OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments made between **1 October** and **31 December 2023**

Office of the Chief Coroner | 2023 (4)

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 Chief Coroner is required by law to maintain a public register of these recommendations and comments. The Office of the Chief Coroner publishes summaries of those which are not prohibited from being published by order of the court or by law. Recommendations Recap includes all those recommendations and comments which have been summarised and published. This edition includes 50 findings with recommendations and/or comments issued by Coroners between 1 October and 31 December 2023.

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Recommendations and comments

1 October to 31 December 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/

Aviation

Jones [2023] NZCorC 142 (9 November 2023)

CIRCUMSTANCES

David Stanley Jones, aged 48, died on 11 December 2013 in the Westland Blocks of 1314 Domett Road, Cheviot. The cause of death was the effects of fire and inhalation of smoke and fumes following a light helicopter crash.

On 11 December 2013 Mr Jones was the pilot flying a Robinson R22 Mariner helicopter on an agricultural spraying operation in Domett, North Canterbury. The helicopter crashed and caught fire. Mr Jones was found dead in the wreckage.

The Civil Aviation Authority (CAA) investigated the crash and concluded that the parallel ground scars found along the hillside fall line, made after the initial contact with the terrain, were likely attributed to Mr Jones levelling the aircraft and discontinuing the spray run after finding that clearance from the ground had been significantly compromised. Mr Jones' actions to recover appeared consistent with realising a problem existed, then electing to fly out of the situation. An immediate jettison of the load may have been beneficial to avoid contact with terrain, however this did not occur. Having contacted terrain, the helicopter's tail boom flexed sufficiently to make contact with the main rotor blades, which subsequently led to the total destruction of the helicopter.

The CAA identified factors it considered likely to have contributed to the crash. Those factors were:

(a) The inherent risks of low level operational manoeuvres;

(b) The helicopter's weight and balance being outside the Flight Manual limitations;

(c) Inaccurate weight and balance information being provided to Mr Jones, post installation of equipment, including spray equipment and GPS systems;

(d) Inaccurate data provided to the CAA during the testing and certification of the Helipod III spray system modification; and

(e) A lack of robust CAA appraisal and approval of the Helipod III modification.

John Fogden provided expert advice. In his view, an unexpected event occurred which resulted in Mr Jones being momentarily distracted from his primary task of maintaining safe separation from the ground, and the helicopter unexpectedly contacting the ground with some degree of forward speed. Mr Fogden also noted that technology now allows for small and relatively inexpensive cockpit video, audio and data recording devices in small helicopters and aircraft to record cockpit instrument readings and pilot inputs to flight controls. If such information can be recovered following the crash, it can potentially provide information that will identify an active failure, act, or condition.

Mr Fogden advised that the fitting of that technology is a standing safety recommendation of the New Zealand Transport Accident Investigation Commission (TAIC) to the CAA, having been made in July 2016. He noted that it remains open.

That recommendation suggests that the Secretary for Transport promote, through the appropriate International Civil Aviation Organisation forum, the need for cockpit video recorders and/or other forms of data capture in the cockpits of certain classes of helicopter. The reply text records that the Director of Civil Aviation is prepared to accept the recommendation but with the caveat that reflects the response of the Secretary for Transport, namely that the Director conduct a safety and cost benefit exercise of installing flight data and/or cockpit video on certain classes of helicopters. It was recorded that the Director would initiate an issue assessment paper on recording devices for certain classes of helicopter, but that the timeframe of such a study was likely to be lengthy and the Director could not provide a completion date “at this stage”. The status of the recommendation is recorded as “open”.

RECOMMENDATIONS OF CORONER DUGGAL

I. At some stage during the crash sequence, the fuel tanks were ruptured, resulting in the fire which caused Mr Jones’ death: he died due to the effects of fire and inhalation of smoke and fumes, with only modest impact injuries reported by Dr Sage, the pathologist.

II. At the time of the crash, a retrofit internal fuel bladder system was being prepared for release for RHC R22 helicopters. The Directive mandating its installation in R22s came into effect on 22 March 2018, with the aim of improving the fuel tanks’ resistance to post-accident rupture and fuel leaks which could result in a non-survivable fire. Installation was required at the next 2200 hour helicopter overhaul, the 12 year inspection, or by 15 January 2020, whichever came first, unless previously accomplished.

III. Given that Directive, I do not consider it necessary to make any comments or recommendations pursuant to section 57(3) of the Coroners Act 2006 in relation to that issue.

IV. I note, however, that the TAIC recommendation to the Director of Civil Aviation in relation to flight data and/or cockpit video in certain classes of helicopters remains open.

V. The absence of any such data has precluded determination of the cause of the crash of Mr Jones’ helicopter. The availability of such data in future may provide information, for example, the effect of certain weather changes or

conditions, mechanical issues, or the cause of pilot distraction, which, if published among those flying helicopters, would reduce the chances of further deaths occurring in circumstances similar to those in which Mr Jones died.

VI. Accordingly, I recommend that the Secretary for Transport complete the issue assessment paper on recording devices for certain classes of helicopters referred to in TAIC recommendation 015/16 and promote the need for cockpit video recorders and/or other forms of data capture in the cockpits of certain classes of helicopter, including the R22.

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.

Wilson [2023] NZCorC 138 (7 November 2023)

CIRCUMSTANCES

Noel Edward Wilson, aged 51, died on 27 March 2017 at bushland near Blairs Road, Cronadun near Reefton of high energy impact injuries to chest, face, pelvis and limbs sustained in a helicopter crash.

On the evening of 27 March 2017, Mr Wilson was flying his Robinson R22 helicopter alone, carrying a slung load as part of a hunting operation near Reefton. Shortly after take-off, while climbing over densely forested terrain, the helicopter crashed. Mr Wilson died instantly on impact.

The Transport Accident Investigation Commission (TAIC) investigated the crash and identified potential contributors to the crash, namely inadvertent contact with the tree canopy, low rotor speed, environmental conditions, and inadequate maintenance. TAIC also found the engine showed signs of wear and tear which were inconsistent with the hours recorded in the logbook.

The Coroner commissioned a helicopter expert, John Fogden, to explore whether directing further evidence and/or inquest was likely to further illuminate the circumstances surrounding Mr Wilson's death. Mr Fogden's advice was that this was unlikely to be the case.

RECOMMENDATIONS OF CORONER TELFORD

I. As discussed above, under the Act, Coroners carry out the important function of helping to reduce the chances of further deaths in similar circumstances through the making of comments or recommendations in appropriate cases.

II. In this regard, Mr Fogden refers me to several previous coronial inquiries in which the Coroner has made recommendations to the Secretary of Transport promoting the need for the mandatory fitment of cockpit video recorder systems (CVRS) in helicopters. The obvious aim of these recommendations is to provide crash and death investigators with valuable information to help explain what has happened when things go wrong and take action to prevent future deaths.

III. Most recently, Coroner Cunninghame concluded an extensive inquiry into a Queenstown helicopter crash (Robinson R44) in 2015.[1] Whilst the circumstances in that case were somewhat different, of particular interest is Coroner Cunninghame's findings in relation to the design of Robinson helicopters and their particular susceptibilities. These findings obviously have some applicability to this instant case and readers are referred to them for consideration in full.

IV. Coroner Cunninghame also reiterated previous coronial recommendations in relation to the development of CVRS.[2] Helpfully, in this case, the director for the CAA advised:[3]

> *The CAA is, and always has been, supportive of the use of cockpit video recording systems and the Coroner's views as to their potential to deliver significant safety improvements are consistent with those of the CAA. The CAA has made submissions in support of recommendations for the use of these systems in a number of previous inquests. … A recommendation that there should be a change in the Civil Aviation Rules would be more effectively made to the Minister of Transport.*

V. Accordingly, Coroner Cunninghame recommended that the CAA and TAIC seek the involvement of stakeholders including the Ministry of Transport and prioritise the implementation of a programme of work to achieve the mandating of CVRS in all helicopters in New Zealand. The coroner also recommended that all owners and operators of helicopters in New Zealand install CVRS devices as soon as reasonably practicable (ie. before it is made mandatory). I wholeheartedly reiterate and endorse those recommendations.

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

Drowning

Cash [2023] NZCorC 155 (6 December 2023)

CIRCUMSTANCES

Francis William Cash, aged 46, died on 8 December 2022 near Tamateatai Point, Whangaruru Harbour, Northland of drowning.

Francis lived with his partner on a property at Tokitoki which could only be accessed by boat at high tide. On 8 December 2022 Francis, his partner and a friend, loaded their three metre dinghy with groceries, blankets and a small backpack and set out. They were not wearing life jackets.

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[1] CSU-2015-DUN-000059/60 (A joint inquiry into the deaths of Stephen Anthony Nicholson Combe and James Louis Patterson-Gardner)

[2] Ibid, at paragraphs 238 and 248

[3] Ibid, at paragraph 345

About five minutes into the crossing, south of Tamateatai Point, a wave swamped their dinghy. The motor stopped working and the dinghy capsized. They held onto the overturned dinghy until it sank. The group then started to make for shore but became separated, with the friend reaching land by himself.

Francis and his partner used a blanket as a buoyancy aid. When the blanket began to sink under their combined weight, Francis let go to allow it to support his partner alone. Francis' partner saw a tree on the shore and made her way towards it. She heard Francis say "we're nearly there" but when she grabbed hold of the tree and turned around Francis was no longer there.

The alarm was raised. Coast Guard found Francis' body shortly afterwards washed up on the beach around the corner from Tamateatai Point.

Maritime New Zealand investigated. It could not determine what caused the dinghy to capsize, but overloading and choppy seas were likely contributing factors. Most three metre dinghies are not suited for carrying three adults except in very calm conditions. MetService forecast and wind readings for 8 December 2022 indicate there were choppy seas. Parts of the crossing were particularly exposed to easterly winds and seas.

COMMENTS OF CORONER HO

I. Regulations require occupants of vessels less than six metres in length to wear life jackets. Maritime New Zealand also recommends that boaters carry at least two means of waterproof communication so that they can call for help if required. Francis' death is a reminder of the importance of life jackets and waterproof means of communication.

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

Harrop [2023] NZCorC 148 (21 November 2023_

CIRCUMSTANCES

Dale Simon Harrop, aged 33, died on 17 December 2022 at Muriwai Beach, Auckland of drowning.

At 3:00pm on 17 December 2022 Dale and a group of friends arrived at Muriwai Beach to go surfing. The surf conditions were described as "tricky and challenging" and only suitable for experienced surfers. The group surfed for about 40 minutes without incident before the strong current pushed them towards the rocks. Recognising some of the group were in distress, lifeguards came to their aid. After returning two of the group to shore the lifeguards found an unmanned surfboard in the water. As they approached the surfboard a body appeared. The surfer, later identified as Dale, was retrieved from the water unconscious and unresponsive. CPR was administered on shore but Dale could not be revived.

COMMENTS OF CORONER FITZGIBBON

I. The Surf Lifesaving New Zealand report identified some recommended safety messaging to prevent another drowning in similar circumstances:

- If you see someone in trouble, call 111 and ask for the Police.
- Know your limits. Don't overestimate your ability in the water.

II. I make no formal recommendation in relation to Dale's death but highlight the safety messaging identified by Surf Lifesaving New Zealand.

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

Kelly [2023] NZCorC 132 (27 October 2023)

CIRCUMSTANCES

Daniel Hamer Kelly, aged 18, died between 22 and 23 April 2023 at Karioitahi Beach, Waiuku of accidental drowning.

On the morning of 22 April 2023, Daniel told his brother that he was going to drive from Papamoa where he lived to Karioitahi Beach for the day. His parents said that it was not unusual for Daniel to go on long day trips.

Later in the afternoon, a member of the public, Brett, was driving on the beach. He saw a young man, later discovered to be Daniel, driving his car on the sand at Karioitahi Beach about 50 to 60 metres past the waterfall. This was the last time Daniel was seen alive.

Another member of the public said he had been in the water that afternoon and described the current as very strong and dangerous. He said that the water looked like there was a rip directly in front of where Daniel's car was parked. At about 5:45pm, Brett drove past the waterfall again. He saw Daniel's car parked near the waterfall entrance facing towards the surf club. He saw a little white dog by the bonnet looking towards the water. He could not see anyone inside the car.

On 24 April 2023, a member of the public called the police after noticing that the car was cold, and no one was nearby. Police attended and found Daniel's sandals 20 metres in front of his car in the direction of the water. There were two empty and one partially consumed cans of alcohol in Daniel's car.

A search and rescue operation was initiated on 24 April 2023. The land surrounding Karioitahi Beach was searched first, followed by police Eagle helicopter and Coast Guard searches over the following two weeks. Daniel was not found, and the search was suspended on 15 May 2023.

Daniel had not presented to any hospitals, accessed his bank accounts, contacted any friends or family, or requested any shifts from his employer since he disappeared. As a result, the Coroner determined that Daniel died of accidental drowning.

Surf Lifesaving New Zealand reported that swimmers were exposed to many hazards at Karioitahi Beach on 22 April 2023 including waves ranging from 1.5 to 2.4 metres, long swell periods, strong currents, and sudden changes in water depth caused by inshore holes. Low tide that day was at 5:02pm and the tide was probably low at the estimated time when Daniel entered the water. During low tide, there are often powerful currents, and it is likely there were sudden variations in the depth of water between the sandbar's perimeter and the deeper inshore holes. The 1.5 to 2.4 metre high

waves, combined with the strong currents, changes in water depth and the low stage of the incoming tide created a high-risk environment for swimmers at the beach.

COMMENTS AND RECOMMENDATIONS OF CORONER MILLS

I. I make the following comments and recommendations pursuant to section 57A of the Coroners Act 2006.

II. I have found that Daniel has died accidentally by drowning. Coastal drownings have continued to increase in New Zealand and surf beaches pose the greatest risk. In the ten years from 2011 to 2021, 38% of beach and coastal fatal drownings in New Zealand occurred at a surf beach.[4] 28% of beach and coastal fatal drownings in the year 2020 to 2021 occurred while swimming or wading.[5]

III. Karioitahi beach, where Daniel drowned, has been described as "one of the most dangerous beaches, top 10 dangerous beaches in New Zealand".[6] Five people have drowned there since 2020. It is known to have strong currents, rips, and deep holes. The evidence before me suggests that there was a significant rip directly in front of where Daniel had parked his car and where he probably entered the water.

IV. Surf Life Saving New Zealand identified that rip currents pose the greatest hazard at a surf beach.[7] Rips are caused by waves bringing water into shore, and the water needing a quick route out to sea. Greater public education about how to recognise rips will help reduce further deaths occurring at our surf beaches. I therefore reiterate the four main features of a rip:[8]

- **Calm patches in surf** with waves breaking each side. The calm gap may look safe to swim but a small patch of calm water in amongst surf or waves is often a rip current.
- A **ripple pattern** on the sand or small holes beneath your feet in the water.
- **Discoloured or foamy water**. Regions of deeper, darker water with less wave breaking activity between areas of white water are like rivers of the sea. The discoloration is created by the current picking up sand in the water as it moves out to sea.
- **Rocky Headlands and Rocky Groins**. Rip currents are also common in areas with piers, jetties and anything else that sticks out from the beach that could catch a longshore current and cause it to start flowing away from shore.

V. Surf Life Saving New Zealand also provided some recommended safety messaging to help prevent other drownings. I reiterate and reinforce the following messages:

- Choose a lifeguarded beach and swim between the flags;

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[4] Surf Life Saving New Zealand, "National Beach and Coastal Safety Report", at pg 3.

[5] At pg 59.

[6] Karioitahi Beach drownings: Surf lifesavers plead with beachgoers to only swim during patrol hours | Newshub

[7] At pg 4.

[8] Surf Lifesaving NZ - Rips

- Don’t overestimate your ability or your children’s ability to cope in the conditions;
- Watch out for rip currents as they can carry you away from the shore. If caught in a rip current,
    - **RELAX** and float,
    - **RAISE** your hand to single for help,
    - **RIDE** the rip until it stops, and you can swim safely back to shore. Remember – nobody is stronger than a rip and the rip will only take you out past the last breaking wave;
- If in doubt, stay out.

VI. Previous Coroners have already made recommendations about additional signage at the Karioitahi Beach to warn of the dangers.[9] As a result of those recommendations Auckland Council has installed three new signs on the beach to warn visitors of the risk of strong currents and rips, large waves, deep holes and unstable cliffs. I encourage the public to take heed of the signage at all beaches, particularly at Karioitahi Beach which has been the location of too many tragic drownings.

Laki [2023] NZCorC 165 (15 December 2023)

CIRCUMSTANCES

Valentino Laki, aged 16, died on 14 January 2018 at the Rangitikei River near Bulls. The cause of his death was presumed drowning.

On 14 January 2018 Valentino and his family arrived at the Rangitikei River near Bulls where they met a group of friends and other family members. The group noticed that the river water was very dirty but did not think it looked “overly dangerous”, as some of them had swum there many times before.

Valentino entered the muddy waters. He was not a strong swimmer and was tragically swept away by the current as he and his friends tried to move to calmer waters. Valentino struggled with the current before sinking under the surface. He did not come back up.

Members of the Police National Dive Squad located Valentino’s body on the riverbed on 15 January 2018.

COMMENTS OF CORONER WILTON

Water safety messages and advice

I. I am mindful of the timing of these Findings and any publication of the same as we approach the summer holiday period for the end of this year and the start of 2024. I record that Valentino’s death occurred in the summer of

[9] See for example *In the matter of an inquiry into the death of Simapreet Singh* CSU-2021-AUK-1364, 20 October 2022

January 2018. This is a time when traditionally, many people engage in recreational water activities involving rivers. Accordingly, I considered the following water safety messages and advice below.

II. Water Safety New Zealand states that swimming in rivers is fun but can be dangerous. Many people do not understand the force of water in a river. If you swim out of a swimming hole into the river current, you can be swept down the river by the force of the water. You could be pulled underwater by the force of the current. The current can be strong even if the river looks calm and the water is slow moving. It can also be difficult to tell how deep a certain part of the river is.

III. Water Safety New Zealand advises in a 'Be River Safe, Swimming in Rivers Fact Sheet' that a good swimming spot has the following:[10]

- Only a very weak current.
- An easy place to get in and out of the water.
- An even bottom that you can see.
- A place you can get out of the water easily in case you get swept downstream.

IV. A good swimming spot does not have muddy water where you cannot see the bottom.

V. Key messaging from Water Safety New Zealand to be river safe is:

- Know your environment.
- Supervise children and learners.
- Stop and think before you enter the water.

Endorsement of water safety messages and advice

VI. After having given due consideration to all the circumstances of Valentino's death, I make no recommendations. I do, by way of comment, endorse Water Safety New Zealand's water safety messages and advice outlined above pursuant to section 57A of the Coroners Act 2006 in the hope that, if drawn to public attention, it may increase the awareness of safe river swimming and reduce the chances of further deaths occurring in similar circumstances to Valentino's.

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

[10] From: https://www.watersafetynz.org/_files/ugd/6f2a10_26c4cd0c38424d3ca26ab3a686bf373d.pdf

Lyall [2023] NZCorC 136 (31 October 2023)

CIRCUMSTANCES

Norman John Lyall, aged 77, died between 22 June and 25 June 2021 at Lucas Creek, Greenhithe, of drowning, in a setting of alcohol toxicity and decreased mobility.

Mr Lyall lived alone on his 45-foot wooden sloop, which was anchored off a private pier in Lucas Creek, Greenhithe. Mr Lyall was a very experienced sailor and boat repairer. He had a history of alcohol abuse and was suffering from significant shoulder injuries that restricted his ability to lift his arms above shoulder height.

On 22 June 2021 at Mr Lyall left his boat to complete maintenance work on another boat in Westhaven Marina. At 6:24pm he sent a message to his employer informing him that the work had been completed. He returned to his own boat sometime after 8:00pm and filled in the invoice for the completed work. He also consumed some alcohol.

Following this, Mr Lyall returned to the dock on his dinghy, not wearing a lifejacket. At some point, he placed his belongings on the dock and whilst tying up or getting out of his dinghy he fell into the water. Being intoxicated and due to his extensive shoulder injuries, he was unable to swim and manoeuvre himself back on to his dinghy or the dock.

At 10:50am on 25 June 2021, Search and Rescue located Mr Lyall's body on the mudflats on the northeast side of Lucas Creek. He was deceased. Toxicology testing detected alcohol in Mr Lyall's blood at a concentration of 204mg/100ml. By comparison, the legal blood alcohol limit for a driver 20 years of age or older is 50mg/100ml.

COMMENTS OF CORONER MILLS

I. Mr Lyall was a very experienced yachtsman who lived on his boat and who loved and knew the ocean. He appears to have died as a result of doing something he did daily - rowing from his boat to the jetty and tying up his dinghy. However, he was not wearing a life jacket and had consumed alcohol at the time of his death which is known to be a lethal combination.

II. I endorse and repeat the key safety messages promoted by Maritime New Zealand that when on a boat, especially a vessel less than six metres long:

- wear a correct sized personal floatation device;
- check the marine weather;
- carry emergency devices; (at least two forms of waterproof communication)
- avoid alcohol; and
- be a responsible skipper.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Mr Lyall during this inquiry, in the interests of decency.

Meehan [2023] NZCorC 160 (8 December 2023)

CIRCUMSTANCES

Perry Brian Meehan, 60, died on 26 December 2019 at Onemana Beach of drowning. The manner of death was accident.

On 26 December 2019, Perry went to Onemana Beach with his family and dog. They set up a spot outside the swimming flags to comply with the beach's dog restrictions.

Perry and his daughter's partner went in for a swim. The waves were big so they decided not to go in too deep, however, after about five minutes, a set of waves dragged them both out to the point where their feet could not touch the seabed. Perry started to panic. His daughter's partner assisted him, but they were continuously swamped by a series of waves which would pull them both under before "popping" them back out to the next wave. The waves eventually started to subside, and his partner was able to swim them both back to shore. A lifeguard was alerted to the situation and came to help, but it was too late.

COMMENTS OF CORONER HO

I. Perry's death is a reminder that sea conditions can change rapidly and can lead to swimmers being trapped in a situation which they did not foresee. It is useful to reiterate safety messaging about safe swimming, especially ahead of the upcoming beach season:

- Choose a lifeguarded beach and swim between the flags.
- Do not overestimate your ability or your children's ability to cope in the conditions.
- Watch out for rip currents which can carry you away from shore. If caught in a rip current, RELAX and float, RAISE your hand to signal for help, RIDE the rip until it stops and you can swim safely back to shore. Remember – nobody is stronger than a rip.
- If in doubt, stay out.
- If you see someone in trouble, call 111 and ask for police.

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

Drugs and Alcohol

Richards [2023] NZCorC 127 (16 October 2023)

CIRCUMSTANCES

Bianca Marie Richards, aged 51, died on 8 April 2022 at North Shore Hospital of multiorgan failure following presumed diethylene glycol toxicity.

On 29 March 2022 Ms Richards' flatmate rang emergency services as Ms Richards was delirious and struggled to breathe. She was taken to North Shore Hospital with abdominal pain. Initial investigations indicated a marked metabolic acidosis. Ms Richards was transferred to acute medical care with renal (kidney) failure. Her condition continued to deteriorate. On 8 April 2022 aggressive care was withdrawn and Ms Richards died. Ms Richards' medical practitioners believed the cause of death was likely to be diethylene glycol poisoning ingested as a contaminant in gammahydroxybutyric acid (GHB).

Ms Richards' friend reported that approximately four to five days before her admission to hospital, she had been on a "Wazz" binge. "Wazz" is a commonly used street name for GBL (gamma-butyrolactone) a colourless, water like liquid drug used to achieve euphoric effect. It is a precursor to GHB (gamma-hydroxybutyrate) which is what GBL is converted to once ingested by the body. Ms Richards had been seen taking it using a syringe that she would put into her mouth. She was known to be a frequent user and using more than a few millilitres.

COMMENTS OF CORONER TETITAHA

I. I make the following comments pursuant to section 57A of the Coroners Act 2006:

II. The Drug Information and Alerts Aotearoa New Zealand (DIANZ) is a function of the National Drug Intelligence Bureau comprising the Ministry of Health, Customs and New Zealand Police. DIANZ publicises drug information and alerts within New Zealand by way of an online website called High Alert.

III. It is recommended that people not take diethylene glycol (DEG) or GBL (Gamma-Butyrolactone) or GBL type substances. The GBL drugs have been found to contain DEG which is found in industrial products such as antifreeze, brake fluids, wallpaper strippers and a plasticiser.

IV. DEG can be identified as a viscous liquid that is clear, colourless, practically odourless and has a sweetish taste.

V. Drug checking services can test for diethylene glycol. KnowYourStuffNZ and the New Zealand Drug Foundation run regular drug checking clinics in Auckland.

VI. I make no recommendations given the above information and alerts are already available regarding the risks of taking possibly adulterated drugs.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Ms Richards during this inquiry, in the interests of decency.

Leisure Activities

Brown [2023] NZCorC 154 (6 December 2023)

CIRCUMSTANCES

Isaac Miles Brown, aged 33, died on 15 September 2019 at Makarori of drowning.

On 15 September 2019, Mr Brown and his cousin decided to go freediving for kina off the coast at Makarori, near Gisborne. Their friend drove them by boat to a spot near a reef, south of their launching point. Mr Brown was wearing a full wetsuit, divers' booties, flippers, and a weight belt when he entered the water. The weight belt was fully belted, with five or six weights on it. Once Mr Brown and his cousin were in the water, the boat's driver left the area intending to fish in a calmer spot.

When Mr Brown entered the water, conditions were quite rough. Once in the water he encountered difficulty, and his cousin observed him struggling to stay afloat, with his head going under the water. The cousin told Mr Brown to remove his weight belt, which he did not do. The cousin tried to assist Mr Brown, but rough conditions caused him to lose his grip. The cousin swam to the reef and a search ensued for Mr Brown. He was found deceased later that night.

Toxicology testing undertaken on samples of Mr Brown's blood identified the presence of THC, the active ingredient of cannabis.

