthcare assistants.

VI. As required by s57B of the Act, I gave those listed below an opportunity to comment upon the proposed recommendations on the basis that they potentially hold relevant expertise or are positioned or mandated to effectively implement those recommendations:

a. Woburn Rest Home / PSC Enliven;

b. Australia and New Zealand Society for Geriatric Medicine;

c. New Zealand Aged Care Association ("NZACA");

d. Ministry of Health;

e. Te Hiringa Hauora - Health Promotion Agency;

f. Health Quality & Safety Commission New Zealand;

g. HealthCERT;

h. Career Force;

i. Toitū te Waiora (Community, Health, Education and Social Services) Workforce Development Council ("Toitū te Waiora");

j. Arjo and Curo, which are identified as the main suppliers of equipment to aged residential care facilities;

k. WorkSafe;

l. Standards New Zealand;

m. BSI [British Standards Institute] Group NZ Ltd ("BSI");

n. Ministry of Business, Innovation and Employment; and

o. Accident Compensation Corporation.

VII. Ms Tlapi, on behalf on PSC Eliven, advised that the organisation was "happy" with the proposed recommendations. Doctor Matuszewska [who examined Mrs Hedges at Woburn Rest Home] advises that the proposed recommendations have been "applied practically from the time of [Mrs Hedges'] death and [there have been] no more similar incidents". Doctor Williamson advised that she had no relevant feedback.

VIII. The Australia and New Zealand Society for Geriatric Medicine provided no response to the proposed recommendations.

IX. The Clinical Advisor of NZACA, Rhonda Sherriff, advised support for both proposed recommendations. In relation to Proposed Recommendation 1 she made the following constructive comments:

Suppliers of pressure relieving mattresses in New Zealand also need to be made aware of the health and safety concerns raised in this report as they sell the product and provide education to staff on how to secure and use air mattresses to optimal effect. These separate air mattresses are very commonly used in aged care for pressure area management, as there is a financial barrier for many aged care providers to purchase the combined pressure relief "all in one" type mattresses.

As part of the formalised training provision there should be specific education provided to all staff on how to inflate, fit, secure, and anchor a pressure relieving mattress that sits atop a base mattress.

Ms Sherriff identified the main suppliers of equipment to aged residential care facilities and offered to raise with those suppliers, who are NZACA Affiliate Members, Proposed Recommendation 1 and the issues she identifies.

X. In relation to Proposed Recommendation 2, Ms Sherriff advised that, when relevant, it will be reflected in future training NZACA carries out for healthcare assistants. However, in her opinion, HealthCERT, the Ministry of Health and the Health Quality and Safety Commission will likely have the greatest reach in communicating the recommendations to the wider sector and monitoring their implementation going forward.

XI. No response was received from the Ministry of Health, although a response was received from HealthCERT and is addressed below. Te Hiringa Hauora – Health Promotion Agency responded by advising that it did not wish to comment upon the proposed recommendations.

XII. The Health Quality and Safety Commission is a Crown entity with a role of leading and coordinating efforts to improve service quality and safety across the health and disability sector and helping providers achieve this improvement.[33] On the New Zealand Government Website[34] it is reported that one of the programme areas in which the Commission is working is "pressure injury prevention". A representative of the Health Quality and Safety Commission advised that, after checking with "our mortality review committee", it was not appropriate for the Commission to provide a response in this inquiry as "… they do not have expertise in this area."

XIII. HealthCERT is responsible for administering the Health and Disability Services (Safety) Act 2001, ensuring hospitals and rest homes provide safe and reasonable levels of service for consumers. The manager of HealthCERT's, Ruihua Gu, responded by agreeing with both proposed recommendations. Ms Gu expressed her view that the proposed recommendations aligned, in a general way, with the following clauses of Ngā Paerewa Health and Disability Services Standard, which must be met by aged residential care providers regulated and certified under the Health and Disability Services (Safety) Act:

2.3 Service management

2.3.2 Service providers shall ensure their health care and support workers have the skills, attitudes, qualifications, experience, and attributes for the services being delivered.

2.3.4 Service providers shall ensure there is a system to identify, plan, facilitate and record ongoing learning and development for healthcare and support workers so that they can provide high-quality safe services.

[33] New Zealand Health and Disability Act 2000, s59B.
[34] https://www.govt.nz/organisations/health-quality-and-safety-commission-new-zealand/

2.4 Health care and support workers

2.4.4 Healthcare and support workers shall receive an orientation and induction programme that covers essential components of the service provided.

Section 4: Person centred and safe environment

4.1.2 The physical environment, internal and external, shall be safe and accessible minimise risk of harm, and promote safe mobility and independence.

XIV. Ms Gu advised that HealthCERT publishes a quarterly online bulletin that is distributed to the wider health sector and is available on its website. She proposes including in a bulletin the finalised recommendations arising from this inquiry together with an "anonymised case study" to enable providers to "reflect on current practice and changes required to meet the recommendations."

XV. Jane Wenman, the Chief Executive of Careerforce, provided a response in which she explained that from September 2022 Careerforce will operate under Te Pūkenga – New Zealand Institute of Skills and Technology to deliver services arranging work-based training, including training for healthcare assistants in aged care facilities. Ms Wenman suggested that, in relation to Proposed Recommendation 2, the following should be specified:

> … that unit standard 28517 Recognise and report changes and risks for a person in a health or wellbeing setting is revised to ensure that risks associated with trapping hazards are made mandatory within the standard.

Ms Wenman recommended that Toitū te Waiora be identified as an interested party in this inquiry given its responsibility for standard setting for the health and wellbeing sector.

XVI. Ms Wenman supported the development of an anonymised case study that is made widely available to the health and wellbeing vocational education sector. On behalf of Careerforce / Te Pūkenga she offered to partner with NZACA in developing this.

XVII. Toitū te Waiora was provided with an opportunity to comment upon the proposed recommendations, Ms Wenman's suggestion regarding unit standard 28517 and NZACA's suggestion that there should be specific education provided to all staff on how to use pressure relieving mattresses that sit atop a base mattress. In response, the General Manager Qualifications and Assurance for Toitū te Waiora, Heather Kingsley-Thomas, advised that NZQA unit standard 28517, will be "formally update[d]" to include explicit reference to the "… use of base mattress and the identification and notification of trapping hazards by health care assistants of a pressure relieving mattress …" and this amendment will be submitted to NZQA for consultation

XVIII. I have been provided with the draft amendments to unit standard 28517, which include the addition of a definition of "trapping" and the following performance criteria:

3.2 Identify situations where trapping may occur and describe measures to mitigate risk.

Range includes but is not limited to – use of pressure relieving mattresses.

Toitū te Waiora has described the purpose of the amendments to unit standard 28517 as providing a response to issues raised by this inquiry and a recommendation that "… people who provide support in a health or wellbeing

setting should … have knowledge of the risks of trapping, particularly in relation to the use of pressure-relieving mattresses." Ms Wenman advised that Toitū te Waiora will request a full report from NZQA on all providers who have consent to assess against unit standard 28517 and then publish a notice of the amendments and advise of the development of a case study, in collaboration with Careerforce and NZACA, to support training.

XIX. In the meantime, Toitū te Waiora has provided a "Moderators Interpretation", dated 21 December 2022, for unit standard 28517 - *Recognise and report changes and risks for a person in a health or wellbeing setting*. This document records that it is issued as a result of this inquiry and requires the addition of the following to a guidance note for unit standard 28517, which is to apply from 1 January 2023:

> Outcome 3
>
> > Assessors are to ensure that the possibility of trapping for the person (as defined in guidance notes) for outcome 3 PC 3.2 in addition to the requirements of the range statement.
> >
> > This means in addition to the two indicators for two types of abuse, neglect or violence that 'Trapping' must be included as an additional 'type', and be described as a condition whereby a 'person' may become trapped between fixed items such as walls and various movable items within the room (such as a bed or large chair), and provide appropriate assessor guidance to ensure correct identification and remedial action.

XX. In addition to the amendments to unit standard 28517, Ms Kingsley-Thomas advised that unit standard 27459 – *Observe, describe and respond to changes in a person in a health or wellbeing setting* will be "look[ed] at" by Toitū te Waiora.

XXI. The two main suppliers of equipment to aged residential care facilities identified by Ms Sherriff of NZACA, Arjo and Cubro, were advised of her suggestion that they assume some responsibility for the training of healthcare workers on the safe use of pressure relieving mattresses which sit atop a base mattress. Cubro advised that it had considered the proposed recommendations and did not wish to comment. A representative of Arjo provided a response which relevantly included the following:

> Arjo delivers products to facilities with the Instructions For Use (IFU). Arjo's recommendation is to follow the IFU in terms of how the product ought to be used.
>
> If required, Arjo provides training to the facilities that report such a need, however, Arjo cannot take the responsibility for training the facility staff on other products than Arjo's. Also, Arjo cannot take responsibility for the facility staff's actions subsequently to training provided.
>
> Arjo's understanding is that facilities follow nursing standards and facilities protocols in terms of patient/resident care and patient safety. Patient care and safety are based on the facilities' clinical patient risk assessment. This assessment would require verifying the person's risk of entrapment and also the verification includes a clinical decision in terms of selecting the appropriate product for the patient's needs.
>
> Publicly available literature on bed entrapment zones; e.g. the "Guide to Assessing Entrapment Risk", "Bed Entrapment Zone Measuring Tool" as well as the "Instructions for Measuring Entrapment Zones", provide guidance and recommendation to the facilities on patient care and safety.

Ultimately, it is the facility's responsibility to implement patient care and clinical assessment protocols and ensure facility staff is aware of how to ensure patient safety.

Arjo provides training facilities, when required, as part of Arjo's standard process, but cannot take responsibility for the awareness or lack of awareness of the facility's staff regarding patient care and safety when using mattresses.

Product Instructions for Use include guidance on how to use the products, therefore Arjo recommends following these instructions.

XXII. Relevant to Arjo's response is that of Alison Houston, Manager, Victim Services and Coronial Services, who responded on behalf of WorkSafe. She acknowledged that WorkSafe had not intervened in relation to Mrs Hedges' death. She advised WorkSafe's view that the proposed recommendations are consistent with PCBU's[35] duty under the Health and Safety at Work Act 2015 to assess and review their risks on a regular basis, including after a significant event. I highlight ss30 and 36(3)(f) of the Health and Safety at Work Act 2015, which provide:

30 Management of risks

(1) A duty imposed on a person by or under this Act requires the person—

(a) to eliminate risks to health and safety, so far as is reasonably practicable; and

(b) if it is not reasonably practicable to eliminate risks to health and safety, to minimise those risks so far as is reasonably practicable.

(2) A person must comply with subsection (1) to the extent to which the person has, or would reasonably be expected to have, the ability to influence and control the matter to which the risks relate.

36 Primary duty of care

…

(3) Without limiting subsection (1) or (2), a PCBU must ensure, so far as is reasonably practicable,—

…

(f) the provision of any information, training, instruction, or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking; …

XXIII. When provided with an opportunity to comment upon the proposed recommendations, Standards New Zealand's was also asked about the British Standard Specification 7068:1989 for alternative pressure air mattresses. Standards New Zealand advised that it was "… unable to respond to technical queries about the content of a standard" and suggested input be sought directly from BSI.

[35] A PCBU means a "person conducting a business or undertaking" and is further defined in 17 of the Health and Safety at Work Act 2015.

XXIV. On behalf of BSI, a response was received from Lisa Cochrane, Health Audit Manager. Ms Cochrane's position was as follows:

> It is essential that not only health care assistants are trained in the identification and notification of trapping hazards, but that mandatory training (also suggested by Ms Sherriff) is provided to all healthcare workers including registered nurses around how to inflate, fit, secure, and anchor a pressure relieving mattress that sits atop a base mattress.
>
> As there are a number of different types of pressure relieving mattresses, training would depend on the type of mattress used. Staff members should be assessed as competent to use that specific mattress which includes identifying any potential risk related to that mattress.
>
> In summary, all staff should be trained and assessed as competent when using any specific equipment as part of the care of that resident.

I agree with Ms Cochrane that training in the use of pressure relieving mattresses needs to be tailored to the features and specifications of the mattress being used, which can vary between the different pressure relieving mattresses available in New Zealand.

XXV. Ms Cochrane supported Proposed Recommendation 2, Ms Wenman's proposal in relation to unit standard 28517 (refer [XV] above), and the development of a case study for training purposes (refer [V] above). However, Ms Cochrane considered more is required and recommended:

> … training of registered nurses to identity any hazards related to equipment being used and ensure interventions are documented to mitigate those hazards/risks within the resident's care plan. This training could be delivered as part of the case study recommendation or identified as part of the ARRC contract.

XXVI. Ms Cochrane recommended updating the standard services agreement with age-related residential care services to be more specific about staff being trained and assessed as competent in relation to any equipment being used and identifying risks associated with such use. She specifically referred to clause D17.5d of the standard services agreement and suggested that training referenced in Proposed Recommendation 2 be delivered as part of that agreement.[36] Ms Cochrane also referenced the Guiding Principles for Pressure Injury Prevention and Management in New Zealand (May 2017) which includes "Principle three: Education and Training: Staff can use the available equipment safety and know how to assess that it is fit for purpose."

XXVII. While there may be merit in the further steps Ms Cochrane proposes, I am not satisfied the circumstances of Mrs Hedges' death enables me to make recommendations wider than those proposed. The circumstances of Mrs Hedges' death indicate issues with the training of only healthcare assistants and only in relation to trapping hazards, particularly those associated with the use of pressure relieving mattresses. Section s57A(3)(a) restricts the parameters of any recommendation I may make to those factors.

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[36] Clause D17.5 d, provides:

> You may arrange the education referred to in clause D17.5(c) at the Facility or externally. Any staff member carrying out tasks, procedures, or treatment must have demonstrated they are competent at performing the task, procedure and treatment, and follow documented policies, and protocols developed by you to ensure safe practice.

XXVIII. The Ministry of Business, Innovation and Employment responded by advising that it is not aware of any incidents or product safety complaints related to pressure relieving mattresses in New Zealand. It offered no comment on the proposed recommendations.

XXIX. ACC advised it did not wish to comment upon the proposed recommendations but advised that they are welcomed.

XXX. Accounting for the responses described above, I make the following observations:

a. There are a variety of pressure-relieving mattresses available in New Zealand which may have different features and specifications. Safe use of those mattresses requires compliance with manufacturers' and suppliers' instructions for safe specific to features and specifications of the particular mattress. Due to the limited evidence I have received regarding the features and specifications of pressure relieving mattresses in use in New Zealand, there is a risk that Proposed Recommendation 1 may not be appropriate for all pressure-relieving mattresses;

b. There exist multiple imperatives for the safe use of pressure relieving mattresses by healthcare service providers and for measures that support such use like specific training of healthcare assistants on this topic. Under the Health and Safety at Work Act 2015, health and disability service providers, including aged-related residential care service providers, are required assess and review risks in their workplace on a regular basis and avoid or mitigate those risks. Such risks must include those associated with the use of equipment such as pressure relieving mattresses. Safe use of pressure relieving mattresses and appropriate training to support this is further supported, in a general way, by Ngā Paerewa Health and Disability Services Standard (refer [XIII] above) and the *Guiding Principles for Pressure Injury Prevention and Management in New Zealand* (May 2017) (refer [XXVI] above). I also refer to Right 4 (Right to services of an appropriate standard) of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, which includes a consumer's right to have services provided with reasonable care and skill and in a manner that minimises the potential for harm;

c. Despite these imperatives, the circumstances of Mrs Hedges' death and the responses described above indicate that currently there is inadequate training available for healthcare assistants to ensure the safe use of pressure relieving mattresses, particularly in relation to the trapping hazard they may pose;

d. As a result of the consultation this inquiry has involved, Toitū te Waiora has underway a consultation process regarding proposed amendments to NZQA unit standard 28517 which addresses the topic of identification and mitigation of trapping hazards, including those relating to the use of pressure relieving mattresses. The development of other tools to assist with training on this topic have been identified and are supported, including the development of a case study relating to the circumstances of Mrs Hedges' death;

e. These findings record the suggestions and recommendations by specialists that may utilised by those responsible for standard setting and improvement in the provision of health and disability services to consumers requiring the use of pressure relieving equipment and by those responsible for ensuring adequate training of healthcare assistants who are involved in the use of such equipment. Suggestions include collaboration and partnership between government organisations and others within the health

and disability sector, review and supplementation of existing standards, and targeted publicity of matters raised in these findings. Through those to whom opportunity to comment has been given under s57B of the Act, I am satisfied that these findings can be made available to all those who can assist in implementing the lessons to be learnt from the circumstances of Mrs Hedges' death, including through further consideration of the suggestions and recommendations of specialists recorded above.