Police National Dive Squad investigated the incident and noted that the amount of weight on Mr Brown's belt, the description of his struggles to stay afloat, and his failure to abandon the weight belt, contributed to his death. In addition, Mr Brown's inexperience and the possible sedative effects of cannabis may have been contributing factors in his death. The coroner additionally found that the support boat's decision to leave the dive site may have been another contributing factor.

COMMENTS OF CORONER SCHMIDT-MCCLEAVE

I. I make the following comments pursuant to section 57A of the Coroners Act 2006. The purpose of these comments is to reduce the chances of further deaths occurring in similar circumstances to those in which Isaac died.

Weight belt

II. The Dive Squad report refers to the following excerpt from the AIDA2[11] Freediving Manual:

[11] AIDA International (International Association for Development of Apnea), one of the two world associations for competitive free diving.

"***Correct weighting***
Apply both rules of thumb to weight yourself correctly:
You should not sink from the surface when exhaling forcefully. Your head might go under water, but you should then stay there.
Weight yourself in order to be neutrally buoyant at a minimum of 10m. Deeper is safer.
By correctly weighting yourself, you save energy while freediving and buddying. Also, you will not be "over weighted" in case of emergency."

III. I am aware that freediving in New Zealand, including for the purposes of gathering kai moana, is an increasingly popular activity that does not require formal diver instruction. I urge those taking part in this undoubtedly exhilarating sport to familiarise themselves with the above recommendation from AIDA, and to take steps at all times to maintain and adjust their buoyancy, including by abandoning weight if required.

IV. I also urge those taking part in freediving to:

- Not ingest any alcohol or drugs before diving.
- Be cognisant at all times of sea conditions in the area where diving is planned, and do not dive when those conditions are too rough for a diver's level of experience.
- Dive to a "one up one down" buddy system and utilise a Flag Alpha on the dive vessel (which should remain at the dive site at all times).

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Mr Brown during this inquiry, in the interests of personal privacy and decency.

Guo [2023] NZCorC 151 (27 November 2023)

CIRCUMSTANCES

Liangliang Guo, aged 38, died on 4 May 2019 at Waipatiki Beach, Hawke's Bay, of drowning.

On 4 May 2019 Mr Guo, an inexperienced and untrained scuba diver, attempted to go scuba diving with his friend and their partner at Waipatiki Beach. Mr Guo had purchased new scuba diving equipment the day prior for this purpose and had left his home at 3:00am to make the drive.

When the group entered the water at about midday, the height of the surf was more than one to 1.5 metres. Due to the rough conditions at the beach, the group initially held hands to support each other. However, when the surf pushed them back, Mr Guo let go and advised the couple he would make his own way through the surf. The couple continued, believing that Mr Guo was a strong swimmer and experienced diver. Once they passed the breaking waves, they looked for Mr Guo but could not find him.

Emergency services were called and attended. The Hawke's Bay Rescue Helicopter service located Mr Guo's body in the water approximately 700 metres off the shore of Waipatiki Beach.

Constable Wynyard of Police National Dive Squad prepared a report addressing the factors which may have led to Mr Guo's death. He identified that no formal dive plan had been put in place covering matters such as contingency plans. Additionally, Mr Guo had not completed any form of dive training and had little experience. Constable Wynyard also reported that Waipatiki Beach is not recommended for scuba diving because it has a lot of surge and wave action. He explained that surf can knock divers over especially when wearing heavy scuba diving gear as Mr Guo was, and the fatigue arising from navigating waves, currents, and an undulating seabed makes divers more susceptible to losing their balance.

Mr Guo's limited experience and unfamiliarity with his diving equipment were factors which heightened the risk of him being unable to effectively respond to any loss of balance and then panicking. When experiencing trouble Mr Guo would ideally have ditched his weights and inflated his buoyancy compensating device which would have made him positively buoyant and kept him on the surface. Constable Wynyard noted the possibility that Mr Guo became panicked and, instead of ditching his weights, attempted to ditch all his scuba diving gear. He also observed that staying with "dive buddies", who can provide assistance and support, is a recommended safe diving practice.

COMMENTS AND RECOMMENDATIONS OF CORONER WRIGLEY

I. It is well recognised that scuba diving is a risky activity. Mr Guo's death tragically demonstrates that such risks include those associated with entering the water to commence a dive.

II. 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 circumstances similar to those in which Mr Guo's death occurred. Recommendations or comments must be clearly linked to the factors that contributed to the death to which the inquiry relates, be based on evidence considered during the inquiry and be accompanied by an explanation of how the recommendation or comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

III. Constable Wynyard advances various recommendations in his report. Those which I identify as relevant to the factors I have found likely contributed to Mr Guo's death are:

- Divers should complete a formal dive course before conducting any diving [without a trained guide].
- Divers should thoroughly familiarise themselves with their dive equipment.
- Divers should check the area where they want to conduct their dive:
    - Do not dive if conditions are adverse.
    - Ensure that it is a safe place to enter the water.
    - Inexperienced divers may want to select sheltered spots to dive to gain experience if they are new to the sport.
- All divers should enter the water together which includes when transiting out to the dive site and remain together for the duration of the dive and end the dive if they become separated.

IV. I have provided opportunity to a wide range of organisations and experts interested in scuba diving to comment upon my proposal to endorse, under s57A of the Act, the recommendations listed above and highlight the danger associated with scuba divers entering the water via a surf beach. Consultees included various pathologists, Water Safety New Zealand, PADI Asia-Pacific, Australasian Diving Safety Foundation (ADSF), New Zealand Underwater Association, Divers Alert Network (DAN) Asia-Pacific and Surf Life Saving New Zealand.

V. Comments provided in response to my proposed comment and recommendations under s57A included the following:

- Professor Gorman, Doctor Chris Sames (Clinical Director of the Hyperbaric Unit in Auckland) and representatives of Surf Life Saving New Zealand, Water Safety New Zealand and New Zealand Underwater Association indicated support for the proposed recommendations and comment;
- The Medical Director of DAN took no issue with any of the "significant statements" in these findings. He observed that a "… beach entry in 5-6 ft is challenging … for someone without training, life threatening";
- On behalf of ADSF Dr John Lippmann described the comment and recommendations as "sound" but suggested some changes. He proposed that inexperienced divers "should" (as opposed to "may want to") select sheltered spots to dive and all divers should check the diving area "for compatibility with their experience". I agree with these suggestions which are captured in my final recommendation and comment below. Doctor Lippmann recommended that the advice about staying with other divers apply to "buddy groups" (as opposed to all divers) because there is often a larger group involved and buddy groups can enter in stages.
- On behalf of the New Zealand National Dive Squad, Constable Wynyard advised that members of the squad do not enter the water from a surf beach and in his 22 years of diving he had never done so himself due to the inherent dangers involved.

VI. The constructive response of Dr Greg van der Hulst, a consultant diving and hyperbaric medical physician, is appended to these findings. Dr van der Hulst endorsed the proposed recommendations and comment. He supported the opinion of Professor Gorman that Mr Guo was unlikely to be experiencing gross problems with balance prior to his death.

VII. Dr van der Hulst proposed a further recommendation of:

> Divers should consider undergoing a formal medical risk assessment with a physician with training in diving medicine before using compressed air underwater.

Dr van der Hulst observed that a recreational diving medical consultation may encourage even those without medical conditions contraindicating diving to seek formal diving training. I readily acknowledge that a medical risk assessment for all would-be scuba divers may be advisable but as I have not found a medical issue played a role in Mr Guo's death, I am not satisfied this is a recommendation that can be made under s57A. I consider it would be speculative to conclude that a specialist medical consultation would have persuaded Mr Guo to undertake training before his fatal dive.

VIII. PADI Asia-Pacific provided a comprehensive response which is also appended to these findings. PADI was largely supportive of the proposed recommendations and provided helpful additional commentary in respect of those recommendations. I highlight advice that there are some circumstances where it is not possible for scuba diving buddies to enter the water at the same time, such as during boat diving when there is limited entry area available. In those circumstances, PADI advises that diving buddies should reunite on the water surface before descending. PADI observed that while the "buddy system" is integral to recreational diving, experienced divers can responsibly engage in dives without a buddy. PADI contends that divers should undertake specialised training before conducting dives through waves assessed as larger than 'mild surf'.

IX. While PADI has identified some exceptions and qualifications to the straight-forward and generalised recommendations made at [X] below, I am satisfied they are appropriate and helpful for public education as the formal dive training recommended will enable divers to identify those exceptions and qualifications which mainly apply to more experienced divers.

X. By way of comment under s57A of the Act I observe that it is dangerous for scuba divers to enter the water via a surf beach. Accounting for all the expert feedback received, I refine the recommendations of Constable Wynyard to make the following recommendations under s57A of the Act:

Scuba divers should:

- Complete formal dive training before diving in open water without a qualified instructor;
- Thoroughly familiarise themselves with their dive equipment before diving;
- Check that the area in which they plan on diving is compatible with their level of experience and
    - not dive if environmental conditions are adverse;
    - ensure that there is a safe place to enter the water; and
    - select sheltered dive locations if inexperienced;
- Not enter the water via a surf beach unless they have received specialised training for this purpose and have significant experience; and
- Follow the "buddy system". Dive buddies should enter the water together, remain together for the duration of the dive and end the dive if they become separated.

XI. If publicised and heeded, I consider these recommendations and my comment about the dangerousness of a surf beach entry are likely to prevent further deaths like Mr Guo's by educating members of the public who, like him, plan to scuba dive but are inexperienced and have no formal training.

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

Hu [2023] NZCorC 164 (14 December 2023)

CIRCUMSTANCES

Qinglin Hu, 54, died on 19 March 2017 at Kaikōura of drowning.

Mr Hu had been a recreational free diver for more than five years. On 19 March 2017 Mr Hu went free diving in Kaikōura at an area called “Bird City” also known as “Shark Tooth Point”. Mr Hu entered the water alone and his wife remained on shore, but she could not watch him in the water as he did not attach his marker buoy to himself.

After several hours Mr Hu did not return to shore. Emergency services were notified, and the Police National Dive Squad (PNDS) were also deployed. At 5:50pm on 20 March 2017, Mr Hu’s body was found by the PNDS wedged in a rocky hole with his arms extended above his head. Unfortunately, he was deceased.

The PNDS carried out a full investigation into the incident and provided a report. It identified several poor diving practices including Mr Hu’s lack of a dive buddy, knife, fins, and dive plan. His weight belt was also too heavy making him negatively buoyant and he made an error in entering the rocky hole without any plan to extricate himself. PNDS concluded that poor diving practices and over confidence on this occasion have been contributing factors to this death.

RECOMMENDATIONS OF CORONER HESKETH

I. I endorse the following recommendations from the PNDS report:

- Always dive with a buddy and constantly monitor each other. Employ, a ‘one-up one-down’ system where there is always one diver on the surface watching the diver below until they surface.
- Free divers should constantly review and adjust their weight in relation to the diving they are conducting. Ideally free divers should manage their weight to maintain a neutral hover point in the water approximately 30-40% of depth they will dive.
- If free diving alone then they should be marked or tethered to a surface float/buoy to show their approximate position under the water. If this is not possible then at least have someone on the surface watching the diver’s movements.
- Have a dive plan covering:
    - Where and for how long the diver is likely to be in the water;
    - The surface observer to understand their role and being observant and being able to assist; and
    - Emergency plan.
- Make regular breaks on the surface even if only to reassure the person on the surface monitoring you.
- Know your limitations and do not take any unnecessary risks.

- Release the weight belt when in difficulty.
- Always carry a knife.
- Always wear fins.

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

Laurie [2023] NZCorC 131 (26 October 2023)

CIRCUMSTANCES

Paul James Laurie, aged 61, died on 18 January 2020 at Kea Basin, Earnslaw track, Mount Aspiring National Park, Wanaka of lethal trauma caused by a fall from a height.

On 17 January 2020 Mr Laurie and a friend set off on a hunting trip in the Kea Basin area. Both were experienced hunters and trampers. Importantly, Mr Laurie was not known to be a risk seeker, although he was used to challenging himself in his Queenstown environment. On 18 January 2020 Mr Laurie and his friend were negotiating a steep section of terrain which sat above a significant fall exposure and was known to be very slippery. Mr Laurie's friend chose to take a more conservative route and the men separated. A short time later Mr Laurie's friend heard some noises and discovered that Mr Laurie had fallen approximately 30 metres onto the rocks at the base of the waterfall below the terrain they had been navigating. He contacted emergency services. Later that evening Mr Laurie was located by the air rescue team and was confirmed deceased.

Toxicological analysis of Mr Laurie's blood confirmed the presence of cannabis. The toxicologist advised in their report that the main psychological and behavioural effects of cannabis include "euphoria and relaxation, an impairment of perception and cognition, and loss of motor coordination". The coroner therefore considered it likely that the use of cannabis would have played a contributory, if not a substantial role in Mr Laurie's death.

An investigation report was provided by the Mountain Safety Council at the request of the coroner. The coroner considered the following summarised points to be relevant to the inquiry:

(a) The terrain and its conditions provided little, if any, opportunity for Mr Laurie to halt his fall.

(b) Mr Laurie was an extremely experienced tramper and hunter. Inexperience was not, therefore, a causative factor in the accident. However, the report raised the possibility that this experience may have inadvertently (and likely subconsciously) led to a degree of complacency.

(c) Mr Laurie appears to have misperceived the risk associated with this terrain which was perhaps evidenced by Mr Laurie's friend's reluctance to navigate the same terrain and Mr Laurie's determination to proceed.

RECOMMENDATIONS OF CORONER TELFORD

I. As noted above, Coroners play a role in making comments or recommendations in appropriate cases to help reduce the chances of further deaths in similar circumstances. In this regard, I am obliged to the authors of the Mountain Safety Council who are experts in this field.

II. The authors primarily highlight the importance of route selection – which almost certainly played the greatest role in Mr Laurie's accidental fall on 18 January 2020. They also make a range of recommendations, which I adapt and adopt, as follows:

- If you are experienced, be wary of the inherent human inclination toward complacency, underestimating risks, and over-estimating personal ability.
- Correct route selection is critical, and an adaptable approach should be maintained in relation to dynamic terrain and circumstances. Critical to this approach is maintaining constant awareness of terrain traps, such as bluffs or cliffs below.
- Stop, think, assess, and talk with your fellow travellers about the options you have, and as you do this consider the likelihood of a fall and the consequences in the event you lose your footing. Avoid terrain traps or do as much as you can to manage the risk of them.

III. The above recommendations are, of course, aimed at trampers, hunters, and other individuals with a reasonable level of experience in outdoor settings. It goes without saying that utmost caution should be exercised by those not experienced in these environments.

IV. Finally, I cannot determine if the use of cannabis contributed to Mr Laurie's death. However, I consider it worth reiterating the advice of the toxicologist, Ms Russell, who (unsurprisingly) highlights the known effects of this substance, including impaired perception and cognition, and loss of motor coordination. It goes without saying that the use of this substance, and many like it, significantly amplifies the inherent risks associated with outdoor activities.

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

Mizokawa [2023] NZCorC 158 (7 December 2023)

CIRCUMSTANCES

Toru Mizokawa, aged 49, died on 7 August 2021 in the Manawatū river of drowning.

On 7 August 2021, Mr Mizokawa went fishing alone in the Manawatū River, near Pinfold Road in Palmerston North. Members of the public reported seeing a fisherman, likely to be Mr Mizokawa, fishing and wearing waders. He was standing in the river and the water came up to his thighs.

On 9 August 2021, emergency services were contacted as Mr Mizokawa did not arrive for work. An extensive search was carried out which included the Manawatū River. The search was initially hampered because the forecast rain had

caused the river flow and its depth to significantly increase. Approximately six weeks later, on 8 September 2021, a member of the public located Mr Mizokawa's body in the mudflats, between the high tide and low tide marks in the Manawatū River.

There was a deep channel in the river, which has a sharp soft bank, near where Mr Mizokawa was believed to be fishing. It is likely that Mr Mizokawa was fishing close to the deeper channel and that he slipped or unintentionally fell into it – it is possible that the sharp soft bank in the river gave way under his feet. Once Mr Mizokawa found himself unexpectedly in deeper water, he would have been in life threatening and immediate danger because, according to his family, Mr Mizokawa could not swim. Furthermore, it is possible that Mr Mizokawa's waders may have filled with water, reducing further his ability to rescue himself.

There are varying beliefs about what occurs when someone wearing waders falls into deep water. Researchers in Australia have recently completed a study into this issue.[12] Different styles of waders were tested and a wader belt (a belt around the waist, the purpose of which is to minimise water entering the lower parts of such waders) was also tested. The testing showed that air trapped in the feet of chest waders (due to the fisher wearing a wading belt) did add buoyancy to the feet and positioned the fisher more horizontally on the surface of the water, enabling the fisher to scull to safety more easily. The research showed the belief that waders when filled with water will pull the wearer under is fundamentally flawed.[13]

COMMENTS OF CORONER KAY

I. The evidence does not enable me to conclude that the waders that Mr Mizokawa was wearing caused or contributed to his death – I do not know what style of waders he was wearing, or whether he was wearing a wading belt. I am therefore unable to make any recommendations regarding waders.

II. However, I make the following comments in the hope that if drawn to the public attention, they may reduce the chance of further deaths occurring in circumstances similar to Mr Mizokawa's death.

III. Fishing is a popular leisure activity for many New Zealanders, but it is not without risks. The Department of Conservation notes that the risk of drowning associated with wearing waders can be reduced in several ways:[14]

- wear a wading belt tightly around your midriff. I note that these belts can be bought from sports shops or online fishing retailers, cost approximately $50, and they may help you to float better by preventing water entering the lower half of your waders;
- ensure that your waders are the correct size for you (not just the correct foot size, but also the right leg length and correct size for your torso);

[12] Lauren A. Petrass, Jennifer D Blitvich and G Keith McElroy "Drowning Deaths among anglers: Are waders a contributing factor? (2017) 24 1 International Journal of Injury Control and Safety Promotion 131-135.

[13] At 134

[14] https://www.doc/govt.nz/parks-and-recreation/places-to-go/central-north-island/places/taupo-trout-fishery/how-to-fish/wading-safety/

- wearing a jacket over your waders can limit water entering your waders (although I note that this may make it more difficult to remove the waders quickly in deep water). Some vests designed specifically for fishing have a ripcord which you can pull in an emergency, inflating it to increase your buoyancy – I note that an alternative would be to wear a life jacket;
- wear polaroid glasses because they cut glare from the water's surface and make it easier for you to see below the water; and
- take a wading stick, which can be similar to a ski or tramping pole, or may just be a similar length piece of wood (which you may possibly find along the water's edge).

IV. I endorse the Department of Conservation's recommendations for reducing the risks associated with wearing waders.

V. In addition to the above risk reduction measures, those fishers who wear waders may be able to find a wader training course; several commercial organisations do, and occasionally a local fishing club may, provide such a course (details of which can be found quickly via an online search).[15]

VI. For completeness, I note that after Mr Mizokawa's death four further people (none of whom were fishing) drowned in the Manawatū river in late 2021/early 2022. Following those further deaths, several organisations worked together to identify ways to make the public aware of the dangers of the river, and then took practical steps to achieve this. These further deaths occurred in different circumstances to Mr Mizokawa's death, and consequently I do not believe that those steps (had they occurred earlier) would have altered the tragic outcome for Mr Mizokawa.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Mr Mizokawa during this inquiry, in the interests of decency.

Skellett [2023] NZCorC 166 (15 December 2023)

CIRCUMSTANCES

Jack Adam Skellett, aged 23, died between 20 and 21 December 2021 at Camp Bay, Lower Hutt of drowning.

On the morning of 20 December 2021, Jack went kayaking on Wellington Harbour in gale force north-westerly winds. Jack had bought his kayak around a month before his death and had limited paddling experience. He was known to be a strong swimmer and generally fit and healthy. He was wearing a lifejacket but was thought not to have any form of communication with him.

After leaving from the Petone Wharf area, Jack was last seen at approximately 1:30pm by the skipper of a boat moored near the southern end of Mātiu/Somes Island. Jack said he was fine and declined the skipper's offers of assistance. Jack

[15] For an example of a course arranged by a local fishing club see Naomi Arnold "Anglers get their fill at safety course" (28 November 2009) https://www.stuff.co.nz/nelson-mail/news/3099650/Anglers-get-their-fill-at-safety-course.

continued back towards Petone up the eastern side of the island, having struggled to make any progress on its western side.

When Jack did not return home that evening, his father contacted Police and a search operation was commenced. Jack was found deceased the following evening at Camp Bay on the Pencarrow Coast, south of Eastbourne, Lower Hutt. His kayak and lifejacket were found washed up in the same area.

As Jack was found wearing only his underwear, his parents believed he may have stopped in a bay on Somes Island and intentionally removed his lifejacket and clothing to go swimming. However, as wave action may have forced Jack's lifejacket and clothes off him in the water, the coroner could not determine whether Jack was more likely to have been swimming or kayaking when he got into difficulty.

The coroner found it was ill-advisable for someone with Jack's limited experience to be kayaking in the severe weather conditions that day. If Jack had intentionally entered the water to go swimming, it was unsurprising he had gotten into difficulty. The coroner concluded Jack's death could have been avoided if he had been wearing a lifejacket when he got into difficulty and taken a waterproof form of communication with him. It also could have been avoided if he had taken heed of the weather forecast and not gone out on the harbour, or when out on the harbour, accepted the skipper's offer of assistance. Post-mortem testing of Jack's blood showed he had MDMA in his system at the time of his death. While the effects of MDMA on Jack could not be known for certain, the coroner could not discount that this may have influenced Jack's perception and decision-making that day.

COMMENTS OF CORONER WILTON

I. I am mindful of the timing of these Findings and any publication of the same as we approach the summer holiday period for the end of this year and the start of 2024. Jack's death occurred in the summer of December 2021. This is a time when traditionally, many people engage in recreational water activities involving the sea. Accordingly, I considered the following water safety messages and advice below.

II. Water Safety New Zealand (WSNZ) has reported that deaths involving kayaking made up only 2% of drownings in the 10 years to December 2021, but that the majority of kayaking deaths were of males aged 15-34. For the five years to December 2021, WSNZ ran a social media water safety campaign over the summer months called 'The Swim Reaper' targeted at males within this age group.

III. With all recreational water activities, WSNZ advises people not take part in the activity alone, and not to drink alcohol or take drugs before or while undertaking the activity. WSNZ promotes the Water Safety Code (alongside Adventure Smart, part of the New Zealand Search and Rescue Council), which includes these messages:[16]

1. Be prepared

Always check your surroundings and the conditions before entering the water. Check for potential dangers, and make sure you are confident in your ability to swim in the area around you, especially if

[16] The Water Safety Code - AdventureSmart - NZ Search & Rescue Council | AdventureSmart

the conditions or weather was to change. Floatation devices and lifejackets should be used for activities on the water, especially on children and for anyone who is not strong or confident in the water.

2. Watch out for yourself and others

Be aware of those around you in the water. If anyone is showing signs of distress, if they seem to be under for too long or if you lose sight of friends or family while recreating in or around the water, it is important to check on them to make sure they are ok. Likewise, remain aware of your own swimming capability and the area or conditions that you're swimming in. Have fun, but always remain alert and don't push yourself beyond your own level of comfort.

3. Be aware of the dangers

Recreating in and around lakes, rivers, the ocean and even in swimming pools can have its dangers. Additional to your swimming capability and your physical state, you must be mindful of the dangers at each area of water you are recreating in or on, as they can change unexpectedly.

4. Know your limits

Even strong swimmers can be caught out by the dangers in water environments such as rips, waves and unexpected changes in the depth or shallowness of water. Enjoy water recreation within your limits, and don't feel pressured to swim or recreate in or around water if you are uncomfortable, or are concerned about potential dangers. Have fun, but always behave responsibly by respecting the water, your limits and the limits of others.

IV. The Safer Boating Forum provides the following advice on how to keep safe on our waters when paddling:[17]

Know your stuff. Make sure you get appropriate training and practice your new skills on a regular basis. Paddlers and the general public underestimate the technical skills and knowledge required to safely paddle on New Zealand's waters. Sometimes it's hard to get back when the wind gets up, and the water gets choppy. Tides and currents also make it difficult to stay on-course and prevent capsizing. Make sure you know the environment and how to use your equipment. It's safer to paddle with mates. Join a waka ama, kayak, canoe or SUP club.

Know and practice what you do when you capsize. Many boating deaths happen when a small craft (under 6m) is swamped or capsizes. Know how to get back into or onto your boat or paddle craft.

Choose a personal flotation device (PDF) or life jacket suitable for the job. Generally, we would recommend a PDF NOT a lifejacket for kayaking – if capsized a life jacket may make it harder to get out and a PFD plus a kayak are good enough for flotation once out.

[17] Paddle Craft Guide - 2018 (saferboating.org.nz)

Check your craft and prep your gear:

Paddle craft – check your craft for leaks, damage, dodgy cables/fasteners, and anything else that could invite trouble.

Lifejackets – check your lifejacket or PFD is undamaged and fits. Know how to adjust the fit.

Communication equipment – take two. A waterproof handheld VHF radio, a personal locator beacon or a cell phone in a waterproof lanyard bag. Carry them on you or stash them in your lifejacket pocket.

Paddle – tether your paddle so you don't lose it if you capsize. Know how to get back on and right your paddle craft.

Wetsuit – dress for the water temperature, not the air temperature. Cold water shocks and hypothermia can kill. Wearing the right gear could save your life.

Waterproof torch – show a bright light from (and during) sunset to sunrise. Check your battery.

Local knowledge – talk to locals about the specific tides, currents and hazards. Check Marine Mate for your local bylaws (search 'Marine Mate' in your app store).

Plenty of food, drink and sunscreen – don't get caught short.

Check the marine weather. Take note of wind speed over water and the size of waves or swell. If on inland waterways and lakes, check the land or mountain weather forecast.

Know the rules. You need to know give way rules, navigational lights, buoys and beacons, and channel paddling.