XXXI. Considering all of the above, I have decided that a slightly modified version of Proposed Recommendation 2 is adequate and warranted to maintain the momentum of work that has begun to ensure the better training of healthcare assistants in relation to the identification and mitigation of trapping hazards, including those associated with the use of pressure relieving mattresses. The amendments to Proposed Recommendation 2 include reference to training about the mitigation of trapping hazards and the used of pressure relieving mattresses. I consider that these amendments, together with the availability of instructions for safe use for pressure relieving mattresses by suppliers and the risk identified at [XXX](a) above, makes Proposed Recommendation 1 redundant and inappropriate.

XXXII. Accordingly, I make the following recommendation pursuant to s57A of the Act:

> The training of healthcare assistants should include that which will teach the identification and mitigation of trapping hazards, including those arising from the use of pressure relieving mattresses.

This recommendation is directed to those responsible for, involved in, or capable of influencing, the training of healthcare assistants to ensure the safe use of pressure relieving mattresses, including: the Ministry of Health including its entities and agency such as the Health Quality and Safety Commission and HealthCERT; Career Force and Te Pūkenga – New Zealand Institute of Skills and Technology; Toitū te Waiora; Arjo and Cubro; WorkSafe; and health and disability services providers such as Woburn Rest Home. As part of this recommendation, I observe that an anonymised case study based upon the circumstances of Mrs Hedges' death is one tool that may be effective when delivering the training recommended.

XXXIII. I consider that this finalised recommendation under s57A will, if brought to public attention, further encourage and or assist in holding accountable those identified above to adopt practices and take initiatives that result in effective training of healthcare assistants that will ensure the safer use of pressure relieving mattresses. In turn, this will assist in preventing further deaths like Mrs Hedges' as well as other harm resulting from trapping due to the unsafe use of such mattresses.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mrs Hedges taken or provided for the purpose of inquiry, upon the grounds of personal privacy and decency.

Pavlik [2023] NZCorC 5 (19 January 2023)

CIRCUMSTANCES

Ryan Jae Pavlik died on 7 June 2019 at Taranaki Base Hospital from perinatal asphyxia associated with placental pathology.

Holley Pavlik was due to give birth on 8 June 2019. She was assessed at the Hawera Maternity Unit at 4:00pm on 7 June 2019. Earlier that day Holley had reported irregular tightening and foetal movement. Holley's pains were 10 to 15 minutes apart but were increasing in strength. A cardiotocograph (CTG) was taken to ascertain foetal wellbeing and monitor contractions. The lead maternity carer (LMC) determined this to be a non-reassuring trace. An examination determined that Holley was not in established labour.

In view of the non-reassuring CTG, ongoing irregular contractions, decreased foetal movements and pain over Holley's previous Caesarean scar line, the LMC consulted the on duty obstetrics team at Taranaki Base Hospital in New Plymouth. It was agreed that Holley would be assessed there. The LMC told Holley to go to New Plymouth; Holley said that her sister would take her. Holley left the unit at 4:45 pm.

At 5:30pm Holley texted her LMC to say that her contractions were strong and every two minutes. Holley said that she had not left Hawera yet as she was still waiting for her sister to arrive. The LMC told Holley to come back to the maternity unit as she would likely need to be transferred by ambulance.

Holley arrived back at the unit at 5:45 pm. The LMC determined she was now in established labour. The LMC decided to transfer Holley to New Plymouth via ambulance and made a request via the St John's transport app, having previously been discouraged by St John from calling 111 at hospital. The LMC took the foetal heart rate which, after initial difficulty in locating it, measured 115 just before getting in the ambulance.

An ambulance arrived at 6:08pm, three minutes after it had been requested, and left Hawera at 6:17pm. It was a patient transfer vehicle rather than a frontline vehicle and as such was not permitted under ambulance protocol to travel under lights and siren. The driver agreed to the LMC's request that they travel under lights and siren anyway.

Shortly after the ambulance left Hawera the LMC was unable to hear the foetal heart rate. The LMC asked the ambulance driver to pull over. While it was stopped the LMC listened again and thought that she located a foetal heart rate of 110. The LMC discussed with Holley her concerns about the baby's heart rate and indicated it could mean that the baby was in trouble. The LMC continued to try to detect the foetal heart rate during the transfer, with sporadic success. The LMC telephoned the labour ward to warn the obstetrics team of Holley's impending arrival.

The ambulance arrived at Taranaki Base Hospital at 7:21pm. No foetal heart rate was detected. The ward staff took over care.

At 7:34pm Holley Pavlik gave birth to a baby boy, Ryan, at Taranaki Base Hospital. Ryan was not breathing and had no heart rate. Hospital staff attempted immediate resuscitation and a heartbeat was identified at 8:12pm but it was irregular and slow. At 8:35pm a heartbeat was no longer detectable and the medical decision was taken to stop resuscitation. Ryan died just over one hour after he was born.

A post-mortem examination found that Ryan was an anatomically normal but growth restricted male infant. The body weight was 2,850 grams and Ryan appeared thin for his gestational age. Internal examination showed minimal subcutaneous fat. These features were in keeping with late onset intrauterine growth restriction. The pathologist opined that the features of growth restriction indicated a period of reduced growth in the late third trimester.

COMMENTS OF CORONER HO

I. Pursuant to s 57A of the Act I may make recommendations or comments for the purpose of reducing the chances of future deaths occurring in similar circumstances. These must be clearly linked to the factors that contributed to this death.

II. I have found that the time taken in transferring Holley from Hawera to New Plymouth was not a causal factor in Ryan's death, and so cannot be the subject of a recommendation or comment under s 57A. However, it is not difficult to envisage future circumstances where a transfer delay could materially affect the outcome. In my view, there needs to be clearer policies, procedures and guidelines about the scope of patient transfer between rural and tertiary centres, including when emergency transfer under lights and siren are warranted. If medical professionals at hospitals are discouraged from calling 111 for a frontline ambulance, then the alternative communication methods they are asked to use should clearly incorporate a mechanism where the referring professional can indicate when a lights and siren transfer is appropriate.

III. I have also found that the missed opportunities to refer Holley for growth scans contributed to the way in which her pregnancy was managed. Although Ryan's restricted growth was likely not a directly contributing factor to why he died, its non-identification did result in circumstances where Holley started labour some distance from tertiary hospital care which, had the growth anomaly been identified earlier, might not have been the case. Ryan's case serves as a timely reminder to midwives and other obstetrics carers to be alert to the criteria for when further investigation, whether it be in relation to growth or any other factor arising in pregnancy, is warranted.

IV. Finally, Ryan's death raises issues about the level and degree of maternity care that can be provided at primary birthing centres. This is a resourcing issue which is a matter for the Ministry of Health and would not appropriately be the subject of coronial recommendation or comment. I confine myself to observing that it would be unfortunate if expectant mothers were disadvantaged from receiving appropriate tertiary healthcare in a timely manner because of where they live.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Ryan taken during the investigation into his death, in the interests of decency and personal privacy.

Miscellaneous

Bellette [2023] NZCorC 16 (2 March 2023)

CIRCUMSTANCES

Colin Stanley Bellette (known to his friend as Cole), aged 53, died between 22 and 24 August 2021 at his cabin at Kairaki Beach Motor Camp of carbon monoxide poisoning. His death was an accident.

Mr Bellette was an artist who lived in a cabin at Kairaki Beach Motor Camp. The cabin was on an unpowered site. The front wall comprised an aluminium sliding door and window. The cabin was heated by a 9 kg gas bottle with a flame unit which was inserted into a curved pipe which led up the wall and was vented to the outside. Mr Bellette kept a small gas cooker and gas cannisters in the cabin.

On 26 August 2021, the manager of Kairaki Beach Motor Camp came to check on Mr Bellette as he had not been seen since 22 August 2021. On entering the cabin, which was unlocked, the manager found Mr Bellette lying on his bed, deceased. A post-mortem examination determined that Mr Bellette died of carbon monoxide poisoning and had been dead for days.

Police commissioned a report from Stephen Share, a certified gasfitter/plumber and a WorkSafe approved practitioner, to determine why Mr Bellette had been exposed to fatal levels of carbon monoxide. Mr Share observed that the cabin had no permanent ventilation which would have been rectified if the gas had been installed by a qualified gasfitter. The gas cylinder, gas canisters and gas cooker were in acceptable working order. As for Mr Bellette's home-made heater, Mr Share found that the heater pipe was blocked with rust, resulting in spillage of carbon monoxide at a level Mr Share described as "off the scale". The spillage was happening because the blockage in the tube resulted in combustion products flowing back out the secondary air intake (and into the room) rather than venting to outside. Mr Share concluded that the heater was unsafe and did not conform to any New Zealand standards. In his opinion it was the most likely piece of equipment to have caused serious harm.

COMMENTS OF CORONER CUNNINGHAME

I. Pursuant to s57A of the Act, I make the following comments.

II. The risk of carbon monoxide poisoning occurring when gas appliances are used in poorly ventilated spaces is well known.

III. Anyone using gas indoors, for any reason, should take great care to ensure that they have adequate ventilation.

IV. Heaters which emit carbon monoxide during the combustion process should not be used unless they are installed by an appropriately qualified gas fitter. Any cost savings that arise from using makeshift heaters, or heaters which are not installed in accordance with industry standards, are outweighed by the risk that arises from using these devices.

V. In making these comments, I repeat my observation above that I understand why people may feel that these devices are their best option for warmth in their homes.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Bellette entered into evidence in this inquiry, in the interests of decency and personal privacy.

Child A [2023] NZCorC 6 (19 January 2023)

CIRCUMSTANCES

Child A, aged 3, died on 20 February 2021 at Christchurch Hospital of global cerebral hypoxic injury due to enclosed space asphyxia. The manner of death was accident.

On 19 February 2021 Child A was playing in and around the family's front-loading washing machine and climbed into it. The machine's door was shut and a wash cycle started. The machine would only operate with the door shut. However, the

manufacturer's settings allowed a cycle to be programmed with the door opened. The machine would then automatically start if the door was closed within 12 seconds. The door would lock closed during a cycle.

Noticing her absence, Child A's family looked for her and noticed a light on the washing machine was flashing. Child A's mother thought this was odd as she had not done any washing. The washing machine was about half full of still and murky water. Realising that Child A was inside, her father was able to force the door open and retrieve her. CPR was commenced and emergency services notified. Child A was transported by ambulance to Christchurch Hospital. After a period of resuscitation and stabilisation, Child A underwent a CT scan which showed significant brain injury. Her condition continued to deteriorate and she died on 20 February 2021.

There was no evidence of any involvement of any adult of any other person in Child A's death. It was not due to criminal wrongdoing or the actions of any adult.

RECOMMENDATIONS OF CORONER HO

I. Deaths of children who trap themselves in washing machines are rare. However, they do occur. Child A's death is the first case of its type in New Zealand, but there have been at least five reported deaths of children aged under five in the United States who have died from washing machine related injuries in the past 15 years. According to the US based Consumer Product Safety Commission, there have been a further 3,000 children aged under five who have gone to hospital emergency rooms since 2014 to be treated for washing machine related injuries.

II. Section 57A of the Act permits me to make recommendations or comments for the purpose of reducing the chances of further deaths that might result from children playing in and around washing machines. To be effective, recommendations should be pragmatic so that there is maximum uptake by the busy parents at whom they are targeted.

III. Part of ensuring effective recommendations is to incorporate in them principles of risk assessment psychology. People who are aware of a risk must decide whether to take steps to mitigate it. In making their decision they will apply three components: their general knowledge about the world and how it works, their set of beliefs and expectations based on experience with the same or similar environment, and their desired outcome and how they will achieve it. All of these components feed into a cost benefit analysis which takes into account the cost of compliance, the perception of danger level, and personal and social decision making factors. It is therefore the perceived risk, the perceived hazard, perceived control and perceived norms that matter – not actual ones.[37]

IV. After Child A's death, Safekids Aotearoa publicised several steps which caregivers could take to prevent injuries from washing machines:

    a. **Restrict access to the laundry room**: lock the door and do not let children play in the room.

    b. **Keep the washing machine's door shut**: leaving the door open on front loaders can help prevent mould, but the door should be kept closed if there are young children at home.

    c. **Engage the washing machine's lockout feature**: many modern washers have a child lock feature.

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[37] Dr Marc Green, "Why Warnings Fail" (February 2004) Occupational Health & Safety Canada.

d. **Use a childproof safety lock**: a safety lock can put on the outside of a front load washing machine's door to prevent children from opening it.

e. **Shut off the water**: when the machine is not in use, turn off the water valve that feeds it. Most front loading washers will stop running and show an error code if the water is off.

f. **Master power switch**: consider installing a master power switch, out of reach of young children, that can turn off mains power to the appliance when not in use.

V. While these are sensible and precautionary steps, and which I recommend should be published on Safekids Aotearoa's website and information resources, there is a real risk that their high cost of compliance mean that they will not be widely adopted. They all require additional time and effort. Families do laundry on a frequent basis. Busy parents are unlikely to have the inclination or energy to take additional cumbersome steps such as turning on and off mains water, or consulting a manual to undo and engage a child lock, every time they start or finish a load of washing. This is particularly so where they perceive the risk of serious harm or death as low. Any meaningful recommendations to prevent deaths like Child A's must account for what users are realistically prepared to do and not add any material inconvenience; in short, they should be easy to carry out.

Make it easy to access child lock information

VI. Most appliances have a child lock setting which, when engaged, prevents the appliance from operating when the start button is pressed. For obvious reasons, engaging the child lock setting is not as simple as pushing one button, and usually requires the user to hold down two or more buttons at the same time or press a sequence of buttons. Repetitive use will eventually consign the required sequence to memory, but that takes time and practice. Initially the user will need to consult, and keep consulting, the relevant page of the manual each time a load of washing is started or completed – something which a busy parent is unlikely to have the time to do.

VII. To illustrate the difficulties of accessing the required child lock information, the instructions for the child lock setting on the family washing machine was at page 10 of the manual. It was sandwiched between information about the different washing machine settings and information about how to adjust the temperature. Unless the user diligently reads every page of the manual, which is unlikely, they will not learn of the child lock's existence or how to engage it.

VIII. The best way to ensure that the child lock feature is used is to make it easy for parents to know about it and how to activate it. I recommend that washing machine manufacturers prominently display by way of sticker or label, on the appliance itself, instructions on how the appliance's child lock settings can be activated. This ensures that the information is available to any adult user of the machine every time all the time. In that respect, I note that New Zealand consumer regulation already requires manufacturers to display on their appliances, by way of sticker or label, energy rating and water efficiency ratings.

Make it easy to implement other child safe settings

IX. While such a sticker would go some way, in my view, to addressing the cost of compliance issues in the psychology of risk assessment, they do not remove them entirely. A parent must still remember to engage the child lock setting after each load of washing is done. Realistically this may not happen in a busy household, especially where other household tasks and childcare responsibilities constantly compete for attention.

X. Child lock type mechanisms can be found in several settings around the home. Safety catches can be installed on drawers or cupboards to prevent them from fully opening, release of which requires the adult to press down on a tab on the catch. Medicine bottles have child safe caps which open by a "press and twist" action. These mechanisms achieve the desired result of child protection because they:

   a. recognise that it is difficult for young children to have the necessary reach, strength or motor function to undertake the required action to release the item; and

   b. incorporate design simplicity in that they require only a single action to engage use. The adult does not have to do anything else before or after the intended task. They press down on the release tab at the same time as they go to open the drawer or cupboard. They press and twist the medicine cap at the same time as they access the contents.

XI. Any child safety mechanism for washing machines or similar appliances should ideally apply the same principles. I recommend that washing machine manufacturers consider including a "double button start" child safety setting which requires the user to simultaneously depress two buttons to start the machine instead of one. Such a setting could be optionally activated and remain activated until a user chose to de-activate it.

Government regulation

XII. This is a safety issue. The government has a role to play in ensuring that the risk is appropriately minimised. I recommend that consideration be given to requiring, by regulation, washing machines sold in New Zealand to:

   a. display, on the appliance itself, instructions on how to engage the child lock settings; and

   b. have an optional double button start child safety setting, or similar, which can be activated by an adult user and which can remain activated until intentionally de-activated.

Responses to proposed recommendations

XIII. Section 57B of the Act requires that I notify proposed recommendations to organisations at whom the recommendations are directed. A copy of my recommendations was provided to Safekids Aotearoa, the manufacturer of the washing machine in which Child A died and the Ministry of Business Innovation and Employment.

XIV. MBIE's National Manager Consumer Protection responded that it would incorporate key messages about child safety in its information resources. MBIE did not respond to my recommendations about regulating child lock labelling or a double button start. It forwarded my recommendations to WorkSafe on the basis that it was the regulator responsible for ensuring the safe supply and use of electricity and gas in New Zealand.

XV. WorkSafe subsequently advised me that under the applicable electricity safety regulations, a washing machine is deemed safe in New Zealand if it meets the relevant international standard[38] as modified for New Zealand.[39] It considered that my proposed recommendations around labelling and a double button start would require an amendment to the international standard or the New Zealand modification.