Be safe be seen. Keep a good lookout at all times and never assume you can be seen. Wear bright clothing and make sure your boat is highly visible with safety flags etc. Wear a white head torch between sunset and sunrise so others can see you. Or even better, display an all-round white light.

Make a plan. Make sure someone on shore knows what you're up to. Tell a mate or family member where you're leaving from, where you're going, how many people you're with and when you think you'll be back. Tell them what to do if you don't return – call the Police on 111 or *500 for the Coastguard NZ – and let them know if you're running late. Or use the Log a Trip tool in the Coast app.

Know your limits. It's easy to get carried away on the water so stick to your limits. And, remember, the further you go the greater the risk, so the more prep you need to do. Beginner paddlers should limit themselves to flat sheltered waters with light winds (less than 11 knots or 19km/h), while experienced paddlers should limit themselves to conditions of less than 25 knots. **If in doubt, don't go out!**

All paddlers should:

- If possible, stay close to the shore line.

- If with mates, paddle in tight formation.
- When possible paddle outside the channel – avoid the centre of the channel or river.
- Keep to the right.
- Take care when entering or crossing channels or shipping lanes.
- Keep clear of large vessels (pass behind them, not in front).
- Aim to paddle against the wind, current or tide so you won't wear yourself out on your return.

Mayday! What to do in an emergency

1. Make sure your lifejacket is fastened.
2. Set off your personal locator beacon.
3. Call a Mayday on your hand-held VHF radio – on Channel 16
4. Call the police on 111 (always carry your cellphone in a waterproof bag)

Stay with your craft – it's much easier to spot in the water than you are. Never attempt to swim to shore unless you're close and wearing a life jacket. If you can, keep warm by climbing onto your craft. If your vessel has sunk or drifted away, huddle to conserve heat and energy.

V. The Kiwi Association of Sea Kayakers (KASK) notes that many recreational paddlers in New Zealand venture out onto the ocean without an understanding of the risks posed and how to avoid them. KASK runs free safety education workshops throughout the country, targeted towards new and prospective recreational paddlers who have not received training and may not be aware of the risks of paddling in a marine environment, and those in need of refresher training. I commend their efforts to educate recreational paddlers to reinforce key safety messages.

VI. Last year, Maritime NZ advised they were undertaking a review of the Maritime Navigation Safety Rules Part 91, including whether people should be legally required to wear a personal flotation device while kayaking and to carry two forms of communication to call for help. On 16 November 2023, an update from Maritime NZ advised that this review was not progressed under the previous Government, and it was uncertain as to when they would be able to progress it in future. Maritime NZ continues to advocate strongly for the wearing of life jackets and the carriage of communication devices on recreational craft through safer recreational boating campaigns and other opportunities, such as comments on draft navigation bylaws proposed by Regional Councils. I commend and endorse their efforts, and I encourage Maritime NZ to take steps to undertake the review of the Maritime Navigation Safety Rules Part 91 as advised to me above.

Endorsement of water safety messages and advice

VII. After having given due consideration to all the circumstances of Jack's death, I make no recommendations. I do, by way of comment, endorse the water safety messages and advice outlined above pursuant to section 57A of the Coroners Act 2006 in the hope that, if drawn to public attention, it may increase the awareness of safety precautions when kayaking and swimming in the sea and reduce the chances of further deaths occurring in similar circumstances to Jack's.

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

Medical Care

Bly [2023] NZCorC 124 (11 October 2023)

CIRCUMSTANCES

Catherine May Bly, aged 79, died on 6 August 2019 at Hutt Hospital of complications of multiple sclerosis, including severe osteoporosis and fractures of the lower extremities.

At the time of her death, Catherine lived at Summerset Trentham Private Hospital ("Summerset"). She had diagnoses of multiple sclerosis and severe osteoporosis. Her condition had deteriorated to the point where she required a very high level of nursing care and support with her everyday activities. This included the use of a mechanical hoist to transfer her from her bed to her wheelchair. Catherine had become unable to communicate verbally and had also developed cognitive impairment. She had received private hospital level care for 19 years.

On 5 August 2019 at around 11:00am, staff identified bruises on Catherine's legs. The nightshift staff had not reported any adverse findings in their last note at 4:29am. That evening, staff at Summerset contacted a general practitioner with concerns that Catherine had become pale with a low level of responsiveness and brief apnoeas, she had also vomited and had rattly breathing. Staff observed bruising on her left knee and lower leg, and her right thigh was swollen on examination. She was treated at Summerset overnight. The following day, the general practitioner recommended that Catherine be transferred to Hutt Hospital as he did not know how extensive the injuries were or how they had occurred. When Catherine arrived at the emergency department, she was found to have bi-lateral lower limb fractures. Her condition deteriorated and she passed away that evening.

The coroner requested further information regarding the significance of the leg fractures to the overall cause of Catherine's death. The Clinical Director of the pathology service provider, Dr Vuletic, advised that it was likely the acute leg fractures were the cause of Catherine's sudden deterioration and final demise.

Following Catherine's death, Summerset conducted a review of the care provided to Catherine. The reviewer stated that in her opinion the fractures had to have been caused by a degree of impact during a moving and handling process. She considered it was most likely to have occurred as Catherine was being hoisted into the chair and that the bruising may have occurred by her leg being banged during the hoisting process. Her view was that it was likely the injuries occurred

at two different points in the moving and handling process. She considered that the most probable cause of the fractures was when Catherine was being lowered heavily into her tilted wheelchair.

The Summerset Head of Clinical Services reported to the District Health Board that the most likely conclusion was that staff delivering personal cares on the day the injuries occurred accidentally injured Catherine due to poor moving and handling technique that fell outside of the instructions in Catherine's care plan. The technique was also outside of the training content that had been delivered at training sessions. Since Catherine's death, Summerset had implemented repeat moving and handling training for staff and clinical staff care plan training for moving and handling of frail older people with complex moving and handling requirements. Summerset also reviewed the moving and handling policies and the moving and handling audit tools, orientation and competency assessment processes.

The coroner sought advice regarding Catherine's care from an independent expert, Dr Spriggs. Dr Spriggs stated that Catherine seemed to have suffered two synchronous fractures prior to 11am on 5 August 2019. He thought it likely that the trauma occurred before the bruises were noticed and possibly several hours before, which would include the period of the night shift. He considered it was very unlikely that these fractures occurred spontaneously without some trauma. The presence of two synchronous fractures suggested to him a more significant traumatic event. However, he noted that the degree of trauma causing the fractures may have been mild, as Catherine's bones were probably very fragile due to the osteoporosis. Dr Spriggs advised that he believed the leg fractures occurred due to a combination of the severity of the osteoporosis, possibly spasticity of the legs, and the manner of turning Catherine in bed or transferring her from the bed to a chair. Dr Spriggs acknowledged that fragile bones and probable leg spasticity made transferring difficult. However, he stated that such fractures should not occur.

RECOMMENDATIONS OF CORONER ANDERSON

I. I have carefully reviewed the information obtained during the course of this inquiry, including the expert advice provided by Dr Spriggs.

II. Catherine's legs were fractured shortly before she died. While Summerset's review has identified the points where the injuries were most likely to have been sustained, it is not possible to determine exactly how, or when, these injuries occurred. I accept the advice of Dr Spriggs that injuries of this nature should not occur, even taking into account Catherine's advanced osteoporosis and general state of health. I also accept the advice of Dr Vuletic that the acute leg fractures were the cause of Catherine's sudden deterioration and final demise.

III. Catherine was in a vulnerable position, being fully dependant on other people for all aspects of her care and unable to verbally communicate. Adequate processes and safeguards must be put in place to prevent avoidable injury and harm for members of our community who require high levels of personal care and assistance of this nature.

IV. While I commend Summerset for the transparent and comprehensive nature of the review undertaken shortly after Catherine's death, I consider that the following further recommendations may assist in preventing similar deaths occurring in the future.

- I recommend that Summerset review the hoist and other assistance equipment used in Catherine's care, with input from a specialised physiotherapist or similar expert, to determine whether these products are the most appropriate option for transferring people with particularly complex health needs, like Catherine.

- That Summerset reviews the training and ongoing support provided to all staff involved in hoist transfers to ensure they are aware of correct practices as well as the additional risks associated with transferring individuals with increased limb tone (spasticity). While it is clear that a number of changes were made shortly after Catherine's death, it is important to ensure that these changes are enduring and that the correct processes are reinforced for caregivers on an ongoing basis.

V. Before making any comments or recommendations for the purposes of reducing the chance of further deaths, I am required under the Coroners Act 2006 to provide notification of the proposed content to parties affected by the recommendation. Accordingly, I informed Summerset of my intended comments and recommendations and gave the organisation a chance to respond.

VI. In relation to Dr Spriggs' report, Summerset considered it highly unlikely that the injury occurred overnight, given that Catherine seemed her usual self and did not appear to be distressed or in pain. Further, Summerset did not consider the time between documented clinical entries (from 4:29am and 11:04am) to be significant, given that the morning shift would typically record progress in the notes following the completion of personal cares for all residents, after taking over from the night shift.

VII. In relation to training on moving and transferring residents, Summerset advised that this training is provided by physiotherapists, under a contract with TBI Health. At the time of Catherine's death, slip hoists were used in all Summerset care centres. However, a national project has since commenced to replace all these hoists with ceiling hoists and there is planned replacement programme in place, with equipment being progressively upgraded.

VIII. In relation to my proposed recommendations, Summerset advised as follows:[18]

> *Of note, Summerset accepts the recommendations made in the report and has already been working proactively on the points raised, which should be noted in the coroner's findings.*
>
> *(a) At Summerset the management of medical capital expenditure for equipment such as hoists sits with the clinical team and is approved by the Head of Clinical. Equipment is replaced within the recommended life span of the equipment provider and review of the items listed on our national product list is ongoing. Since 2019 all hoists at Trentham and nationally have been replaced with newer improved models.*
>
> *(b) Summerset has now also reviewed the use of sling hoists and is embarking on a project to replace sling hoists with ceiling hoists. Our first site commenced using the installed ceiling hoists in early August 2023. The Trentham care centre will have ceiling hoists installed in 2024 and by the end of 2025 all sites will be operating using ceiling hoists.*

[18] Letter from Anna Carey, Clinical Improvement Manager, Summerset Group Holdings, dated 4 October 2023

Research demonstrates multiple benefits of ceiling hoist systems for safety and comfort of both staff and residents. These benefits include easier positioning of the resident as there are no mechanical obstructions or intrusions like mobile floor lifts to contend with and the transfer is stable due to use of a fixed structure, less space restrictions in the room due to the bulky nature of sling hoists, the gradual lifting motion will eliminate sudden movements and there is less risk of skin tears and bruising, using ceiling hoists. The main benefit that would have assisted in this incident is the increased space and reduced risk of placing equipment during transfers in a manner that creates further risk.

(c) An external review of staff orientation and training in all aspects of moving and transferring residents is well underway. Dr Fiona Trevelyan, a senior lecturer in the AUT School of Clinical Sciences Health and Rehabilitation Research Institute has been contracted by Summerset since June 2023 to conduct a full review of moving and transferring residents at Summerset. Dr Trevelyan is a trained physiotherapist and has a PhD in Health Ergonomics. At the time of writing this response she has just provided her final report for consideration. Included in this report is a view that while the current contract with TBI Health for delivery of moving and handling training is adequate, enhancements to this contract are recommended to improve Summerset's overall moving and handling strategy. Dr Trevelyan's recommendations encompass a number of areas of the moving and handling strategy at Summerset with a view to ensuring best practice can be implemented alongside the significant financial investment currently being made to move to ceiling hoists across all our care centres.

IX. I acknowledge these additional steps that are being taken by Summerset and consider that they will further reduce the likelihood of other residents suffering injuries similar to those that Catherine experienced.

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

Cook [2023] NZCorC 121 (3 October 2023)

CIRCUMSTANCES

Anne Elizabeth Cook, aged 61, died on 25 January 2017 at Dunedin Hospital of necrotising fasciitis causing a pulmonary artery thromboembolism. Antecedent cause was sepsis, and the underlying conditions included uterine/vaginal infection.

In December 2016, Mrs Cook was diagnosed with Group A Streptococcus by her general practitioner (GP) following a vaginal swab. She was prescribed amoxicillin and clavulanate. On 24 January 2017, she presented to her GP severely unwell and reported that she had been unwell for 24 to 48 hours with nausea, vomiting, and one episode of diarrhoea. She was also lightheaded and had significant pain in her right bicep and chest areas. She informed her GP that she had sustained a right arm injury on 21 January 2017 when she was riding her horse causing an injury to her bicep area and pecs. Mrs Cook indicated she could barely move her right arm and that the pain was quite severe. The GP referred Mrs Cook to Dunstan Hospital where she arrived at midday.

Mrs Cook was examined on arrival and underwent a CT scan. She was observed to have a large amount of soft tissue swelling and a haematoma to her right lateral chest wall and underarm, consistent with extensive muscle injury. Over the course of that afternoon Mrs Cook's condition deteriorated resulting in her being airlifted to Dunedin Hospital at about 5:45pm.

At Dunedin Hospital, Mrs Cook was found to have extensive soft tissue damage which was subsequently identified as necrotising fasciitis type II, an infection of the deeper soft tissues, and multi organ failure due to toxic shock syndrome. She underwent a debridement operation during the night of 24 January. On 25 January she was taken back into the surgical theatre to be prepped for further surgery, however, she suffered a cardiac arrest from which she could not be revived.

COMMENTS OF CORONER HESKETH

I. Necrotising fasciitis can be caused by several different types of bacteria, and the infection can arise suddenly and spread quickly. Early signs include flu-like symptoms and redness and pain around the infection site. A prompt diagnoses and treatment are essential. If the infection is not treated promptly, it can lead to multiple organ failure and death.[19]

II. Symptoms often begin within hours of an injury and typically include intense pain and tenderness over the affected area. The pain is often severe and may resemble that of a torn muscle. Early symptoms may be mistaken for the flu and can include fever, sore throat, stomach-ache, nausea, diarrhoea, chills, and general body aches. The patient may notice redness around the area that spreads quickly; the affected area can eventually become swollen, shiny, discoloured, and hot to the touch. In addition, ulcers or blisters may develop. If the infection continues to spread, the patient may experience dehydration, high fever, fast heart rate, and low blood pressure.

III. Treatment requires accurate and prompt diagnoses, treatment with intravenous antibiotics, and surgery to remove dead tissue are vital in treating necrotising fasciitis. As the blood supply to the infected tissue becomes impaired, antibiotics often cannot penetrate the infected tissue. Therefore, surgery to remove the dead, damaged, or infected tissue is the primary treatment for necrotising fasciitis.[20]

IV. If diagnosed and treated early, most patients will survive necrotising fasciitis. If tissue loss is significant, skin grafting may be necessary. Early surgery may minimise tissue loss, eliminating the need for amputation of the infected body part.[21] In some patients, amputation of the affected area is required. Up to 25% of patients will die from necrotising fasciitis, due to complications such as kidney failure, blood poisoning and organ failure. The particular type of bacteria, the health of the patient, the location of the infection, and the speed of treatment can all influence the outcome. This is a rare diagnosis which can be difficult to establish and progresses rapidly, even with appropriate treatment.

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

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[19] Necrotising fasciitis. DermNet New Zealand Trust, 4 March 2016; http://www.dermnetnz.org/bacteria/necrotising-fasciitis.html

[20] Ibid. See also Sarani, Babak: Necrotizing Fasciitis, National Organization of Rare Disorders (NORD), 2015; http://rarediseases.org/rare-diseases/necrotizing-fasciitis/

[21] Edlich, Richard: Necrotizing Fasciitis, Medscape Reference, 9 July 2015; https://emedicine.medscape.com/article/2051157-overview?form=fpf

Donaldson [2023] NZCorC 156 (7 December 2023)

CIRCUMSTANCES

Eva Grace Donaldson, aged 25 days, died on 9 February 2017 at the Newborn Intensive Care Unit of Waikato Hospital in Hamilton. Following the maternal collapse of her mother, Eva died from antepartum asphyxia, leading to hypoxic ischaemic brain injury, with an underlying condition of post-natal pneumonia.

Eva was the second child of Andrea Donaldson and her husband. She was born by emergency caesarean at Waikato Hospital on 15 January 2017 after Andrea suffered a maternal collapse following a uterine rupture. Following increasing respiratory distress, other complications, and a poor prognosis for the quality of her life, ventilation was withdrawn, and Eva passed away on 9 February 2017.

Andrea had a complex gynaecological history. The quality of medical care and treatment that Andrea received leading up to Eva's birth was investigated by the Deputy Health and Disability Commissioner (HDC). The Donaldson family, then Waikato District Health Board (now known as Te Whatu Ora Waikato (TWOW)) and medical personnel who were the subject of adverse comments, were given the opportunity to comment on HDC's provisional report and recommendations. Whilst acknowledging that HDC's investigation was necessarily limited to Andrea's care and treatment, the coroner recognised the interrelationship between the care and treatment of a pregnant mother which impacted on the cause and circumstances of her infant's death.

COMMENTS AND RECOMMENDATIONS OF CORONER LLEWELL

I. Under section 57A of the Act, I must consider whether it is appropriate to make any recommendations or comments to reduce the chances of further deaths occurring in similar circumstances to Baby Eva. The threshold is the "potential reduction" of similar deaths, not complete avoidance.

II. Section 57A(3)(a) of the Act dictates that recommendations or comments must be clearly linked to the factors that contributed to the death, have a basis on the evidence considered in an inquiry, and requires an explanation how such recommendations or comments if drawn to public attention reduces the chance of further deaths occurring in similar circumstances.

III. Having regard to the evidence and submissions of the parties, the determination of issues and other matters raised during the course of this inquiry, I consider there are sound reasons to provide formal recommendations. However, it is recognised that HDC's investigation also produced a number of practical recommendations for improving the care and services provided for Andrea (some of which would likely have improved Baby Eva's viability and chances of survival).

IV. With competing evidence and the significant delay in appreciating Andrea's condition, we cannot say for sure whether more timely assessment might have led to a different outcome. However, given my earlier finding that it was more probable than not that Andrea had suffered an internal iliac artery aneurysm as a precursor to the uterine artery and uterine ruptures that in combination lead to her maternal collapse - I am satisfied that had diagnosis and treatment of the mother's condition occurred, the maternal collapse could have been avoided and Baby Eva would not have suffered the catastrophic brain injury and subsequent demise.

V. In other words, recognition of the symbiotic relationship between mother and foetus would have allowed a treatment plan that was collaborative and proactive with mitigating risks to them both. Earlier and thorough investigation of Andrea's condition could have resulted in a managed (rather than emergency) caesarean delivery of Baby Eva followed by the necessary surgical intervention for an internal iliac artery aneurysm, thereby avoiding maternal collapse with subsequent uterine artery and uterine ruptures which all had a direct impact on Eva's brain injury.

VI. Accordingly, I draw the attention of TWOW to the following recommendations made under section 57A of the Act:

- Introduction of a policy and procedures concerning Obstetric Registrar Supervision (Christchurch Women's Hospital example at footnote 21) for guidance on the hierarchy of responsibility and conditions requiring escalation, specialist attendance, specialist consultation and specialist supervision.
- Improve the planning and monitoring of any pregnant woman who presents with a complex gynaecological history and escalation of concerning issues for immediate review by the responsible Obstetrician.
- Implementation of New Zealand's National Maternity Early Warning System (MEWS) with incorporating vital sign pain charting with hourly recording where a pregnant woman is unwell or is displaying pain and/or where there is foreseeable delay to appropriate radiological investigation in order to identify and diagnose the cause of maternal deterioration and pain.
- All sonographers, obstetricians, and general surgeons to undergo an education session about symptoms, causes and management of right iliac fossa pain in pregnancy - including aneurysms, how such may develop in women with a history of pelvic surgery, endometrioses, congenital diseases of connective tissue, congenital malformations of blood vessels, and how an iliac artery aneurysm may contribute to uterine artery and uterine ruptures.
- All levels of obstetric personnel to undertake six-monthly education on reading and interpreting Cardiotocography (CTG) and understanding the consequences and meaning of abnormal readings.
- Consider and develop standards associated with maternal collapse for delivery of the foetus within 5 minutes (i.e., ROCOG and Australian standards at footnotes 19 and 20).

VII. In accordance with sections 57B(1)(a)(iii) and 57B(1)(b) of the Act, TWOW and Dr PAK Nair were provided with my provisional findings (dated 17 October 2023) for the opportunity to comment on proposed recommendations above. The statutory deadline for responses was on or before 16 November 2023.

VIII. My provisional findings were provided to Baby Eva's family.

IX. A courtesy copy of my provisional findings was also provided to Dr X along with her solicitor. Because adverse comments about this doctor were previously made by HDC, I am not required to follow the same consultative procedure under the Act that was afforded to TWOW. Whilst I acknowledge there are some strong words or

characterisation of the Obstetric Consultant in these findings, those are similarly not attributable to me and have come from evidence in my inquiry.

X. A courtesy copy of my provisional findings was also provided to Dr David Ferrar and the Deputy Health and Disability Commissioner.

XI. On 25 November 2023, my Case Manager was advised by a staff member of TWOW that due to staff change and administrative oversight, the opportunity to comment on my provisional findings and proposed recommendations had not been actioned. This was extremely disappointing when I had intended issuing my final findings before the end of November 2023 in advance of the Christmas period and pending anniversary of Baby Eva's death.

XII. Having regard to the principles of natural justice and participatory rights afforded to interested parties under the Act, I gave Directions on 27 November 2023 extending the deadline to receive comments from outstanding parties on or before 1 December 2023.

Feedback from Deputy Health and Disability Commissioner

XIII. I received feedback by way of written response dated 15 November 2023 which was appreciated.

XIV. The dates associated with Commissioner's final report and recommendations were confirmed resulting in minor amendments to paragraphs [7], [73] and [114] of my provisional findings.

XV. In relation to paragraph [19] above, HDC agreed with my assessment that there were no new compelling facts or basis for my formally referring the Donaldson's complaint back to HDC. It was accepted that HDC's report might have been clearer with respect to Andrea's diagnosis, but as it was not known by clinicians at the time, this would not impact on HDC's investigation and findings which focused on the standard of care provided.

XVI. HDC considers that their investigation process was extremely thorough, my coronial findings do not warrant reopening of the HDC investigation and there are no compelling public interest reasons to do so. Accordingly, I have given effect to the request of HDC to remove the concluding sentence of paragraph [19] of my provisional findings.

Feedback from Solicitor on behalf of the Obstetrics Consultant

XVII. I received feedback by way of email dated 30 November 2023 from Wotton Kearney, Solicitors of Wellington which was appreciated.

XVIII. There were no substantive comments on my provisional findings.

XIX. However, it was noted that my findings repeat aspects of HDC's report. It was stated that Dr X does not accept all of HDC's opinion and its process did not allow for certain evidence to be tested.

XX. With reference to paragraphs [63] to [68] above, it was requested that I make a permanent non-publication order under section 74 of the Act. In the circumstances, that is appropriate but in order for that to have any practical

meaning and effect, the consultant's name must necessarily be referred to in these findings. Thereby, amendment has been made to paragraphs [9], [63], [68] and [132] of my provisional findings, with an associated non-publication order set out in paragraph [194].

Feedback from Te Whatu Ora Waikato

XXI. I received feedback by way of covering letter dated 1 December 2023, two written reports and supporting documents. TWOW's apology for oversight and delay is recognised.

XXII. TWOW's comments on proposed recommendations and other aspects of my provisional findings was provided by their Interim Nurse Director Women's and Children's Health on behalf of TWOW's Operations Director, who has oversight of the Newborn Intensive Care Unit (NICU), delivery suite and the medical, nursing and midwifery staff who support those services.

XXIII. TWOW advised that Dr David Ferrar had no feedback. Dr PAK Nair is now retired but was provided with my provisional findings and suggested that NICU give consideration to matters raised in paragraphs [119] to [123] of my provisional findings about some care issues.

XXIV. TWOW also advised that there have been a number of recommendations from HDC's final report dated July 2020 that have been complied with. As noted earlier in my findings[22] it is HDC's responsibility to monitor compliance and ongoing reporting for its recommendations.

XXV. Overall, TWOW's comments on my proposed recommendations have been well-considered, constructive and appreciated. Since Baby Eva's passing in 2017, there has been development of TWOW policy, procedure, protocol and guidelines that correlate with my proposed recommendations. There has also been national introduction of New Zealand's National Maternity Early Warning System (MEWS) (February 2019) and a corresponding TWOW procedure for that system's implementation.

XXVI. I will address TWOW's feedback according to each proposed recommendation. My additional observations and recommendations are aimed at enhancing the subject document to provide greater certainty that Andrea's experience and Baby Eva's subsequent death might be avoided in similar circumstances.

First Written Report from Specialist Obstetrician and Gynaecologist on behalf of the Clinical Director of Obstetrics

Recommendation a)

XXVII. TWOW has a policy in place entitled "Senior Medical Officer (SMO) and Resident Medical Officers (RMOs) Responsibilities and the Limits of Delegation of Responsibilities to RMOs". This policy version 3.2 was issued on 8 March 2022. It is a generic policy that outlines the responsibilities that a SMO has for patients, referrals and scope of responsibility that can be delegated to RMOs.

[22] Refer paragraph [61].

XXVIII. The SMO is ultimately responsible for all patients seen or admitted into the hospital by the RMO's, and the SMO remains accountable for the decisions and actions of their RMOs. RMO's have a professional responsibility under their delegated responsibility to remain within their area of competence and to seek assistance of their SMO when required. SMOs must also ensure they are kept reasonably informed about the condition of their patients and they, or another SMO, should always be available to give assistance to their RMOs.

XXIX. TWOW expectations are that all inpatients are seen every weekday by a RMO, and that the responsible SMO is informed of any significant change in their patients' condition. For weekends and out of hours, the on-call SMO is responsible for all inpatients admitted under their speciality or seen by their on-call RMOs. Every patient should have a documented weekend plan, and the on-call SMO should be informed of any deviation from that plan.