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[38] In the case of washing machines, IEC 60335-2-7 ed 7.1.
[39] In the case of washing machines, AS/NZS 60335.2.7.

XVI. I read the international standard to which WorkSafe referred me. It relevantly states in section 1 (scope):

> […] this standard […] does not take into account:
>
> - persons (including children) whose physical sensory or mental capabilities or lack of experience and knowledge, prevents them from using the appliance safely without supervision or instruction;
> - children playing with the appliance.

XVII. The plain language of the exclusion in the standard suggested to me that WorkSafe was wrong. I notified WorkSafe that I did not accept that my recommendations would likely require an amendment to the standard and referred it to the express limitation. I invited WorkSafe to reconsider its position but, if it continued to maintain that the standard applied, to refer me to what it considered to be the applicable clauses of the standard.

XVIII. WorkSafe maintained its view that changing the relevant standard was the most appropriate and effective vehicle to assess and potentially implement the proposed recommendations and remained adamant that changing local regulations was the wrong option. It did not refer me to any relevant clause in the standard that supported its view. It suggested I contact the relevant Standards New Zealand committee and MBIE.

XIX. Standards New Zealand's response was unsurprising. It pointed to the express exclusion for children in the relevant standard which I had identified to WorkSafe. It stated that my recommendations could not be addressed by the standard in its current form and invited me to contact MBIE's Consumer Protection team.

XX. As recorded at [XIII], MBIE was the first organisation contacted. It was its Consumer Protection team which referred my proposed recommendations to WorkSafe.

XXI. I remain unenlightened as to the appropriate government entity responsible for considering the recommended regulatory changes. MBIE told me it was WorkSafe. WorkSafe referred me to the standards committee. The standards committee sent me back to MBIE. The inference from the circularity of correspondence can only be that the government entity responsible must also be similarly unenlightened of its own jurisdiction to progress regulation in this area.

Summary of recommendations

XXII. Safekids Aotearoa should publish the preventative steps set out at [IV](a) to (f) on its website and in its information resources.

XXIII. Washing machine manufacturers should consider displaying, on the appliance itself, instructions on how to engage the child lock settings.

XXIV. Washing machine manufacturers should consider introducing a double button start child safety setting, or similar, to minimise the risk of children unintentionally starting the washing machine. Such a setting should be able to be optionally activated by an adult user and remain activated until intentionally de-activated

XXV. Government consideration should be given to requiring, by regulation, that washing machines sold in New Zealand:

a. display, on the appliance itself, instructions on how to engage the child lock settings; and

b. have an optional double button start child safety setting, or similar, which can be optionally activated by an adult user and which can remain activated until intentionally de-activated.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of the deceased taken during the investigation into her death, in the interests of decency and personal privacy. Orders under section 74 of the Coroners Act 2006 also prohibit the publication of the deceased's name, the name of one of the deceased's relatives, and certain factual findings, in the interests of justice.

Trainor [2023] NZCorC 10 (31 January 2023)

CIRCUMSTANCES

Olive Trainor, aged 73, died on 15 June 2019 at Gisborne Hospital from a probable infection from a sacral pressure ulcer and advanced dementia.

Olive suffered from dementia, congestive heart failure, atrial flutter, hypertension, diabetes mellitus and asthma. Her health had significantly deteriorated in the final three years of her life; she had become wheelchair bound and was unable to communicate, resulting in her daughter caring for her at their family home.

On 31 May 2019, Olive was examined by her general practitioner (GP) for a foot injury. Her GP immediately referred her to the Emergency Department (ED) for an x-ray and review. The GP's impression was that the family were poorly resourced, under stress and finding it difficult to cope. They did not have sufficient finances to get money for petrol to drive Olive to hospital. The GP offered for a health worker to drive the family to the hospital however that offer was declined. Olive did not present at ED that day.

On 2 June 2019, Olive's daughter called for an ambulance as Olive was unresponsive to commands. She was admitted to hospital, where doctors found that she had a reduced level of consciousness and possible sepsis, hypotension, and progressive neurological deterioration. Additionally, Olive had a sacral pressure ulcer that had likely been present for over a week and contributed to her septic condition. The doctor advised Olive's family that her prognosis was poor, and a decision was made to commence her on comfort cares. Olive passed away at the hospital on 15 June 2019.

COMMENTS OF CORONER DUNN

I. The reality of the care of elder family members who are immobile and suffer from dementia with chronic underlying health issues can be overwhelming. Despite the best intention it can be difficult to provide proper health cares. This is exacerbated when family have limited financial resources and there are other family commitments. The demands of feeding, bathing, toileting and mobilising an elderly person requires support and assistance.

II. I encourage any person who has the responsibility of caring for an elderly family member to seek outside assistance and help. Support can be accessed through the family GP, local health service providers, direct contact with family support providers or the Needs Assessment Service Coordination (NASC) service.

III. Te Whatu Ora Tairāwhiti have advised me that the following services are available to assist families caring for their elders.

a. Pressure injury information on the website for whānau with links to national information such as the wound care society and ACC information on pressure injuries. The website also includes all the local resources for community organisations to make use of.

   Provision of information to whānau though articles on the Te Whatu Ora Tairāwhiti Facebook page and to staff via the weekly staff newsletter.

b. Wound care nurses support the community with pressure injury care and provide education for example SKINNS training.

   A pressure injury working group will be established and include hospital as well as community providers.

   Families are provided with education for those at risk of pressure injuries on discharge from hospital.

c. Occupational health provides pressure relieving equipment to whānau to help them prevent and manage pressure injuries e.g., mattresses and cushions.

   Physiotherapy supports whānau with simple exercises to relieve pressure injury sites.

d. Needs Assessment Service Coordination – for a comprehensive assessment of support needs and access to associated support services such as home help and personal cares. For those 65 and over a referral can be through the GP or direct to the service on (06) 86 892090. For those under 65 direct to the Life Unlimited service on (06) 8632836.

e. District and Community Nursing Services including continence, pressure area, home oxygen, support devices and wound management services.

f. Te Ara Tiaki Pakake is a specialist older person's service that provides a wrap-around service for older persons in the community.

g. **Aged Care facilities**

Undertake pressure injury assessments on all residents that go into the facility which is ongoing. Aged care facilities receive support from the Te Whatu Ora Tairāwhiti wound care nurse specialists and can access tools on the Te Whatu Ora Tairāwhiti website

All facilities have pressure relieving equipment.

Monitoring of pressure injury rates.

h. **GP services**

Provide support to individuals and families to assess and manage the conditions a family member has and to put in a plan of care for those e.g., managing diabetes, skin conditions. They also refer people to Te Whatu Ora Tairāwhiti Specialist Community based services such as NASC, OT, wound care nurses, district nurses and physiotherapy services

i. **Community services**

Iwi providers Ngāti Porou Hauora and Tūranga Health (06 8690457) provide comprehensive rural health services to people in their home including comprehensive pressure injury prevention and treatment services.

Matakaoa	(06) 864 4801
Ruatōria	(06) 864 8316
Tawhiti	(06) 864 6803
Tokomaru Bay	(06) 864 5859
Uawa	(06) 862 6650

Tūranga Health also provide a kaumātua programme.

j. **Hospice Tairāwhiti** (06 869 0552) provide comprehensive palliative care for people across Tairāwhiti and refer people to Te Whatu Ora Tairāwhiti Specialist Community based services.

k. **Life Unlimited** provide support for people under 65 years of age with disabilities (06 863 2836).

l. **Community organisations that also provide support to whānau in Tairāwhiti with pressure injuries.**

- Age Concern (06 867 6533)
- Alzheimer's New Zealand (06 867 0752)
- Parkinson's Foundation (0800 473 4636)
- Multiple Sclerosis Society (06 868 8842)
- Heart Foundation (06 868 5890)
- Stroke Tairāwhiti (06 863 2716)
- Diabetes Society (0800 342 238)
- ACC spinal injuries care is provided through HealthCare NZ (0800 002 722) and Geneva Healthcare (0800 436 382).

IV. The above services can provide advice on nutrition, mobilisation, support, and personal cares. There is also opportunity for paid caregiving by family members and respite care can be provided. Equipment and home modifications can be made if necessary.

V. In relation to bedsores (pressure sores) they are a common problem for elderly and immobile patients. Advice and devices for pressure area management can be provided to caregivers.

VI. I encourage Te Whatu Ora – Health New Zealand to ensure that whānau are made aware of the services that are available to assist them with the responsibility of caring for elderly whānau members. This is particularly important where the elderly are unable to communicate their needs. Had Olive's family accessed advice and assistance from community services Olive may have been spared the pain and suffering that was evident upon her admission to hospital.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Olive taken during the Police investigation, on the grounds of decency and personal privacy.

Motor Vehicle

Blackie [2023] NZCorC 23 (15 March 2023)

CIRCUMSTANCES

Zara Joy Blackie, aged 14, died on 23 October 2018 at Oamaru Hospital of chest injuries sustained when she fell onto Severn Street, Oamaru in front of an oncoming vehicle which struck her.

Zara lived with her parents in Oamaru. According to her mother, she had started drinking alcohol after beginning a relationship about nine months prior to her death. Zara was allowed to drink alcohol only at home under supervision, but her mother was aware that she was consuming alcohol at her boyfriend's home, where she spent a lot of her time. Her parents were also aware that Zara was smoking cannabis outside of their home.

On the evening of 23 October 2018, Zara returned to her parents' home with her boyfriend and a male associate at about 7:30pm and left again at about 8:00pm. Her parents did not think she was under the influence of anything at that time.

The male associate told Police that the three of them went to his home, where they shared a bag of cannabis, before later shoplifting and consuming two 1.5L bottles of cider between the three of them. At about 10:00pm, the three came to Police attention after Zara's boyfriend suffered a seizure in public. Zara was assessed as "grossly intoxicated" and was transported home by Police.

Zara became very upset and wanted to check on her boyfriend, who had been returned to his own home. Her parents tried to persuade her to stay at home but at about 10:45pm, she ran in the direction of her boyfriend's home. Witnesses saw her running a few steps from the footpath on Severn Street, at the end of Oamaru Creek bridge, before falling forwards onto the road. She had likely tripped over a chain dividing the footpath from a reserve area she had just run through.

The driver of an oncoming vehicle tried but was unable to avoid colliding with Zara. She sustained multiple injuries in the collision and was transported to Oamaru Hospital, where her death was confirmed. Alcohol at a level of 191mg/100mL and cannabis were detected in Zara's post-mortem blood.

The Serious Crash Unit (SCU) investigation found that the driver was not speeding at the time of the collision and had had insufficient time and distance to allow for effective evasive action. Reconstructions of the scene established that Zara

should have been able to both hear, and see the headlights of, vehicles travelling along Severn Street as she ran through the reserve.

The Coroner concluded that Zara's use of cannabis and gross intoxication by alcohol was a key contributor to her ultimately fatal fall. She noted that Zara's death supports research showing that alcohol abuse amongst adolescents is associated with increased risk of a variety of accidents, including pedestrian accidents and falls.

COMMENTS OF CORONER WRIGLEY

I. By way of comment under s57A of the Coroners Act 2006 I endorse the parenting advice provided by Te Hiringa Hauora – Health Promotion Agency at https://resources.alcohol.org.nz/resources-research/alcohol-resources/research-and-publications/alcohol-and-your-kids-booklet. I emphasise the following messages. The safest approach is for young people under the age of 18 years to drink no alcohol. Supply of alcohol to young people by parents or caregivers can increase the odds of them misusing alcohol. Parents or caregiver's own inappropriate use of alcohol and permissive attitude towards young people drinking alcohol can increase the chances they will misuse alcohol. Role modelling appropriate use of alcohol is important. Developing close relationships with young people and monitoring their whereabouts, activities and friends can assist in protecting against their misuse of alcohol.

II. Under s57A of the Coroners Act 2006 I recommend that within the next year Te Whatu Ora – Health New Zealand, Te Aka Whai Ora – Māori Health Authority and Te Pou Hauora Tūmatanui – the Public Health Agency collaborate to:

   a. further publicise the advice provided to parents and caregivers at https://resources.alcohol.org.nz/resources-research/alcohol-resources/research-and-publications/alcohol-and-your-kids-booklet about protecting rangatahi (young people) from alcohol misuse and associated harm, ensuring the advice is and remains specific, practical, comprehensive, informative and evidence based; and

   b. devise, and make easily accessible, additional resources and support for parents and caregivers to assist them in developing parenting skills that support rangatahi (young people) to avoid alcohol misuse and associated harm.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Zara entered into evidence, upon the grounds of personal privacy and decency.

Blonda [2023] NZCorC 8 (21 January 2023)

CIRCUMSTANCES

Pietro Blonda, aged 21, died on 15 February 2021 at State Highway 57, near Shannon of multiple blunt trauma, predominantly to the head.

Mr Blonda was visiting New Zealand as a working tourist at the time of his death. He and his friend, Edoardo Noseda purchased a car to travel together around the country. On 15 February 2021, the pair made plans to travel from Hastings

to Wellington. After driving for the first 45 minutes, Mr Noseda switched with Mr Blonda who took over driving duties. Mr Noseda fell asleep shortly after Mr Blonda began driving.

At around 4:00pm, Mr Blonda and Mr Noseda were travelling in a southerly direction on State Highway 57 when their vehicle drifted into the northbound lane, colliding with an oncoming truck. Mr Noseda survived the collision however Mr Blonda died at the scene as a result of his injuries.

Witnesses to the crash noted that Mr Blonda was driving erratically prior to the crash. The driver of the truck noted that both Mr Blonda and Mr Noseda were slumped forward as their vehicle was driving towards him.

Mr Blonda's toxicology results revealed evidence of Lysergic Acid Diethylamide (LSD) and cannabis use. There was also a trace of alcohol detected in the blood which may have been due to means other than deliberate ingestion (i.e. as a normal part of the body's processes after death).

Mr Noseda confirmed that the pair had attended a party the night before the crash where Mr Blonda was observed to drink around six or seven beers and take half an LSD tablet at around 9pm. Mr Blonda stopped drinking around midnight and they both went to their rooms to sleep at around 1:00am.

The New Zealand Police Serious Crash Unit (SCU) investigated the accident and provided a report. The SCU considered the evidence gathered along with Mr Blonda's toxicology results. Although speculative, they suggested that fatigue might have been a contributing factor to the collision.

COMMENTS OF CORONER TELFORD

I. This is undeniably a most dreadful tragedy – one which is difficult to contemplate for Mr Blonda's parents, family and friends. Mr Blonda was a young man in the prime of his life, enjoying a working holiday in New Zealand when the worst possible thing happened.

II. However, the evidence provided to my inquiry does not lead me to discount this as a simple accident.

III. I have no evidence of Mr Blonda's historic driving experience. However, he was young, a visitor to New Zealand and had only fairly recently acquired a car. I therefore infer that Mr Blonda was an inexperienced driver – and particularly inexperienced at driving in New Zealand. I also note that this crash occurred in the context of a long road trip, during which only one short break was taken, on territory unfamiliar to Mr Blonda.

IV. I have evidence that on the night prior to this crash, after consuming a large amount of alcohol and some LSD (a potent psychedelic drug), Mr Blonda went to bed very late (1am). Although there is evidence that Mr Blonda woke late the following day (10am), it is likely the quality of his sleep was significantly affected by this disturbed pattern and the consumption of alcohol and other drugs. A post-mortem toxicological analysis found LSD and cannabis in Mr Blonda's system (although these tests do not show the levels of these substances and when the cannabis was ingested).

V. Studies unsurprisingly show that factors such as alcohol, drugs and fatigue have a detrimental effect on the complex task of driving. Specifically, fatigue resulting from sleep deprivation has been demonstrated to increase

the likelihood of lane drift,[40] impair the ability to maintain a constant speed[41] and increase the likelihood of involvement in a collision.[42] Studies have also convincingly found that even one night of sleep deprivation can severely impair a person's ability to control a vehicle.[43] Recent figures show that in New Zealand, fatigue was a factor in 25 driving deaths and 113 serious injuries.[44]

VI. On the day of the crash, the evidence points to Mr Blonda falling asleep whilst driving – demonstrating an extreme form of fatigue. On balance, I find that this was the case and that his fatigue was likely to be due to a disturbed sleep pattern and the use of alcohol and other drugs.

VII. Although younger drivers (18-24) have been shown to be at a higher risk of road crashes, I suggest this tragedy could at the very least serve as a reminder to all drivers - young and old alike. Many of us drive routinely as part of our daily lives and take it for granted. However, driving is a complex task which requires us to be alert and in good shape. The cost of driving whilst fatigued or otherwise affected (whether due to poor sleep, alcohol or other substances) can be extremely high – to the driver, other road users and those who love us and are left behind.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Blonda entered into evidence, upon the grounds of personal privacy and decency.

Chandler [2023] NZCorC 30 (27 March 2023)

CIRCUMSTANCES

Karen Diane Chandler, aged 67, died on 26 March 2021 at State Highway 2, near Eketāhuna of multiple injuries sustained in a motor vehicle incident.

On 26 March 2021, Ms Chandler was the front seat passenger in a Toyota Hilux travelling south towards Eketāhuna. At the same time, a Mercedes-Benz Atego ("the Atego") fertiliser truck was travelling north from Eketāhuna towards Pahiatua.

At about 5:20pm, the front right tyre of the Atego blew out. The driver of the Hilux saw the Atego cross to his side of the road. The Atego driver attempted to correct the vehicle. The driver of the Hilux then veered towards the northbound lane in an attempt to avoid the Atego that was coming into his lane. However, the Atego crashed into the passenger side of the Hilux and Ms Chandler died at the scene.

The Serious Crash Unit investigated the crash and concluded that the main causative factor was the sudden explosive deflation of the Atego's tyre which caused the Atego to veer into the opposing lane where it collided with the Hilux. Under-inflation and/or overloading of the tyre are considered possible causes for the sudden tyre deflation. A tyre defect or prior damage could not be ruled out.

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[40] SH Fairclough and R Graham "Impairment of driving performance caused by sleep deprivation or alcohol: a comparative study" (1999) 41(1) Human Factors 118.
[41] JT Arnedt and others "Simulated driving performance following prolonged wakefulness and alcohol consumption: separate and combined contributions to impairment" (2000) 9(3) J Sleep Res 233.
[42] LA Reyner and JA Horne "Evaluation 'in-car' countermeasures to sleepiness: cold air and radio" (1998) 21(1) Sleep 46.
[43] Wendy M Bosker and others "MDMA (ecstasy) effects on actual driving performance before and after sleep deprivation, as function of dose and concentration in blood and oral fluid" (2012) 222(3) Psychopharmacology (Berl) 367 and Stefan Jongen and others "Sensitivity and validity of psychometric tests for assessing driving impairment: effects of sleep deprivation" (2015) 10(2) PLoS ONE
[44] NZTA, 2020, NZTA website, accessed on 22 September 2022, <www.nzta.govt.nz/safety/what-waka-kotahi-is-doing/education-initiatives/fatigue/driver-fatigue>.

COMMENTS OF CORONER TELFORD

I. Although the precise reason for the tyre's deflation cannot be determined, failure of the tyre may have been exacerbated by excessive load and/or tyre underinflation.

II. Regardless, this tragic case should serve as a reminder to all drivers of the importance of operating vehicles at their correct tyre pressures and ensuring they are not overloaded. This is particularly important for heavy vehicles, as they can cause more harm to other road users if faults occur – particularly whilst travelling at speed.

III. Given the discrete circumstances surrounding this death, apart from the above comments, I consider there are no recommendations I can helpfully make of wider applicability.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Ms Chandler entered into evidence, in the interests of personal privacy and decency.

Day [2023] NZCorC 20 (10 March 2023)

CIRCUMSTANCES

Luke Kevin Day, aged 36, died on 28 October 2021 at the Christchurch Northern Corridor due to positional asphyxia resulting from inversion after a vehicle rollover.

On 27 October 2021, Mr Day drove his Isuzu Bighorn SUV ("the Isuzu") to visit a friend in Amberley. He arrived at his friend's house at about 6:40pm and told his friend he had been unable to sell the Isuzu because the power steering pump was blown from a trip to the river the weekend before. Mr Day said the Isuzu was 'stiff' to drive. Mr Day consumed alcohol while at his friend's house. He left his friend's house between 10:40pm and 11:00pm.

At 12:41am on 28 October 2021, the Isuzu was captured on CCTV travelling south on the Christchurch Northern Corridor section of Highway 74, at speeds of between 103km/h and 115km/h. It was drifting from the left-hand lane into the right-hand lane and back. As the Isuzu approached the Queen Elizabeth offramp it veered to the left and made a late entry to the offramp. This caused it to enter an anti-clockwise rotation, roll over the wire rope safety barrier and collide with a lamppost before coming to rest on its roof in a gully on the eastern side of the motorway. At approximately 1am, a member of the public saw the Isuzu and stopped to see if the driver needed assistance. Mr Day was found lifeless and unresponsive. He was pronounced dead at the scene.

Blood samples taken from Mr Day indicated a blood alcohol level of 155mg/100ml. The presence of cannabis and THC, the active component of cannabis were also confirmed in Mr Day's blood.

Police Serious Crash Unit (SCU) investigated the crash and found that the speed and the accumulated pea gravel within the painted island may have been a factor in Mr Day losing control of the Isuzu. The Isuzu was inspected and no evidence of a steering fault was found. The SCU considered the fact that Mr Day had complained about stiff power steering, which may have affected his control of the vehicle. The SCU also found that drug and alcohol use would have contributed to Mr Day taking longer to react to what was occurring around him.

COMMENTS OF CORONER CUNNINGHAME

I. Coroners have made many comments about the terrible consequences of driving while intoxicated. Mr Day's death further illustrates the importance of not driving while under the influence of drugs or alcohol. I do not make any specific recommendations, but I endorse the efforts made by the New Zealand Police, Waka Kotahi/NZTA and other organisations to educate the public about the need to comply with our traffic laws and to drive safely and sensibly.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs that show Mr Day entered into evidence in this inquiry, in the interests of decency and personal privacy.

Kenrick [2023] NZCorC 13 (21 February 2023)

CIRCUMSTANCES

Aniwaniwa Te Orora Haumapuhia Kenrick, aged 21, died on 6 March 2020 at State Highway 5, Te Haroto of haemorrhagic blood loss due to a ruptured aorta, liver and spleen following a motor vehicle crash.

On the evening of 6 March 2020, Ms Kenrick was travelling to Tūrangi. She was the sole occupant of her vehicle and was driving on State Highway 1 through Te Haroto. Earlier that evening, Ms Kenrick had purchased the vehicle equipped with snow tyres. While driving around a slight bend in the road, Ms Kenrick lost control of the vehicle, crossed the centre line and collided with another vehicle. She died at the scene as a result of her injuries.

The New Zealand Police Serious Crash Unit (SCU) investigated the accident and found that Ms Kenrick's four new winter tyres, while legal, were not fit for purpose for driving in normal driving conditions and likely reduced the available grip between the tyre and road surface.

RECOMMENDATIONS OF CORONER MCKENZIE

I. I recommend that Waka Kotahi | NZTA and the Automobile Association continue to publish and further develop freely available guidance material regarding the use of winter tyres and the dangers if they are not used in accordance with their intended use.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Ms Kenrick entered into evidence, on the grounds of decency or personal privacy.

Kraleva [2023] NZCorC 11 (7 February 2023)

CIRCUMSTANCES

Krasimira Antonova Kraleva, aged 52, died on 14 October 2020 at Massey from blunt force injuries to her torso as a result of a motor vehicle accident (pedestrian).

Krasimira (also known as Krassy) worked as a style consultant for a curtains and blinds company. On 14 October 2020, Krassy had parked her van up a driveway and had started to walk down the driveway to meet her clients. Unbeknownst to her, the van had started rolling down the driveway towards her, knocking her to the ground and trapping her underneath. Krassy died at the scene as a result of her injuries.

The New Zealand Police Serious Crash Unit (SCU) investigated the accident and found that Krassy did not engage the handbrake when she exited her vehicle. Instead, she left the gear selector in drive and removed the ignition key, causing the van to roll backwards down the driveway.

The SCU suggested a number of recommendations to help avoid further accidents like this, namely:

- Education to drivers about the issues and what they need to do before getting out of their vehicle and walking away from it.
- That all vehicles be fitted with the current technology installed in some vehicles today, whereby a key cannot be removed whilst the gear selector is in 'D' (drive), 'R' (reverse) and 'N' (neutral) and only when it is placed in 'P' (park), can it be removed.
- If a key is able to be removed whilst the gear selector is in 'D', then as soon a car door is opened, an alarm sounds notifying the driver that the hand brake is not on, the gear selector has not been put into park and the driver has removed the key.

COMMENTS AND RECOMMENDATIONS OF CORONER MILLS

I. Krassy's tragic death has drawn attention to changes in modern vehicle technology and the differing safety features and systems. I have considered whether there are any recommendations or comments I could make that, if drawn to the public attention may reduce deaths occurring in similar circumstances. I have also considered the serious crash unit investigator's recommendations.

II. In older automatic vehicles it was generally not possible to take the key out of the ignition without putting the gear-lever into the park position. However, many automatic vehicles now allow the key to be withdrawn before the car gear-lever is in "park". In addition, many vehicles these days, do not even have an ignition key and it is possible to exit the vehicle with the key while the vehicle is still running. However, in older manual vehicles it has always been possible to leave a car in "neutral" and remove the keys without engaging the hand brake, so the problem is not entirely new.

III. It is possible for additional safety mechanisms such as alarms that alert drivers to the fact that they have not engaged the handbrake or have not put the vehicle in "park" to be installed. However New Zealand has an older vehicle fleet than many countries,[45] and there are so many variables and on-going changes to technology that I do not consider it practical to make specific technical recommendations. Ultimately, I consider it largely to be a matter of driver education. I note that use of the hand brake is already included in the Road Code study guide published by Waka Kotahi[46] and other learn to drive resources.[47]

IV. I acknowledge that it is easy when busy and thinking about other things to get distracted and to forget to do things that are usually automatic – like engaging the hand brake. I therefore simply remind people that:

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[45] https://www.transport.govt.nz/assets/Uploads/Report/AnnualFleetStatistics.pdf
[46] https://www.nzta.govt.nz/roadcode/general-road-code/licence-and-study-guide/driving-skills-syllabus/2-starting-and-stopping-the-engine/
[47] https://www.drivingtests.co.nz/resources/how-and-when-should-you-use-your-handbrake-or-parking-brake/ https://drive.govt.nz/get-your-restricted-licence/skills/set-up-and-get-moving/starting-the-engine-moving-off-and-stopping/

V. If you have an automatic gearbox, apply the handbrake first, then put it in P “park” prior to exiting your vehicle.

VI. If you have a manual gearbox, apply the handbrake then put the gearbox in neutral on flat ground, reverse if you are parked facing downhill, or first if you are parked facing uphill. If the handbrake fails, or it wasn’t applied tightly enough, the resistance from the engine will stop it rolling on the hill.

VII. In addition, if you are driving a car you are unfamiliar with, ensure you familiarise yourself with how it operates prior to driving.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Krasimira Antonova Kraleva during this inquiry, on the grounds of decency.

Panapa [2023] NZCorC 29 (23 March 2023)

CIRCUMSTANCES

Robert Joseph Panapa (also known as Joseph Robert Panapa), aged 73, died on 9 December 2020 at State Highway 5, Hamurana from a severe frontal head injury secondary to a motor vehicle accident.

In 2019, Mr Panapa underwent a cognitive assessment which showed he had a moderate degree of cognitive impairment. It was mainly memory impairment but he was found to have a reasonably preserved frontal lobe and constructional skills. The assessing psychiatrist therefore concluded that, cognitively, Mr Panapa remained safe to drive, but should contain his driving to local areas because of his cardiac condition.

On 26 September 2020, Mr Panapa was spoken to by Police after they received a complaint about his manner of driving. The attending Police considered him to be “vacant” and very forgetful, and thought he was potentially of unfit mental state to drive a motor vehicle. He was thus served with a notice forbidding him to drive from that date until Waka Kotahi reviewed his fitness and confirmed his ability to continue driving safely. Police sent notice of the roadside suspension to Waka Kotahi.

Waka Kotahi prepared a notice of driver license suspension and sent it via courier to Mr Panapa however he never received it. Mr Panapa did not tell his family or his general practitioner (GP) that he was not allowed to drive and he continued to drive as usual.

On 9 December 2020, Mr Panapa was driving east on State Highway 5, Hamurana, west of the intersection with Dalbeth Road. At the same time, a dwelling was being transported on a house transporter truck and trailer unit. Two wide load pilot vehicles were in front of the house transporter truck and trailer unit and two followed behind. Mr Panapa proceeded past the vehicles without slowing and collided with the dwelling. Mr Panapa suffered fatal injuries as a result of the collision and died at the scene.

The New Zealand Police Serious Crash Unit investigated the collision and found that a combination of driver state of mind and fatigue likely contributed to Mr Panapa failing to react to the hazard before him and take the appropriate evasive action.

Following Mr Panapa’s death, Waka Kotahi reviewed their file and discovered that the suspension notice had not been served. At the time, all suspension notices were sent by courier and had to be signed for by the intended recipient. If the licence holder was not served within a designated timeframe, the suspension notice and accompanying documentation

were destroyed. Waka Kotahi records confirm Mr Panapa's notice was destroyed on 21 October 2020, after an unsuccessful attempt to have it served. Although Waka Kotahi had a process in place to ensure that notices which are not delivered on the first attempt were re-sent, this process was not followed in Mr Panapa's case.

COMMENTS OF CORONER BATES

I. Waka Kotahi were notified by Police on 26 September 2020 that Mr Panapa was suspended from driving pending medical assessment for fitness. Police understood Waka Kotahi would then take steps to arrange the assessment. Waka Kotahi, having received notice of the Police suspension and reasons, also elected to suspend Mr Panapa's driver licence until he had undergone a medical assessment for fitness. If Waka Kotahi had served Mr Panapa with notice of this as intended, it would have been Mr Panapa's responsibility to arrange the assessment with his GP or with a medical specialist.

II. Service of the Waka Kotahi documents was not achieved, and a driver assessment never took place. Mr Panapa's GP was never made aware of the Police suspension or that the Waka Kotahi process had been initiated.

III. It is clear that Mr Panapa was not of a mind to concede there was any issue with his driving, or to notify his GP, whānau, or others that he had been forbidden to drive.

IV. Almost three months passed from the time Mr Panapa was forbidden to drive by Police until his death. He continued to drive as usual during this period.

V. In response to a provisional recommendation by me that Waka Kotahi engage in the practice of notifying licence holders' GPs when they issue a notice of suspension, they respectfully advise this is something they could not implement for the following reasons:

> Waka Kotahi state that in the present case they would not have been aware of who Mr Panapa's GP was. They do not have the power to require licence holders to provide or update details of medical practitioners. As a result, Waka Kotahi does not generally hold reliable information about a licence holder's GP, particularly in instances of a first interaction between the Driver Safety Team and the licence holder, as in Mr Panapa's case.

VI. In my view, a system that relies upon a licence holder volunteering information to their GP, whānau, or others following suspension by Police on cognitive fitness grounds, or receipt of notice from Waka Kotahi (assuming service was achieved), puts the subject individual and the general public at risk.

VII. The risk is the licence holder will continue to drive without disclosing their licence suspension or the reasons for it, without undergoing an assessment for fitness to drive, and without any follow-up to ensure they are aware of the requirement for an assessment. They will not be reminded of their forbidden or suspended licence status. Therefore, they are more likely to continue driving. Realisation of this risk is evidenced by Mr Panapa's death.

VIII. It appears there is need for better communication between Waka Kotahi, Police, and a licence holder's GP when a licence holder is referred to Waka Kotahi by Police for assessment.

IX. Had Mr Panapa's GP been informed of Mr Panapa's forbidden driver status and Police referral to Waka Kotahi, it would likely have resulted in timely follow-up with Mr Panapa by his GP. I expect that, had Dr Tan been aware of

these matters during his consultation with Mr Panapa on 13 November 2020 he would have raised them with Mr Panapa and queried whether Mr Panapa had been assessed. Dr Tan would have been in a position to reinforce the message that Mr Panapa was forbidden to drive pending medical assessment and clearance, and could have completed the assessment himself, or referred the matter to a specialist.

Changes to Waka Kotahi service of documents

X. Mr Panapa had difficulty following instructions. He did not accept there was anything wrong with his driving. Waka Kotahi failed to serve notice of his licence suspension. Suspension notices are accompanied by information for the licence holder regarding the concerns held and the steps to be taken to have their license reinstated. It is essential that these notices are served.

XI. In November 2021, Waka Kotahi reviewed its service of suspension notices. Suspension notices for non-rural areas continue to be served by courier and are manually checked to confirm they have been served. If the notice is not served within the designated timeframe, it is re-sent by the Driver Safety Team. The addressee is no longer required to sign for the notice. However, an attempt is still made by the carrier to obtain a signature when serving the notice.

XII. Notices to rural delivery areas are now served by standard post, as opposed to courier, with suspension being made effective 14 days from the time of being posted. 14 days are allowed to enable sufficient time for mail delivery because suspension cannot start before a person receives notice. Service by post complies with Waka Kotahi's obligations under section 210 of the Land Transport Act 1998, which enables service by post to a person's last known residential address.

XIII. Waka Kotahi advise that since shifting to the new service process in November 2021, they have seen an improvement in the number of notices being successfully served. They anticipate that service will continue to improve once they are able to digitalise the process for serving notices.