XXX. TWOW has also has a guideline in place entitled "Support for Registrars in the Department of Obstetrics and Gynaecology". This guideline version 2.1 was issued on 2 October 2023 and it specifically lists when the hospital expects the SMO in that discipline is to be notified and any procedures where the SMO should be present within the hospital.

XXXI. It has been specifically acknowledged that Andrea's presentation and Baby Eva's case would fall under the category of "Complex clinical situations" in terms of this guideline.

XXXII. Having regard to my recommendation a) - it has been suggested that a new bullet point be included in this guideline for notifying the on-call SMO for the scenario of "Women with uncontrollable escalating pain requirements, despite analgesia." I endorse that amendment.

XXXIII. Additionally, given the circumstances in this case and findings, in my view it would also be appropriate to reproduce a situation from the generic policy (refer page 4, clause 2.2, fourth bullet point) into the O&G guideline for notifying the on-call SMO for the scenario of "Any woman for whom the diagnosis or management is unclear; and for whom a delay of management until the next ward round would be inappropriate." This is important to ensure that maternity patients with unclear or unascertained medical causes are not left without escalation to senior medical personnel.

Recommendation b)

XXXIV. TWOW noted that Andrea was on continuous fetal monitoring, with regular normal observations, and stable blood tests until the time of her maternal collapse. Having regard to these findings and with respect, the severity of pain that was unresolved and the presence of uterine movements when Andrea was not experiencing labour does not appear to be "normal".

XXXV. TWOW was not certain that any other monitoring could be instituted in this regard. However, it was stated the hospital can certainly ensure that if escalation of concerning issues are not met by the on-call on-site Obstetrician's immediate review (by way of example, due to clinical workload with emergency surgery keeping them in theatre) there is a process for the backup Obstetrician to be notified and arrange immediate obstetrical review of the woman concerned.

XXXVI. I note that the additional points underlined in paragraphs [155] and [156] to a degree give effect to my recommendation b). However, it would be helpful and not unreasonable for the above principle (i.e., of an immediate review by backup Obstetrician if the responsible one is unavailable) to also be stipulated in the O&G guideline.

Recommendation c)

XXXVII. TWOW confirmed that New Zealand's National Maternity Early Warning System (MEWS) was implemented into the Women's Health Service in 2019.

XXXVIII. TWOW has a procedure entitled "Maternity Early Warning System (MEWS)". This procedure version 1.0 was issued on 22 November 2021. The MEWS (including maternity vital signs chart user guide) forms Appendix B of this procedure.

XXXIX. TWOW advise that as part of orientation all nursing, midwifery and medical staff are required to undertake e-learning module about MEWS. As well, all pregnant women including 42 days post-partum have all observations documented on the MEWS chart.

XL. In terms of my recommendation c), I note that clause 2.4 (page 6 of 17) of the MEWS recognises pain and that it can be a sign of deterioration. Pain score is included at the bottom of the MEWS chart on the basis that it would normally be monitored with the same frequency as the other vital signs. The pain score does not count or contribute towards the overall MEWS score in any given situation. The locality of the pain score relative to the chart for all other maternity vital signs is demonstrated on page 11 of the user guide.

XLI. MEWS is a national user guide and standards published by Te Tāhū Hauora - Health Quality & Safety Commission New Zealand. I understand the Commission has now handed the responsibility for monitoring and sustainability of MEWS to the Maternity Team of Manatū Hauora - the Ministry of Health. In that context, I acknowledge TWOW may have limited influence in achieving an amendment to MEWS relating to pain charting as promoted by my recommendation c). Thereby, I will direct a copy of these findings to the responsible agency for MEWS for their consideration.

Recommendation d)

XLII. TWOW advised that on 10 December 2020, the Donaldson case has already been presented at a teaching session attended by members of their Obstetric, General Surgery and Anaesthesia multi-disciplinary team. This was also addressed in a letter to HDC in regard to the complaint on 12 November 2020. I am not party to that correspondence, but assume this related to HDC's report recommendation c).

XLIII. TWOW's teaching session did not involve sonographers, and so it has been suggested that hospital leadership can take my recommendation d) forward and arrange education (i.e., about right iliac fossa pain in pregnancy etc.) for sonographers, relevant to their clinical practice. I endorse that proposal.

Recommendation e)

XLIV. TWOW advised that they host the Fetal Surveillance Education Programme (FESP) associated with interpretation of Cardiotocography (CTG). This programme is run by educators of the Royal Australian New Zealand College of Obstetricians and Gynaecologists (RANZCOG). The expectation of TWOW is that all staff attend this programme two yearly.

XLV. In terms of my recommendation e), TWOW do not have the capacity to host this education on a 6-monthly basis for all staff. Furthermore, TWOW notes that no other hospital units are subject to such a regime and neither would my recommendation be supported by RANZCOG.

Recommendation f)

XLVI. TWOW advised that Practical Obstetric Multi-Professional Training (PROMPT) is delivered four times a year and attended by multi-professionals working within the Women's Health Service. This is a seven hour course which provides a solid foundation for all clinicians involved in ante-natal and intra-partum care. All PROMPT participates also undertake a FESP assessment at the end of each training session.

XLVII. TWOW has a protocol entitled "Maternal Cardiac Arrest". This protocol version 04 was issued on 20 May 2019. The purpose of this protocol is to facilitate and guide practitioners in and during an obstetric maternal collapse to restore the patient's spontaneous heartbeat and respirations, and also to prevent hypoxic damage to the brain and other vital organs. Fulfilling these goals requires a team approach.

XLVIII. This protocol outlines clinical management (including possible causes of a maternal collapse), potential reversible causes, an algorithm for the management of maternal cardiac arrest which includes documentation stating if resuscitation (of the mother) is not successful by 4 minutes to carry out a peri-mortem caesarean section if >24 weeks (term of pregnancy). This guideline is also articulated in the protocol as aim for delivery (Peri-mortem CS) in 4 min if no return to spontaneous circulation, with baby born by 5 minutes.

XLIX. I am satisfied the protocol reflects and is consistent with recommended timings for delivery of the baby following a maternal collapse contained in the Australian standards discussed at paragraphs [105], [106] and associated footnotes 19 and 20 of this finding. As well, the protocol stipulates "the 4 H's and 4 T's" (albeit slightly different ordering of those reversible causes and their respective explanations).

L. However, that said I note that the algorithm and instructions for a peri-mortem caesarean section only apply for maternal cardiac arrest, and not a respiratory arrest or haemorrhage or any other potential cause of a maternal collapse. This is despite the protocol's purpose referring broadly to an "obstetric maternal collapse" and its definition recognising any rapid deterioration of a pregnant woman sufficient to cause loss of consciousness.

LI. In practical application of the protocol, it should not matter what caused the maternal collapse – if the mother is not responding to resuscitation measures, then delivery of the baby is paramount. Adopting the wording of the Queensland Clinical Guidelines, this is because the gravid uterus impairs venous return and reduces cardiac output secondary to aortocaval compression. It is primarily in the interests of maternal, not fetal survival.

LII. TWOW's protocol gives effect to my recommendation f) but it could be more concise by either renamed entirely or some section headings to "Maternal Collapse" with an additional narrative that if resuscitation measures are

not successful by 4 minutes regardless of the cause of the maternal collapse, delivery should be undertaken within the specified timings.

LIII. The protocol contains reference to haemorrhage (clause 2.3, first bullet point) and massive haemorrhage (clause 2.4 alongside Hypovolaemia). Consideration should also be given to expanding the description of haemorrhage cause(s) with matters such as an abruption, uterine atony, genital tract trauma, uterine artery and uterine ruptures, uterine inversion, ruptured aneurysm. This is on the basis noted in paragraph [105] that these are reportedly the most common causes of a maternal collapse.

Concluding Observations

LIV. This first written report, explanations and provision of TWOW policy, procedure, protocol and guidelines that correlate with my proposed recommendations is to be commended. As noted earlier, my further suggestions are aimed at more precision and certainty for other pregnant mothers and their babies.

LV. It is important to recognise that for policies, procedures, protocols and guidelines to be implemented and effective they need to be accessible, monitored, reviewed to accommodate changing circumstances and/or medical advancements and technology, and that practitioners are regularly educated about the documents.

LVI. Lastly, I acknowledge that medical education suggested in my recommendations requires adequate resourcing. So long as there is consistent and regular training opportunities on these subjects, then in theory that should achieve refreshment for existing personnel and capture of new staff members coming into the hospital setting.

Second Written Report from Specialist Neonatal Paediatrician and Head of Department of NICU

LVII. This report does not concern recommendations, but rather communicates and affirms certain matters raised in paragraphs [118] to [123] of my provisional findings in relation to some care issues.

LVIII. I consider it appropriate for the Donaldson family and for the public record to set out the feedback provided. In doing so, I am hopeful it provides some reassurance and closure for Baby Eva's family.

LIX. TWOW apologised that the Donaldson family left NICU with the experience of a lack of open and professional communication. The Head of Department stated that it was a personal endeavour to ensure this is guaranteed and provided by the whole team looking after NICU families.

LX. In relation to paragraphs [119], [120] and [121], it was stated that there is an expectation that significant medical findings and their consequences are relayed to families in a timely manner. To support that, a special section in the hospital's clinical notes has been introduced where conversations with families are documented, and can easily be reviewed so that the treating team are aware what information has been relayed to the family.

LXI. It was stated that NICU would not normally advise a family of the details of a cord gas result, but use this as an indicator that there was a significant compromise to the baby.

LXII. This report confirmed that there were three head scans performed on Baby Eva (in contrast to the narrative in paragraph [41] above). The first scan was on 17 January 2017 but there is no report of that. The second scan on

18 January 2017 was reported to demonstrate bilateral parasagittal echo densities (which might be indicative of an intracranial bleed). The third scan on 21 January 2017 was reported to have "… a small grade1 IVH on the left side. No other abnormalities are evident. The cerebellum may also have a small focal haemorrhage".

LXIII. In general terms, an isolated Grade 1 bleed was said to have a very low risk of long-term consequences, and those scan findings would not have changed the course of the treatment and the ability to re-direct care. It was not until Baby Eva started to deteriorate that this became an option.

LXIV. In relation to paragraphs [122] and [123], the Head of Department apologised to Andrea and her husband for their experience and agreed that it would have been traumatic. The layout of NICU does require an exit strategy through the unit's corridor, the doors to the nurseries and other parent rooms are closed, and other parents are unaware of the situation.

LXV. An alternative option would have been to walk down the corridor with Baby Eva placed into an incubator or cot, however it was recognised that some parents do choose to carry their deceased babies. There is no other means of getting from a nursery to a parent room without going down one of the two corridors.

LXVI. NICU is currently in the process of re-designing a special room that can be used for re-direction of care in a private setting without the need to relocate after a baby passes away.

LXVII. Finally, in relation to paragraph [143] of my provisional findings on causes of death, there was a suggestion to reorder causes on the basis that the direct cause of Baby Eva's death was post-natal pneumonia, with underlying conditions of hypoxic ischaemic brain injury secondary to antepartum asphyxia.

LXVIII. I do not consider that appropriate. It may be interpreted as minimising the primary medical implications for Baby Eva that flowed from her mother's maternal collapse that contributed to death and its causes. My preference and discretion is to use the framework for causes of death from the post-mortem examination as was reported to the Coroner by Consultant Perinatal Pathologist Dr Jane Zuccollo.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Eva obtained during the investigation of her death, in the interests of decency and personal privacy. Additionally, an order under section 74 prohibits the making public of the name of Dr X in the interests of justice and personal privacy.

Finau [2023] NZCorC 143 (10 November 2023)

CIRCUMSTANCES

Ruth Kathleen Toka aka Finau, aged 30, died between 18 and 20 July 2021 at Auckland of sudden unexpected death in epilepsy.

Ms Finau suffered from an intellectual disability along with epilepsy and diabetes. At the time of her death she lived in a small flat with another supported person. She received cooking and cleaning support from Spectrum Care in the afternoons.

Ms Finau had a history of aggressive behaviour including seven recorded incidents of verbal and physical aggression. At the time of her death she was prescribed a range of medications. Spectrum Care staff had "negotiated" with her so that she had one week of blister packed medications to self-administer. Staff reminded her daily about taking medications and if she was in a good mood, she would usually take medications without concern. However, she would often refuse to take medication when she was angry. Ms Finau would also hide the blister pack so staff could not check if she had taken medication or not. Sometimes she would forget to take medications.

On 18 July 2017, Ms Finau had given a staff member food to be cooked for dinner. The meal was delivered shortly thereafter. On 19 July 2017, a staff member went to her room to ask what she wanted for dinner. Music could be heard and Ms Finau was seen lying in her bed. The staff member decided not to wake her due to fears of aggressive behaviour. On 20 July 2017, at 11am a staff member went to check on Ms Finau and noticed she was in the same sleeping position as the day before. Emergency services were called and Ms Finau was confirmed deceased.

COMMENTS OF CORONER TETITAHA

I. I make the following comments pursuant to section 57A of the Coroners Act 2006.

II. I have concerns about the standard of care Ms Finau received whilst resident at Spectrum Care services.

III. The post-mortem report shows Ms Finau was not taking her anticonvulsant medication. There was no evidence of epilim and levels below normal use of lamotrigine. Both are anticonvulsant medication.

IV. There was no formal monitoring being undertaken to ensure Ms Finau was medication compliant at the time of her death. The evidence indicates staff were reluctant to actively monitor Ms Finau due to aggressive behaviour.

V. Due to fears of aggressive behaviour, staff also allowed Ms Finau to remain in her room unchecked for two days between 18 and 20 July 2021. Given she had epilepsy and was known to be at times medically non-compliant, regular physical checks on her welfare should have been undertaken.

VI. Spectrum Care services should undertake its own audit of the care Ms Finau received against its policies. Remedial action should be identified. It should also consider providing a report to Ms Finau's family of the outcome.

VII. These comments are directed to Spectrum Care services.

RECOMMENDATIONS OF CORONER TETITAHA

I. I had intended making a recommendation pursuant to section 57A of the Coroners Act 2006 that Spectrum Care Services undertake an audit of the care they provided to Ms Finau.

II. I have now received a reply from Spectrum Care Services regarding the above comments and recommendation together with a copy of a report of an investigation undertaken into this death by Dr Aloma Parker and Rangi Pouwhare dated 6 September 2021. Given the content of the investigation there is no utility in recommending any further internal audit of this death by Spectrum Care Services.

III. The investigation report identified similar concerns to those set out in my findings as well as additional matters such as the clash between Ms Finau's independence and her Samoan family's expected standards of care to be undertaken by Spectrum Care Services. Recommendations from the report were that Spectrum Care:

- Consider a definition with minimum requirements for "oversight" of people receiving 24/7 support.
- Ensure formal procedures are in place across the service where people are managing their own medicine.
- Undertake cultural reviews for all clients.
- Plan so that staff don't have to carry on with shifts following serious incidents.
- Establish procedures for maintaining communication with families who are hard to contact.

IV. The above recommendations (if actioned) could prevent similar deaths to Ms Finau. I endorse and make the same recommendations pursuant to s57A.

Reference to Health and Disability Commissioner

V. The Health and Disability Commissioner (HDC) is empowered to enforce the Code of Health and Disability Services Consumers Rights (the Code). These rights include the right to be treated with respect, freedom from discrimination, coercion, harassment and exploitation, dignity and independence, services of an appropriate standard, effective communication, full information, informed choice and informed consent, support, teaching all research and the right to complain.[23]

VI. Ms Finau was entitled to services of an appropriate standard and the right to support under the Code of Health and Disability Services Consumer Rights (the Code). There are indications on these facts that the services provided fell below those standards.

VII. I consider that a reference to the Health and Disability Commissioner pursuant to section 119 of the Coroners Act 2006 is warranted. There is a public interest in having this death investigated by the Health and Disability Commissioner and performance of its functions. There are concerns raised about the care received including whether it met the standards set out in the Code.

VIII. Accordingly, I refer this death to the Health and Disability Commissioner pursuant to section 119 of the Coroners Act 2006.

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

[23] See the Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) regulations 1996 https://www.legislation.govt.nz/regulation/public/1996/0078/latest/whole.html

Pope [2023] NZCorC 168 (18 December 2023)

CIRCUMSTANCES

Vincent Robert Pope, aged 77, died on 25 March 2021 in Dunedin Hospital as a result of asphyxia occurring in the context of upper airway obstruction by impacted food matter (choking).

Mr Pope suffered from dementia and was admitted to Dunedin Hospital on 10 February 2021 following a fall. Due to concerns about his ability to live at home he was assessed by psychiatric services and became subject to a Compulsory Assessment Treatment Order. He was cared for in Ward 6C of the hospital, pending long-term accommodation becoming available. A Do Not Resuscitate (DNR) Order was in effect from 17 February 2021.

On 25 March 2021 while Mr Pope was eating dinner, he began to cough continuously and was unable to respond to a nurse. Recognising he was choking, staff responded by applying blows to his back. There were no suction units in the dining and lounge area. Mr Pope was moved to another room in order to find appropriate equipment and to move him away from other patients. The nearest crash trolley, which contained a portable suction unit, was locked away in a neighbouring Ward 6ATR. Realising there was no appropriate equipment nearby, nurses moved Mr Pope to a private room and lay him on the ground in the recovery position while appropriate equipment was located. A nurse was able to suction out two small pieces of carrot. However, because Mr Pope was on the ground, they could not use oxygen tubes which were designed for bed use and thus too short. Nurses also could not lift Mr Pope onto the bed as he was too heavy. An extension tube was acquired but the supply of oxygen did not assist Mr Pope.

Hospital staff continued to apply back blows and suction vomit from Mr Pope's mouth. An electrocardiogram showed his heart had stopped beating. CPR was not performed on the basis of the DNR Order. Mr Pope was pronounced dead at 5:38pm.

The Southern District Health Board conducted a Clinical Incident Review and found that Mr Pope's death was a non-preventable event, with his pre-existing medical conditions more than likely contributing to the outcome. It also found:

> (a) that there was no immediately accessible crash trolley on Ward 6C, the nearest being in the adjacent Ward 6ATR; it also found that having access to a shared crash trolley would have been optimal;
>
> (b) the double doors between the units were locked with one-way access, which had not been corrected since Covid-19 lockdown preparations despite repeated requests by the Wards;
>
> (c) there was another door through which the crash trolley could have been retrieved, however it was located some distance away; and
>
> (d) a suction unit was not able to be located quickly so Mr Pope was taken to a room that had one.

In response to the above, the hospital advised that the release button on the door between the two Wards was reinstated after the incident, the inactive codes relating to Covid-19 lockdown preparations had been removed from the system, and a notification procedure for outstanding maintenance requests was put in place.

COMMENTS AND RECOMMENDATIONS OF CORONER SCHMIDT-MCCLEAVE

I. I note that, as helpfully advised to me by Te Whatu Ora[24] that:

- The emergency response to a choking incident is back blows and chest thrusts until the patient's airway either becomes clear or the patient becomes unconscious.
- Suction and oxygen are not needed at this time, but will be important once the resuscitation team arrives, and securing of the airway is attempted using equipment from the resuscitation trolley.
- If the doors had not been locked, the resuscitation trolley in Ward 6ATR (the emergency equipment for Wards 6C and 6ATR shared across the floor) would have been accessed promptly, and includes a mobile suction unit, oxygen, and an Automated Emergency Defibrillator (AED). Additional equipment to aid in airway management would also have been available.

II. The comments and recommendations I make below are reflective of the above points.

III. I make the following comments and recommendations pursuant to section 57(3) and 57A of the Coroners Act 2006. The purpose of these comments is to reduce the chances of further deaths occurring in similar circumstances to those in which Mr Pope died:

- Te Whatu Ora Southern Hospitals to review all hospital clinical areas to ensure they have ready access to emergency equipment relevant to the setting (as determined by the Resuscitation Committee).
- Te Whatu Ora Southern Hospitals to ensure processes are in place to familiarise all clinical staff with where the emergency equipment is located, and what is available in particular areas and Wards.

IV. I also urge all hospitals in New Zealand to ensure they have an up-to-date and accurate system for ensuring all maintenance requests are on a timetable for action, particularly any which may have arisen due to preparations made at the time of the Covid-19 pandemic.

Note: An order under section 74 of the Coroners Act 2006 prohibits making public any of the photographs of Mr Pope entered into evidence, on the grounds of personal privacy and decency.

Tapuvae [2023] NZCorC 141 (8 November 2023)

CIRCUMSTANCES

Solofua Sharon Tapuvae, aged 54, died on 29 July 2021 at Auckland of hemopericardium as a result of an aortic dissection.

[24] Letter dated 12 December 2023 from Sharron Feist, Director of Nursing for Planning, Funding, Population and Public Health and Acting Chief Nursing and Midwifery Officer.

At around 5:45pm on 29 July 2021, Solofua called out to her husband, Makarafu, after experiencing pain in her chest. Makarafu immediately contacted emergency services. When asked by the call taker about Solofua's symptoms, Makarafu noted that she had a "sore stomach". After the first call, Makarafu called the ambulance back around five times, but they told him they could not find a close vehicle.

At approximately 7:08pm the ambulance dispatcher was informed that Solofua had stopped breathing. The emergency service call taker advised him to start CPR, which he did. At that point, a paramedic ambulance was dispatched. Around 15 minutes after Makarafu started CPR he noticed that Solofua had no pulse. She was not breathing and had become cold. Ambulance personnel arrived on scene and continued resuscitation events, but Solofua was unable to be revived and was declared deceased.

A post-mortem examination found that Solofua died of hemopericardium (blood in the pericardial sac of the heart). This was caused by an aortic dissection that resulted from hypertensive cardiovascular disease. Obesity was noted to be a contributing factor.

St John noted that there was a very high workload at the time Makarafu called and that all available ambulances in the region were committed to patients at the time the initial 111 call was made.

Independent clinical advice was obtained from Dr Gary Clearwater, the coronial service Chief Medical Advisor, who explained that an aortic wall dissection is a serious, life-threatening condition. He noted that Solofua had what was known as "Type A" dissection, which requires prompt major chest surgery. As a result, there was a very narrow window of opportunity for Solofua to have survived the medical event. Dr Clearwater also noted that abdominal pain occurs in approximately 20% of cases of aortic dissection, as well as chest pain. In this case he thought the abdominal pain might have been a distractor and that it was possible a higher triage priority may have been given if chest pain was identified as a significant symptom at any stage during the five phone calls.

Dr Clearwater noted that Makarafu may have had difficulty understanding some of the questions that he was asked regarding the nature of the pain Solofua was experiencing. He stated that in his experience people with English as a second language can sometimes have difficulty conveying their symptoms accurately when answering open ended questions.

RECOMMENDATIONS OF CORONER ANDERSON

I. On the basis of the evidence that is available, it is not possible to conclude that Solofua would have survived if an ambulance had been more quickly dispatched. She experienced an extremely serious medical event with a high mortality rate, even when optimal care and surgery is provided in a timely manner. However, I am very concerned at the lack of ambulance availability after Solofua collapsed. I am also very mindful of the desperate situation Makarafu found himself in, calling repeatedly for emergency assistance while his wife was dying, and being told that there was no ambulance available to assist them. Solofua's tragic death highlights the serious and distressing impacts that can occur when there are insufficient ambulances resources available for our communities.

II. I have also given careful consideration to the matters raised by Dr Clearwater and consider that there are opportunities for St John to reflect on aspects of the services provided in relation to Solofua's care. While these

matters may not have changed the outcome for Solofua, they may assist in improving communication with families seeking urgent ambulance assistance in future.

III. Accordingly, I make the following recommendations to St John pursuant to s 57 of the Coroners Act 2006. These recommendations are made for the purpose of reducing the chances of further deaths occurring in similar circumstances:

- That St John continue its efforts to obtain further funding and resources from central government so that it can adequately meet the needs of the communities that depend on it for the provision of ambulance services; and
- That St John consider whether any changes are required to emergency call taking processes to improve communication with callers who may not speak English as their first language, in light of Dr Clearwater's comments.

IV. As required under s 57A of the Act, I informed St John of my intention to make these recommendations. I received a reply from the St John General Manager of Clinical Effectiveness. He advised that St John accepted the recommendations, and he extended condolences to Solofua's family and acknowledged the distress caused by the delay in the ambulance attending. He provided information about the steps being taken in relation to the recommendations and advised that since Solofua's death a further 9.5 12-hour emergency ambulance shifts per day had been added in the Auckland area.

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

Miscellaneous

Master A [2023] NZCorC 122 (5 October 2023)

CIRCUMSTANCES

Master A, aged 17 months, died on 12 October 2015 at Southland of brainstem and upper spinal cord ischaemia, due to upper cervical and thoracic spine hyperflexion injury due to occipital impact injury. Multiple peripheral bone fractures of varying ages were identified as a contributing condition.

Master A was discovered deceased by his mother on 13 October 2015. Her partner, Mr D, was charged with the murder of Master A. Mr D died before the conclusion of the criminal process. The coroner concluded on the balance of probabilities that Mr D intentionally inflicted the injuries which caused Master A's death.

Prior to Master A's death, he was taken to Southland Hospital by his mother four times in September and October 2015 due to a leg injury. This injury was eventually diagnosed in Christchurch Hospital as a healing spiral fracture of the left tibia. Master A also had injured fingernails, a dislodged tooth, and bruising. Following a hospital review with Master A's

mother, a Report of Concern was made to Oranga Tamariki (OT), formerly Child, Youth and Family (CYF). A referral was also made to the Christchurch Police Child Protection Team. Master A was discharged from Christchurch Hospital and his mother was advised to return to Southland Hospital for a skeletal survey.

As a result of the Report of Concern, a Police officer and two staff members from OT met Master A and his mother at the airport and transported them to Southland Hospital. While in Southland Hospital, an OT social worker met with Master A's mother and discussed a safety plan. This safety plan was not recorded in writing. According to the social worker, the safety plan included that Mr D would not be alone with Master A at any time. Master A was discharged home with his mother on 8 October 2015. Master A's mother said it was never described to her as a safety plan, she did not think there was any safety plan in place, and she disagreed that she was told that Mr D could not be alone with Master A.