RECOMMENDATIONS OF CORONER BATES

Improving the flow of information

I. Waka Kotahi advise that the current statutory regime is designed to require information to flow from health practitioners to Waka Kotahi.[48] Practitioners are required to notify Waka Kotahi if they believe a person should not be permitted to drive or should only be permitted to drive under certain conditions, and that despite their advice, the person is likely to drive. One obvious difficulty with this, as highlighted in the present case, is that health practitioners are not always made aware of information that should be notified to Waka Kotahi.

II. When Police serve a roadside notice suspending a driver licence on medical fitness grounds, a simple request could be made for that person's GP details. The person may not have a GP, or they may not agree to provide this information to Police. There is no legal requirement for them to provide this information. However, in some instances GP details may be forthcoming. When it is, Police should include it with the information they send to

[48] Section 18 of the Land Transport Act 1988.

Waka Kotahi. Waka Kotahi would then be able to notify the GP regarding the person's driver licence status and the requirements of any review that is underway. The GP could follow the matter up with their patient.

III. When Police refer these matters to Waka Kotahi, in addition to including GP details (if provided), I recommend they inform the GP directly of concerns about medical fitness to drive and licence status.

IV. Obviously, it will not always be possible for Waka Kotahi and/or Police to notify a GP of a person's licence status and any review process underway. The ability to do so depends entirely upon the cooperation of the subject person. However, whenever this can be achieved, it would reduce the chance of drivers being lost to follow-up, assessment, and reminders regarding their licence status.

V. I recommend that when Waka Kotahi serve documents on persons required to undergo a medical assessment, and/or whose licence they are suspending, they request GP details as part of the process for reinstatement of the licence (assuming the person has a GP). Again, I acknowledge there is no regulatory/statutory requirement for licence holders to provide this information, and their cooperation is required. However, requesting the information will in some instances result in its provision. Receipt of this information would enable its flow between agencies. Again, the result would be a reduction of instances of missed follow-up, assessment, and reminders regarding licence status.

VI. Every effort should be made, by Police, Waka Kotahi, and GPs to share concerns about a person's fitness to drive and licence status. The information should flow freely in any direction amongst these parties, to ensure as few cases as possible slip through the cracks.

VII. Having made the above comments, I accept that even when all relevant groups (Police, Waka Kotahi, GPs, whānau) have played their part, if a person is determined to drive, there are limited enforcement options available to prevent them from doing so.

VIII. I recommend this finding is sent to Waka Kotahi, the New Zealand Police, and the Medical Council of New Zealand so they may continue to develop strategies to protect the public from transport related deaths.

Response to Provisional Findings

IX. A copy of my Provisional Findings was sent to Waka Kotahi, Police and Dr Tan. A response to my comments and recommendations was received from Waka Kotahi and is annexed to these Findings.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Panapa taken during the investigation into his death, in the interests of decency and personal privacy.

Self-Inflicted

Bolton [2023] NZCorC 35 (31 March 2023)

CIRCUMSTANCES

Jonathan Alexander Bolton (also known as Jono), aged 25, died on 2 February 2020 at 151 Palmers Road, Christchurch. His death was self-inflicted in circumstances amounting to suicide.

On 1 February 2020, Jono was stopped by Police and found to be driving with excess breath alcohol. While undergoing an evidential breath test, he made comments of self-harm. Police offered to take him to Christchurch Hospital, which he declined. They then left him in the care of his flatmate, Jared Riley, who spent the evening talking to Jono until he fell asleep. Jono was found deceased the next day.

RECOMMENDATIONS OF CORONER ELLIOTT

Actions of Police officers

I. Mr and Mrs Bolton felt that the officers ‘made a wrong judgement call in leaving Jono with Jared Riley’ and should have ‘bypassed his desire not to take him to the hospital and have taken him there for his own safety.’

II. Inspector Craig McKay responded to this:

> Regarding Mr and Mrs Bolton’s comments that they believe the officers decision to leave Jonathan at home with his flatmate was wrong…:
>
> > The officers had checked that there were no additional risk flags in the National Intelligence Application NIA to satisfy themselves that there was no recorded previous mental health or suicide risks flagged.
> >
> > A decision was made not to release Jonathan directly from New Brighton Station but to take him home for his safety.
> >
> > The officers discussed with Jonathan involving his family for support, however; Jonathan informed them he was not in contact with his family, and they lived outside of Christchurch.
> >
> > Jonathan was further advised that they could take him to hospital which he declined.
> >
> > Returning Jonathan to his place of residence, an officer sat with him and discussed his self-harm comments, to assess if these were serious. They further advised Jonathan of services available, providing him with the 1737 National Mental Health and Addiction helpline number, and additionally suggested he make an appointment with his doctor.
> >
> > The Officers spoke with his flatmate who was made aware of their concerns and agreed to look after Mr Bolton.

> In addition, the Officers had also sought guidance from their supervisor Sergeant van Eerden as to the appropriate cause of action.
>
> …while Section 36 (1)(b)(ii) also permits 'A Constable" to take an intoxicated person to a temporary shelter, there are unfortunately no such shelters in Canterbury. The officers were compliant with the legislation by taking Mr Bolton to his place of residence.
>
> …
>
> As previously submitted, in reviewing the officer's actions we have the benefit of hindsight. In retrospect it is acknowledged that the officers could have sought further advice from the Crisis Resolution Team when Jonathan expressed the wish to self-harm or called the custodial triage line. However, the officers' decision to leave Jonathan at home in his friend's care was made in good faith and with the view that it was the best place for Jonathan at that time.

III. Inspector McKay also provided some context:

> In the 2019 FY Police received 58,124 calls involving a person having a mental health crisis (33,132) or threatening or attempted suicide (24,992). Every 24 hours police staff respond to 100 calls involving a person having a mental health crisis (16,272 in the 2019 FY), including suicide threats and attempts (22,985) attempted or threatening suicide calls in the 2019 FY.
>
> The demands on police to deal with mental health calls are increasing by around 9 percent a year and undoubtedly many other calls not coded 1M Mental Health or 1X Suicide also stem from mental distress.

IV. Constable Keil said:

> We discussed the possibility of transporting BOLTON to Christchurch ED to be assessed by Crisis Resolution however from my experience I understand they don't assess any patients if they are intoxicated
>
> I know from my experience in the Police Crisis Resolution don't assess patients if they are intoxicated. If BOLTON wasn't intoxicated, I would have considered calling Crisis Resolution before transporting him to ED however due to his intoxication level I didn't phone ahead.

V. Constable Dixon said:

> We considered this but I was advised by Constable Keil and Sergeant van Eerden that the Crisis Resolution Line will not assess a patient if they are intoxicated.

VI. Maria Taylor, Customer Services Coordinator, Specialist Mental Health Services with the Canterbury District Health Board, provided the following information:

> There is an established process for Police to have direct access to a mental health nurse by telephone.
>
> …
>
> The Crisis Resolution team do undertake to initiate assessments of people who are under the influence of substances. However, the level of intoxication can often determine the level of assessment that can be completed at that time.

If the level of intoxication prevents a clear and safe plan being developed, the assessment is suspended. Alternative options are considered for monitoring the person safely until they are able to participate in the assessment.

If the person is in the Emergency Department (ED) this may include requesting the ED team to arrange a bed for the person so the assessment is able to be completed later, or discharging the person and providing support and advice to family or friend to stay with the person until they are sober enough to participate in an assessment.

If the person is taken to the Watch House, police then ask the Watch House Nurse to see the person.

Discussion

VII. The following options were available to the officers:

1. Allow Jono to leave New Brighton Police Station

VIII. The officers decided not to do this. Given Jono's level of intoxication and mental state, the time of night and the fact that he would have been leaving alone and on foot, their decision reflects concern for his welfare.

2. Seek advice from Mental Health Services

IX. The officers considered the possibility of seeking advice from Mental Health Services. However, their understanding was that Crisis Resolution does not assess patients if they are intoxicated.

X. Ms Taylor said that the Crisis Resolution Team does undertake to initiate assessments of people who are intoxicated although the level of intoxication can often determine the level of assessment.

XI. There appears to be a divergence of views between Police and Te Whatu Ora Waitaha Canterbury about whether mental health assessments are always carried out on people who are intoxicated. It is not possible for me to resolve this.

XII. However, it is clear that the officers were acting in good faith. They believed that Jono would not be assessed because he was intoxicated.

XIII. The situation was further complicated by the fact that they offered to take Jono to the hospital but he declined. Therefore, if they took him there, they would have been doing so without his consent. There would have been nothing to stop Jono simply leaving the hospital if he was taken there.

XIV. It is possible that, if Jono had engaged with the Crisis Resolution Team, his death might have been prevented with their assistance. However, this is only a possibility. Unfortunately, people still take their lives even while receiving mental health care.

XV. Nevertheless, given that Jono was making suicidal comments, the best course would have been for Police to seek advice from Mental Health Services. In saying this, I make no criticism of the individual officers who were acting in good faith in a difficult situation and understood that no mental health assessment would be carried out given Jono's state.

XVI. The chances of deaths occurring in similar circumstances may be reduced if Police seek advice from Mental Health Services where a person has expressed suicidal intentions, even if the person is intoxicated and even if

there are no previous mental health or suicide risks noted on NIA. If advice is sought in such cases, it means that a mental health professional can assess what steps should be taken to assist the person.

XVII. I therefore recommend that Police always contact Mental Health Services for advice where a person in their care or custody expresses suicidal intentions, even if that person is intoxicated and even if there are no previous mental health or suicide risks noted on NIA.

XVIII. A consequence of this recommendation is that Mental Health Services must be sufficiently resourced to provide assistance when required. Inspector McKay made the following comments about this:

I am of the opinion:

> That District Health Boards should have mobile Psych nurses or teams available 24/7 in the field to attend suicide and mental health calls for service, currently the domain of New Zealand Police and St John. The provision of adequately resourced specialist crisis intervention teams by experts which can respond in a timely manner and free up emergency services is required. I say this as the vast majority of calls for service relating to suicide and mental health have committed no criminal offence, the response therefore should be a health led one.
>
> Mr Bolton's death is a tragedy, but there was no way the constables involved could have predicted that he would take his own life that night. Nonetheless, further to Mr and Mrs Bolton's suggestions, it is my opinion and recommendation that:
>
> The Ministry of Health establish a national triage line for emergency services personnel dealing with individuals suffering from mental health issues. Currently there are 20 DHBs and 12 Policing districts, and we need 'One Point of Truth' which will provide consistency and better access to medical information to inform emergency services first responders decision making process.
>
> …
>
> Any additional mental health training for front line Police officers should be delivered by mental care professional(s) to demystify mental health illness. Such training would likely empower staff to understand correct language and response strategies that would potentially improve incident outcomes.

XIX. I asked Te Whatu Ora Waitaha Canterbury and Manatū Hauora/Ministry of Health to respond to these comments. The Associate Deputy Director-General, Mental Health and Addiction, Manatū Hauora/Ministry of Health provided a response. This is annexed to these findings.

XX. I note that this response also addresses some of the issues which Jono's parents made in their submissions, namely:

a. The response to emergency mental health demand.

b. Multi-agency responses that bring together health, Police and other services.

c. Training for Police.

XXI. Given the ongoing work referred to by the Associate Deputy Director-General, I make no comments or recommendations in relation to these matters.

3. Take Jono to Christchurch Central Police Station

XXII. Section 36 of the Policing Act 2008 states:

> **36 Care and protection of intoxicated people**
>
> (1) A constable who finds a person intoxicated in a public place, or intoxicated while trespassing on private property, may detain and take the person into custody if—
>
> (a) the constable reasonably believes that the person is—
>
> (i) incapable of protecting himself or herself from physical harm; or
>
> (ii) likely to cause physical harm to another person; or
>
> (iii) likely to cause significant damage to any property; and
>
> (b) the constable is satisfied it is not reasonably practicable to provide for the person's care and protection by—
>
> (i) taking the person to his or her place of residence; or
>
> (ii) taking the person to a temporary shelter.
>
> (2) A person detained under subsection (1)—
>
> (a) must be released as soon as the person ceases to be intoxicated:
>
> (b) must not be detained longer than 12 hours after the person is first detained, unless a health practitioner recommends that the person be further detained for a period not exceeding 12 hours.
>
> …
>
> (4) In this section,—
>
> **intoxicated** means observably affected by alcohol, other drugs, or substances to such a degree that speech, balance, co-ordination, or behaviour is clearly impaired
>
> **temporary shelter** means a place (other than a place operated by the Police) that is capable of providing for the care and protection of an intoxicated person.

XXIII. Taking an intoxicated person into custody is a last resort. An officer cannot exercise this option unless satisfied that it is not reasonably practicable to provide for the person's care and protection by taking the person to his place of residence or a temporary shelter.

XXIV. In addition, being locked up in a cell may not have been conducive to Jono's mental health. As Inspector McKay said:

> It is my belief that a custodial facility is the last place an intoxicated or mentally unwell individual should be taken; such facilities are detrimental to the wellbeing of such individuals.

4. Take Jono to his place of residence

XXV. The officers raised the possibility of involving Jono's family for support, however Jono was not willing to do this.

XXVI. The officers therefore took Jono to his current place of residence. Constable Keil spoke to Mr Riley and told him that Jono was intoxicated and had made comments self-harm. He asked Mr Riley if he was in a position to look after Jono. Mr Riley agreed and said he would look after Jono and ensure he went to sleep. Mr Riley watched Jono until he went to sleep.

XXVII. Mr and Mrs Bolton suggested that Mr Riley was not the best person to assist Jono in that situation. Section 36 provides that Police may take an intoxicated person to his or her place of residence. However, where the intoxicated person has also expressed suicidal intentions (a situation which is not contemplated by section 36), a layperson is not the best person to assist. I have already noted that the best course would have been for Police to involve Mental Health Services to seek advice.

XXVIII. Section 36 of the Policing Act refers to temporary shelters. This option, if available, would have been preferable to taking Jono to his place of residence if those in charge of the shelter were in a position to monitor Jono at all times.

XXIX. The chances of a person dying in similar circumstances may have been reduced if a temporary shelter was available that night. I therefore proposed to recommend that temporary shelters should be established (noting that shelters relate to people who are intoxicated and that, where an intoxicated person is also at risk of suicide, the best course remains to seek advice from Mental Health Services, which may result in hospital admission rather than attendance at a temporary shelter).

XXX. My proposed recommendation was directed to Manatū Hauora/Ministry of Health. The Associate Deputy Director-General, Mental Health and Addiction said:

> In relation to the proposed recommendation that temporary shelters be established, we note it is important that people under the influence of drugs and alcohol have safe and appropriate spaces available to recover. While the term 'temporary shelter' does not refer to a defined service that exists within the health system, many different contexts can provide such support, depending on the severity of need.
>
> For example, it is common practice for Police to take a heavily intoxicated person to an Emergency Department to support them to recover sufficiently and safely for further assessment to occur. There is access to relevant health practitioners in Emergency Departments, though we acknowledge they are not always a conducive environment for people in distress or experiencing withdrawal from substances. While it is described in your Provisional Findings why this did not happen in this case, it did highlight a need to be clearer on the existing processes.
>
> Though it has not been explored in detail at this time, establishing a temporary shelter as a specific or standalone service is likely to need combined medical and mental health and addiction oversight and multiple practitioners. Setting up such a temporary shelter service would require additional resource and place pressure on a workforce

> already experiencing serious shortages. People whose health is at high risk would likely still need to be taken to an Emergency Department to access suitable care.
>
> Manatū Hauora and Te Whatu Ora preference at this time is to focus on improving crisis response options and settings through the work described earlier in this letter. Establishing a new standalone service may duplicate the capacity and capability available through an Emergency Department.

XXXI. The Associate Deputy Director-General stated that the establishment of temporary shelters has 'not been explored in detail at this time.' I acknowledge the potential practical impediments. However, in my view, given that section 36 of the Policing Act 2008 specifically contemplates the availability of temporary shelters, Manatū Hauora/Ministry of Health should at least consider establishing them.

XXXII. I therefore recommend that Manatū Hauora/Ministry of Health considers establishing temporary shelters as contemplated by section 30 of the Policing Act 2008, with such consideration including exploring the possibility in detail.

Effects of alcohol

XXXIII. In 'Acute alcohol use and suicide deaths: an analysis of New Zealand coronial data from 2007-2020,'[49] the authors state:

> Acute alcohol use is a known proximal risk factor for suicide and has been shown to significantly increase risk of suicide attempt, particularly at high levels of acute consumption. For suicide deaths, reviews find the prevalence of acute alcohol use range from 10% to 69%, differing by population demographics including age and sex.
>
> Alcohol may cognitively trigger suicide attempts by increasing impulsivity and disinhibition, weakening psychological barriers to suicide attempts, or by increasing despair, and cognitively impairing efforts to mitigate despair. Acute use of alcohol is associated with use of more lethal suicide means, and may potentiate the effects of other drugs consumed in overdose, thereby reducing the likelihood of surviving an attempt. These findings suggest that acute alcohol use should be a focus for suicide prevention.
>
> …
>
> The World Health Organisation emphasises that almost one in five of all suicides can be attributed to alcohol use, highlighting alcohol policy as a point of intervention for reducing suicide. Not targeting alcohol represents a missed opportunity for suicide prevention efforts. This is pertinent, as New Zealand has high levels of alcohol use; 80% of New Zealanders [15 years or older] have drunk alcohol in the past year; 20% drink at hazardous levels. However, the relationship between alcohol and suicide has not been examined systematically in New Zealand, and the national Suicide Prevention Strategy fails to identify alcohol harm reduction strategies as a means of suicide prevention.
>
> [Footnotes omitted]

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[49] Rose Crossin, Lana Cleland, Annette Beautrais, Katrina Witt, Joseph M Boden, New Zealand Medical Journal, 15 July 2022; 135(1558) at 65.