At the time of Master A's death, a Memorandum of Understanding dated August 2011 was in place between OT, the Police, and Te Whatu Ora. The Memorandum outlined a collaborative working relationship between the agencies to ensure health and safety outcomes for children and young people.

The Memorandum required that where a child is admitted to hospital with suspected or confirmed abuse or neglect, a Multiagency Safety Plan must be in place prior to discharge. Clause 44 of the Memorandum states "The core elements of this plan will be developed prior to the discharge planning meeting, in consultation with CYF, the paediatrician under whose care the child was admitted and key contact persons from other agencies involved."

RECOMMENDATIONS OF CORONER ELLIOTT

I. Counsel for Mr M [Master A's father] submitted that it would be appropriate to create or nominate an organisation outside of the agencies involved in the Memorandum of Understanding to carry out regular and unannounced audits to ensure that these documents are being complied with.

Discussion

II. I agree that audits from an independent organisation would be a means of monitoring compliance with the Memorandum of Understanding, albeit after the event. However, it is far more preferable that the relevant parties understand the importance of fully complying with the Memorandum at the relevant time.

III. The Memorandum describes the requirements of a safety plan, including that it should be in writing. This case illustrates the importance of complying with the Memorandum and, in particular, ensuring that the plan is in writing.

IV. Counsel for Police said that discharge meetings between Oranga Tamariki, Southland Hospital and the Police have now been formalised and a template agreed. Further, safety plans are now always in writing and provided to each agency.

V. The Memorandum states:

> 5. Guiding principles
>
> The parties agree to be guided by the following principles:
>
> …

> Families have the right to participate in decision-making about their children and young people.

VI. However, while the Memorandum provides that the safety plan will be developed 'in consultation with CYF, the paediatrician under whose care the child was admitted and key contact persons from other agencies involved,' the family is not mentioned.

VII. A safety plan is more likely to be effective where the primary caregiver participates in the decision-making about the proposed plan and agrees to what is being proposed. This may not be possible where a family member is suspected of having harmed the child, however presumably in such cases any safety plan would not incorporate that person in a primary caregiver role.

VIII. I therefore recommend that the Memorandum be amended to read:

> 44. The core elements of this plan will be developed prior to the discharge planning meeting, in consultation with the primary caregiver, CYF, the paediatrician under whose care the child was admitted and key contact persons from other agencies involved.

IX. Oranga Tamariki provided the following comments in relation to this recommendation:

> A review of the MoU between Te Whatu Ora, Police and Oranga Tamariki has been scheduled for some time to start this year. In line with the Coroner's recommendation, a requirement to involve primary caregivers in safety planning prior to pēpi being discharged from hospital care will be considered.
>
> Oranga Tamariki is mindful that the upcoming review will need to consider the appropriate health agency representation, following the health reforms that established Te Whatu Ora and Te Aka Whai Ora. This could impact the usual review timeframes.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of names of Mr D, Master A and Master A's mother and any name or particular likely to lead to their identification, and photographs that show Master A deceased, in the interests of justice, decency and personal privacy. A further order under section 74 prohibits the publication of the names of witnesses and any particulars likely to identify them, the names of any person referred to in the inquest bundle, evidence or submissions or any particulars likely to identify them, the names of members of Master A's whānau, the contents of the inquest bundles (except to the extent that their contents were referred to in court at the inquest commencing on 17 October 2022 and in the subsequent findings), and the name of the town where Master A lived, in the interests of justice and personal privacy.

Wrigley [2023] NZCorC 147 (20 November 2023)

CIRCUMSTANCES

Promise Kaye Te Awhina Wrigley, aged nine months, died on 9 August 2020 at Starship Childrens Hospital of hypoxic ischaemic encephalopathy. This occurred when Promise accidentally became caught in the harness of her car seat.

Promise and her twin sister were born on 7 November 2019. Promise was a healthy baby.

On 5 August 2020, Promise and her parents went to her grandparents' house in their van. On arrival, the parents parked the van and took their two young sons and Promise's twin sister into the house with them. As Promise was drinking a bottle of formula while buckled into her car seat, they left her in the van to finish drinking. The car seat was not strapped

into the vehicle and the car seat buckles across Promise's chest were done up. However, the buckle between her legs was not connected to the centre clasp and the straps were left loose so Promise could move around.

Promise's parents went inside the house but left the sliding door of the van open so they could see Promise from inside the house. They checked on her several times; she was still awake and leaning back in her seat and drinking her bottle. After about 10 minutes, Promise's father went to the van to bring her inside. He found her leaning slightly forward and her lips were purple. CPR was commenced and emergency services were called. Promise was taken to Rotorua Hospital where she was placed on a ventilator before being transferred urgently to Starship Hospital in Auckland. Doctors at Starship provided neuroprotective intensive care for 72 hours. Testing showed that Promise had a severe hypoxic injury and that almost her entire brain was severely and irreversibly damaged. This damage was consistent with a lack of oxygen to the brain. Promise remained unconscious and intensive care supports were discontinued. Promise was kept comfortable until she died on 9 August 2020.

COMMENTS OF CORONER ANDERSON

I. It appears that Promise was a much loved and cared for baby. Her parents were close by and were checking on her regularly as she finished drinking her bottle in the back of their vehicle. In between checks, Promise became caught in either the straps or buckle of her car seat harness. The harness was only partially secured, with the crotch strap unbuckled. This meant that Promise was able to move around and could potentially slide downwards. Her breathing was impeded and due to the lack of oxygen, Promise suffered severe and irreversible brain damage within a short period of time.

II. Promise's tragic death is a reminder about the importance of closely supervising young children, including while they are restrained in car safety seats. Babies and children should never be left unattended while buckled into safety restraints, even for short periods of time. Asphyxiation can occur very quickly, with devastating consequences.

III. Promise's car seat had prominent warning labels located on the equipment and there is existing guidance about the safe use of car seats and other child restraint devices such as strollers and prams. This includes the information on the Plunket website which states as follows.

> *Prams, strollers, portacots and child restraints:*
>
> *Always check that harnesses are used correctly. If babies can slide down in a bouncer or car seat, they may get tangled in the straps. Using a five-point harness according to the manufacturer's instructions, and keeping a close eye on your baby, can help prevent this from happening.*

IV. I wish to draw attention to this advice and the need for extreme care with infant equipment. These sad events highlight the importance of being alert to safety warnings and ensuring that car seats and other devices are always used in accordance with the manufacturer's instructions.

V. I will send copies of these findings to Safekids and Plunket, to assist in raising awareness about child safety related matters and safe use of car seats. A copy will also be sent to the National Mortality Review Committee.

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

Motor Vehicle

Cairns, Campbell, Chand and Wallace [2023] NZCorC 161 (11 December 2023)

CIRCUMSTANCES

Avinash Avinesh Chand, aged 33, Sheryll Jean Cairns, aged 67, Donald James Wallace, aged 62, and Jonathan Marlo Campbell, aged 54, died on 4 June 2021 of high energy impact injuries sustained in a motor vehicle collision on Cochranes Road, Ashburton.

At approximately 9:35am, Mr Chand was driving south on Cochranes Road in an eight-seat Toyota Hiace van. There were five passengers in the van including Ms Cairns, Mr Wallace and Mr Campbell. At the intersection with Wakanui Road, Mr Chand drove past a stop sign and through the intersection. An oncoming truck travelling west along Wakanui Road collided with the van.

Mr Chand, Ms Cairns and Mr Wallace died at the scene from their injuries. Mr Campbell died from his injuries later that day at Ashburton Hospital. The two other passengers in the van and truck driver survived the crash.

The Canterbury Serious Crash Unit (SCU) concluded that the crash occurred due to Mr Chand's apparent lack of awareness of the stop sign and/or the intersection. It noted there was no advance warning sign of the intersection on Cochranes Road. The SCU found that the minimal signage and lack of clear road markings had limited the visibility and conspicuity of the intersection. It also found a shelterbelt of conifer trees on the right side of Wakanui Road had contributed to the crash, as it blocked the view of approaching vehicles on Cochranes Road and so eliminated any avoidance opportunities for the truck driver.

Ashburton District Council advised that the road markings had been repainted since the crash occurred, with advance warning signs and larger stop signs also erected. It reported that stop signs at other rural intersections would also be replaced with larger signs to increase their visibility. In addition, Waka Kotahi advised it was carrying out a project to address the safety risks associated with rural crossroads.

COMMENTS OF CORONER ELLIOTT

I. This crash has highlighted once again the danger associated with this type of rural crossroads. Ashburton District Council has taken steps to address the danger at this and other similar intersections and this work is ongoing. I anticipate that Waka Kotahi's Rural Crossroads Project will result in the identification of further steps which can be taken to address this issue. I therefore conclude that there is no need to make any recommendations to Ashburton District Council or Waka Kotahi.

II. It is important that drivers are alert to the dangers of this type of crossroad. This may reduce the chances of deaths in similar circumstances. I therefore make the following comment pursuant to section 57A of the Coroners Act 2006:

> This crash illustrates the danger that drivers on long, straight rural roads may not identify the presence of an intersection. Drivers should be alert to the possibility of intersections on rural roads and pay close attention to signs and road markings warning of an approaching intersection.

Day [2023] NZCorC 169 (21 December 2023)

CIRCUMSTANCES

Kody Denym Hone Day, aged 29, died on 26 September 2021 at Forest Hill Road, Auckland, of multiple injuries (head, chest, abdomen, and limbs) as a result of a motor vehicle impact.

On 26 September 2021 Kody was drinking with his friends. As the day wore on, Kody grew increasingly enthusiastic about racing his car. At around 9:15pm, Kody and his friend decided that they would go for a drive in Kody's car. While navigating a left-hand bend along Forrest Hill Road, Kody drifted into the path of an oncoming truck and collided. Kody suffered significant injuries in the collision and was declared deceased at the scene. His friend sustained significant injuries.

The New Zealand Police Serious Crash Unit investigated the crash and noted that Kody's blood alcohol level was nearly 3.5 times the legal limit. Additionally, Kody was not wearing a seatbelt at the time of the accident and was driving at a high speed prior to the collision. Moreover, he was not a holder of a New Zealand driver's license and had been prohibited from driving by the Police since January 2008. Kody had also faced multiple charges for driving while intoxicated.

COMMENTS AND RECOMMENDATIONS OF CORONER MILLS

I. Kody's death is a tragic reminder of the risks of driving too fast, not wearing a seat belt and driving whilst under the influence of alcohol. Numerous safety campaigns, as well as other Coroners' findings, have highlighted these risks. I make the following comments pursuant to section 57(3) of the Coroners Act 2006 to reinforce those messages:

- Kody's avoidable death reinforces the dangers of driving while intoxicated by alcohol. It is unsafe to drive while intoxicated by alcohol, whatever you perceive your alcohol-tolerance to be. People cannot reliably estimate their driving abilities when intoxicated and the simple message is – Do not drink and drive.
- Do not drive at excessive speed. The posted speed limit is there for your safety and the safety of others.
- Always wear a seatbelt. While it is not known if Kody would have survived the accident had he been wearing a seatbelt, the advice on the Waka Kotahi website states that your chances of being killed or injured in a road crash is reduced by 40% if you wear a seatbelt.

II. These comments are directed to the driving public of New Zealand, for the purposes of public education.

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

Frankum [2023] NZCorC 167 (18 December 2023)

CIRCUMSTANCES

Russell Phillip Frankum, aged 57, died on 17 September 2020 at the intersection of Brougham Street and Collins Street in Christchurch of head and torso trauma injuries sustained when his bicycle collided with a Toyota HiAce van.

At approximately 7:45pm on 17 September 2020, Mr Frankum was riding his bike wearing a helmet and dark coloured clothing under his high visibility ("Hi-Vis") vest. It was dark and he had no lights on himself, his helmet or his bike. He entered a pedestrian-cycle crossing on Brougham Street, crossing against a red light.

Mr Neilson was driving his van along Brougham Street and had a green light at the crossing intersection. The van struck Mr Frankum at the crossing. Emergency services were called and he was pronounced dead at 8.40pm.

Toxicology analysis detected alcohol in Mr Frankum's blood at a concentration of 220mg/100mL. This meant Mr Frankum was over four times the legal driving limit of 50mg/100mL.

The Serious Crash Unit (SCU) investigated the crash and found that Mr Frankum's Hi-Vis vest was less visible from the side; his failure to comply with traffic lights was causative of the crash; and his judgement was likely impaired by alcohol.

SCU further noted that shrubbery on the side of the road blocked the view of cyclists and pedestrians coming from Collins Street until approximately six metres from the edge of Brougham street. Any cyclist entering from the north on Collins Street would therefore not be able to see the traffic approaching from Brougham Street until they have passed the shrubbery.

COMMENTS AND RECOMMENDATIONS OF CORONER SCHMIDT-MCCLEAVE

I. I understand that over the years several schools and businesses in the area of the Brougham Street/Collins Street cycle-pedestrian crossing have raised concerns about the safety of this crossing.

II. For the purpose of considering whether any recommendations were needed I consulted with Waka Kotahi and the Christchurch City Council as to any plans currently in place, or changes made, at the Brougham Street/Collins Street intersection and crossing. I thank both organisations for the information they provided to me.

III. Waka Kotahi provided me with details of the proposed Brougham Street upgrade, which includes a dedicated walking and cycling bridge over the State Highway, with rams to access it from either side. At ground level, immediately adjacent to the road carriageway, it is intended there will be a fence/barrier extending fore and aft of the overhead bridge to prevent pedestrians from crossing at ground level (as they currently can do via the median strip). The project is aiming to commence in September 2024 (subject to consent, property acquisition and

funding) and will take between 18-24 months to complete. During completion, the pedestrian crossing will continue to be maintained.

IV. In turn, the Christchurch City Council advised me that the shrubbery at the pedestrian crossing has previously been on a reactive maintenance regime with shrubbery cut back when the Council was notified. This has now been placed on a regular maintenance round and will be inspected on a monthly basis, with any necessary trimming of trees and bushes undertaken. The shrubbery, including around the streetlight, was cut back in the week commencing 11 December 2023.

V. In light of the above information, I therefore make the following comments and recommendations pursuant to section 57(3) and 57A of the Coroners Act 2006. The purpose of these comments is to reduce the chances of further deaths occurring in similar circumstances to those in which Mr Frankum died.

Alcohol and cycling

VI. The perils of driving while under the influence of alcohol have been commented upon by coroners on many occasions. Similar considerations with respect to impairment apply to riding a bicycle.[25] Riding while under the influence of alcohol can affect not only reaction times, and capacity to scan for hazards, but also the ability to safely control the bicycle.

VII. Without a doubt, Mr Frankum was an experienced cyclist who used his bicycle as his primary form of transport around town. He was likely very experienced in using the cycle-pedestrian crossing on Brougham Street, as he lived nearby. With his blood alcohol being more than four times over the legal driving limit, however, it is probable that his reaction times to vehicles approaching, and to other hazards present, would have been negatively impacted.

VIII. I urge the public to exercise the same restraint when it comes to drinking alcohol and riding a bicycle as for driving a vehicle.

Lights

IX. Although Mr Frankum was appropriately wearing a Hi Vis vest, the remainder of his clothing and helmet were dark, and his bicycle only sported a rear red reflector light.

X. Visibility when riding at night-time is critical for safety.[26] Bicycle lights are required to be used between sunset and sunrise, and at any other time when a cyclist is unable to see a person or vehicle 100 or more metres away, a distance that Waka Kotahi estimates is about the length of a rugby or football field. Waka Kotahi also advises that shadow from trees or buildings can also reduce visibility.

[25] www.nzta.govt.nz/roadcode/code-for-cycling/the-purpose-of-this-code/

[26] www.nzta.govt.nz/roadcode/code-for-cycling/equipment

XI. Front lights are required to be white or yellow, and rear lights red. Flashing lights are permitted and may enhance visibility because drivers will be more likely to notice the unusual rhythm created by a pulsating light.

XII. Further, all bicycles must have a red or yellow reflector facing backwards, and pedal reflectors on the front and back of each pedal.

XIII. I encourage all cyclists to use adequate lighting, as set out on the Waka Kotahi website referred to in footnote 2 below, and wear Hi Vis clothing, when cycling in dark or low visibility conditions.

Brougham Street/Collins St intersection and cycle-pedestrian crossing

XIV. I endorse the changes that both Christchurch City Council and Waka Kotahi have advised me have been made, or are planned to be made, to the cycle-pedestrian crossing, and to Brougham Street generally with respect to cyclists and pedestrians. I am heartened by the proposed upgrade in train from Waka Kotahi and consider that the safety concerns that my finding has highlighted will be addressed by the upgrade. Until the upgrade is complete, I urge both Waka Kotahi and the Christchurch City Council to continue their maintenance of the crossing, including by the regular trimming back of the shrubbery.

Note: An order under section 74 of the Coroners Act 2006 prohibits the making public of any photographs taken of Mr Frankum during this inquiry, in the interests of personal privacy and decency.

Galbraith [2023] NZCorC 128 (17 October 2023)

CIRCUMSTANCES

Warren Victor Galbraith, aged 68, died on 21 October 2019 at Christchurch Hospital of traumatic brain injury sustained in a motorcycle accident.

Mr Galbraith was retired and lived with his wife in Rakaia. He was passionate about motorcycles and was an experienced driver. On 19 October 2019 Mr Galbraith was at home and had washed his motorcycle to ready it for sale. He then drove the motorcycle onto Railway Terrace to dry it. He did not put on a helmet for this trip.

As Mr Galbraith was driving north on Railway Terrace towards the intersection with Dunford Street, a motorist was driving his car east on Dunford Street towards the same intersection. The motorist stopped at the intersection to turn right onto Railway Terrace. On seeing the car, Mr Galbraith braked heavily, causing the motorcycle to skid for 18 metres before skewing sideways, flipping onto its side and throwing Mr Galbraith forward over the handlebars. He was thrown approximately 10 metres before landing on the roadway. The motorcycle continued to skid and came to rest on top of Mr Galbraith's legs. Mr Galbraith was unresponsive at the scene. He was taken to Christchurch Hospital, where he was diagnosed with an unsurvivable brain injury. Mr Galbraith's life support was withdrawn on 21 October 2019 and he died shortly after.

The Police Serious Crash Unit (SCU) carried out an investigation into the crash and noted that the intersection of Railway Terrace West and Dunford Street is an uncontrolled intersection with no road markings. Due to the lack of road

markings and layout of the intersection, the car may have appeared to Mr Galbraith to be in the middle of the intersection when it was not. As a result, Mr Galbraith activated his brakes resulting in the crash.

The SCU calculated that the motorcycle was travelling at a speed of between 72km/h and 77km/h at the time of the crash. The posted speed limit for the road was 50km/h. Mr Galbraith could have stopped in time had he been driving at the speed limit and therefore excessive speed was considered to be a contributing factor. Mr Galbraith had not been wearing a helmet at the time of the crash and it was highly likely that he would have survived had he been wearing a helmet.

RECOMMENDATIONS OF CORONER TELFORD

I. At the conclusion of their investigation, the SCU team noted that it was likely that the layout of the intersection and lack of road markings contributed to the crash.

II. I have also received similar submissions from Mr Galbraith's widow (on behalf of the family). Ms Galbraith tells me that she believes road markings are necessary along with a roundabout and/or signage.

III. I have therefore indicated to Ashburton District Council my intention to make the following recommendations:

- That Ashburton District Council make suitable changes to the layout of the intersection of Railway Terrace West and Dunford Street and install appropriate traffic signs and road markings.

IV. I have since received a helpful response from the Council in which they advise they are going to install a 'Give Way' sign and paint appropriate lines at the Railway Terrace West/Dunford Street intersection. To be consistent with the signage and line marking, they will also install the same signs and line markings at the other three intersections on Railway Terrace West (at the Normandy Street, Michael Street and Rolleston Street intersections respectively). The council advises this work is scheduled for completion by the end of this month – October 2023.

V. Considering this response, I am able to make the following recommendations which precisely mirror the council's proposed work plan:

- **By the end of October 2023, Ashburton District Council install a 'Give Way' sign and paint appropriate lines at the Railway Terrace West/Dunford Street intersection. To be consistent with the signage and line marking, the same signs and line markings are installed at the other three intersections on Railway Terrace West (at the Normandy Street, Michael Street and Rolleston Street intersections respectively).**

Comments

VI. It is also unavoidable to comment that Mr Galbraith was exceeding the speed limit and not wearing a helmet at the time of the crash which led to his death. I consider that, if he were travelling slower and (in particular) wearing a helmet, his injuries were much less likely to have been fatal.

VII. Nevertheless, as safety messages in relation to safe driving and helmet use are commonly broadcast by New Zealand Transport Agency, I do not make any formal recommendations in this regard.

VIII. However, this tragic outcome should stand as a solemn reminder to all drivers. As Mr Galbraith's case most acutely illustrates, even the briefest of journeys, such as a quick drive "around the block" without a helmet cannot ever be considered safe. Helmets should always be worn, without exception.

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

Marsden [2023] NZCorC 162 (11 December 2023)

CIRCUMSTANCES

John Gordon Marsden, aged 60, died on 26 August 2022 at Christchurch Hospital of a traumatic brain injury sustained in a bicycle versus motor vehicle collision on 21 August 2022.

Just after 6:00pm on 21 August 2022, Mr Marsden had consumed alcohol and was riding his bicycle in central Christchurch. It was getting dark and the weather was poor with heavy drizzle. Mr Marsden entered the intersection of Fitzgerald Avenue and Hereford Street against a red light. A motorist accelerated into the intersection when it turned green and did not see Mr Marsden when he travelled into her path and collided with her vehicle.

An inspection of Mr Marsden's bicycle showed that the brakes were disconnected and not working at the time of the crash. There were also no bike lights on the bicycle but there were standard static reflectors on it.

The Police Serious Crash Unit (SCU) investigated the incident and considered the following to be contributory factors to the crash: poor visibility, the brakes being disconnected on the bicycle, the lack of bicycle lights, Mr Marsden's alcohol level, the lack of hi-visibility clothing, and Mr Marsden not stopping at the red traffic light. The SCU also considered the lack of a bicycle helmet was a contributory factor in the outcome of the crash.

COMMENTS OF CORONER MCKENZIE

I. A coroner may make recommendations or comments in relation to a death for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred. Recommendations or comments must:

- Be clearly linked to the factors that contributed to the death to which the inquiry relates; and
- Be based on evidence considered during the inquiry; and
- Be accompanied by an explanation of how the recommendation or comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

II. In considering whether any recommendations are appropriate in this matter, I am mindful of existing cycle and more general road safety campaigns. I do not make any further recommendations in these circumstances but urge cyclists to be mindful of matters including being visible on the road (such as by wearing high-visibility clothing

and using bike lights), wearing an appropriately fitted helmet, not crossing counter to red lights, and ensuring their cycle is in good working order.

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

Patuwai [2023] NZCorC 149 (22 November 2023)

CIRCUMSTANCES

Eru Warikihi Patuwai, aged 21, died on 23 October 2020 at Auckland City Hospital of head injuries sustained from a motorcycle/motor vehicle collision.

On 20 October 2020 around 7:35pm, Eru was riding a motorcycle south on Weymouth Road towards Blanes Road in South Auckland. At the same time Hone Tukariri was also traveling south on Weymouth Road. As Mr Tukariri passed through a roundabout at the intersection of Weymouth Road extension and Waimahia Avenue, he increased speed and pulled out to the right-hand side to drive past vehicles and motorcycles in front of him on the road. Eru, who was following closely behind Mr Tukariri's vehicle, also pulled out right to pass. Near the next intersection with Gibbons Road, Mr Tukariri braked heavily. Eru also braked but collided with Mr Tukariri's vehicle and impacted the ground. Eru was seriously injured and was transported to hospital in a critical condition. He subsequently died at Auckland City Hospital on 23 October 2020.

The Serious Crash Unit investigated the crash and found that excessive speed was a factor causing the crash and that Eru had been riding too closely behind Mr Tukariri's motor vehicle for the speed he was travelling. This meant he was unable to stop his motorcycle in time when Mr Tukariri stopped suddenly in front of him. Eru was also wearing an unbranded half helmet that was consistent with what is expected of a bicycle helmet, rather than a motorcycle helmet.

Toxicology testing of samples taken from Eru when he was in hospital before he died confirmed that he had some alcohol and cannabis in his system. These factors could also have contributed to the accident.

COMMENTS OF CORONER WOOLLEY

I. The collision was caused by Mr Patuwai travelling at excessive speed and following the motor vehicle in front of him too closely. The dangers of travelling at excessive speed, and the need to maintain a safe distance when following other vehicles on the road are both well-known safety messages that have been, and continue to be, promoted by Waka Kotahi. Given Waka Kotahi's ongoing work promoting these safety messages I do not make any formal recommendations pursuant to s 57A of the Act, but I endorse Waka Kotahi's safety messaging in this area and encourage all road users to drive safely within speed limits at a safe following distance.

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

Scott [2023] NZCorC 130 (19 October 2023)

CIRCUMSTANCES

Ronnie TeTama Scott (known as Tama Scott), aged 15, died on 3 September 2021 at the corner of State Highway 4 and Miro Street, Manunui, Taumaranui as a result of head and facial injuries sustained in a motor vehicle crash (pedestrian struck by vehicle).

At around 7:20pm on 3 September 2021 Tama and a friend were walking south alongside the northbound lane of State Highway 4 before crossing State Highway 4 at the intersection of Racecourse Road. The friend was one to two metres in front of Tama. At the same time a Mitsubishi Pajero, driven by a local man, was approaching on State Highway 4 towards Miro Street, Manunui, travelling at 80 kilometres per hour. As Tama's friend approached the centre line of the road he saw the vehicle approaching and ran to the other side of the road while calling out to Tama to run as there was a car coming. Moments later Tama was struck by the vehicle causing him to be flung into the air before landing face-down. Tama was pronounced dead at the scene.

An investigation was undertaken by Central District Serious Crash Unit (SCU). It noted that it was dark at the time of the crash and that Tama was wearing a black hooded jersey with the hood up. He also had a headphone in one of his ears. The SCU concluded that the environment could not be discounted as a contributing factor in the crash. The crash investigators considered that the lighting in the area where the crash occurred did not provide sufficient illumination for approaching drivers to see pedestrians crossing the road between the residential areas in Manunui. The SCU recommended that consideration be given to increased lighting to assist drivers to identify pedestrians moving between the residential areas of the Holiday Park, Manunui and Taumaranui.

COMMENTS OF CORONER GREIG

I. One issue which arose in the course of the Police inquiry into Tama's death is the adequacy of the lighting in the area where Tama was struck by the vehicle and died – which Police identified as inadequate.

II. On the basis of the Police evidence, I consulted with the Chief Executive of Waka Kotahi about a recommendation I proposed to make that Waka Kotahi considers increasing road lighting on State Highway 4 between the residential areas of the Holiday Park, Manunui and Taumaranui to assist drivers to see pedestrians crossing the road between the residential areas in Manunui. To assist with this consideration, a copy of the crash investigation report prepared by the Serious Crash Unit, Central District following Ronnie TeTama Scott's death was provided to Waka Kotahi.

III. Waka Kotahi responded via Peter Brown, National Manager Maintenance and operations is set out below.

> The section of State Highway 4 referred to is a road with a 100 km/h speed limit and is classed as a rural connector in our One Network Framework. The volume of pedestrian movement on this section of the state highway is expected to be very low given:
>
> - it's a high-speed environment, and not a pedestrian area
> - there is a low density in housing

- there are limited pedestrian activity generators in the area, and
- there is no pedestrian infrastructure (such as footpaths or crossing points) to support or encourage pedestrian use.

On the basis of the factors outlined above, Waka Kotahi considers it would not be appropriate to provide infrastructure that might encourage pedestrian activity in the current environment of this section of State Highway 4.

In general, lighting for pedestrians is only considered appropriate on roads where pedestrian movements are frequent and expected. For such isolated rural locations, lighting is generally not installed to assist drivers to detect pedestrians along the corridor. Such environments are not safe for pedestrians, and we do not believe lighting should be installed that might encourage pedestrian activity where there are no other facilities, or need, to support the activity.

Waka Kotahi will, however, undertake a study of pedestrian activity at this location to determine its frequency and find the most appropriate way in which the safety of pedestrians could be improved.

IV. On the basis of Waka Kotahi's response that it will undertake a study of pedestrian activity at the location where Tama died, to determine its frequency and find the most appropriate way in which the safety of pedestrians could be improved, I make no formal recommendation.

V. Waka Kotahi has noted that they expect their analysis will show low density of pedestrian traffic in the location where Tama died, and that they have a policy of general discouragement of pedestrian activity in such areas such as the location where Tama died. Notwithstanding this, I urge that their assessment takes into account the needs of those who live locally, even though their numbers may be small, and that Waka Kotahi both identifies and implements ways in which the safety of pedestrians can be improved. Tama and his friend were two local schoolboys travelling on foot between the family homes they lived in. Their journey required them to cross the road – which they did without appreciating the dangers. Tama's life was tragically cut short. Implementing measures which improve the safely of pedestrians in the vicinity may prevent deaths in similar circumstances in future.

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

Sell-Henriksen [2023] NZCorC 139 (8 November 2023)

CIRCUMSTANCES

Leroy Sell-Henriksen, aged 23, died on 27 March 2021 at Balcairn Amberley Road of high energy impact injuries to his head, spine and chest after being ejected from his vehicle in a single vehicle rollover road crash.

On the evening of 27 March 2021 Leroy was driving his BMW vehicle in a northerly direction on Balcairn Amberley Road. At around 8:55pm he lost control of his vehicle on a straight piece of road at speed. This caused the vehicle to yaw across and exit the road. It collided with a bank before sliding back across the road and colliding with another bank. Leroy was not wearing his seatbelt and was thrown from the car, exiting through the rear windscreen. Leroy had no license at the time of the collision and had an active charge for driving while disqualified.

The New Zealand Police Serious Crash Unit investigated the crash and found that Leroy was travelling well over the speed limit prior to the collision at 157 to 161 km/hr. His blood alcohol level was nearly three times the legal limit. There was also evidence that he had taken cannabis and methamphetamine prior to the collision. Further, the BMW had a space-saver tyre fitted to the right rear. It was found to be inflated to 39 psi with the recommended inflation being 60 psi, although it is not known if the tyre was inflated to the recommended level before the crash. The three other tyres were deflated.

COMMENTS OF CORONER SCHMIDT-MCCLEAVE

I. I make the following comments pursuant to section 57A of the Coroners Act 2006. The purpose of these comments is to reduce the chances of further deaths occurring in similar circumstances to those in which Leroy died.

Alcohol, drugs and driving

II. Coroners repeatedly provide public cautions against the practice of drinking and consuming recreational drugs and driving. This crash, like so many others involving excessive alcohol consumption and drug use, was avoidable. It demonstrates again the tragedy and suffering that can occur when drivers consume alcohol, combined with recreational drug use, and proceed to drive.

III. It is unsafe to consume alcohol and recreational drugs when driving. The risk of being involved in, or causing, a fatal vehicle accident are magnified even when relatively low quantities of alcohol are consumed.[27] Leroy's blood alcohol was approximately three times the legal limit, and he was also likely under the influence of drugs which would have impaired his assessment of risk, and his decision-making capability. Drinkers cannot dependably estimate their own ability to safely drive a vehicle.

IV. As many coroners have stated on many occasions, do not drink and drive. I urge the public to follow the alcohol awareness and driving safety advice that is promulgated by the Ministry of Transport, the NZTA, the NZ Drug Foundation and other agencies, and abstain from driving while under the influence of alcohol.

Seatbelt use

V. Leroy was not wearing a seatbelt.

VI. Again, as stated by coroners on many, many occasions, drivers and passengers should always wear a seatbelt. Seatbelts save lives. Advice on the Waka Kotahi NZ Transport Agency website states that wearing a seatbelt reduces the chance of being killed or seriously injured in a road crash by 40%.[28]

Space-saver tyres

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[27] See Keall, Frith and Patterson "The Influence of Alcohol, Age and the Number of Passengers on the Night-Time Risk of Driver Injury in New Zealand," *Accident Analysis and Prevention* (2004) 36(1), 49-61 at 57.

[28] https://nzta.govt.nz/safety/vehicle-safety/safety-belts-and-restraints

VII. Finally, I urge the public to remember the purpose of space-saver tyres. They are for emergency use, to assist in travelling to a place where the damaged tyre the space-saver is replacing can be repaired. They are not designed for long-term use, and they are certainly not designed to be used on a vehicle travelling above 80 km/hr, let alone the excessive speeds at which Leroy was driving. The ability to safely control and manoeuvre at speed a vehicle with a space-saver tyre is significantly impaired.

VIII. I exhort the New Zealand public to follow the guidelines on the Waka Kotahi NZ Transport Agency website as to the safe and proper use of space-saver tyres.[29]

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

Sherwood [2023] NZCorC 134 (27 October 2023)

CIRCUMSTANCES

Barry Edgar Sherwood, aged 77, died on 29 October 2018 at State Highway 82, Hakataramea Valley, Waimate of multiple injuries sustained in a motor vehicle crash.

Mr Sherwood had a range of health issues, primarily relating to his heart, including high blood pressure. He also suffered from sleep apnoea, and had skin cancer. In the days before his death, both his daughter and his case worker thought he was very tired and not his usual self.

At around 12:30pm on 29 October 2018, Mr Sherwood was driving east on State Highway 82. He was the sole occupant, and it is unknown where his journey started or where he was heading, although he was less than 10 kilometres from his home. The following events were not witnessed but the evidence showed that Mr Sherwood's car successfully negotiated a moderate bend near Kapua School Road before travelling along a 600 metre straight. When the car approached a second bend to the right (which had a speed advisory of 65km/h), the car continued to travel straight and then crossed the centre line so that it was on the wrong side of the road. It then returned to the eastbound lane, crossed through it and went off the left verge where it hit a tree. The car eventually came to rest in a paddock.

Mr Sherwood's car was discovered by a motorist who saw steam coming out of the bonnet. On inspection, the motorist found Mr Sherwood in the driver's seat breathing, but with no discernible pulse. Emergency services were notified, and the attending paramedics confirmed that Mr Sherwood had passed away.

Toxicology analysis indicated the presence of temazepam in Mr Sherwood's blood. There was no evidence of Mr Sherwood being prescribed temazepam. The pathologist advised:

> *The only potentially contributing factor on toxicological analysis is the presence of temazepam in the blood. This is not present at an excessive level, but its presence might suggest he had been having sleep problems and so may have been tired. However, this can only be a supposition and cannot be stated with any degree of certainty.*

[29] Tyres | Waka Kotahi NZ Transport Agency (nzta.govt.nz)

The Police investigated and formed the general hypotheses that after travelling on the road for some time and through a number of bends and turns successfully, Mr Sherwood failed to negotiate the right-hand bend. Potential causative factors included fatigue, or a preceding medical event. The coroner concluded that, given what people observed in the time prior to Mr Sherwood's death, a key antecedent cause of Mr Sherwood's fatal accident was fatigue.

RECOMMENDATIONS OF CORONER TELFORD

l. With this in mind, I make the following recommendations, which are essentially reiterations of safety messages already in the public domain:

- It is well known that fatigue in drivers (amongst other things) reduces attentiveness and slows reactions and decision-making abilities. Fatigue can also cause drivers to inadvertently drift in and out of sleep. Unsurprisingly, fatigue is seen as a key factor in many deaths that come before coroners. It is for this reason that the New Zealand Transport Agency (NZTA) regularly promotes safety messages relating to fatigue. For further details about these important messages, readers are directed to the website of the NZTA: www.nzta.govt.nz.

- Guidance from the Ministry of Health and other related agencies is clear – never take prescription medication unless it is prescribed for you. Doctors, nurses and other prescribers receive extensive training in prescribing medicines. These professionals have specialist knowledge about individual health needs, side-effects and how drugs interact with each other. Therefore, it is never safe to take someone else's medication.

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

Te Kura [2023] NZCorC 163 (13 December 2023)

CIRCUMSTANCES

Lewis Te Huia Te Kura, aged 49, died on 19 March 2021 on Raetihi Ohakune Road, Ohakune, of multiple injuries sustained in a motor vehicle crash.

Mr Te Kura was drinking with some friends in Ohakune on the evening of 19 March 2021 and may have also shared a 'joint' with a friend. Shortly before 9pm Mr Te Kura decided to go for a drive from Ohakune to Raetihi. As he drove away, Mr Te Kura was seen driving fast, screeching his tyres at the roundabout.

At approximately 10:45pm, a passer-by noticed a car had crashed into a paddock on the Raetihi Ohakune Road, just beyond a right-hand curve. The passer-by stopped and looked at the vehicle, but could not see anyone near the car, so left the scene. Early the next morning, while looking for Mr Te Kura, his friend came across his car in the same paddock. He looked around but was unable to find Mr Te Kura. He left and then returned again at 7:30am. He located Mr Te Kura's body some nine metres from the car, in a farm drain obscured by grass. On arrival to the scene, emergency services confirmed Mr Te Kura was deceased.

Toxicology testing detected alcohol in Mr Te Kura's blood at a concentration of 198mg/100ml. By comparison, the legal blood alcohol limit for a driver 20 years of age or older is 50mg/100ml. THC (the main psychoactive ingredient in cannabis) was also detected.

The Serious Crash Unit investigated the crash and identified several contributing factors, including Mr Te Kura's excess blood alcohol levels; driving with excess speed around a corner; mechanical defects in the vehicle, particularly in relation to the brakes; and the failure to wear a seatbelt which led to Mr Te Kura being thrown from the vehicle.

COMMENTS OF ASSOCIATE CORONER MOORE

I. There is no interested party to whom I consider it appropriate to direct recommendations under section 57A of the [Coroners] Act [2006]. I do not find that any other party has causally contributed to Mr Te Kura's death.

II. However, I make the following comments pursuant to section 57(3) of the Act:

- Mr Te Kura's death reinforces the serious dangers of driving while under the influence of alcohol. Intoxication has well-known effects on people's judgement, vision, co-ordination and reaction-times.
- The risks of speeding while driving are similarly well-known. This risk is exacerbated by the effects of intoxication noted above. Where a driver's co-ordination and reaction time is impaired, there is even less margin for error when travelling at excessive speeds.
- There is a wealth of publicly available information advising against both driving while intoxicated and speeding. I encourage all drivers to follow the alcohol awareness and driving safety advice that is made available by the Ministry of Transport, Waka Kotahi New Zealand Transport Agency, and other entities.
- This crash also highlights the importance of correct and consistent use of seatbelts. Advice on the Waka Kotahi New Zealand Transport Agency website states that wearing a seatbelt reduces your chances of being killed or injured in a road crash by about 40 percent.[30]

III. These comments are directed to the driving public of New Zealand, for the purposes of public education in safe driving. If drawn to public attention, I consider it possible that – together with other driver education – these comments may reduce the chances of further deaths occurring in similar circumstances.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Te Kura taken during this inquiry, in the interests of decency.

[30] https://www.nzta.govt.nz/safety/driving-safely/seatbelts/

Self-Inflicted

Chand [2023] NZCorC 123 (6 October 2023)

CIRCUMSTANCES

Roshni Chand, aged 61, died on 20 June 2020 at Northpark in circumstances that amount to suicide.

On 8 January 2017, Roshni was admitted to the intensive care unit at Middlemore Hospital after taking an intentional overdose. She identified significant stress arising from the actions of her oldest son, Neil. He was living at home at the time, and she said he was being aggressive, abusive, and verbally threatening towards her. The Police had been called to the house on numerous occasions and Roshni reported she was afraid to make him leave. She thought that if she gave him an ultimatum he might return to the house and kill her.

On 27 April 2020 Roshni was seriously assaulted by Neil. She called emergency services to report that Neil had been telling her to call the Police or he would kill her. She ran to the neighbour's house and waited for Police to arrive. She declined to make a statement and said she would stay with her other son to avoid any confrontation.

The next day, Roshni spoke with her general practitioner over the phone due to Covid-19 restrictions. She outlined the events of the assault the previous day and she was referred for four funded sessions with a psychologist.

On 29 April 2020 Police made a referral to the Eastern Refuge Society (ERS), advising that Roshni was at high risk. On 4 May 2020 an ERS advocate completed an initial report with Roshni. Roshni disclosed high levels of anxiety and attributed this to the numerous threats that Neil had made against her.

On 7 May 2022 Roshni completed a victim video statement with the Police outlining the events of 27 April. On the same day a temporary protection order was issued against Neil. The people protected by the order included Roshni and other family members who Neil had made threats against. Two days later, Neil was charged with assault on a person in a family relationship, assault with a blunt instrument, impeding breathing, and threatening to kill. He was remanded in custody.

On 25 May 2020, Roshni sent a text message to the ERS advocate advising that she was scared if Neil got bail that he would kill her and her family. Neil was granted bail and on 28 May 2020, the ERS advocate made a referral to the Whānau Project, a national home safety service that strengthens safety at home for high-risk victims. The referral was accepted, and arrangements were made to install a safety alarm at Roshni's home.

On the morning of 20 June 2020 Roshni was at home with her husband, Praveen. He made a telephone call to Neil to discuss the protection order that was in place. Roshni listened to this conversation and left the bedroom after the call. Later Praveen went to look for Roshni and found her deceased in the garage.

Police found several notes written by Roshni in her bedroom asking for clemency for Neil and for the protection order to be rescinded. An additional letter was addressed to the prosecutor asking for the charges against Neil to be withdrawn.

Following Roshni's death, Police laid further charges against Neil as a result of additional information that they became aware of. Neil sent a text message to Praveen on 14 June 2020 suggesting that Roshni should tell the Police that she

was confused and made incorrect statements to the Police. He then visited his parents' home on the night of 15 June 2020, in breach of the protection order that was in place. Neil told his parents that he would end his life if he was convicted and sent to prison. On the morning of 20 June 2020, Neil sent an email to Praveen written as if it was composed by Roshni. The content requested that the protection order be cancelled because Roshni had provided incorrect and misleading information. Neil was charged with two charges of breaching a protection order and attempting to defeat the course of justice. Neil died in circumstances amounting to suicide between 26 November and 1 December 2021.

COMMENTS OF CORONER ANDERSON

I. It is clear that Roshni was under immense stress at the time she died. She had experienced a prolonged and vicious assault by her son in her own home. She reported the matter to Police who laid criminal charges against him. Significant support was provided to Roshni by the agencies that she came into contact with, including the Police, Eastern Refuge and her general practitioner. She was assisted to obtain a protection order and was referred for psychological support. Roshni was also provided with information, advice and practical assistance including the installation of an emergency alarm at her home.

II. The evidence that I have reviewed indicates that Roshni was scared of her son and was very concerned at the possibility that he might cause further harm to her. It appears that his harmful and threatening behaviour towards her had been longstanding, dating back to at least the period before her 2017 hospital admission. However, Roshni was also feeling conflicted about the possible consequences for Neil, including conviction and imprisonment, as a result of the criminal charges laid against him after the 27 April 2020 assault.

III. Roshni's death was a tragedy. It highlights the ongoing vulnerability of people who experience family violence, and the significant impacts that this conduct has on mental and physical wellbeing. Being a victim of violence and bullying are known risk factors for suicide.[31] People who experience family harm can also come under significant pressure, both internal and external, when they take steps to hold perpetrators to account.

IV. As a community we must continue efforts to identify when family harm is occurring and to intervene early, and effectively, to reduce health impacts for everyone who is affected.

V. I am sending a copy of my findings in relation to the deaths of both Neil and Roshni Chand to the National Mortality Review Committee, for the attention of the Committee's family violence and suicide subject matter experts. I am taking this step because of my concerns regarding the non-partner family harm that occurred in this case, and the suicides of both the perpetrator and victim. I consider that my findings will be of relevance to the Committee's ongoing work in these areas.

[31] See for example https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/suicidal-feelings-what-look-out

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 Roshni entered into evidence, in the interests of personal privacy and decency.

Harawira [2023] NZCorC 129 (18 October 2023)

CIRCUMSTANCES

Kahi Takimoana Harawira, aged 26, died at his home in Kaitaia between 2 and 5 January 2023, in circumstances amounting to suicide.

Kahi was raised in whānau deeply rooted in tikanga Māori. His whānau described him as handsome, bright and engaging. He had recently accepted an appointment to the role of Iwi Liaison Officer for a Crown Research Institute which he was looking forward to. He had three daughters who lived with their mothers. Kahi had no known history of mental health difficulties, self-harm or suicidal thoughts.

On 29 December 2020 Kahi was at his grandfather's house with his daughters. He then left to take his daughter's home. He was to return to his grandfather's, to talk about his plans for the New Year and his new job but he did not return. On 30 December Kahi and his partner argued and she went to stay with a friend due to difficulties in their relationship. Kahi did not spend New Year with his whānau which was unusual. Over the next couple of days, Kahi was distressed due to his relationship issues, missing his children and being alone. He was using methamphetamine. Kahi was last seen alive on 2 or 3 January 2021. On 5 January 2021 Kahi's partner returned home along with her friend and found Kahi deceased.

COMMENTS OF CORONER MILLS

I. Kahi was not a regular user of methamphetamine, and it is hard not to reach a conclusion that it played a significant role in his death. He did not have a previous history of self-harm or suicidality. I therefore make these general comments as Kahi's death is a tragic reminder of the risks associated with methamphetamine use. It is a warning and a reminder to all that methamphetamine is a high-risk drug. It can impact on users in many ways and can have consequences that go beyond the use of the drug itself.

II. It is well known that following an initial high, people who use methamphetamine experience a crash or "come down" in the following days, which can include exhaustion, prolonged sleep, depression and anxiety.[32] Suicidality is also more common among users of methamphetamine.[33] The impulsivity, disinhibition and psychosis associated with methamphetamine use is likely to be a factor in this.

III. While methamphetamine, also known as meth or "P", is used in every community in Aotearoa New Zealand, the negative impacts are particularly severe in communities with high pre-existing levels of deprivation and where

[32] https://bpac.org.nz/2018/meth.aspx

[33] Yasbek, P., Mercier K., Dr Elder, H., Dr Crossin, R., Prof. Baker, M. (2022), *Minimising the Harms from Methamphetamine*, The Helen Clark Foundation and New Zealand Drug Foundation, Wellington; https://bpac.org.nz/2018/meth.aspx

prevalence of use is significantly higher than the population average.[34] It is ranked as the most harmful drug in New Zealand for dependent users.[35] Wastewater testing shows highest per capita methamphetamine use in rural towns in Northland, Bay of Plenty, and Hawkes Bay.[36] Kaitaia has a well-publicised methamphetamine problem.[37] Methamphetamine use has a negative impact that extends beyond the individual user. It harms mokopuna, whānau and the wider community.

IV. Māori are significantly and disproportionately impacted by methamphetamine use. Māori use methamphetamine at a higher rate than non-Māori and are criminalised for its use at a disproportionately higher rate.[38] The flow-on impacts of colonisation and ongoing systemic racism lead to Māori being more likely to suffer from mental health and addiction issues, and generally from poorer health overall. That means that methamphetamine use takes a higher toll on Māori, who also face greater barriers to accessing appropriate healthcare.[39]

V. It is beyond the scope of this inquiry to make any further specific recommendations. The fact that there are limited resources and that there is a huge need for addiction and prevention programmes, particularly Kaupapa Māori programmes, in Kaitaia and throughout the motu is well known.[40] I therefore simply draw attention to the risks associated with methamphetamine use and the need for appropriate ongoing funding and resourcing of addiction and harm prevention initiatives.

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 Kahi taken during this inquiry, in the interests of decency.

Lee [2023] NZCorC 157 (7 December 2023)

CIRCUMSTANCES

Annie Jade Lee, aged 23, died on 27 November 2018 at 21 Waikari, Dunedin in circumstances amounting to suicide.

Ms Lee had experienced difficulties with depression and anxiety since she was 15 years old. She later cited her anxiety and inability to connect with others as reasons for her withdrawal from school and polytechnic. These issues later had a significant impact on her ability to work.

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[34] Yasbek, P., Mercier K., Dr Elder, H., Dr Crossin, R., Prof. Baker, M. (2022), *Minimising the Harms from Methamphetamine*, The Helen Clark Foundation and New Zealand Drug Foundation, Wellington.

[35] McAvoy BR, Methamphetamine - what primary care practitioners need to know, J Prim Health Care 2009;1:170–6.

[36] Yasbek, P et al above at [34].

[37] https://www.beehive.govt.nz/release/fighting-meth-harm-regions

[38] Yasbek, P et al above at [34]; https://bpac.org.nz/2018/meth.aspx

[39] Ibid.

[40] New Zealand Mental Health and Wellbeing Commission (2022), Te Huringa: Change and Transformation Mental Health Service and Addiction Service Monitoring Report 2022. https://www.mhwc.govt.nz/assets/Reports/Te-Huringa/2022/MHWC-Te-Huringa-Service-Monitoring-Report.pdf

Ms Lee had attracted a range of different diagnostic impressions including an eating disorder, attention deficit hyperactivity disorder (ADHD), depressive disorder, alcohol misuse and cannabis misuse. It was noted that her difficulties were chronic in nature and might be better explained by her personality difficulties rather than by a primary mental health diagnosis.

Ms Lee's relationship ended in February 2018, and from that point her mother, Ms Paul, recalled that Ms Lee's mood "plummeted". She often cried, was suicidal and felt guilty, hopeless, and despairing. Ms Lee frequently negatively compared herself to her siblings and friends and thought of herself as a failure and a burden.

Ms Lee was a client of the North Community Mental Health Team from 23 May 2018 until 14 November 2018. When assessed in June 2018 the clinician found Ms Lee fulfilled the criteria for ADHD, but concerns were raised about the possibility of bipolar disorder. She twice met with a clinical psychologist but was reluctant to engage in talking therapies other than to receive assessment for a potential diagnosis of ADHD. Ms Lee declined to attend further appointments with the clinical psychologist.

In another assessment in June 2018 Ms Lee was found to be displaying evidence of major depressive disorder. She was not able to be fully evaluated for ADHD.

In August 2018 clinicians noted concerns about Ms Lee's inability to tolerate visits or assessments for longer than ten minutes. She cited ADHD as the cause of this and sought Ritalin to assist.

Ms Paul last saw Ms Lee at 10:45pm on 26 November 2018. She heard her moving around in her bedroom between 6 and 7am on 27 November 2018 and left for work at 10am. As arranged, her father, Mr Lee, arrived at the Wakari home after Ms Paul had left for work. Ms Paul and Mr Lee had arranged rotating "shifts" to watch their daughter due to concerns for her safety and wellbeing. This had been happening for about a year.

Ms Lee had withdrawn and did not want to interact with people. Respecting this, Mr Lee did not enter his daughter's bedroom or see her while he was at the house. While there, Mr Lee did not hear any noises coming from Ms Lee's bedroom and assumed she was sleeping, as was often the case. He remained at the house until midday.

When Ms Paul returned home from work at 4:45pm she found Ms Lee. Paramedics confirmed Ms Lee had died.

RECOMMENDATIONS OF CORONER TELFORD

I. This is a tragic case, which is a sadly familiar one to Coroners.

II. Ms Lee had complex needs stemming from crippling anxiety that seems to have taken hold of her from adolescence. This cruel illness had a devastating impact on her life and opportunities. Although I cannot be sure about why Ms Lee took the drastic action to end her life, it seems likely that she could not tolerate this situation any longer ultimately, she lost hope.

III. Ms Lee's parents went to extraordinary lengths to help and protect their daughter. They clearly did everything within their power to avoid this outcome – one they no doubt anticipated and dreaded every waking moment.