XXXIV. Jono was affected by alcohol on the night he died. Alcohol would have increased his impulsivity and disinhibition, increased his despair and weakened his psychological capacity to deal with this despair. It is more probable than not that alcohol contributed to his death.

XXXV. The chances of people taking their own lives in similar circumstances may be reduced if alcohol harm reduction strategies are incorporated into the Suicide Prevention Strategy as a means of suicide prevention.

XXXVI. I therefore proposed to recommend that Manatū Hauora/Ministry of Health takes steps to incorporate alcohol harm reduction strategies into the national Suicide Prevention Strategy.

XXXVII. The Associate Deputy Director-General stated:

> Kia Manawanui Aotearoa - long-term pathway to mental wellbeing is the Government's high-level plan for transformation over the long term and includes several focus areas relating to alcohol and other drug use and reducing substance related harm. This includes strengthening both specialist alcohol and other drug services, and a public health approach to regulation and enforcement of alcohol and other drugs, a focus on prevention and early intervention, and increasing mental wellbeing literacy about harm from alcohol. The efforts set out in Kia Manawanui all contribute to the goal of reducing suicide in New Zealand.
>
> The Suicide Prevention Office (SPO) sits within Manatū Hauora and is conscious of the impact alcohol has in relation to confirmed suicides and suicide attempts. The SPO is considering this and other kaupapa to be included in the next iteration of the action plan for the Every Life Matters national strategy (2024-29).

XXXVIII. It does not appear that there is disagreement with my proposed recommendation.

XXXIX. I therefore recommend that Manatū Hauora/Ministry of Health takes steps to incorporate alcohol harm reduction strategies into the national Suicide Prevention Strategy.

Summary

XL. In summary, I have made the following recommendations pursuant to section 57A of the Coroners Act 2006:

a. Police always contact Mental Health Services for advice where a person in their care or custody expresses suicidal intentions, even if that person is intoxicated and even if there are no previous mental health or suicide risks noted on NIA.

b. Manatū Hauora/Ministry of Health considers establishing temporary shelters as contemplated by section 30 of the Policing Act 2008, with such consideration including exploring the possibility in detail.

c. Manatū Hauora/Ministry of Health takes steps to incorporate alcohol harm reduction strategies into the national Suicide Prevention Strategy.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death.

Chad [2023] NZCorC 21 (13 March 2023)

CIRCUMSTANCES

Dylan Chad, aged 22, died between 2 and 3 March 2019 at Auckland in circumstances amounting to suicide.

Dylan had lived with his grandparents for most of his life and lived in a free-standing garage on their property in Massey, West Auckland. In 2013, at the age of 17, he was convicted of the manslaughter of his friend Tyler resulting from an illegal street car race. Dylan's mother believed that he had not been able to cope with Tyler's death, and that he had been subjected to blame and unkind comments about it on Facebook. After self-harming in early 2014, he was prescribed anti-depressants and referred to post-traumatic stress disorder counselling. A mental health assessment in 2018 found that Dylan had cluster B personality traits with maladaptive coping and cannabis dependence issues.

On the afternoon of 2 March 2019, Dylan helped his grandfather complete some work on the deck. After returning to the garage, he started playing music loudly, but turned it down after his grandmother sent a message asking him to at around 8:30pm.

At about 6:00pm the following day, Dylan's grandmother went to the garage and found several notes from him addressed to family and friends, along with a note taped to the bedroom door indicating intention to end his life. Dylan's grandfather entered the room and found Dylan unresponsive. Emergency services were contacted and upon arrival soon afterwards, confirmed that Dylan had died.

Concerns were raised that Dylan may have indicated an intention to end his life during communications with several friends, but that they took no action. His friends told Police that they had not believed Dylan was serious about ending his life.

COMMENTS OF CORONER ANDERSON

I. It is clear that Dylan found life difficult at times and that he was profoundly affected by the death of his friend Tyler. Dylan had a history of impulsive behaviour and self harm and seems to have found it difficult to talk about his emotions. Because of this, the depth of his struggles was not always obvious to those around him. At times he expressed thoughts of suicide and showed suicidal intent, including during the period immediately prior to his death. However, it was not thought that he would follow through with these intentions and Dylan's death came as a shock to his family and friends.

II. I do not consider that any recommendations are necessary in the circumstances of this case. However, I do wish to highlight the importance of intervening and taking action if there are concerns about an individual's mental state, particularly if they could be suicidal.

III. The Ministry of Health produces resources and information about what steps can be taken if someone is threatening suicide or is thought to be at risk of suicide. These resources include contact details for agencies that can provide further advice and information. It is important to seek urgent advice and assistance if there are any concerns that an individual is contemplating suicide, even if there is uncertainty about whether they genuinely intend to harm themselves or take steps to end their life.

IV. The Ministry of Health information is available at: https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal

V. Similar resources can be accessed through the Mental Health Foundation website at https://mentalhealth.org.nz/suicide-prevention/suicide-prevention-resources

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Dylan entered into evidence, in the interests of personal privacy and decency.

Lloyd [2023] NZCorC 3 (16 January 2023)

CIRCUMSTANCES

John Oliver Lloyd, aged 70, died over the period of 1 – 2 May 2021 at 267 Old Taupiri Road, Ngāruwāhia in circumstances amounting to suicide.

COMMENTS OF CORONER HESKETH

I. The following comments are made pursuant to section 57(3) of the Coroners Act 2006, for the purpose of public education aimed at avoiding further suicide by anyone in circumstances similar to those in which John Oliver Lloyd died.

II. Help is available to anyone who is struggling and thinking of harming themselves. Help is also available to anyone who is concerned or aware that a friend, family member or anyone else is thinking that way.

III. Information about the ways you can support someone who is thinking of harming themselves is available at https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide.

IV. The website contains information about what to do if you think someone needs urgent help. If someone has attempted suicide or you're worried about their immediate safety, do the following:

   a. Take them seriously. Thank them for telling you, and invite them to keep talking. Ask questions without judging.

   b. Call your local mental health crisis service or go with the person to the emergency department at the nearest hospital.

   c. If they are an immediate danger to themselves or others call 111.

   d. Remain with them and help them to stay safe until support arrives.

   e. Try to stay calm and let them know that you care.

V. Some options and the contact details of some agencies that can help are listed below:

   a. For counselling and support - these are free and generally available anytime: Lifeline - 0800 543 354 Samaritans - 0800 726 666

VI. For children and young people:

a. Youthline - 0800 376 633, free text 234 or email talk@youthline.co.nz (for young people, and their parents, whānau and friends)

b. *What's Up - 0800 942 8787 (for 5-18 year olds; 1 pm to 11 pm)

c. *The Lowdown - visit the website, email team@thelowdown.co.nz or free text 5626 (emails and text messages will be responded to between 12 noon and 12 midnight)

d. *SPARX - an online self-help tool that teaches young people the key skills needed to help combat depression and anxiety.

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of John Oliver Lloyd entered into evidence, in the interests of decency and personal privacy.

McMinn [2023] NZCorC 4 (16 January 2023)

CIRCUMSTANCES

Bruce Scott McMinn, aged 62, died on 26 February 2018 at North Shore Hospital in circumstances amounting to suicide.

COMMENTS OF CORONER HESKETH

I. The following comments are made pursuant to section 57(3) of the Coroners Act 2006, for the purpose of public education aimed at avoiding further suicide by anyone in circumstances similar to those in which Mr McMinn died.

II. Help is available to anyone who is struggling and thinking of harming themselves. Help is also available to anyone who is concerned or aware that a friend, family member or anyone else is thinking that way.

III. Information about the ways you can support someone who is thinking of harming themselves is available at https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide.

IV. The website contains information about what to do if you think someone needs urgent help. If someone has attempted suicide or you're worried about their immediate safety, do the following:

a. Take them seriously. Thank them for telling you, and invite them to keep talking. Ask questions without judging.

b. Call your local mental health crisis service or go with the person to the emergency department at the nearest hospital.

c. If they are an immediate danger to themselves or others call 111.

d. Remain with them and help them to stay safe until support arrives.

e. Try to stay calm and let them know that you care.

V. Some options and the contact details of some agencies that can help are listed below:

a. For counselling and support - these are free and generally available anytime: Lifeline - 0800 543 354 Samaritans - 0800 726 666

VI. For children and young people:

a. Youthline - 0800 376 633, free text 234 or email talk@youthline.co.nz (for young people, and their parents, whānau and friends)

b. *What's Up - 0800 942 8787 (for 5-18 year olds; 1 pm to 11 pm)

c. *The Lowdown - visit the website, email team@thelowdown.co.nz or free text 5626 (emails and text messages will be responded to between 12 noon and 12 midnight)

d. *SPARX - an online self-help tool that teaches young people the key skills needed to help combat depression and anxiety.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr McMinn taken during the investigation into his death, in the interests of decency and personal privacy.

Mr X [2023] NZCorC 7 (20 January 2023)

CIRCUMSTANCES

Mr X, aged 44, died by the side of State Highway 1, north of Totara Park Road, Foxton sometime between the evening of 27 and 28 July 2018. His death was self-inflicted in circumstances amounting to suicide.

At the time of his death, Mr X, was facing allegations of sexual criminal offending. While Police had informed him of the allegations, he had not been formally charged. Despite Mr X seeking the specifics of the allegations from Police on multiple occasions, the information was not provided.

Mr X told Police the allegations had taken a “significant personal toll” on him but there was no indication to Police that he was at any risk of self-harm. An IPCA investigation concluded that Police handled their investigation in a manner consistent with best practice and policy.

RECOMMENDATIONS OF CORONER TELFORD

I. As outlined above, I must turn my mind to whether any recommendations and comments should be made for the purpose of reducing the chances of further deaths occurring in similar circumstances. In doing so, I make no comments in relation to the alleged offending or the substance of the associated investigation as these matters are beyond this Court’s jurisdiction.

II. Mr X’s death occurred in the context of him being a suspect in a criminal investigation relating to his alleged sexual offending against one of his children. This type of offending is arguably perceived as one of the most serious and repugnant to our society and people who commit these types of crimes are typically vilified by that same society.

III. From my review of the evidence, I can see that Mr X felt isolated and unsure about the Police process. I infer that Mr X, in fact, became acutely distressed by the allegations and the Police process and this ultimately led to a mental health crisis. I cannot imagine this is an uncommon response from people facing these kinds of allegations (regardless of there being a basis to them), for the reasons outlined above and associated feelings of shame/whakamā.

IV. I accept that practical restraints and resourcing issues create delays and limit what Police officers can do in their many and varied interactions with all manner of people. These interactions often occur in the context of competing priorities and by nature require considerable, multi-faceted skills.

V. After reviewing the evidence, I am satisfied that at the time of each engagement with the Police, Mr X never gave any indication he was at obvious risk of self-harming or taking his life. On 12 July 2018 he did say that the matter was taking a "significant personal toll", but in the context of the situation, I consider that this would not necessarily alert Police to imminent risks.

VI. In terms of the provision of information and timeframes, I consider suspects will always want to know what is happening and where they stand. Not knowing this will often lead to compounding distress, which for some will become intolerable. I find that this was sadly the case for Mr X, who had no option but to tolerate living with limited information and broad uncertainty for twenty days, until he took the gravest of steps to end his life. However, there is the inescapable reality that there will be times where the Police simply cannot give information and timeframes, howsoever desperately the suspect craves it.

VII. I also accept the position (if so taken) that the Police are fundamentally not there to provide pastoral care to people facing criminal investigations. However, I return to the Police Investigative Interviewing Suspect Guide which states to officers "… it is paramount you consider the suspect's well-being and investigative needs in decision relating to interviews". This suggests a policy-based acceptance that there is at least some duty to consider the wellbeing of suspects whilst carrying out core policing tasks.

VIII. With this in mind, I recommend that operational policy is augmented to include a duty on investigating officers to provide suspects with the contact details of the local Crisis Team or its equivalent service. I recommend officers are required to do this at their first engagement with the suspect and for this to be reiterated at key points of Police contact with that person (regardless of their perceived presentation). This simple step carries a low burden for officers and effectively points the person (if they are in distress) to an agency that can help them. This action also creates an inherent requirement for the attending Police officer(s) to have an intentional discussion with the person about their mental wellbeing and could act as a prompt to consider their dynamic risks.

IX. I consider this to be particularly important for people who are the subject of investigations relating to sexual offending, for the reasons outlined above. However, I see a similar need for people facing allegations of any kind of serious offending – particularly if they are unfamiliar with the criminal justice system.

X. As I have made some recommendations, the law requires that I give the Police an opportunity to respond. I have therefore sent the Police a copy of my draft findings and invited them to file a responses for my consideration before I issue these final findings.

Response from Police

XI. I have received a response from the Police in which I am advised my recommendations accord with current investigative best practice. I am assured that my recommendations will be incorporated into Police policy in the following areas:

a. Child protection investigations (including online child abuse);

b. Adult sexual assault investigations; and

c. Investigative interviewing suspect guide.

XII. I understand this work will require significant resourcing, but the response I have received from the Police assures me that this important matter will receive due priority.

XIII. I am obliged to the Police for their considered response and prompt action.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of: (i) the deceased's name and any particular that may identify him, in the interests of justice and personal privacy; and (ii) photographs of Mr X taken during the investigation into his death, in the interests of decency and personal privacy.

Thoms [2023] NZCorC 34 (30 March 2023)

CIRCUMSTANCES

Zane Luke Thoms, aged 29, died between 25 and 26 July 2019 in circumstances amounting to suicide.

In June 2019, Mr Thoms was experiencing difficulties with his mental health due to a number of personal stressors. Consequently, his general practitioner (GP) made a referral for him to be seen by the Crisis Resolution Service (CRS) at Canterbury District Health Board (DHB) - now known as Te Whatu Ora.

On 11 July 2019, Mr Thoms was discharged from the care of CRS as there was a notable improvement in his mental state, and he had expressed a willingness to continue engaging with his GP and other service providers. Sadly, Mr Thoms was found deceased two weeks later.

Canterbury DHB commissioned an independent file review of the care provided to Mr Thoms by CRS. The review found that while there were no factors which were causative of Mr Thoms' death, several quality improvement factors were identified:

- A wellness and safety plan were not completed, and an information kit was not given to Mr Thoms (though the Blokes Book[50] was provided).
- Mr Thoms' ethnicity information was not recorded correctly nor subsequently amended. Based on this there was no referral to Pukenga Atawhai.

[50] A comprehensive guide to health issues affecting men.

- Mr Thoms' family were not involved in his care with CRS although Mr Thoms had authorised some family members to be involved. In particular, CRS did not consult with Mr Thoms' family prior to discharging him on 11 July 2019.

COMMENTS AND RECOMMENDATIONS OF CORONER DUGGAL

I. Having considered the circumstances of Mr Thoms' death, I endorse the recommendations of the internal review carried out by Canterbury DHB into care provided to him. In particular, I endorse the recommendation that contact should have been made with family. This would have enabled the CRS team to gather further information about Mr Thoms' situation as well as to provide information about treatment and referrals.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Thoms entered into evidence, upon the grounds of personal privacy and decency.

Tuatai [2023] NZCorC 25 (16 March 2023)

CIRCUMSTANCES

Issac Robert Parua Nae Tuatai, aged 21, died at Middlemore Hospital on 17 December 2020, in circumstances amounting to suicide.

Issac had a difficult upbringing involving drug and alcohol addiction, psychosis, and criminality. In 2019 Issac was diagnosed with schizophrenia with the differential diagnosis of a drug induced psychosis with ongoing alcohol, cannabis and methamphetamine abuse.

Issac was subject to electronically monitored bail in July 2019 but due to numerous breaches and absconding he was remanded in custody for a period of about five months in November 2019. On 15 May 2020 Issac's uncle died by suicide when Issac was present in his home. Following his uncle's tangi, Issac was remanded in custody for a further breach in relation to the consumption of alcohol. Issac remained in prison on remand until he was sentenced on 26 August 2020. His sentence of home detention was cancelled, and he was sentenced to five months' imprisonment with special release conditions.