IV. What is also clear is that many others tried to help Ms Lee over the years. I have no doubt that the clinicians interacting with Ms Lee tried their very best to help her with the resources they had. For some reason, she was

highly resistant to that help. However, this is a situation that is not unusual for someone with such high and complex needs.

V. In a recent case before me (which bears striking similarities),[41] I quoted Associate Professor Giles Newton-Howes who had given advice to the Health and Disability Commissioner. Dr Newton-Howes (in my view) aptly summarise the situation thus:

> There are deficiencies in broad service provision for young people with BPD, or indeed severe mental disorder [in New Zealand]. Although this is not a failure to meet a New Zealand standard, this rather speaks to a failure of services to invest in the appropriate publicly funded streams of support … A gold standard would be the provision of multiple options, a menu of evidence-based services to ensure optimal catchment.

VI. Unfortunately, these deficiencies continue, and their systematic remedy is not in sight. I therefore direct that these findings are sent to appropriate people within Health New Zealand with the repeated plea for more investment and innovation in taking a proper, compassionate approach to those who so desperately need it. If we are to avoid more coronial cases with such similar facts, complex needs, often presenting as "difficult to engage" need to be met with a commensurate response.

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 Ms Lee taken by police, in the interests of decency or personal privacy.

Manuel [2023] NZCorC 146 (20 November 2023)

CIRCUMSTANCES

Clement Julius Manuel, aged 28, died between 7 and 10 August 2020 at Te Toro Point Boat Ramp in circumstances amounting to suicide.

Clement was diagnosed with schizophrenia and had been taking medication for most of his life. He had been in contact with mental health services on and off since 2011 with periods of inpatient admissions and had also experienced substance dependence issues. He had no prior history of deliberate self-harm or suicide. In the year prior to his death Clement attended several primary care practices. He transferred from Conifer Gardens Medical Centre to a medical practice in Kaikohe in October 2019. In January 2020 Clement transferred again, to Waiuku Health Centre. Clement last attended Waiuku Health Centre on 2 March 2020. His mental state was stable at that time and he had a high level of self-awareness.

On 30 March 2020 Clement contacted Counties Manukau Mental Health Services asking for help with food, accommodation, and medication which they provided. Following this, he moved to Manukau Heads to live with his aunt. As Clement had moved out of his current mental health team's catchment area his care was transferred to Te Rawhiti Mental Health team at Counties Manukau District Health Board (CMDHB). During this period Clement was taking his

[41] Emma Beattie CSU-2018-CCH-000229 (Coroner Telford)

medication, his mood remained stable, and he had no thoughts of self-harm. Subsequently, Clement was discharged to Conifer Gardens Medical Centre on 30 April 2020.

On 8 May 2020 Clement contacted his mental health social worker asking to be referred back to his general practitioner at Waiuku Health Centre. They met in person to discuss this, and Clement was given an appointment letter for a medical review with a psychiatrist on 19 May 2020. However, on 19 May Clement did not turn up to the meeting. On the same date, the Counties Manukau Mental Health Service sent a letter to Conifer Gardens Medical Centre stating that Clement had been discharged from the service at his request. The letter also indicated that his keyworker had no safety concerns for Clement at the time of discharge.

In the month prior to Clement's death, he stopped taking his medication and he became more reclusive and had lost weight. On 7 August 2020, Clement's aunt visited him and this was the last time Clement was seen alive. On 10 August 2020 a member of the public found Clement deceased in a cubicle in the changing sheds at Te Toro reserve.

RECOMMENDATIONS OF CORONER ANDERSON

I. The evidence I have reviewed indicates that Clement was very mobile in the year prior to his death, moving between various addresses in South Auckland, Kaikohe and spending time in emergency accommodation. This made it difficult for health providers to maintain contact with him. Clement also attended at least three GP practices during this period.

II. At the time he died, Clement was not an active patient of Counties Manukau District Health Board Mental Health Services. He had been discharged from the service on 19 May 2020. Significantly, it appears that information regarding his discharge was sent to a medical practice where he was no longer enrolled. Clement had transferred from Conifer Gardens to a medical practice in Kaikohe in October 2019. He had then transferred again to Waiuku Health Centre in January 2020. As recorded in his Counties Manukau District Health Board mental health services notes, in May 2020 Clement requested to be discharged to the care of his GP at Waiuku Health Centre. It is unclear why his discharge information was instead sent to the Conifer Gardens medical practice, despite Clement specifically identifying that his GP was at Waiuku Health Centre and requesting discharge to that practice.

III. In these particular circumstances, I do not consider that the incorrectly directed discharge information is likely to have altered the outcome for Clement. It appears that he did not in fact return to the Waiuku Health Centre as agreed for his follow up consultation with his GP. Nor did Clement initiate any contact with the general practice, the hospital or mental health services in the months leading up to his death.

IV. Clement was not required to accept compulsory mental health care of any type at the time he died. He had a track record of recognising early warning signs of his illness and seeking appropriate assistance from health professionals when he was becoming unwell. He had no history of prior suicide attempts or deliberate self-harm and there appears to have been nothing significant about his behaviour in the period prior to his death that would have alerted his family members that he was planning to end his life.

V. While I do not consider that the incorrectly addressed discharge information was a significant factor in this particular case, accurate and timely transfer of information is a critical component of safe and effective mental health care.

VI. For the purposes of reducing the chance of future deaths occurring, I make the following recommendation to Te Whatu Ora Counties Manukau, the agency currently responsible for the operations of the former Counties Manukau District Health Board:

> *That Te Whatu Ora Counties Manukau Mental Health Services review the process and systems it uses for identifying and recording GPs for service users, to ensure that discharge letters and other important details are sent to the correct primary care practice.*

VII. In accordance with the requirements of s57 of the Act, I informed Te Whatu Ora Counties Manukau of my intention to make this recommendation. Te Whatu Ora Counties Manukau advised me that it accepted the recommendation and that its mental health services could commit to reviewing the processes in place for identifying and recording general practitioners for service users.

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 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 Clement of entered into evidence, in the interests of personal privacy and decency.

Mehlhopt [2023] NZCorC 152 (28 November 2023)

CIRCUMSTANCES

Malcolm Ralph Mehlhopt, aged 67, died on 26 or 27 March 2017 at Christchurch in circumstances amounting to suicide.

Mr Mehlhopt had a mental health history for a number of years. Following the death of his wife, he lived alone with the support of family and friends.

Mr Mehlhopt was last seen on the evening of 26 March 2017 at around 8:00pm, at which time he reported to his friend that he felt dizzy. When that friend did not hear from Mr Mehlhopt the next day, he became concerned and went to Mr Mehlhopt's house to check on him, where he found him dead.

COMMENTS OF CORONER SCHMIDT-MCCLEAVE

I. Having given due consideration to all of the circumstances of this death, I do not consider there are any recommendations that could usefully be made pursuant to section 57(3) of the Coroners Act 2006. In particular, I have no evidence that suggests any shortcomings in the support that was available to Mr Mehlhopt after the death of his wife.

II. In the interests of public awareness, however, I make the following comments pursuant to section 57(3) of the Coroners Act 2006:

- The Ministry of Health publishes information about suicide prevention, the signs to watch for, and ways of supporting someone who is suicidal. That information can be found at: https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide.

- The Ministry of Health suicide prevention online resources also include contact details of a number of organisations that offer assistance and support: https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/supporting-someone-who-suicidal.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may publish any particulars of this death without a Coroner's permission except for those expressly permitted in that section. An order under section 74 of the Coroners Act 2006 prohibits the making public of any photographs taken of Mr Mehlhopt during this inquiry, photographs of the scene in which Mr Mehlhopt was found, or details of his mental health history, in the interests of personal privacy and decency.

Pasene-Hansen [2023] NZCorC 120 (11 December 2023)

CIRCUMSTANCES

Kalani Jack Pasene-Hansen, aged 15, died on the night of 18-19 June 2020 at 177 Knowles Street, Christchurch. Kalani's death was self-inflicted but did not amount to suicide.

Kalani was "a great and happy child" but his behaviour began to change when he was about 14. He suffered from low mood, anger, and would self-harm. He attended St Bede's College in 2018 and 2019 for years 9 and 10 and then moved to Papanui High School in year 11. Kalani experienced some bullying at school. His parents tried to get some help and timely counselling for him but were not successful.

A Case Review Meeting was held in court on 16 September 2022.

RECOMMENDATIONS OF CORONER ELLIOTT

I. Section 57A of the Coroners Act 2006 states:

> **57A Recommendations or comments by coroners**
>
> (1) A responsible coroner may make recommendations or comments in the course of, or as part of the findings of, an inquiry into a death.
>
> (2) Recommendations or comments may be made only for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred.
>
> (3) Recommendations or comments must—
>
> (a) be clearly linked to the factors that contributed to the death to which the inquiry relates; and
>
> (b) be based on evidence considered during the inquiry; and
>
> (c) be accompanied by an explanation of how the recommendation or comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

II. The effect of this section is that a coroner can only make comments or recommendations in relation to things which are clearly linked to the factors that contributed to a person's death.

III. It is not possible to know exactly why Kalani […]. However, his actions were consistent with previous acts of self-harm, which were a consequence of the state of his mental health. The various stressors described above no doubt contributed to this.

IV. The central theme of the discussion at the Case Review Meeting was the availability of support for young people, both in schools and through the health system.

V. Kalani saw [his general practitioner], Dr Middleton, at his own instigation on 27 September 2019. He had three consultations with a social worker in October and November 2019. On 11 November 2019, Ms Pasene contacted Mental Health Services and an appointment was arranged for 3 December 2019. Dr Benjamin Image [a general practitioner at his practice] saw Kalani on 12 November 2019. Counselling support was also offered to him at school.

VI. However, Ms Pasene said:

> We were unable to get timely counselling support for Kalani when he needed it. As I said, Kalani did not want to see the counsellor at St Bede's as he was extremely fearful that his peers would find out and that this would be a further source of bullying.
>
> We were unable to source an external youth counsellor while Kalani was at St Bede's. As a 'stop gap' we arranged for [another] counsellor to see Kalani, although youth counselling was not her area of expertise.
>
> During this time, his mood appeared to fluctuate. I contacted Child, Adolescent and Family Mental Health Service at a particular low point. However, when they contacted me again Kalani had appeared better and it did not appear in need of immediate support. Because he did not need immediate support he was discharged. This effectively meant that the 'clock' started back to zero then, and when Kalani needed support again there was another six-week waiting time. I feel services like CAF are so hard to access. They emphasised to me that if Kalani was not at risk of immediate harm then there wasn't anything they could do for us. But people's wellness or unwellness is unpredictable, it fluctuates from one day to the next, from one moment to the next. So then we are left floundering to deal with it all ourselves.

VII. In her report to me, Dr [Valerie] Black [Clinical Director, Child, Adolescent & Family Mental Health Service, Specialist Mental Health Service, Canterbury District Health Board (now Te Whatu Ora)], said:

> To put this in context it is important to understand that every week we receive many more referrals for care then we can possibly treat and if we were to accept all the referrals we receive our waiting time would increase out beyond an average of four months to beyond a year. The cases we do accept all have evidence of mental illness and significant impairment in functioning and majority also have suicidal thinking and risk.

VIII. Dr Black also made the following comments at the Case Review Meeting:

> It well exceeds the capacity to deliver. It's quite stressing, sitting in the triage meetings and seeing the people referred in and thinking about who is the most at need and they're the people obviously that we take in, and yeah it is really difficult.

> We've had to do quite a lot of things to I guess essentially raise our threshold which fits with what you were saying, just because if we didn't we would have manageable wait lists of well over a year, which is completely useless unless you have milder, unless you have ADHD you might be able to wait that long, but not for most things.
>
> So yeah no, it is really difficult. But obviously we have to triage the people who are presenting at the highest risk.

IX. Ms [Fiona] Kay of 298 Youth Health Centre said:

> We have huge numbers of people who want to access our services, the demand is massive and we just simply do not have the resourcing to meet all those needs.
>
> …
>
> We're probably still only accept about 40% of the referrals we receive.
>
> …
>
> We deliberately try and make ourselves youth friendly and youth centric in our appeal. So yeah the dream would be to have a couple afternoons a week where you could rock up after school or earlier in the afternoon and have an inviting environment in which to hang in until you're able to be seen by someone. I think that would go a long way to solving a lot of problems for a lot of people.

X. Dr Middleton said:

> We have various places that we can refer for counselling. There is just about always a really long wait for those, even if we refer them, you know, there is often weeks and weeks, sometimes months wait before they can get seen. I think in Canterbury we do, since then, we now have access to a thing called brief intervention counselling which previously was only available for over 18's and we do now have that available, which is a bonus, we have that available for 12 to 18 year olds and that does give them access to some counselling, usually within three or four weeks so that was not available back then. I mean, we just need more resources, more counsellors available, there needs to be more funding, there just isn't enough and even privately we cannot get kids into see private psychologists. The wait is massive, most of them have closed books, we just don't have enough.
>
> …
>
> [C]ounselling and psychologists are probably the number one thing. Look I am sure we would love to have more psychiatrists available; you know it is, any extra in that would be used and snapped up straight away. You know anything that is available we can access and use and that would help all of us.

XI. Kalani faced a number of stressors and his capacity to deal with them fluctuated. This meant that the ongoing maintenance of his mental health was important. This included the need for access to timely and ongoing support from mental health professionals, particularly given the various stressors he was experiencing.

XII. The comments quoted above relating to the lack of availability of mental health support in Canterbury, and counsellors and psychologists in particular, were disturbing. The availability of such support would reduce the chances of deaths in similar circumstances. I therefore proposed to recommend under section 57A of the Coroners Act 2006 that Te Whatu Ora takes steps to address these deficiencies.

XIII. Pursuant to section 57B of the Act, Te Whatu Ora was given notice of this proposed recommendation. Te Whatu Ora did not disagree that there are deficiencies in the availability of mental health support, and counsellors and psychologists in particular, for young people in Canterbury or that the proposed recommendation is warranted. However, its position is that 'action is being taken to improve access to services and to improve the well-being support available through the health system' and that there is 'considerable investment and activity in the health sector led by Te Whatu Ora in improving health and wellbeing services in general and for young people as a priority group.' A copy of Te Whatu Ora's reply is attached to these findings. This sets out the work it is undertaking.

XIV. I acknowledge the work Te Whatu Ora is doing and recommend that it continues to take steps to address deficiencies in the availability of mental health support, and counsellors and psychologists in particular, for young people in Canterbury.

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.

Popata [2023] NZCorC 126 (13 October 2023)

CIRCUMSTANCES

Sudden Hondo Tyrel Popata, aged 27, died on 10 January 2019 at Palmerston North in circumstances amounting to suicide.

Sudden had been consuming alcohol on 9 January 2019 and those that saw him throughout that period noted that he appeared to be his usual self. Toxicological analysis of Sudden's blood identified an alcohol reading of 182mg/100 ml. For comparison purposes, the legal driving limit for a driver over 20 years of age is 50mg/100ml of blood. Methamphetamine and the active components of cannabis were also detected.

COMMENTS OF CORONER ANDERSON

I. I have formed the view that no recommendations are necessary in the circumstances of this case. However, I consider that it is highly unlikely that Sudden would have taken the steps that he did if he had not been affected by alcohol and methamphetamine. The risks of impulsive and out of character actions are heightened by the consumption of these substances and can be a factor in suicides occurring in people who may not otherwise be considered at risk. Sadly, many deaths of this nature come before the Coroners Court. It can be particularly difficult for family and loved ones who are left behind in these situations. They often struggle to understand why the death occurred, and frequently cannot find answers to the questions that they are left with.

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 Sudden entered into evidence, on the grounds of personal privacy and decency.

Sands [2023] NZCorC 150 (24 November 2023)

CIRCUMSTANCES

Mark John Sands, aged 49, died on 23 February 2019 at 580 Kaiatea Road, Matapouri in circumstances amounting to suicide.

Mr Sands was a farmer and lived alone on his farm after his partner died in an accident in January 2018. He was described as a perfectionist and may have been stressed about the state of his farm. According to Mr Sands' sister, he had suffered from depression for the last 20 years and was "really down" about 10 years prior to his death but came through it. However, it appears that he never sought professional help for his mental health.

On 23 February 2019, Mr Sands phoned emergency services and advised that he was going to end his life. Police were dispatched to his address and found Mr Sands deceased.

COMMENTS OF CORONER TETITAHA

I. There are comments that could usefully be made pursuant to section 57A of the Coroners Act 2006, for the purposes set out in section 4.

II. I sought comment from Te Whatu Ora and Federated Farmers regarding suicide prevention resources and support available to farmers based in Northland. Te Whatu Ora have provided a comprehensive reply for which I express my thanks. They have identified the following suicide prevention resources for farmers:

III. **Northern Rural Support Trust**: a charitable organisation set up to work with rural communities "when times get tough". They are part of a nationwide network which helps rural people and their families during and after extreme weather or events which affect livelihoods. The trust has access to RealNetworks and professionals, health services and providers, local and central government agencies and civil defence allowing them to be well-placed to assist in times of need. The trust provides free and confidential help through the coordinator Rachael O'Callaghan 0800 787254. A facilitator can be allocated to assist people to come to a solution and offer 3 free counselling sessions with a trained registered counsellor. The trust also organises events for farmers to help them get off the farm and talk to their neighbours.

IV. **Farmstrong**: a nationwide well-being program for the rural community. Their aim is to help farmers "live well to farm well." Their website www.farmstrong.co.nz provides information and resources promoting well-being and mental wellness including videos (featuring All Black Sam Whitelock) and a blog. It also provides contact details and links to specific support for needs such as depression, anxiety, mental illness, suicide prevention and crisis situations.

V. I am satisfied there is a need to draw attention to the availability of the above suicide prevention resources available to farmers and their families. There is no evidence Mr Sands accessed any of these resources in the period leading up to this death. These resources are specifically aimed at reducing the chances of further deaths occurring in similar circumstances.

VI. All farmers should be made aware of their availability especially “when times get tough”.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may, unless granted an exemption under section 71A or has permission under section 72, make public the matters referred to in section 71(2). An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Mr Sands during this inquiry, in the interests of decency.

Stack [2023] NZCorC 140 (8 November 2023)

CIRCUMSTANCES

Kevin Derek Stack, aged 53, died between 17 and 19 June 2020 at Kaikohe in circumstances amounting to suicide.

Kevin had experienced mental health difficulties in the years leading up to his death and had received inpatient care. On 14 November 2019, Kevin presented to his General Practitioner (GP) with low mood and suicidal ideation, and was referred by his GP to Northland District Health Board (Northland DHB) Mental Health and Addiction Services (MHAS).

On 15 November 2019, Northland DHB’s MHAS opened what they termed a “partial case” for Kevin. This was a category introduced as part of a new triage project being rolled out within the service. An entry was made in the clinical notes recording the triage plan that had been identified for Kevin. This was to arrange a face-to-face assessment. It appears that no steps were taken to action this plan or to arrange an assessment of Kevin after MHAS received the GP referral.

On 12 February 2020, Kevin reported to his GP that he had not had his appointment with MHAS. He advised that there was a power outage on the day of his appointment and that he was going to call and reschedule.

On 5 March 2020, Kevin presented to Northland DHB’s MHAS seeking a triage appointment. He stated that he had been expecting contact from a community mental health nurse. The Northland DHB notes from this visit record that Kevin was a new client, requesting a triage appointment and that he had been waiting for contact. No assessment was made during this presentation. The notes record that later the same day a community mental health nurse called and left a voice message for Kevin to contact her about an appointment the following Thursday, 12 March 2020. This is the last entry recorded in the Northland DHB clinical notes prior to Kevin’s death. Kevin did not attend the appointment on 12 March 2020.

Northland DHB investigated the care provided to Kevin and noted that Kevin’s referral to MHAS was overlooked, resulting in the DHB being unable to engage with him. The reviewers identified that this was due to a new triage system being trialled by the service. After a referral was received, a case would be “partially opened” until a decision was made about whether the referral would be accepted. In these cases, a “partially opened” file would be entered into the case management system, rather than a new case file being opened for each referral. This resulted in patients with partially opened files not showing up on client case lists and plans not being actioned. When the triage nurse printed out the caseload list, partially opened files were not included, resulting in the clients became “lost to the service”.

RECOMMENDATIONS AND COMMENTS OF CORONER ANDERSON

I. The mental health triaging process in place at Northland District Health Board in late 2019 / early 2020 was unsafe and completely unsatisfactory. This serious systems failure resulted in a lost opportunity for contact with Kevin. While it is impossible to know whether the outcome would have been any different for him if he had been assessed by secondary mental health services, it is deeply concerning that he was deprived of this chance. His referral was apparently "lost" in the system not once, but twice. One of these instances occurred after he physically went to the mental health service clinic to find out why he had not been allocated an appointment.

II. It appears that a message was subsequently left on Kevin's phone asking him to make contact regarding a potential appointment on 12 March 2020. However, it is not clear from the information that is available whether he returned the call, or whether there was any further follow up from the service when he did not attend. This is extremely concerning given his clinical background and the information contained in the referral sent by his GP on 15 November 2019.

III. I note the steps already taken by Northland DHB to review the care provided to Kevin and to address the recommendations that were made by the review team.

IV. For the purposes of reducing the chances of further deaths occurring in future I make the following recommendation to Northland DHB (now known as Te Whatu Ora Te Tai Tokerau):

- That a full risk assessment and analysis be undertaken before any changes are made to clinical referral triage systems to reduce the chances of referrals being "lost" or overlooked by service providers.
- That Te Whatu Ora Te Tai Tokerau consider what further steps can be taken to ensure that clinical referrals are actioned in a timely manner and that there is appropriate follow up with patients and with primary health care providers who have made referrals to the service.

V. In accordance with the requirements of s 57A of the Coroners Act 2006, I notified Te Whatu Ora Tai Tokerau of my intention to make the above recommendations.

VI. The Chief Medical Officer of Te Whatu Ora Te Tai Tokerau responded, advising me that the flawed triage process was immediately ceased after the investigators identified that there was an issue. An audit was completed by 1 September 2020 of all other "partially opened" cases to ensure that no other clients were at risk. It was confirmed that there were no other "partially opened" cases in the system.

VII. In February 2021 in-service training about the Health Pathways referral and triage process was completed for the relevant clinical team. The Chief Medical Officer also confirmed that should any changes to clinical referral triage systems be contemplated in the future, a full risk assessment and analysis will be undertaken before any changes are made.

VIII. In relation to my second recommendation, the Chief Medical Officer advised me that clinical referrals that are non-urgent are actioned with a week timeframe. Follow up with primary care providers is arranged as part of the treatment plan. Furthermore, a pathway and flow chart has been developed to ensure any person presenting without an appointment receives a risk assessment from a clinician. This pathway was developed in consultation

with community staff and was implemented and socialised across all community mental health teams by 26 February 2021. A copy of the process has been provided to me.

IX. In conclusion, the Chief Medical Officer stated that Te Whatu Ora Te Tai Tokerau is committed to providing patients with a safe and effective triage system moving forward.

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 Kevin entered into evidence, on the grounds of personal privacy and decency.

Vermylen [2023] NZCorC 144 (15 November 2023)

CIRCUMSTANCES

Declan Adolf Maunga Kaha Vermylen, aged 17, died between 14 and 15 August 2021 at Hawera in circumstances amounting to suicide.

Declan had a history of mental health and behavioural issues. He was referred to Taranaki District Health Board in 2010 and 2017 for behaviour concerns however no formal diagnosis could be made.

Between 2019 and 2021, Declan had four consultations with his GP. In June 2021, his GP assessed him as having moderate to severe depression and commenced him on antidepressants. He also referred Declan to a local counselling service along with Taranaki District Health Board's Child and Adolescent Mental Health Service (CAMHS). Because of a long wait list, CAMHS opted to re-direct the referral, together with CAMHS recommendation for therapy, to a non-government organisation in the hope Declan would receive quicker therapeutic support.

On 26 July 2021 Declan's GP again made a referral to CAMHS and to the counselling service, who Declan had not heard from. Declan met with a CAMHS therapist on 10 August 2021 for the completion of an acute needs assessment. Following this, the plan was that Declan be reviewed by a CAMHS doctor and allocated a key worker from CAMHS as soon as possible. However, Declan died before this could occur. Prior to his death, Declan had disclosed to his GP that he had stopped taking his antidepressant medication. His GP wrote to CAMHS and advised them of this however this letter was received by CAMHS after Declan had died.

COMMENTS OF CORONER GREIG

I. People who take their own lives usually do so as a result of a complex range of factors.[42] The Ministry of Health has reported that "*it is usually the end result of interactions between many different factors and experiences across a person's life*".[43]

[42] Ministry of Health, *New Zealand Suicide Prevention Action Plan 2013-2016* (May 2013).

[43] Ministry of Health, *A strategy to Prevent Suicide in New Zealand 2017: A draft for public consultation* (April 2017).

II. Declan had had a turbulent life and was deeply troubled. Psychiatrist Dr Doran identified that for Declan, hardship and trauma maintained an ongoing depression and its consequences. His assessment and treatment had been patchy over his short life, although a number of organisations had been sporadically, but ineffectively, involved with him. Very sadly, at the time Declan died, the building blocks of some positive support for him were in place through his GP who was caring and persistent in seeking specialised help for Declan, through support from his school, including in particular the school counsellor, and through CAMHS who were about to start working with Declan, having assessed him and recognised that he was a young person at risk who needed immediate specialised intervention from CAMHS. This was about to begin.

III. The evidence presented to this inquiry highlights how stretched the DHB's (now Te Whatu Ora's) Child and Adolescent Mental Health Services and counselling services in the Taranaki region were during Declan's life – and how important early and effective intervention is for young people like Declan so that they receive the help and support they need.

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 Declan entered into evidence, on the grounds of personal privacy and decency.

Sudden Unexpected Death in Infancy (SUDI)

Bourne [2023] NZCorC 135 (30 October 2023)

CIRCUMSTANCES

Cartel Darcy Bourne, aged three and a half months, died on 5 February 2021 at Sandringham, Auckland of an unascertained cause associated with a dangerous sleeping environment.

The day after Cartel's birth, his mother was provided with education regarding safe sleeping for babies while in hospital. Her Lead Maternity Carer noted that a cot, wahakura, or Pēpi-Pod was required for Cartel. Cartel's father was not present during this education.

When Cartel and his mother were discharged home, they moved into Cartel's grandmother's address. On 2 February 2021, Cartel's mother and father moved into temporary emergency accommodation together with Cartel and their other son. The accommodation was a hotel-style room with one queen size bed and a bathroom. While staying there, Cartel co-slept with his parents and brother.

On the evening of 4 February 2021, Cartel and his mother, father, and brother co-slept in the queen bed. At 3:00am on 5 February 2021, Cartel's father heard him crying but did not wake fully or check on him. Around 7:00 or 8:00am, Cartel's mother woke. She checked Cartel and discovered he was unresponsive with liquid coming from his nose. CPR was attempted but Cartel could not be revived. He was pronounced deceased.

Police located cigarettes next to the bed and cigarette butts on the deck outside the bedroom, suggesting that one or both parents smoked. Cartel's father was later seen by Police holding cigarette papers.

COMMENTS OF CORONER BATES

I. I take this opportunity to reinforce to the general public the message of safe sleeping for infants. This message cannot be repeated too often.

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 two key modifiable risks of SUDI: unsafe bed sharing and exposure to tobacco smoke during pregnancy. Such measures are clearly desirable to reduce instances of infant deaths. In the present case there was bed sharing and one or both of Cartel's parents smoked. It is unclear whether his mother smoked while pregnant.

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.

V. I am satisfied that safe sleep advice was given to Cartel's whānau. It appears that when his parents moved into temporary emergency accommodation with their children, that advice was not followed. Cartel's sleeping arrangements prior to this are unknown. Cartel's death serves as a tragic reminder that every sleep for a baby should be a safe sleep.

VI. I record that members of Cartel's whānau smoked tobacco inside their one bedroom accommodation. It is likely that Cartel was exposed to tobacco smoke. It will remain unknown to what, if any, extent this exposure contributed to his death. Exposure to tobacco smoke continues to be a known SUDI risk factor 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 Cartel taken during the investigation into his death, in the interests of decency and personal privacy.

Erihe [2023] NZCorC 125 (11 October 2023)

CIRCUMSTANCES

Taumaro Tuwharerangi Erihe, aged six months, died on 12 March 2020 at Otangarei, Whangārei. The cause of death was unascertained in the context of unsafe sleeping and is subsequently recorded as a Sudden Unexpected Death in Infancy (SUDI).

Taumaro's mother, Honey-Jade Paora, smoked while pregnant with Taumaro. Her midwife discussed the increased risk of harm to her baby from smoking, but she declined assistance with smoking cessation. The midwife also noted from Honey-Jade's previous pregnancies, that she tended to have the baby in bed with her and had previously used a wahakura. Honey-Jade confirmed she was aware of the need for a safe sleeping environment and with her consent the midwife referred her to the District Health Board (now Te Whatu Ora) for a Pēpi-Pod. The midwife also confirmed that she and Honey-Jade discussed the benefits of fully breastfeeding the baby to try to decrease the risk of cot death/SUDI. Honey-Jade said that she planned to breastfeed but also intended to give the occasional bottle.

When the midwife visited Taumaro after his birth, he was noted to be doing well and had a Pēpi-Pod. During a hospital admission in September 2019 Taumaro was diagnosed with bronchiolitis and it was believed he had contracted a virus that had caused an inflammation of his airways. It was also noted that Taumaro was exposed to cigarette smoke.

On 11 March 2020, Taumaro spent the day with his father and siblings at his grandfather's address. The adults consumed some beer during the afternoon. That evening, Taumaro was placed to sleep in a single bed with his father and sister. The bed had several cushions and pillows. When Taumaro's father woke the next morning, Taumaro was unresponsive. Resuscitation was attempted but paramedics confirmed Taumaro was deceased. Taumaro's father said he thought Taumaro must have either gone under his right arm or got tangled up in the pillows.

COMMENTS OF CORONER MILLS

I. I make the following comments and recommendations pursuant to section 57A of the Coroners Act 2006.

II. The sudden and unexpected death of a young pēpi is devastating for all whānau. SUDI is an umbrella term that describes the death of an infant that was not anticipated within the first year of life. Between 40 to 60 babies die suddenly in their sleep every year in New Zealand. The combination of bed sharing and the exposure to tobacco smoking in pregnancy (and after birth) statistically increases the risk of SUDI significantly.[44] Sadly Taumaro was exposed to both. I acknowledge, however that it is not always easy to ensure a safe sleeping space or a smoke free environment when whānau are living in overcrowded houses, are transient, or staying with other whānau. Recent research confirms that poverty and housing circumstances often limit the ability to provide safe and separate sleep arrangements.[45]

[44] MacFarlane et al 2022 Infants Sleep Hazards and the Risk of Sudden Unexpected Death in Infancy. (J Pediatr 2022;-:1-9). Research, SUDI Prevention Coordination Service, https://sudinationalcoordination.co.nz/research

[45] Tipene-Leach D, Fidow, JF.2022. *Sudden Unexpected Death in Infancy Prevention in New Zealand: The case for Hauora – a well being approach, Wellington: Ministry OF Health published May 2022.*

III. Sudden infant death occurs inequitably among Māori infants who are nine times more likely and Pasifika infants who are six times more likely than non-Māori to die from SUDI.[46] The Ministry of Health's SUDI Expert Advisory Group's (the EAG) recent report advocated for a change of approach to SUDI prevention. It called for a hauora wellbeing approach that is led by Māori and Pacific woman and a cross-sectoral approach to addressing the underlying determinates of health. It also made several recommendations aimed at addressing some of the underlying structural causes of SUDI.

IV. I endorse the recommendations from the Expert Advisory Group. While it is important to continue to reinforce the key messages of safe sleep, there is also a need to address the real drivers behind SUDI as discussed in the EAG report, many of which were present in the circumstances leading to Taumaro's death.

V. In addition, I reiterate the importance of making every sleep a safe sleep for all pēpi/babies by:

- Placing baby in their own baby bed in the same room as their parent or caregiver for at least the first six months. Put your baby to sleep in their own safe sleep space – a bassinet or cot, or a wahakura or Pēpi Pod if you choose to have your baby in bed with you.
- Positioning baby flat on their back to sleep, with their face clear of bedding or anything else. They should sleep with their feet to the end of their bed, on a firm flat mattress. When pēpi sleeps on their back, their airway is clear and open and this helps them breathe easier.
- Eliminating smoking in pregnancy and protect baby with a smokefree whānau (family), whare (home) and waka (car). There's a strong link between SUDI and smoking. Healthy babies have an inbuilt 'wake up' response that protects their breathing. This response in babies is seriously weakened by smoking, especially in pregnancy.
- Encourage and support breastfeeding and the gentle handling of baby. Mothers can sustain tikanga ūkaipō (traditional practice of breastfeeding) with positive breastfeeding experiences.
- If you're on a low income, you might be able to get help from Work and Income to buy a baby bed. See more information on WINZ website - https://www.workandincome.govt.nz/eligibility/children/having-a-baby.html

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Taumaro taken during this inquiry, in the interests of decency.

[46] Ibid.

Manu [2023] NZCorC 145 (20 November 2023)

CIRCUMSTANCES

Simulata Yoko Manu, aged 86 days, died on 26 September 2020 at Titirangi Road, Auckland. The cause of death is unascertained but occurred in association with an unsafe sleeping environment.

Simulata was born at 36.6 weeks gestation via a planned caesarean section to her parents Maryann and Pauliasi Manu. Over the four weeks following her birth, Simulata was healthy and expected milestones.

Simulata's mother was provided advice on safe sleeping on 11 August 2020, by a Plunket nurse. This included the need for Simulata to be placed to sleep in her own bed, with her face clear, with no toys or pillows in the cot, and her arms free.

Having slept in her bassinet during the night, at around 5:00am on 26 September 2020 Simulata awoke and started crying. Her mother woke up and tried to settle her for a couple of hours. At around 7:00am, they both fell asleep on the bed. Between 8:00am and 9:00am, Simulata's mother woke up and fed her but Simulata was restless, so her mother continued to lie in the bed with her. Shortly after 9:00am, Simulata's grandfather checked on them and saw that Simulata's mother was asleep in the middle of the bed, while Simulata was lying beside her. Simulata was lying face up, with her head between her mother's left arm and body. He woke Simulata's mother up who tried to wake Simulata but found that she was unresponsive and had some blood coming out of her nose. Emergency services were immediately contacted but Simulata could not be revived.

COMMENTS OF CORONER ANDERSON

I. In Aotearoa between 40 and 70 babies die suddenly each year while they are asleep. The Ministry of Health[47] advises that many of these deaths can be prevented, and it has published guidelines on how to keep babies safe in bed. These guidelines are available on the Ministry's website and several of the relevant sections are set out in some detail below:

> ***Make every sleep a safe sleep***
>
> *Sudden unexpected death is a risk to babies until they are about 12 months old, but most deaths can be prevented.*
>
> *There are things that we can do to protect our babies. Although for some babies the cause of death is never found, most deaths happen when the babies are sleeping in an unsafe way.*
>
> *Always follow these safe-sleep routines for your baby and your baby's bed.*
>
> ***Make sure that your baby is safe***
>
> *To keep your baby safe while sleeping, make sure:*
>
> - *they always sleep on their back to keep their airways clear*

[47] https://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/6-weeks-6-months/keeping-baby-safe-bed-6-weeks-6-months

- *they are in their own bassinet, cot or other baby bed (eg, pēpi-pod® or wahakura) – free from adults or children who might accidentally suffocate them*
- *they are put back in their own bed after feeding – don't fall asleep with them (to protect your back, feed your baby in a chair rather than in your bed)*
- *they have someone looking after them who is alert to their needs and free from alcohol or drugs*
- *they have clothing and bedding that keeps them at a comfortable temperature – one more layer of clothing than you would wear is enough; too many layers can make your baby hot and upset them*
- *they are in a room where the temperature is kept at 20°C.*

Make sure that your baby's bed is safe

Baby's bed is safe when:

- *it has a firm and flat mattress to keep your baby's airways open*
- *there are no gaps between the bed frame and the mattress that could trap or wedge your baby*
- *the gaps between the bars of baby's cot are between 50 mm and 95 mm – try to get one with the gaps closer to 50 mm if you can*
- *there is nothing in the bed that might cover your baby's face, lift their head or choke them – no pillows, toys, loose bedding, bumper pads or necklaces (including amber beads and 'teething' necklaces)*
- *baby has their feet close to the end of the bed so they can't burrow under the blankets*
- *baby is in the same room as you or the person looking after them at night for their first 6 months of life.*

II. I do not consider that any recommendations are required in the context of this case. As noted above, there are existing guidelines that provide advice on how to put babies down to sleep safely. These guidelines emphasise the importance of ensuring that every sleep is a safe sleep.

III. A copy of these findings will be sent to the National Mortality Review Committee and Safekids.

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

Pukeiti [2023] NZCorC 133 (27 October 2023)

CIRCUMSTANCES

Aziz Israel Pukeiti, aged 5 months, died on 17 March 2023 at Barnardos Early Learning Centre, Otara from sudden unexpected death in infancy (SUDI).

Aziz was born at Middlemore Hospital after an uncomplicated pregnancy and labour. In the early hours of 8 March 2023 Aziz was taken to Middlemore Hospital by his parents with a cough and suspected fever. Aziz was diagnosed with tonsilitis or viral illness. He was treated with liquid paracetamol and discharged home with a prescription for paracetamol and ibuprofen as required. Aziz's mother reported that she gave Aziz paracetamol twice a day and in the week following he was fine but with a 'normal' runny nose and cough.

On the morning of 17 March 2023 Aziz was dropped off by his parents at Barnardos Early Learning Centre. Otara. Staff said he was his normal self. At about 11am after being fed lunch, a bottle and burped, Aziz was placed to sleep in the sleep room at the Centre in his own cot. The sleep room is maintained at a constant temperature of 18 degrees Celsius. Aziz was dressed in a cotton t-shirt and nappy and placed on his back and covered with a loose baby-sized fleece blanket over his chest and legs. The blanket was not tucked in as was the policy of the centre to allow the child to move around. Aziz was then checked approximately every ten minutes as per Barnardos' procedures. At the check at 12:10pm Aziz was found on his back still with the blanket covering his chest and upper legs but his feet sticking out of the blanket. His face was pale. When staff picked Aziz up some vomit fell out of his mouth. Staff immediately ran for help. CPR was commenced but unfortunately Aziz could not be revived.

A post-mortem examination did not reveal a cause of death.

Barnardos Early Learning was noted to have groupwide policies around safe sleep. These provide:

(a). clean individual beds and bedding are to be available and appropriate for the age of each child;

(b). outer layers of clothing, and anything that poses a risk of suffocation or strangulation or could become a choking hazard, are to be removed from children before sleep;

(c). linen is arranged so that it does not cover the child's face while sleeping, particularly for children under the age of two;

(d). pillows, cushions, bumper pads or any other items that have the potential to harm a child must not be used in cots; and

(e). all infants are to be placed into their cots flat on their back;

(f). children are not to have access to food or liquids while in bed;

(g). staff are to monitor children's breathing, warmth and general wellbeing every five to ten minutes and these checks are to be recorded; and

(h). the temperature in the sleep room is to be maintained at 18 degrees Celsius.

It was also noted that it was the practice of teachers at the Centre in Otara to place babies at the bottom of the cot to minimise the risk of any covering moving up the baby's body during sleep and covering the baby's face. The coroner noted that the evidence indicated full compliance with these policies and there was no obvious explanation for Aziz's sudden deterioration between the 12:00pm and 12:10pm checks.

COMMENTS OF CORONER HO

I. I do not make any recommendations under s 57A of the Act. I do however note the following points.

Loose bedding

II. Best practice is to not use any loose bedding in cots or, if there is bedding, to place the baby in the cot with his or her feet against the bottom end to minimise the risk of the bedding moving up over the baby's face during sleep.

At the time of Aziz's death, Barnardos Early Learning had no formal policy about the use of blankets or linens other than that noted at (c)] above, although it appeared that the teachers generally abided by the informal practice of placing the baby at the foot of the cot. This omission from Barnardos Early Learning's policies was surprising, but it explained that its internal sleep and rest policy was based on Ministry of Education guidance including specific licensing criteria and guidance for early childhood education and care services, which states:[48]

> When putting a child to bed, it is recommended by the Child and Youth Mortality Review Committee (CYMRC) that:
>
> - bedding should be sufficient to keep the child warm but not to overheat them
> - bedding must be arranged so that it does not cover the child's face – this is especially important for babies
> - children under 2 should not use pillows

III. In this case, the blanket was infant sized and according to Aziz's teacher was found in the same position over the chest and legs as when Aziz was placed to sleep. It is unlikely that the blanket was contributory to death. That notwithstanding, the presence of loose bedding is a recognised SUDI risk factor and Barnardos Early Learning has responsibly committed to updating its sleep and rest policy to require its centres to either not use loose bedding in cots or to place the baby in the cot with feet at the bottom end of the cot to minimise the risk of the bedding moving up over the baby's face during sleep. I encourage the Ministry of Education to also consider updating its guidance to its premises and facilities licensing criteria for early childhood education and care services to include the same.

Safe sleep

IV. It is critical that every sleep for baby is 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 (being a firm, flat surface with no pillow) and with their face clear.

V. The fact that Aziz died in a safe sleep environment should not discourage parents and caregivers from heeding safe sleep messages. Safe sleep is not an absolute guarantee against SUDI. Rather, it is a means within adults' control which can materially reduce the risk of such deaths.[49]

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

[48] Guidance to Premises and Facilities Licensing Criteria PF31.

[49] Best Practice Advocacy Centre New Zealand (BPAC) (2013) 56 Upfront *Sudden unexpected death in infancy: Where are we now?* https://bpac.org.nz/bpj/2013/november/docs/BPJ56-upfront.pdf

Tito-Matthews [2023] NZCorC 153 (29 November 2023)

CIRCUMSTANCES

Josephine Reremoana Lee Mitai Tito-Matthews, aged two months, died on 6 May 2021 at Papanui, Christchurch due to sudden infant death while bedsharing.

Josephine and her twin were born on 3 March 2021 at 35 weeks and two days. The twins were in the care of the neo-natal ward at Christchurch Hospital for about three weeks. There were no specific concerns for either twin's health during their stay.

When the twins were discharged, a community midwife visited the whānau for some weeks and had no concerns for their care. She brought woollen clothing for the twins with her and provided the parents and whānau with a copy of the Ministry of Health safe sleeping arrangements pamphlet. The pamphlet contains recommendations, including that babies have their own bed in the parent or caregiver's room, always sleep on their backs in their own beds with their faces clear, and are dressed in woollen rather than synthetic clothing.

When the twins were seven to eight weeks old their care was transferred to a nurse. The nurse advised the whānau that "tummy time" should only be practiced when the babies were awake. After observing the twins wrapped in synthetic fibres during a visit, the nurse provided merino wool blankets, talked to the whānau about the preference for natural fibres to prevent babies overheating, and demonstrated how to wrap the babies and place them in their respective bassinets.

On 5 May 2021 the twins were vaccinated in their home and were grumpy and tired as a result. Because of this, their parents decided to keep the twins close by bedsharing. The twins were fed, wrapped in polar fleece materials, and placed on their parents' bed. Josephine was placed on her stomach, with her head to the side, because she was bigger than her twin and Josephine's grandmother had advised that Josephine was ready to be on her stomach.

Josephine slept until about 10:30pm when she became unsettled. She went back to sleep around 3:00am. When Josephine's mother woke on the morning of 6 May 2021, she became aware that her toddler niece was in the bed as well. She then saw Josephine face-down on the bed and realised that Josephine had died. Emergency services were notified, and CPR was carried out until emergency services arrived and took over resuscitation. However, Josephine could not be revived.

COMMENTS OF CORONER SCHMIDT-MCCLEAVE

I. The evidence showed Josephine to be a healthy baby. On the night Josephine died, she was co-sleeping with her parents, baby twin sister and toddler cousin, on her stomach and wrapped in synthetic materials. This was an unsafe sleeping environment and a known significant risk factor for SUDI.

II. All the health professionals involved with Josephine's whānau provided them with advice about the risks of SUDI from co-sleeping and using synthetic bedding, advice which was followed most of the time by the whānau. Sadly, due to Josephine being unsettled after her immunisation, this advice was not followed on 5 May 2021.

III. There has been increasing focus in New Zealand on promoting key, research-based, safe sleep messages. Specifically that, for every sleep, babies up to one year of age should be put to sleep on their backs, in their own sleeping space (such as a cot, bassinette or pēpi-pod) with no pillow and their faces clear. The challenge for those working with parents and caregivers is how to ensure that the importance of the safe sleep message is appreciated by parents and caregivers so that they take the steps necessary to ensure that every sleep is a safe sleep.

IV. I acknowledge that the unsafe sleeping environment was accidental. This is a tragic loss for Josephine's family.

V. A number of recommendations and comments made by coroners focussed on the issue of safe sleep. Given this, I do not consider further recommendations are necessary, but urge New Zealand families to heed the safe sleeping guidance they are given by ante-natal and post-natal professionals and to follow it on every occasion without exception.

Note: An order under section 74 of the Coroners Act 2006 prohibits making public any of the photographs of Josephine entered into evidence, on the grounds of personal privacy and decency.

Virtue [2023] NZCorC 159 (7 December 2023)

CIRCUMSTANCES

Zaaliyah Tania Miracle Virtue, aged two months and one day, died on 11 August 2020 at Auckland of accidental asphyxia due to unsafe sleeping environment.

Zaaliyah was born on 10 June 2020 by emergency caesarean at 31 weeks and 4 days gestation. She weighed 1040 grams and experienced respiratory distress, and was immediately transferred to Middlemore Hospital's neonatal intensive care unit. Zaaliyah remained in hospital for 53 days. Before she was discharged on 2 August the risks of sudden unexpected infant death (SUDI) were discussed with her parents, including the dangers and risks of co-bedding.

On 10 August 2020, at 10:00pm, Zaaliyah's mother fed her and put her to bed in a bassinet which was on top of her own double bed. On 11 August 2020 at around 2:00am, Zaaliyah was crying and hungry so her grandmother came into the bedroom to check on her. She took Zaaliyah to another room and fed, burped and changed her. At approximately 3:00am she brought Zaaliyah back into the bedroom, but Zaaliyah was crying and would not settle in her bassinet. Her mother then laid her down next to her in the bed. Zaaliyah was lying on her back with her head leaning against her mother's forearm and her body out to the side. They were partly covered by a double-sized duvet and both fell asleep.

In the morning, Zaaliyah's grandmother went into the bedroom, turned the lights on and asked where Zaaliyah was. Zaaliyah's mother then lifted up the duvet, which had been covering Zaaliyah's body and face. Zaaliyah had blood coming out of her nose and was not responsive. Emergency services were called and confirmed Zaaliyah was deceased.

COMMENTS OF CORONER ANDERSON

I. Given my findings in relation to the cause of Zaaliyah's death, I have considered whether any comments or recommendations are required in order to reduce the chance of further deaths occurring in future.

II. Zaaliyah died of accidental asphyxia, while in an unsafe sleeping environment. Safe sleeping advice is available from a number of sources and information about safe sleeping is routinely provided to new parents by healthcare providers. In order to reduce the chance of accidental death occurring, this advice must be followed every time a baby is put down to sleep, even when a baby is unsettled.

III. The following safe sleep guidelines are available on the Ministry of Health's website:[50]

> *Always follow these safe-sleep routines for your baby and your baby's bed.*
>
> ***Make sure that your baby is safe.***
>
> *To keep your baby safe while sleeping, make sure:*
>
> - *they always sleep on their back to keep their airways clear*
> - *they are in their own bassinet, cot or other baby bed (eg, pēpi-pod® or wahakura) – free from adults or children who might accidentally suffocate them*
> - *they are put back in their own bed after feeding – don't fall asleep with them (to protect your back, feed your baby in a chair rather than in your bed)*
> - *they have someone looking after them who is alert to their needs and free from alcohol or drugs.*
> - *they have clothing and bedding that keeps them at a comfortable temperature – one more layer of clothing than you would wear is enough; too many layers can make your baby hot and upset them*
> - *they are in a room where the temperature is kept at 20°C.*
>
> ***Make sure that your baby's bed is safe.***
>
> *Baby's bed is safe when:*
>
> - *it has a firm and flat mattress to keep your baby's airways open*
> - *there are no gaps between the bed frame and the mattress that could trap or wedge your baby*
> - *the gaps between the bars of baby's cot are between 50 mm and 95 mm – try to get one with the gaps closer to 50 mm if you can*
> - *there is nothing in the bed that might cover your baby's face, lift their head or choke them –*
> - *no pillows, toys, loose bedding, bumper pads or necklaces (including amber beads and 'teething' necklaces)*
> - *baby has their feet close to the end of the bed so they can't burrow under the blankets*
> - *baby is in the same room as you or the person looking after them at night for their first 6months of life.*

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

[50] https://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/6-weeks-6-months/keeping-baby-safe-bed-6-weeks-6-months

Workplace

Seyb [2023] NZCorC 137 (1 November 2023)

CIRCUMSTANCES

Yvonne Susan Jeanette Seyb, aged 64, died on 2 August 2020 at Waikato Hospital of non-survivable injuries to skull and brain sustained from an unwitnessed quad bike accident.

Yvonne lived and worked on a Taranaki dairy farm. When she rode the quad bike Yvonne would ride with both of her legs on the left side and did not usually wear a helmet. She had been suffering from occasional dizzy spells in the months prior to her death.

At approximately 8:45am on 1 August 2020 Yvonne was driving a quad bike on the dairy farm where she worked. In an unwitnessed incident Yvonne fell from the quad bike and hit her head. She suffered fatal skull injuries and died the following day.

The quad bike was examined by a vehicle inspector who identified the following faults:

(a) The right front tyre pressure was 1 PSI, the left front was at 10 PSI. The recommended pressure is 5-6 PSI. In addition, the left front tyre had very little remaining tread. A low trye pressure can cause problems such as a lack of control and can make the bike vulnerable to rolling. A high tyre pressure can result in reduced grip.

(b) The steering had a worn lower pivot bush which contributed to excess play at handlebars and front wheels. Excess play can make the handlebars feel tight to turn.

(c) Visually the front brake reservoir appeared low on fluid. Low brake fluid can, eventually, result in a loss of braking function.

Exactly what caused Yvonne to come off the quad bike is unknown but the coroner noted several possible contributing factors:

(a) She may have suffered a dizzy spell and/or lost control of the quad bike as it drove into a gutter.

(b) The faults with the quad bike may have resulted in Yvonne losing control of the bike.

(c) Unfortunately, Yvonne was not wearing a helmet when riding the quad bike and the position that she had to sit on the quad bike may have made her more vulnerable to coming off the bike if she lost control.

COMMENTS OF CORONER WOOLLEY

I. The dangers associated with quad bikes have been recorded by coroners on many occasions. In addition, Worksafe publishes guidelines on the safe use of quad bikes. The guidance is primarily aimed at the use of quad

bikes in agricultural workplaces/on farms because that is where the majority of quad bikes are found. Of relevance the guidance emphasises:

- Wearing a helmet at all times when riding a bike because quad bikes can suddenly become unstable, and riders can easily lose control of quad bikes.
- Undertaking regular maintenance checks of quad bikes to ensure they are in reliable working condition.

II. Of relevance to the circumstances of Yvonne's accident, the guidelines also note that a quad bike rider needs to shift and use their body weight to control the bike. The guidelines recommend that the rider keeps both hands on the handlebars and both feet on the foot pegs while riding a quad bike.

III. To assist members of the community most likely to be using quad bikes on agricultural properties being made aware of these comments and the Worksafe guidance, a copy of these findings will be sent to the Ministry for Primary Industries and Federated Farmers.

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

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