In September 2020 Issac's prison medical records indicate that his mental health was deteriorating. He described hearing multiple voices inside his head that sometimes argue or hold conversations. Issac was assessed by a consultant psychiatrist in prison on 23 September 2020 and his medication was increased.

Issac was released from prison at short notice on 28 September 2020, which meant that he was unable to participate in the reintegration programme that would have been recommended for him. The Northland Regional Corrections Facility health manager stated that had they been aware of Issacs's planned release, he would have been provided with at least one week's medication plus a prescription for one month to take to a local pharmacy. However, this did not occur. Issac was released to no fixed address in Kaitaia with a requirement that he report weekly to his probation officer.

Issac failed to attend four appointments with his drug and alcohol counsellor and psychiatrist as required by his probation officer. He also failed to report to his probation officer on 22 October 2020 and was given a warning. On 27 October 2020

his probation officer discussed with Issac the importance of complying with his conditions and made a plan to refer him to a psychiatrist until the Hope House programme was available. However, on 30 October 2020, without any prior arrangement, Issac reported to the Otara probation office in South Auckland. On 24 November 2020 probation recorded that Issac had decided to stay with his mother in Auckland.

On the evening of 14 December 2020, Issac was staying alone at his mother's house. A family member who was dropping off food to Issac found him unresponsive inside the home. Ambulance services were called and, following resuscitation and CPR, a return of circulation was achieved. Issac was taken to Middlemore Hospital where, after four days in intensive care, he was declared brain dead on 17 December 2022.

RECOMMENDATIONS OF CORONER MILLS

Monitoring of special release conditions

I. In addition to my concerns about Issac's release without medication discussed above, I also have concerns about the supervision provided by probation services of Issac when released on 28 September 2020. Issac was a highly vulnerable young man. He had drifted between health care services and in and out of custody. He had a diagnosis of schizophrenia but had never received sustained treatment. He also had a history of drug and alcohol abuse but had never engaged in long term treatment. He had a recent history of suicidal ideation in prison, had experienced the recent loss of a close relative through suicide, which was known to the Department of Corrections, and had reported deteriorating mental health five days before his release. He was released early without his medication or any on-going plan.

II. The Court had imposed special release conditions on Issac including attending, as directed by his probation officer, the Hope House residential rehabilitation program and other mental health, drug and alcohol addiction and counselling services. Unfortunately, there was no placement for him at Hope House and his early release meant no plan had been put in place in lieu of this.

III. On release Issac failed to attend any medical appointments or assessments despite being directed to by his probation officer. His decision to move to Auckland meant that he reported to different duty probation officers who did not know his history and did not have a relationship with him.

IV. I cannot criticise the individual probation officers as a review of Issac's notes indicate they had concerns about his lack of progress with his release conditions, his transience, and his general non-compliance with his conditions. However there appears to have been a systemic failure in that the probation officers do not appear to have been advised of the deterioration in his mental health prior to his release nor were they aware that he was released without his medication. There therefore does not appear to be any urgency attached to Issac's need to be assessed by the community mental health team or of the need to ensure he had his medication. There was also a delay in transferring his file formally to a new probation office and assigning of a new officer. Overall, there does not appear to have been any plan made to ensure he was assessed and to ensure he received his medication, which, given his history and his recent deterioration in prison should have been considered a priority.

V. While I cannot say with certainty that the outcome would have been different, the failings I have identified provide an opportunity to learn and to improve services. I therefore recommend that the Department of Corrections and

the probation service undertake an internal review of the services provided to Issac to identify how the services could be improved.

VI. A draft copy of these Findings was provided to the Department of Corrections who declined to comment.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of the making public of any photographs taken of Issac during this inquiry (being photographs of a deceased person), in the interests of decency.

Tusani [2023] NZCorC 12 (16 February 2023)

CIRCUMSTANCES

Pareina Andrew Tusani, aged 28, died on 31 December 2019 at Auckland in circumstances amounting to suicide. Mr Tusani was of Samoan ethnicity and had been experiencing low mood in the period before his death due to his relationship ending.

COMMENTS OF CORONER GREIG

I. It can be very frightening if you are worried that someone you know may be thinking of suicide. Research shows that it is important that steps are taken to support a person in this situation – although what to do is not generally known by people who have not been in such a situation. The organisation Le Va[51] has produced some helpful guidance particularly developed for Pasifika which can be found at its website (https://www.leva.co.nz/). Le Va's website provides information about what to do if you are worried that someone is thinking of suicide: https://www.leva.co.nz/our-work/suicide-prevention/finding-help/worried-about-someone/what-to-do/

II. Le Va advises that if someone makes a suicide attempt this may be a warning of more suicide attempts to come in the future. It states that making a previous attempt is a very high risk factor for suicide and that it is necessary to make sure the person gets the help and support they need as soon as possible. Le Va's website provides information on steps to take: https://www.leva.co.nz/our-work/suicide-prevention/finding-help/after-a-suicide-attempt/

III. The Le Va website also refers to the advice given by the Mental Health Foundation: https://mentalhealth.org.nz/conditions/condition/suicide-supporting-someone-after-a-suicide-attempt

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of the body of Mr Tusani entered into evidence, upon the grounds of personal privacy and decency.

[51] Le Va's purpose is to support Pasifika families and communities to unleash their full potential.

Viti [2023] NZCorC 33 (29 March 2023)

CIRCUMSTANCES

Uate Joshua Viti, aged 28, died on 26 October 2019 at Lauderdale Road, Birkdale, Auckland. Mr Viti's death was self-inflicted in circumstances amounting to suicide.

At around 7am on 26 October 2019, Mr Viti was found unresponsive by members of the public, who thought he had passed away. Although this was reported to Police promptly, they did not arrive until 7:30am and also thought Mr Viti had died. However, when examined by paramedics a short time later, the paramedics thought that Mr Viti may still be alive and unsuccessfully attempted to revive him.

A review was undertaken by Police, and included the views of Dr Smith, the Medical Director of St John. Based on the evidence available, it was his opinion that Mr Viti was dead when Police first arrived. However, Dr Smith also advised that checking Mr Viti's pulse was an unreliable way of determining whether someone had died. It was also considered that the 111 call should have been categorised as a higher priority, which would have required a faster Police response.

COMMENTS OF CORONER GREIG

I. In the absence of very clear and obvious signs of death, time is of the essence in commencing resuscitation - to give the best possible opportunity to try and resuscitate the person. It is essential that emergency calls such as the one made about Mr Viti being found hanging are handled competently and that emergency responders start CPR unless it clear the person has died.

II. As the result of the internal Police Critical Incident Review after Mr Viti's death, changes have been made to the procedure Police Emergency Communications Centre staff must follow when they receive calls about any apparent completed suicide that address several issues identified in this inquiry. In particular, Communications Centre staff are required to call an ambulance (and not place reliance on advice from members of the public as to whether or not the person is still alive) on receipt of such a call. This will help to ensure that ambulance staff are despatched as promptly as possible in such situations. In addition, calls about any apparent completed suicide are now required to be categorised as priority 1, which will ensure a quicker Police response – with an onus on Police to assess carefully whether to attempt resuscitation if they arrive at the scene before ambulance personnel.

III. There remains an outstanding matter arising from the circumstances of Mr Viti's death on which I consider a recommendation is appropriate.

RECOMMENDATIONS OF CORONER GREIG

I. I recommend that the New Zealand Police amend the Police Initial Procedure When Attending a Sudden Death of the Sudden Death Police instruction, cited above, by adding information that conveys Dr Smith's advice that that pulse checks on their own are an unreliable means of determining that a person is dead and, in the absence of very clear and obvious signs of death, where it is safe for the Police to do so, resuscitation should be commenced.

Response to Recommendation – Police changes

II. New Zealand Police were consulted about the recommendation and a response on behalf of the Police was received from New Zealand Police's Director of Capability at Police National Headquarters, Superintendent Dave Greig.

III. Superintendent Greig confirmed that as a result of the Critical Incident Review the Police Emergency Communication Centres have updated their 'Standard Operating Procedures' to ensure response prioritisation to self-inflicted deaths.

IV. In response to my recommendation, Superintendent Greig advised that Police will update its first aid training to include that pulse checks on their own are an unreliable means of determining that a person is dead. He stated that "Police's view is that First Aid training is the best mechanism by which to embed this messaging". He advised that the information will also be communicated through a 'Lessons Learned' bulletin board notice that can be viewed by all Police staff on the Police intranet.

V. Superintendent Greig advised that Police will also amend the 'Initial procedure when attending a sudden death' of the Sudden Death Police instruction to include:

> *Check for signs of life and in the absence of very clear and obvious signs of death, where it is safe for the police to do so, resuscitation should be commenced. If alive, give emergency medical assistance and call an ambulance. If it is clear that medical treatment or resuscitation is not feasible or appropriate, call a duly qualified person to complete verification of death.*

VI. These changes address the concerns identified during this inquiry.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Viti's body entered into evidence, in the interests of personal privacy and decency.

Sudden Unexpected Death in Infancy (SUDI)

Pearce [2023] NZCorC 26 (20 March 2023)

CIRCUMSTANCES

Te Awhina Ataahua Hinewairangi Sharon Pearce, aged six weeks, died at 16 Newall Street, Kawerau on 3 November 2019 from sudden unexplained death in infancy (SUDI).

In the two weeks prior to Te Awhina's death, she started becoming unwell. Her mother, Waiwera Pearce, described Te Awhina's symptoms as a bad cough and reported to Police that she had bronchiolitis. On 24 October 2019, Te Awhina and Ms Pearce presented at Whakatāne Hospital. Te Awhina was assessed and diagnosed with a likely upper respiratory tract infection as a result of viral illness. She was not prescribed medication, other than saline drops and paracetamol, and was discharged home.

Te Awhina usually slept in a pēpi-pod or a bassinette located next to Ms Pearce's double bed. However, on the evening of 2 November 2019, Te Awhina was still unwell and was sleeping in bed with her mother. Her mother fed her at two points in the early hours of the morning, nothing that Te Awhina was coughing and sounded "chesty".

Around 7:00am on 3 November 2019, Ms Pearce woke to find Te Awhina was purple in the face and not breathing. Emergency services attended but sadly, despite resuscitation efforts, Te Awhina could not be revived and was pronounced deceased at the scene.

Nasal viral culture collected during the post-mortem examination tested positive for rhinovirus/enterovirus. In addition, Te Awhina's lungs showed the presence of chronic inflammation due to chronic bronchitis. Anterior livor of the face suggested face-down positioning at the time of Te Awhina's death. The forensic pathologist reported that it was unclear what role, if any, the virus had on the cause of death, in the context of the sleeping arrangement. She concluded that Te Awhina died due to sudden unexpected death in infancy (SUDI) with co-sleeping and unsafe bedding.

COMMENTS OF CORONER BATES

I. I take this opportunity to reinforce to the general public the message of safe sleeping for infants. In my view this message cannot be repeated too often. Repetition of this message is not intended as criticism of the care provided to Te Awhina. Te Awhina was loved and cared for.

II. In the past, coroners have made multiple recommendations to agencies to ensure the safe sleeping message from health professionals is consistent, and appropriately given to new parents. It is an important message because it is effective in preventing infant deaths.

III. The Ministry of Health launched a SUDI prevention programme in August 2017, directed at significantly reducing the number of deaths of babies. A key focus of the programme is to target the two key modifiable risks of SUDI: unsafe bed sharing and exposure to tobacco smoke during pregnancy. Such measures are clearly desirable to reduce the instances of infant deaths. In the present case there was bed sharing and Te Awhina's mother smoked during the pregnancy.

IV. Every sleep for a baby should be a safe sleep. That is, for every sleep, babies up to one year of age should be put to sleep on their backs, in their own sleeping space (a firm, flat and level surface with no pillow), with their face clear. The challenge is to ensure the safe sleep message, and what research shows safe sleep means for a baby, is clear to all parents and caregivers. It must also be delivered in a way that is understood, and the importance of the message appreciated. I am satisfied that the safe sleep message was given to Te Awhina's whānau and that this advice was usually followed by them.

V. Te Awhina did not always co-sleep with her mother. Overnight 2 – 3 November 2019 was an exception motivated by Ms Pearce's desire to more closely monitor and care for Te Awhina due to her being unwell. However, Te Awhina's death serves as a tragic reminder that every sleep for baby should be a safe sleep.

VI. I record that members of Te Awhina's whānau, including her mother, smoked tobacco during and after the pregnancy. I have no doubt that Te Awhina was exposed to tobacco smoke. It will remain unknown to what, if any, extent that exposure contributed to her death. Exposure to tobacco smoke continues to be a known SUDI risk and should be avoided if at all possible.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Te Awhina taken during the investigation into her death, in the interests of personal privacy and decency.

Workplace

Dinakaran [2023] NZCorC 15 (28 February 2023)

CIRCUMSTANCES

Perumal Dinakaran, aged 23 years, died on 24 May 2018 at the Hawkes Bay expressway between Napier and Hastings (State Highway 50A) (‘the Expressway”) from head injuries sustained following a head on collision between his vehicle and a truck travelling in the opposite lane.

At around 7:40am on 24 May 2018, Mr Dinakaran was driving his vehicle south along the Expressway in the course of his employment with George Weston Foods (‘GWF’). After travelling through the Links Road intersection and while still north of the Ngaruroro Bridge, Mr Dinakaran’s vehicle was seen to gradually cross the centreline while travelling through a long, sweeping left hand curve in the road. As Mr Dinakaran’s vehicle moved across the centreline it collided with an oncoming Mercedes Benz logging truck and trailer. This caused Mr Dinakaran’s vehicle to be projected into the air before landing on its roof on a grass verge. Mr Dinakaran was pronounced dead at the scene.

Mr Dinakaran worked as a chef at the Water Bar. His shifts generally started at about 3pm or 4pm and finished at about 10pm. On average Mr Dinakaran worked 40 hours per week and usually had Wednesdays off. In the week of Tuesday 15 May 2018 till Tuesday 22 May 2018, Mr Dinakaran worked 43.15 hours at the Water Bar.

Approximately three weeks prior to his death, Mr Dinakaran commenced a second job as a bread merchandiser with GWF. This job required him to restock bread on the shelves of several supermarkets in the Hawke’s Bay region, and he was required to use his own vehicle to travel between supermarkets. He did so four days a week, from 5am to approximately 2:30pm with two shift breaks. He had Tuesdays off. However, the evidence indicated that Mr Dinakaran had been working longer than his guideline working hours.

Police Serious Crash Unit (SCU) investigated the crash and concluded that the exact reason why Mr Dinakaran crossed the centreline can only be ‘speculated upon’. However, they considered there to be strong evidence that fatigue was a likely factor.

- GWF reported that Mr Dinakaran had told them he was working 30 hours per week at the Water Bar and accepted this employment on the basis that he did not work there full-time. According to GWF, Mr Dinakaran’s work schedule was designed to be manageable and optimise time for rest.

The Coroner provisionally found that GWF’s tools in managing Mr Dinakaran’s fatigue were ineffective. A provisional version of the findings was provided to GWF. GWF subsequently advised that they verify the total number of hours worked by employees by way of an employee declaration. Further steps taken by GWF since the collision include:

(a) identifying fatigue as one of the identified “threats to life” in its business;

(b) ensuring fatigue has a regular place in health and safety talks;

(c) requiring merchandisers to complete online driver awareness training;

(d) ensuring merchandisers have appropriate breaks by ensuring that their rosters account for both driving time and for break time;

(e) including in an induction manual for merchandisers a requirement that:

i. their total hours (including secondary employment) do not exceed 50 hours per week;

ii. if their total hours do exceed 50 hours per week, they report this to their manager; and

iii. they report to their manager if they are feeling fatigued, even if due to events outside of work.

The Coroner recorded the processes put in place by GWF and found that GWFs conduct is to be considered in light of the complex nature of fatigue, the challenges of managing driving-related fatigue risk, the inaccurate information that Mr Dinakaran may have provided to GWF regarding his working hours and the limited nature of publicly available information and guidance on fatigue.

The Coroner found that on the balance of probabilities, the reason Mr Dinakaran veered into the path of the truck was due to fatigue and that Mr Dinakaran's death was preventable for two reasons. First, more could have been done by him and his employer to manage the risks of driving in a fatigued state. Secondly, the Police reported that a centre median wire rope barrier separating the north and south bound lanes of the Expressway at the scene would have prevented the collision and that these barriers have now been put in place.

As part of her inquiry, the Coroner commissioned a report from Professor T Leigh Signal who is a professor of fatigue management and sleep health at the Sleep/Wake Research Centre, School of Health Sciences, Massey University, Wellington.

RECOMMENDATIONS OF CORONER WRIGLEY

I. I commissioned Professor Signal to prepare recommendations that may assist in ensuring others, in circumstances like those of Mr Dinakaran, do not drive in a fatigued state. I asked Professor Signal to have particular regard to Mr Dinakaran's working hours which involved him working two jobs one of which started early in the morning and involved split shifts and the other which finished at night.

II. Professor Signal prefaced her recommendations with advice that fatigue is a complex workplace hazard to manage and fatigue science is a complex topic. She explains that this complexity arises partly because when the hours of work impact upon a worker's opportunity for sleep, the elimination of work-place fatigue is very unlikely and the risk must instead be managed. Another complicating factor is that the hazard of fatigue can be influenced not only by what happens in the workplace, but also by events that occur, and choices made by workers, outside of work.

III. Due to the complexities just noted, Professor Signal considers that workers, employers and stakeholders all need to be knowledgeable about the causes and consequences of fatigue and must work together to ensure appropriate processes are in place to effectively manage the hazard of fatigue within a particular industry. Professor Signal

contends that responsibility for fatigue management must be shared across the work system, and workers and employers need to be supported in this by industry organisations and regulatory agencies. Her recommendations are directed towards achieving this and are partly based on the premise that if:

a. Mr Dinakaran and GWF had a greater awareness of fatigue and its impact on driving safely; and

b. Mr Dinakaran and GWF understood how the combination of Mr Dinakaran's hours of work for both his jobs contributed to his sleep loss, fatigue, and inability to recover from fatigue; and

c. Mr Dinakaran was aware of his responsibility to be fit to drive for work and to notify GWF if he was not; and

d. GWF had processes in place for managing fatigue in workers required to drive,

then Mr Dinakaran may have changed his behaviour in a way that would have stopped him driving in a dangerously fatigued state and thereby averting the fatal collision.

IV. Professor Signal's recommendations are also premised upon the absence of adequate and publicly available information and guidance on fatigue and driver fatigue. In her opinion, information that is publicly available is "introductory and simplistic and unlikely to provide sufficient detail to allow employers and workers to adequately understand the complex nature of fatigue and manage driving-related fatigue risk".[52]

V. I set out below, in full, Professor Signal's recommendations, which include helpful information for all those concerned with the risks associated with driving whilst fatigued.

RECOMMENDATION 1

It is recommended that employers provide workers with education on what fatigue is and what causes it (e.g., role of early starts, long hours, and late finishes); the impact of fatigue on driving safely; and how to manage the risk of fatigue when driving.

Workers must have information so they can understand what fatigue is and what causes it, and the impact that fatigue may have on driving safely. They must know how to manage their time away from work to recover from fatigue created through exposure to previous periods of work and prepare adequately for subsequent periods of work. Workers should be provided with appropriate information on the fatigue-related risks associated particular aspects of work, such as early starts, long work hours, and late finishes, and the risks that fatigue poses to their (and other's) health and safety when driving.

To aid understanding of fatigue and driving-related fatigue risks, workers must have basic knowledge of the amount and quality of sleep needed to safely function and strategies to support obtaining sufficient good quality sleep, the consequences of obtaining poor or insufficient sleep in both the short and long term, the process of recovering from sleep loss, and strategies or organisational processes they can use to manage fatigue.

[52] Professor Signal refers to information available at: https://www.worksafe.govt.nz/topic-and-industry/fatigue/ and https://www.nzta.govt.nz/safety/what-waka-kotahi-is-doing/education-initiatives/fatigue/.

As part of this education, workers should be made aware of their responsibilities under the HSWA (2015), section 45, duties of workers, in relation to the identification and management of fatigue when work includes early starts, or long work hours, or late finishes and involves driving. This includes the responsibility to arrive fit for work and monitor for fatigue-related impairment while at work, which includes not being fatigued to the extent that their alertness and ability to safely drive is impaired. In addition, if a worker does not feel they are fit to drive safely at work, they have a responsibility to notify their employer of this. The worker must also be provided with information on the organisational processes to be followed if they are too fatigued to drive.

Because of the relative complexity of this topic, information must be tailored to the issues relevant in a workplace, be provided at a level that enables the worker to understand the concepts, and via a medium that the worker will engage with. This education should also be provided to those individuals in an organisation who make decisions about resourcing that might influence the management of fatigue and driving-related fatigue risks, those developing fatigue management processes for managing driver fatigue, and those who are responsible for scheduling work that involves driving. It should occur as part of workplace-related training and therefore should include competency assessment, be recurrent, and a record of completion should be kept.

RECOMMENDATION 2

It is recommended that employers have a process for workers to follow if they are too fatigued to commence a driving-related task or continue with a driving-related task.

This process should be clear and well communicated and not only include what a worker should do if they are too fatigued to begin driving-related work but also outline what workers should do if they experience fatigue while driving. It is suggested that the process include:

- who the worker should notify (e.g., manager, health and safety person),
- what information the worker needs to provide (e.g., where they are, what tasks they were completing, any other hazards they may be exposed to),
- what actions the worker needs to take (e.g., stop driving or stop work tasks, change to other tasks, take a short break, finish work for the day), and
- when they can return to driving and other work tasks (e.g., after a short break, after a night-time sleep opportunity).

When a worker is driving, in addition to the above, the process must also include:

- stopping the vehicle as soon as possible in a safe location,
- either taking a nap (in a location other than the driver's seat) or being provided with alternate transport that does not require them to drive, and
- if driving is allowed to continue after a nap, an assessment of the worker's fatigue level before driving recommences.

In conjunction with establishing a process for workers to follow, employers must also create an environment where a worker feels supported and encouraged to notify them if they are not fit drive or continue to drive due to fatigue, without repercussions for their employment.

RECOMMENDATION 3

When driving is required as part of the work task, it is recommended that employers make a clear distinction between the time required to drive from one location to the next and time for rest breaks.

This recommendation is to ensure that rest breaks are appropriately scheduled within the work day and can occur as planned. In addition, where possible, adequate locations for rest between periods of work should be provided. Ideally, this should be a location where a worker is removed from the place of work for a period of time, there is access to refreshments, and there are facilities so that they can physically rest.

RECOMMENDATION 4

It is recommended that employers obtain information on the timing, duration, frequency and nature of any secondary employment so that driving-related fatigue risks can be identified and managed.

When work is arranged so that it consistently occurs early or late in the day and total work hours per week do not constitute full-time employment, employers must consider the risk of workers undertaking secondary employment. A fulltime employee may also seek secondary employment. The fatigue risk that secondary employment poses for driving safely, is likely best managed through effective worker education (see recommendation 1), and a process whereby employers enquire about secondary employment at recruitment and require existing workers to declare any new secondary employment. The information an employer requires about secondary employment should include the specific timing, duration, frequency, and nature of the employment. This enables the employer to identify possible driving-related fatigue risks in their own work setting and, if necessary, put in place appropriate measures and controls. This recommendation is not intended to absolve workers of their responsibilities to ensure they are fit for work, which includes not being fatigued to the extent that their alertness and ability to safely perform their work-related duties are impaired.

RECOMMENDATION 5

It is recommended that government agencies, in collaboration with appropriate industry organisations, develop fatigue management resources and provide opportunities for fatigue management training for employers and their workers.

Because fatigue science is a complex topic, and educational information must be accurate and well-designed to be effective, it is unreasonable to expect employers to develop and provide educational material without support. Appropriate government agencies should develop comprehensive, high-quality material that could then be tailored by industry organisations and employers to their industry and

organisation, respectively. The audience, delivery modes, content, frequency of delivery and assessment of this training has been outlined in recommendation 1 above.

RECOMMENDATION 6

It is recommended that government agencies in collaboration with appropriate industry organisations assist employers to develop processes for the management of driving-related fatigue.

Recommendation 2 states that employers should have clear and well communicated processes for workers to follow if they are too fatigued to start or continue safely driving for work. In line with recommendation 5, it is unreasonable to expect employers to develop effective and comprehensive driving-related fatigue management processes in isolation and without support. The development of processes to manage driving-related fatigue should be led by government agencies in collaboration with industry organisations. Individual employers may then need to modify these for use within a particular organisation.

RECOMMENDATION 7

It is recommended that government agencies and industry organisations collaborate with employers to identify cross-industry issues that may increase the likelihood of driving-related fatigue and consider whether there are changes that could be made to reduce driving-related fatigue risks.

As an example, in the industries where this accident occurred (food and grocery, and supply chain), consideration should be given to factors such as when goods need to be collected and delivered and when merchandising needs to occur. Clearly such activities must meet the needs of suppliers, supermarkets and their customers but should also be balanced with the driving-related fatigue risks that are created for those that provide the goods and services.

VI. I am satisfied that if Professor Signal's recommendations are made public and followed this could prevent further deaths like Mr Dinakaran's in the following ways:

a. for workers who drive, bringing about changes in working hours and opportunity for rest which reduce the likelihood of them of being fatigued when needing to drive; and

b. bringing about changes in workplace training, systems and processes which make it more likely that workers will choose not to drive when dangerously fatigued and ensure that the risks involved in driving when fatigued are effectively managed.

VII. There is a strong imperative to take action to reduce the incidence of death and serious injury arising from crashes caused by drivers' fatigue. Waka Kotahi reports that in 2020 20 deaths and 113 serious injuries sustained on New Zealand roads were related to driver fatigue.

VIII. I have considered what method would best publicise and advance Professor Signal's recommendations, which are directed to all those operating businesses involving driving, and associated industry organisations and

government organisations. Accounting for the range of industries and the number of organisations and individuals targeted by Professor Signal's recommendations, I consider WorkSafe and Waka Kotahi have the mandate, resourcing, authority and powers to most effectively lead the advancement, and publicise the contents, of the recommendations.

IX. Accordingly, under s57A of the Act and for the reasons given at [XVI] to [XVIII] above, I make the following recommendation:

Coronial Recommendation 1:[53]

Within the next two years WorkSafe and Waka Kotahi work together with relevant industry organisations and fatigue science experts to develop, and make publicly available, comprehensive risk management resources, services and training opportunities for businesses and their workers on the topic of driving when fatigued.

Coronial Recommendation 2:[54]

Within the next two years WorkSafe and Waka Kotahi lead collaboration between government organisations, industry organisations and relevant businesses to identify and address cross-industry issues which increase the likelihood of workers driving when fatigued.

X. WorkSafe and Waka Kotahi were provided with a provisional version of these findings which included the two coronial recommendations above as well as a third recommendation addressed at [XIII] below. WorkSafe responded on behalf of both itself and Waka Kotahi, with which WorkSafe consulted. In response to Coronial Recommendation 1 and the third proposed recommendation WorkSafe advised:

> In mid-2021 we refreshed our suite of fatigue-related guidance by supplementing the existing fatigue guidance and online information with a Good Practice Guide *'Managing the risks of shift work'* and Guidance for workers *'Keeping safe and healthy when working shifts'*. These resources were developed with the assistance of the Sleep/Wake Research Centre based at Massey University and included cross-organisation, industry and public consultation.
>
> There are many options within the market for a Person Conducting a Business or Undertaking (PCBU) to access fatigue training for their workers as a part of their risk management requirements under the Health and Safety at Work Act (HSWA). The Act also calls out the PCBU's primary duty of care to ensure, as far as reasonably practicable, the health and safety of their workers and any other people who are influenced or directed by the PCBU. To meet their Health and Safety duties PCBUs must effectively manage risks that arise from their work.
>
> Waka Kotahi advised it is in the process of refreshing its external online fatigue pages in consultation with a sleep specialist. It has recently completed a pilot of a shift worker driver fatigue tool that may eventually be made available to businesses. We are also in the process of reviewing and re-releasing our fatigue calculator which allows anyone to self-assess their level of fatigue before driving.

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[53] Refer Professor Signal's recommendations 1 to 6. This recommendation changes the reference to "employers" in the version first proposed to "businesses" as this better captures the targeted groups, which includes contractors.

[54] Refer Professor Signal's recommendation 7. This recommendation changes the reference to "employers" in the version first proposed to "businesses" as this better captures the targeted groups, which includes contractors.

> Waka Kotahi and WorkSafe will continue to collaborate with each other, unions, industry and other government departments to reduce the risk of work-related road activity.

XI. In response to Coronial Recommendation 2 WorkSafe advised:

> WorkSafe and Waka Kotahi continually work towards bringing government, unions and industry together working on cross-industry issues around risk while driving. Following recommendations of its commissioned report of safety in the supply chain, we established an ongoing tripartite group within transport to meet and work on safety issues. Work continues around how to broaden the effect of this work with Waka Kotahi.

XII. I consider that neither of WorkSafe's responses warrant amendment to Coronial Recommendations 1 and 2.

XIII. I had proposed making the following third recommendation directed towards GWF which was based upon Professor Signal's recommendations 1 to 4:

GWF immediately makes arrangements to:

a. provide to its workers whose jobs involve driving ("workers who drive") education on what fatigue is and what causes it, the impact of fatigue on driving safely, and how to manage the risks of driving when fatigued;

b. develop and implement an effective process for workers who drive to follow if they are too fatigued to commence, or continue with, a driving-related task;

c. ensure a clear distinction is made and communicated between the time a worker is required to drive between locations and time for rest breaks; and

d. obtain from its current, and future, workers who drive up to date information about the timing, duration, frequency and nature of any secondary employment to assist in the identification and management of the risks of driving when fatigued.

XIV. This third proposed coronial recommendation is relevant to all those operating businesses that involve driving. Accounting for the impracticality of consulting, under s58B of the Act, with such a wide group, I reached the view that WorkSafe and Waka Kotahi were better positioned to effectively advance the substance of this recommendation, something which falls within the scope of Coronial Recommendation 1. It was for this reason that I proposed to direct the third coronial recommendation towards only GWF.

XV. GWF, through its lawyers, took issue with the third coronial recommendation I proposed making for the following reasons. First, it is relevant to all employers and so should not be directed to only GWF. Second, it is unnecessary due to the steps GWF has taken since the collision, and has committed to take in the future now having the benefit of Professor Signal's recommendations, to manage the risk of employees driving whilst fatigued.

XVI. Some of the steps GWF reported it has already taken are addressed […] above. The future steps GWF has committed to take include:

a. Immediately adding to its "e-learning platform" a learning module specific to fatigue which reflects the recommendations of Professor Signal and which will be rolled out to all GWF employees;

b. Adapting the time recording application it uses, iMobi, to record all hours worked by its merchandisers (both for GWF and in secondary employment) to allow for the monitoring of the total hours worked and notification to managers when that total poses a risk of fatigue. This will better enable steps to be taken to mitigate that risk, as required; and

c. Ensuring merchandisers receive regular fatigue related notifications and reminders using options such as automated text-messages or an alert on iMobi.

Through its lawyers GWF has indicated its willingness to contribute to the development of new guidance in relation to sleep debt linked fatigue for all employers. I consider these initiatives, in combination with those GWF reported it has already taken, largely address the substance of the third proposed coronial recommendation.

XVII. Due to the scope of Coronial Recommendation 1 and the commitment by GWF to further action to improve management of the risk of workers driving when fatigued I have decided to make no further coronial recommendations. I do not consider the third coronial recommendation I proposed making would do significantly more to prevent further deaths like Mr Dinakaran's than that likely to be achieved by the implementation of Coronial Recommendation 1 and the future steps GWF has committed to take.

Summary of findings and recommendations

XVIII. I find that Perumal Dinakaran, born 2 July 1994 and late of 301 Kennedy Road, Onekawa, Napier, died on 24 May 2018 on the Hawke's Bay Expressway (State Highway 50A) between Links Road and Evenden Road. Mr Dinakaran's cause of death was a head injury sustained as a result of a head on collision between the Suzuki Swift he was driving and an oncoming Mercedes Benz logging truck. The collision was caused by Mr Dinakaran's vehicle drifting into the lane of the truck due to his fatigued state. Mr Dinakaran had become fatigued due to the timing and duration of his working hours across two jobs. Neither Mr Dinakaran nor his employer, GWF, had taken adequate steps to effectively manage the risks of driving whilst fatigued, which include the risk of a fatal collision.

XIX. Under s57A of the Act I make the following recommendations based upon the seven recommendations of Professor Signal:

Coronial Recommendation 1:[55]

Within the next two years WorkSafe and Waka Kotahi work together with relevant industry organisations and fatigue science experts to develop, and make publicly available, comprehensive risk management resources, services and training opportunities for businesses and their workers on the topic of driving when fatigued.

Coronial Recommendation 2:[56]

Within the next two years WorkSafe and Waka Kotahi lead collaboration between government organisations, industry organisations and relevant businesses to identify and address cross-industry issues which increase the likelihood of workers driving when fatigued.

[55] Refer Professor Signals recommendations 1 to 6.
[56] Refer Professor Signal's recommendation 7.

XX. I am satisfied that if made public and followed these recommendations, accompanied by Professor Signal's recommendations, could prevent further deaths like Mr Dinakaran's in the following ways:

a. for workers who drive, bringing about changes in working hours and opportunity for rest which reduce the likelihood of them of being fatigued when needing to drive; and

b. bringing about changes in workplace training, systems and processes which make it more likely that workers will choose not to drive when dangerously fatigued and ensure that the risks involved in driving when fatigued are effectively managed.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Dinakaran entered into evidence, upon the grounds of personal privacy and decency.

OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND