MINISTRY OF JUSTICE
Tāhū o te Ture

Annual Report 2019/20

Kai Tirotiro Matewhawhati Rangatira o Aotearoa
Office of the Chief Coroner of New Zealand

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Ki te iwi Māori he tikanga nui tō te mate me te whakahemohemo. He taunga te whānau ki te tūpāpaku, ā, kei reira rātou mō te nuinga o ngā whakaritenga tae noa ki te nehunga. Ko te tiaki i te tūpāpaku, ko te tangi me te tuku kōrero ki a ia – puta ake ai ēnei hei whakaatu, ahakoa kua mate, ora tonu ai te wairua.

Death and dying are a central part of Māori life. The family have an intimate connection with the body of the deceased and are usually closely involved with the preparations leading up to the burial. Respect – in the form of caring for the tupāpaku, mourning the deceased and speaking to them – is shown because, although the physical remains of a person are lifeless, the spirit continues to live on.

New Zealand Law Commission, Coroners: A Review, Preliminary Paper No 36, Wellington, 1999, para 17.

INTRODUCTION

Welcome to the 2019-2020 Annual Report of the Chief Coroner

In last year's Annual Report, we highlighted the 15 March 2019 tragedy in Christchurch. The 2019/2020 financial year was marked by another tragedy – the eruption of Whakaari White Island. Twenty-two people lost their lives as a result of the eruption. Many more live with the results of the eruption, including those with extensive injuries and those who lost loved ones. Our thoughts go out to those whose lives were changed on 9 December 2019.

The purpose of this Annual Report is to provide a summary of the mahi undertaken by coroners in the last financial year. This mahi includes responding to the Whakaari White Island mass fatality incident and the ongoing receipt of reports of deaths and the subsequent investigations.

This report also contains a summary of the provisional suicide statistics released by me every year. This year, the suicide rate decreased slightly from a rate of 13.93 deaths per 100,000 people, to 13.01 deaths per 100,000 people. Overall, the number decreased by 31 deaths from 685 to 654.

The number of deaths reported to coroners has fallen slightly compared to last year. Coroners took jurisdiction over 3603 deaths in the financial year. This is a decrease of 197 from the 2018/2019 financial year.
This year also saw the welcome appointment of eight relief coroners. The relief coroners are .75% FTE and undertake all the roles of full-time coroners, including being included in the duty coroner roster, accepting new files, conducting investigations and making written determinations on their files. It is hoped that the increase in coroner numbers will increase the timeliness of coroners' investigations.

I hope you find this Annual Report of interest. It contains a sample of the kinds of recommendations / comments coroners made during the year. This is an important aspect of a coroner's role, designed to prevent similar deaths occurring in the future. Further examples can be found in our recommendation recaps which are published on the Ministry of Justice website.

https://coronialservices.justice.govt.nz/findings-and-recommendations/recommendations-recap/

Nāku noa,

Judge D Marshall
Chief Coroner

CORONIAL SERVICES OF NEW ZEALAND

Purongo O te Ao Kakarauri

The New Zealand coronial bench consists of 25 coroners and one Chief Coroner. They are supported in their roles by the Ministry of Justice's Coronial Services Unit and operate throughout Aotearoa New Zealand.

The Chief Coroner's main function is to help ensure the integrity and effectiveness of the coronial system. This includes helping to achieve consistency in coronial decision-making and other coronial practices.

Coroners are independent judicial officers with a legal background who investigate sudden, unexplained or suspicious deaths. They are based throughout the country, with offices in Whangārei, Auckland, Hamilton, Rotorua, Hastings, Palmerston North, Wellington, Christchurch and Dunedin.

Coroner D Llewell

Ko Donna Llewell toku ingoa	My name is Donna Llewell
Kua whānaunau ahau ā Te Puke	I was born in Te Puke
Ka pakeke au kei waenganui ngā hau e whā,	I grew up at the place of four winds,
ara Ko Kaingaroa	that is Kaingaroa
Ko Pīpīwharauroa toku ingoa Māori	My Māori name is the Shining Cuckoo
Tēnā ra koutou katoa	Sincere greetings to you all

Someone recently said to me that being a Coroner seemed the most natural and logical judical pathway for me. When I think about that proposition, it is true that both my legal professional and personal life experiences have led me to the role of Coroner. People say *"… it must be dark and morbid…"* but for me, I see the work in completely opposite ways - an opportuntity to shine the light on someone's passing so that families are not left pondering, using my analytical brain in forensic circumstances, and having a duty to offer solutions or improvements to mitigate against future deaths.

I was a foundation student of Te Piringa – Faculty of Law, Waikato University completing a co-joint Batchelor of Laws & Arts (Māori) in 1995. I was admitted to the bar in the Rotorua High Court and so it is canny to make a full circle in my career by returning to now sit in the Rotorua Coroners Court. I was the first New Zealander to obtain a Masters in Law from the University of South Pacific with a focus on the integration of customary and environmental laws.

I have worked in challenging and interesting areas of the law throughout my legal career. Starting in a "boutique" resource management private law firm, to central government as solicitor for Te Papa Atawhai / Department of Conservation, Crown Counsel in (then) Treaty & International Law team where I had the privilege of participating in historical and contemporary Treaty settlement negotiations throughout Aotearoa, three years of voluntary service in Vanuatu and Bougainville with environmental, customary and constitutional issues, and my last role before being appointed a Coroner was in local government as the inaugural In-House Legal Counsel for Toi Moana / Bay of Plenty Regional Council. I was fortunate to have civil defence training and provided legal input for civil defence responses to natural disasters in the region.

I have also been a customer of coronial services with a suicide and an accidental drowning in my immediate whānau. Both deaths were the subject of coronial inquests. These experiences ignited my interest in becoming a Coroner and have given me empathy to deal with individuals and families experiencing the various stages of the grieving process. Having lived, worked and survived in two different developing countries were things can be tough compared with our Kiwi standards of

living and resourcing, this taught me to be sensitive to, and appreciative of, other ways of life and values, and most importantly gave me the emotional resilence to deal with complex and stressful situations.

The majority of my legal career has been in the public sector, adminstrative and regulatory laws, with all my advocacy and litigation experience in courts of specialist and inquisitorial jurisdictions. I wanted to become a Coroner to be in a role that combined my professional knowledge and skills, to work in an environment which requires collarboration with others and where I could give effect to my long-standing ethics of public and community service. As well, I am hopeful to add value and bring diversity to the coronial bench with my cross-cultural working experience, commitment to biculturalism and awareness of mātauranga me te reo Māori.

Being appointed as a Coroner at the beginning of the March 2020 COVID-19 national lockdown has had its challenges with training and working remotely as a judicial officer for the intial three months.

I am inspired and grateful to my fellow Coroners for their assistance during that time. In moving back into chambers, the enormity of the role and volume of work that needs to be done is clear. I am really enjoying the challenge of new learnings with medical and pathological information. For some files, the potential criminal interface and/or other regulatory investigations are new areas of the law for me. It is an important consideration for effective use of public resources not to reinvent the wheel or duplicate process.

Finally, in every step of the way and decision about each of my coronial files, I always pay my respects and recognise that I am dealing with a person, a life, someone that was part of a family and a community. The role of Coroner requires integrity, intelligence, empathy, dedication and professionalism. It seems like a tall order, but I have to remind myself that my life's journey has prepared me for this.

Kia kaha, kia maia, kia manawanui
Be strong, be brave, be open hearted

Donnna Llewell
Coroner, Rotorua

Following Te Kooti Whenua Māori pōwhiri / Māori Land Court welcome for new Rotorua coroners on 24 July 2020.

Coroner Heidi Wrigley, Chief Coroner Judge Deborah Marshall, Coroner Bruce Hesketh, and Coroner Donna Llewell (far right)

Coroner A Cunninghame

I was born in Ōtepoti and went to school here, I went to the University of Otago twice – first to get a BA(Hons) in English, and a few years later to get an LLB. In between my stints at university was a period working in hospitality in Perth, Western Australia, and then four years teaching English to kindergarten and elementary school students in Gwangju, South Korea.

I was fortunate to be offered a position in the litigation team at Anderson Lloyd, first as a summer clerk, and then as a graduate solicitor in 2008. In my ten years at the firm I appeared in nearly all New Zealand's courts, and many of the tribunals as well. I prosecuted matters for Councils and for the New Zealand Law Society. I acted as defence counsel in the criminal jurisdiction and in relation to regulatory prosecutions. I spent almost five years working on the litigation relating to the statutory management of the late Allan Hubbard's funds, during which I clocked up an enormous amount of air miles flying between Dunedin and Christchurch.

As time went on, my focus was increasingly on representing clients investigated and charged under the Health and Safety at Work Act and its predecessor legislation. This meant that I visited many fascinating workplaces, on farms, in factories, in mines, and in schools. In 2015 and 2016 I spent a lot of time at Waihi following an accident at the mine, and I have often reflected on how valuable, and how humbling, it was to be invited into a community that was grieving, and to work with those involved to establish what had happened, and why.

At the beginning of 2018 I took a position as Professional Practice Fellow at the University of Otago Legal Issues Centre, an independent research centre housed within the Faculty of Law. The Centre's focus is on researching innovations that can promote a more affordable, accessible, and efficient civil justice system in Aotearoa. During my time at the centre I worked with academics, lawyers, the NZLS, members of the judiciary, and the public, to promote the Centre's research and to encourage innovation and reform. Projects that I was involved with included user testing a model online dispute resolution system, promoting rule reform to better provide for delivering litigation services on unbundled retainers, and producing a series of animations to explain court processes to laypersons.

I was a member, and then convenor, of the NZLS' National Standards Committee that was formed in 2018 to hear sensitive complaints relating to lawyers, and briefly sat on the Civil Litigation and Tribunals Committee, before stepping off those committees as a result of my appointment as Relief Coroner. I was also the Co-Chair of ActionStation Aotearoa, a people-powered, member-funded organisation that advocates for a society, economy, and democracy that serves all people and Papatūānuku. I am on the Board of Trustees of Otago Boys' High School and was previously Chair of the Board of Trustees of Dunedin North Intermediate School. I was a management committee member of Community Law Otago, and had a long association with the Otago Women Lawyers' Society committee, including two years as convenor.

My son Max is roughly the same age as my legal career, having been born three weeks after I started second year law. I am grateful for the support and

encouragement that has been given to me over the years by my family and my friends, and also by my employers. It is not easy juggling full time study or work (particularly in a large firm litigation team) with children, and parenting alone brings extra challenges.

I spend a lot of my spare time outdoors. I am a firm believer that being in the natural environment is good for mental wellbeing, and I am fortunate to be able to access our wonderful back country. I am currently training for the Kepler Challenge, with a goal to complete it faster than I did back in 2017, when I literally dragged myself over the finish line! I do as much tramping and skiing as time and the unpredictable mountain weather allows. In pre-Covid times I was often travelling and at live music events, but such things have taken a back seat to baking cakes and reading in 2020.

I am proud to have been able to step into the role of Coroner. One of my earliest memories is meeting an American woman who had come to New Zealand to meet my father (a mountaineer and search and rescue leader) who had brought the body of her son out of the Darran Mountains. I remember this woman's dignity, and her desire to understand the place in which her son had lost his life. Being able to help people find answers, and to prevent further tragedies occurring, is important work, and I hope to be able to do this with compassion and with the motivation to make life in our country better for all of us.

Alexandra Cunninghame

Relief Coroner, Dunedin

WHAKAARI DISASTER

The Whakaari/White Island eruption on 9 December 2019 was another dark day for New Zealand, following the events of 15 March 2019 in Christchurch.

Whakaari/White Island erupted when dozens of people were on the island. Twenty-two people were killed.

As the number of fatalities became apparent, Chief Coroner Judge Deborah Marshall declared the eruption a Mass Fatality Incident (MFI) and the MFI contingency plan was enacted – the second time in nine months.

The Coronial Services team split into units: one would focus on the disaster victim identification (DVI) process for the eruption; the other would ensure NIIO continued to ensure business as usual for other deaths around New Zealand continued.

The Chief Coroner led the Whakaari response, supported closely by Coroner Anna Tutton, Coroner Debra Bell and then-Coroner Morag McDowell.

From aerial footage it was clear there were a number of deceased on the Island. Two were missing – and never to be recovered – and many more succumbed to their injuries over the coming days, weeks and months in hospital.

Thirteen people died on 9 December 2019; another eight died between then and the end of January 2020, and one more died on 2 July 2020 in Germany.

The Coronial Services team worked hard to quickly identify the deceased and return them to their families as soon as possible.

The internationally approved process for DVI was being followed, which was stringent and ensured the correct person was identified and returned to their families.

The team worked closely with pathologists and NZ Police to gather post mortem and ante mortem information to ensure each of the deceased was correctly identified.

The first body was released to family on 14 December; the second on 16 December; five more on 17 December; three more on 18 December; one on 19 December; two on 20 December; two on 24 December and the last to die in New Zealand was released on 31 January 2020.

As a number of victims were from Australia, they needed to be repatriated also, all of which (16 in total) was completed by 23 December 2019.

The Coronial Services team send its condolences to all victims' families of the Whakaari/White Island eruption, and wishes survivors well in their recovery.

The Whaakari Memorial Service at Te Mānuka Tūtahi Marae in Whakatane, 9 December 2020

THE FIRST 48 HOURS

The National Initial Investigation Office (NIIO) (or Duty Coroner's Office) has had another busy year.

The figures below show the 2018/19 year and the 2019/20 year to give some comparisons:

	2018/19	**2019/20**
Jurisdiction Accepted:	3,792	3,603
Doctors issued Certificates:	1,746	1,595
Total Cases Reported:	5,538	5,198

This year, we have not had many changes in staff, which has meant we have a very stable and knowledgeable team of people providing assistance to the Duty Coroners. We have a Service Manager, two Senior Coordinators, and 15 Coordinators, with four of these working in part-time roles. This team of 17 work in shifts providing a 24/7 service 365 days a year.

The work is ever changing and reactive to the notifications received. Sometimes pressure comes from the number of notifications being dealt with at one time and sometimes from the complexity of a death, including such things as gathering information for the Duty Coroner to enable identification or contacting families overseas or where English is a second language.

In March of this year, Aotearoa New Zealand went into COVID-19 Alert Level 4 lockdown. The NIIO team were essential workers, working each day from our office. Changes were made to our roster to ensure a minimum crossover of staff. Continual sanitising of our work space and physical distancing were priorities. The NIIO staff worked extremely hard during these weeks of lockdown, with several staff having to isolate for two-week periods because they had been in at-risk situations, for example returning from holidays overseas. As part of our mahi we collated a spreadsheet of Coronial post mortem COVID-19 testing, which the Ministry provided to the Ministry of Health.

During the lockdown period, the number of deaths reported to the Coroner dropped from the usual number of 90-120 per week to 70-80 per week. As a comparison, during the period 1 April to 7 June 2019, there were 1,045 reported deaths, whereas for the same period in 2020, only 845 were reported. This was attributed to less reporting of motor vehicle accidents, deaths resulting from recreational activities and the usual autumn illnesses that would normally affect our more vulnerable citizens.

In the latter part of the year, several new Coroners were appointed. The new financial year will start with these newly-appointed Coroners undergoing Duty Coroner training, both onsite at NIIO and remotely from their Regional Offices.

The NIIO Team has, once again this year, been dedicated to and focused on assisting the Duty Coroners, while at the same time demonstrating compassion and empathy to families/whānau at a traumatic time in their lives. The team supports and encourages each other work through what can be very difficult case situations with a combination of humour, goodwill and a determination to make NIIO a success.

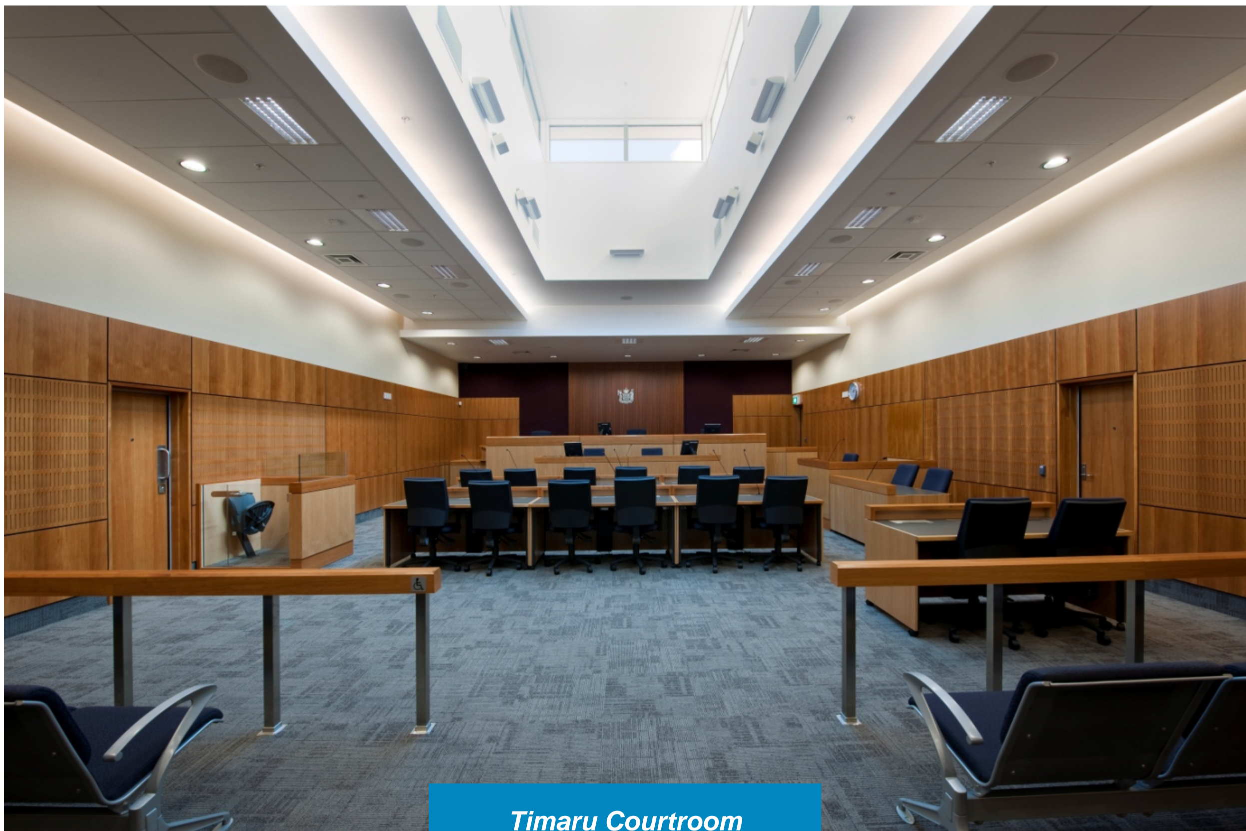
This is our seventh year since NIIO became a 24/7 operation. The year ends with my decision that it's time for me to return home to Christchurch, reduce my hours of work, and have more time to enjoy the company of family and friends. I've enjoyed my time as the NIIO Service Manager and have felt honoured to lead such a dedicated team of people. Thank you to my team and I wish them and the service well moving forward.

Merelyn Redstone

NIIO Service Manager

JURISDICTION OF THE CORONER

The Coroners Court of New Zealand has jurisdiction under the Coroners Act 2006 (the Act) to investigate unexpected, unexplained and unnatural deaths, as defined in sections 3 and 4 respectively of the Act.



Timaru Courtroom

The coronial process is an inquisitorial, fact-finding jurisdiction that is informed by family/whānau concerns. Part 3 of the Act gives coroners the power to hold inquests. An inquest is a hearing, normally held in court, for the coroner to investigate the death.

As well as their statutory obligation to establish, where possible, the identity, cause and circumstances of reportable deaths, one of the purposes of the Act is to make specific recommendations or comments to help reduce preventable deaths.

Reportable deaths

The coronial system in Aotearoa New Zealand is a 24-hour-a-day service. There is always a coroner on duty to receive reports of deaths. About 5,700 deaths are reported to coroners every year; of these, coroners accept jurisdiction for around 3,600.

Sections 14 and 15 of the Act state that a death must be reported if:

- the body is in Aotearoa New Zealand
- the death appears to have been without known cause, or self-inflicted, unnatural, or violent
- the death occurred during, or appears to have been the result of, a medical procedure and was medically unexpected
- the death occurred while the person concerned was affected by anaesthetic and was medically unexpected
- the death of a woman while giving birth
- the death occurred in official custody or care
- the death in relation to which no doctor has given a death certificate.

Coronial process

Once a death has been reported, the coroner decides whether to accept or decline jurisdiction. If a coroner accepts jurisdiction, they can open an inquiry or direct a pathologist to perform a preliminary inspection or post mortem.

A preliminary inspection can consist of an external visual examination of the body and/or the use of medical imaging. This helps to avoid unnecessary and costly post mortems. If a post mortem is needed, it can be either a full internal and external examination of the body, or a lesser examination. Often, a pathologist tries to perform the post mortem as soon as possible (usually the next working day), though in some cases it may take longer. After the post mortem, the coroner decides whether to order further investigations, wait for the results of further investigations already underway, put the investigation on hold (due to other processes) or make their final findings about the death.

If an inquest is held, evidence is collected. Witnesses and experts are gathered to present their evidence to the coroner. During this process, the coroner and the immediate family/whānau can ask relevant questions. After the inquest, written findings are issued. In some cases, the coroner might make recommendations or comments to help prevent similar deaths in the future.

CORONIAL RECOMMENDATIONS OR COMMENTS

In a coroner's findings, a coroner might also make recommendations or comments to help reduce the chances of the occurrence of other deaths in similar circumstances.

The Act ensures that recommendations or comments are:

- linked to the factors that contributed to death
- based on evidence considered during the inquiry, and
- accompanied by an explanation of how recommendations, if drawn to public attention, may reduce the chances of further deaths in similar circumstances.

Coroners must also notify any person or organisation to whom the recommendations or comments are directed and allow them time to respond.

In accordance with section 7 of the Act, the Chief Coroner maintains a public register of coroners' recommendations or comments. This register is publicly available on the Coronial Services of New Zealand website at coronialservices.justice.govt.nz and the New Zealand Legal Information Institute (NZLII) website at nzlii.org. In some cases, such as suicide deaths, publication restrictions prevent the publication of the recommendations.

The following are some of the recommendations or comments made and responses received by coroners during the financial year.

File Ref: CSU-2013-AUK-000016

2019 NZCorC 37 30/07/2019

Date of Finding: 30 July 2019

SUMMARY OF RECOMMENDATIONS

Hans Christopher Dalton died at Tafaigata Prison, Samoa, on 26 December 2012. The cause of death was drowning.

Mr Dalton suffered from schizoaffective disorder (bi-polar type). He had a long history of engagement with mental health services and was subject to a community treatment order. In early December 2012, he travelled to Samoa for a family function, with his sister.

Prior to travelling to Samoa, Mrs Wilson, Mr Dalton's mother, arranged a meeting with Dr X and Mr McKenzie, Mr Dalton's key worker. The purpose of the meeting was to discuss the prospect of Mr Dalton travelling with his family

to Samoa. Mrs Wilson wanted to obtain medical advice to ensure that Mr Dalton was well enough for the trip and her initial concern was whether Samoa had appropriate facilities to care for Mr Dalton if he became unwell there. Mrs Wilson and family were informed that they could contact ACOS if any problems arose with regard to Mr Dalton's mental health state while he was in Samoa. The mental health professionals considered it was not necessary to liaise with or transfer information regarding Mr Dalton to the Samoan mental health service, although this was not communicated to Mr Dalton's family.

On 24 December, while in Samoa, Mr Dalton was transported to the psychiatric unit at the hospital in Apia, due to a deterioration in his mental health state. He was subsequently transferred to Tafaigata Prison and placed in a cell, because of his aggressive and violent behaviour. On the morning of 26 December, Mr Dalton was found deceased in his cell with his head and torso submerged in a 44-gallon drum of water. The evidence on what happened to cause Mr Dalton's death is incomplete and inconclusive. Therefore, the manner of Mr Dalton's death cannot be determined.

COMMENTS OF CORONER RYAN

I. A draft of proposed recommendations was provided to the ADHB to enable submissions to be made on those recommendations. Submissions have been received from counsel for the ADHB. The submissions indicate that it is already standard practice for the mental health service to offer a letter of introduction for patients who inform the staff of their intention to travel. The implication is that such a protocol is not required.

II. The ADHB submissions also referred to potential breach of a patient's right to privacy if the patient's consent is not given for such a letter, and the heavy burden it would place on the mental health service to obtain knowledge of foreign mental health systems to be able to inform patients and their families.

III. The submissions go on to note that modern methods of communication easily allow for transfer of information to foreign mental health services as the need arises. The ADHB suggests that the concerns intended to be addressed by the proposed recommendations would be better dealt with by discussions between the service and the patient and family about the risk of relapse while travelling overseas and therefore the desirability of the travel.

IV. I have given consideration to the submissions, but do not consider the matters raised override the potential benefit for having a formal policy. Clearly any such policy would note the limitations on knowledge and would address the patient privacy issues covered in counsel's submissions.

V. In my view the lack of a policy covering the situation faced by ADHB staff and Mrs Wilson when discussions were being held regarding Mr Dalton travelling to Samoa contributed to a misunderstanding between the parties. As a result, Mrs Wilson believed

arrangements were being made which in fact was not the understanding of the ADHB staff.

VI. I do not consider my proposed recommendations impose a duty upon the ADHB to research any foreign mental health service to ascertain the level of care that service can provide to travelling patients, nor to pre-determine where and how information on a patient might have to be sent. But it is not unreasonable to expect the ADHB mental health service to discuss with a patient and their family the possibility that mental health services in the proposed country of travel may have limitations. If a patient requires information to be sent to a foreign country due to a relapse there, that service would of course contact the ADHB for information.

VII. I am therefore satisfied that the recommendations set out below are appropriate, particularly as they are not prescriptive.

RECOMMENDATIONS OF CORONER RYAN

VIII. I make the following recommendations pursuant to section 57A of the Act:

a. That the Auckland District Health Board should consider developing a protocol covering the actions by ADHB Mental Health Services when a client of the Service is about to travel to another country.

b. Such a protocol should address (inter alia) the following issues:

i. The circumstances in which the ADHB should provide the client and/or the family with a letter outlining in brief the client's mental health history and current treatment regime, to provide a colleague in a foreign mental health service with some immediate information about the client if required.

ii. The circumstances in which the ADHB should communicate with the mental health service in the country to which a client of the ADHB is about to travel, to provide information to that service about the client instead of or beyond what might be contained in the letter proposed in (i) above, and (in appropriate cases) to discuss whether the local mental health service has the resources to cope with that client if required.

iii. The understanding of the client and/or the family that the mental health service of the country to which the client is travelling may have limited resources if the client's mental health deteriorates, so that the client and the family can make a fully informed decision on whether to travel.

IX. This recommendation is directed to the Chief Executive Officer and the Chief Medical Officer of the Auckland District Health Board.

X. The purpose of this recommendation is to encourage the development of a protocol which clinicians can follow to:

a. Assist families to determine whether it is appropriate for a family member with mental health issues to travel overseas.

b. Facilitate the immediate or early transfer of information to the mental health service of another country where a client of the DHB is travelling to, thereby ensuring the best opportunity for optimal psychiatric care if it is required.

XI. Such a protocol would also cause clinicians to consider whether they should pre-empt the possibility of the patient requiring psychiatric care in another country by discussing the patient with the mental health service in that country before the patient arrives there.

XII. This Court has no jurisdiction in Samoa and therefore it is not appropriate for any recommendations to be made relating to factors identified within Samoa that have contributed to Mr Dalton's death. Instead I will provide a copy of my Finding to the Attorney-General of Samoa in the hope that any lessons that can be learned from the distressing circumstances of Mr Dalton's death will be taken on board.

Note: An interim order under section 74 of the Coroners Act 2006 prohibits the publication of the name, or any names or particulars likely to lead to the identification, of Dr X. This order remains in force until the application for a permanent order has been dealt with.

File Ref: CSU-2018-PNO-000243

2019 NZCorC 44 16/08/2019

Date of Finding: 16 August 2019

SUMMARY OF RECOMMENDATIONS

Warren Peter Wano of Levin died on 29 June 2018 of high-impact traumatic injuries sustained when he was struck by a train as he attempted to walk across the railway lines in a railway yard just north of Levin Railway Station.

RECOMMENDATIONS OF CORONER WINDLEY

I. Notwithstanding the paucity of NZTA's incident data for this location, there is clear evidence before my inquiry that pedestrian trespass through the railway yard and across railway lines where Mr Wano was struck presents a real and ongoing risk of unintentional pedestrian-train incidents. At best these will be near misses, and at worst result in avoidable loss of a life like Mr Wano's. I therefore disagree with NZTA's assessment that the activities in question at this location do not present any greater risk than that presented along most of the rail network in New Zealand. Moreover, I consider NZTA to have an important role as safety regulator to drive timely safety improvements at the location where Mr Wano was struck.

II. NZTA subsequently provided a further response advising:

> We are now aware that the Coroner has been advised that the Horowhenua District Council are only accepting responsibility to repair existing fencing and are not accepting responsibility for the installation of new fencing along the railway lines in the subject location. We were not aware of the position of the Horowhenua District Council until being advised by the Coroner.
>
> In light of this new information we are now in the process of assessing whether there is a need to change our regulatory response. …

III. In light of HDC's response, I also sought further clarification from KiwiRail as to the nature, extent and location of the fencing it referenced in its initial response. KiwiRail further advised:

> KiwiRail can confirm that vegetation along the area of the rail corridor in question is being cut back to 5 meters off rail. This work has started and is expected to be completed within a week.
>
> Once that work is completed, fencing contractors … will erect fencing[1] as identified by the Blue line [refer Image 2] ... This is new fencing and will be installed from the 90km NIMT mark to the first level crossing (South Lane) and then on to Bath Street (approximately 1.3km north of the yard) as per the

[1] Being wire mesh fencing 1.8 metres high.

plan. It is anticipated that this work will begin the week of 19 August 2019.

KiwiRail is committed to erecting the fencing as described above.

IV. The need for agencies with safety responsibilities for areas in and around railway lines to work collaboratively and effectively with a focus on enhancing safety is self-evident. I consider KiwiRail to have now given a clear and firm undertaking to promptly undertake what is a fencing project of some scale, independent and irrespective of any licensee obligations upon HDC.

V. KiwiRail's engagement with the safety issues raised in my inquiry, and planned practical improvements in response to my recommendations, demonstrate a recognition and commitment to improving rail safety. However, as these are still planned works, I cannot yet be satisfied that the safety risk identified has been mitigated such that my proposed recommendations are no longer necessary.

VI. I should note that it is not lost on me, or any of the organisations I have engaged with in relation to this inquiry, that Rail Safety Week 2019 has focussed its public campaign on near miss incidents between people and trains, and vehicles and trains,[2] of which there were in excess of 400 last year. Implementing these planned improvements are practical means by which rail safety will be immediately enhanced and the chances of serious injury or death markedly reduced at this location. The potential future development of a shared pathway/cycleway through Levin may incidentally provide a rail safety solution along a much greater area of Levin's rail network in the longer-term.

VII. I therefore confirm my final recommendations as follows:

a. That **KiwiRail** complete the work outlined in its undertakings to my inquiry to:

i. identify and implement means by which members of the public can be physically excluded or discouraged from accessing the railway yard at this specific location, specifically by erecting or supplementing fencing, and erecting signage warning of trains and directing pedestrians to the level crossing; and

[2] See www.nearmisses.co.nz

ii. ensuring planting in close proximity to the track in this location is trimmed back to allow for greater visibility for train drivers to identify any risks including the presence of any person.

b. That the **NZTA**, in its capacity as the safety regulator, closely monitor the pace and extent of progress towards full implementation of KiwiRail's above undertakings to my inquiry, and if it should become necessary, give consideration to the exercise of its regulatory powers to drive forward implementation of these safety improvements.

VIII. Upon issuing this Finding my jurisdiction in relation to this matter ends. Unfortunately, in New Zealand, there is no mandatory requirement under the Coroners Act 2006 for organisations to report on the action that has been, or will be taken, in response to a coroner's recommendation.[3] Notwithstanding this, I invite KiwiRail and NZTA to provide to the Chief Coroner an update as to progress with safety improvements at this location within **three months** of this Finding.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Wano in the interests of decency and personal privacy.

[3] Supplementary Order Paper No 146 to the Coroners Amendment Bill proposed amendment to the Coroners Act 2006 to introduce a new section, section 57C, which would require Government agencies to respond to coroner's recommendations describing the action taken, or planned to be taken, as a result of the coronial recommendations, within 60 days (clause 30). The explanatory note records this proposed amendment was in recognition of the critical role coroner's recommendations have in understanding the causes of, and preventing further, deaths. The ability for agencies to ignore coronial recommendations was identified as undermining this role. This proposed amendment was not carried through to the Coroners Amendment Act 2016.

File Ref: CSU-2016-AUK-000868

2020 NZCorC 3 24/1/2020

Date of Finding: 24 January 2020

CIRCUMSTANCES

Daryl Arthur Murray (aka Darryl Arthur Murray) of Auckland died between 20 July 2016 and 21 July 2016 at Auckland of sepsis as a result of mega-colon with evidence of colitis, with clozapine a contributing factor.

Mr Murray, aged 43 years, lived with his mother, Jennifer Rutgers, and his stepfather in Auckland. He was single and had been living with them for the 18 months prior to his death. He suffered from schizophrenia for most of his life, for which he was taking clozapine. He had no other health issues.

On 20 July 2016, Mr Murray, his mother and stepfather had dinner together. Mr Murray went to bed after this. Ms Rutgers woke up around 1:00am on 21 July 2016 and could not sleep. She heard Mr Murray go to the toilet some four times, the last visit being at 4:00am. She considered this unusual for him. Ms Rutgers went to work the next morning at around 7:00am and noticed Mr Murray's bedroom door was closed. When she returned from work at 4.45pm she went to say hello to Mr Murray but found him lying unresponsive in his bed. Mr Murray was pronounced dead at the scene by attending ambulance staff.

Mr Murray was a client of Cornwall House Community Mental Health Centre at the time of his death, having been diagnosed with schizophrenia in 1989. His illness was unresponsive to traditional antipsychotic medication, so he was started on the atypical antipsychotic medication clozapine in 1995 or early 1996. After starting on clozapine Mr Murray's mental condition was stable and positive.

On 29 February 2016, Mr Murray's Cornwall House case manager noticed Mr Murray developed constipation as a side effect of clozapine. He was checked in six-week intervals by his treating team. By 23 May 2016 Mr Murray told his case manager that his condition had improved and a script for laxatives was provided to him.

The Coroner noted, relying on a medical expert's report, that clozapine, while being efficacious in reducing the disabling symptoms of schizophrenia, is known to have potential side effects, including fatal constipation/bowel obstruction. This is the leading cause of death related to clozapine in New Zealand. As such, it is a drug that requires a good assessment of the risks and benefits for each patient before it is prescribed. To prevent clozapine-induced constipation, the medical expert advised that patients should be encouraged to drink enough water, eat fruit and fibre, take their medication regularly and get regular exercise. To prevent death from constipation, each patient and their family and caregivers should know how regular their bowel motions are and regularly remind the patient/family to contact their GP or mental health team if the patient develops constipation/abdominal pain or vomiting.

The Coroner found that Mr Murray's death arose from a known and significant side effect of clozapine. His treating team was alert to the

effects of clozapine and monitored him for any issues regularly. When issues arose for Mr Murray, advice was dispensed and when the issues deteriorated in following months it was managed appropriately.

COMMENTS OF CORONER GREIG

I. Auckland District Health Board has in place evidence-based guidelines for staff entitled Clozapine Use and Management of Side Effects. This document includes information on monitoring for and managing constipation.

II. The evidence before me is that the ADHB clinical staff caring for Mr Murray were aware of constipation as a side effect of clozapine and monitored for it routinely as stipulated by the guidelines.

III. These matters are to be commended.

RECOMMENDATIONS OF CORONER GREIG

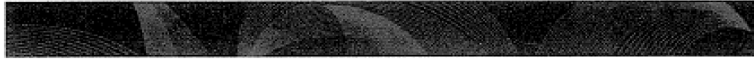
I. Given that fatal constipation/bowel obstruction is the leading cause of death related to clozapine in New Zealand and that the complication can arise even when a person has been taking the medication uneventfully for many years (which was the case with Mr Murray) I recommend that Auckland District Health Board gives consideration to:

   a. strengthening the warnings about the dangers of constipation in those taking clozapine in the guidelines for *Clozapine Use and Management of Side Effects*; and

   b. including stronger messages in the guidelines about proactive follow up and assertive education and management of patients who raise constipation as an issue or potential issue.

II. A copy of these findings will be sent to the Centre for Adverse Reactions Monitoring (CARM) in Dunedin and to Medsafe.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Murray in the interests of personal privacy and decency.



133 Molesworth Street
PO Box 5013
Wellington 6140, New Zealand
T +64 4 496 2000
W www.medsafe.govt.nz

5 February 2020

Coroner KH Greig
Coronial Services Unit
Auckland District Court
65-69 Albert Street
Auckland 1010
E: csu.auckland@justice.govt.nz

Dear Coroner Greig

RE: Final findings report of a death associated with clozapine treatment

Thank you for sending the Final findings report (CSU-2016-AUK-00868) to Medsafe and for highlighting the Comments and Recommendations paragraphs of the report. Medsafe agrees with your recommendation to strengthen the warnings about the dangers of constipation during treatment with clozapine.

In New Zealand, the data sheet contains information relating to the safe and effective use of a medicine. Data sheets are prepared by the company marketing the medicine, reviewed by Medsafe and subsequently approved by the delegate of the Director-General of Health.

Medsafe recently reviewed the data sheets for all the currently approved medicines in New Zealand containing clozapine because of some identified shortcomings. One of the issues was gastrointestinal effects, including constipation.

The data sheets already include useful information, such as the importance of asking patients about their bowel habits, identifying constipation early and to effectively manage constipation to prevent complications. However, the companies have been asked to further clarify the message in the text, by creating a separate section about gastrointestinal hypomotility and constipation. In addition, we have requested other changes such as reducing the usual maintenance dose and the monitoring requirements.

This process is currently ongoing. Once the changes have been finalised we communicate them to prescribers through *Prescriber Update*.

I hope this information is of interest. Please feel free to contact me if you have any questions or need any clarifications.

Yours sincerely

Chris James
Group Manager
Medsafe

PERFORMANCE MEASURES

FROM 1 JULY 2019 TO 30 JUNE 2020

5198

Deaths were reported to the National Initial Investigation Office

3603

Number of cases in which coroners had jurisdiction

Compared to 2018/19, this is an increase of

197 cases*

Closing a case took an average of **519** Days**

This is marginally higher than last year

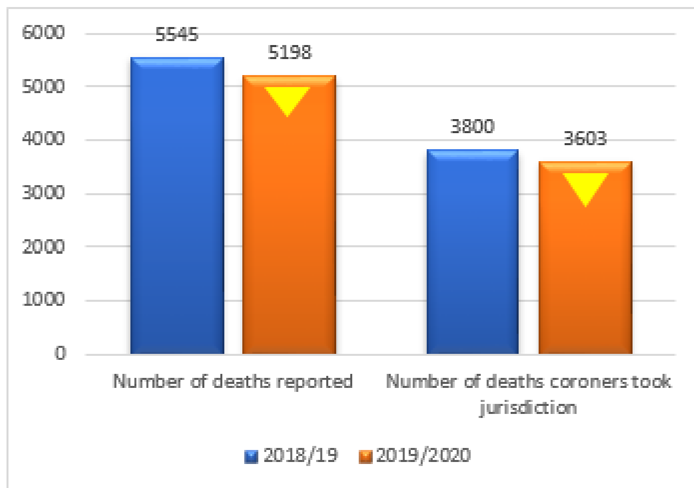
NOTE:

Numbers are based on the Ministry of Justice's Case Management System as at end of 5 September 2020. Since this is an operational system, numbers for 2018/19 have been updated since published in previous annual reports.

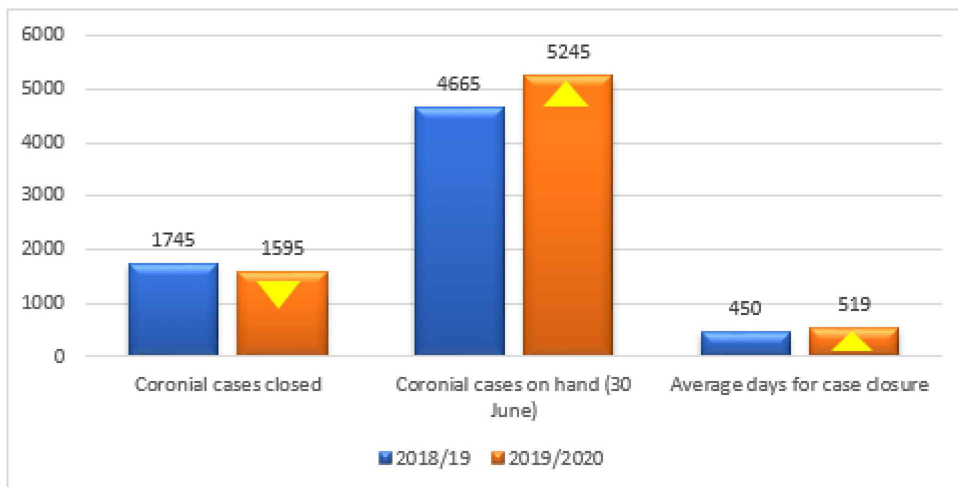
***This is the average age of coronial cases only, which are those cases where the Coroner accepts jurisdiction for a death. The number published in previous annual reports also included advice cases, which are those cases where the Coroner declines jurisdiction and a doctor certifies the death. This has had the effect of increasing the average time to close a case.*

Year in review: 2019-2020

During the 2019/20 year, 5,198 deaths were reported to NIIO. Of these, coroners took jurisdiction over 3,603 deaths. As of 30 June 2019, coroners are investigating 5,245 deaths. For the financial year, coroners have closed 1,595 cases. On average, it took 519 days to close a case, which is a slight increase when compared with last year.



The number of coroners' jurisdiction deaths has decreased compared to the previous year

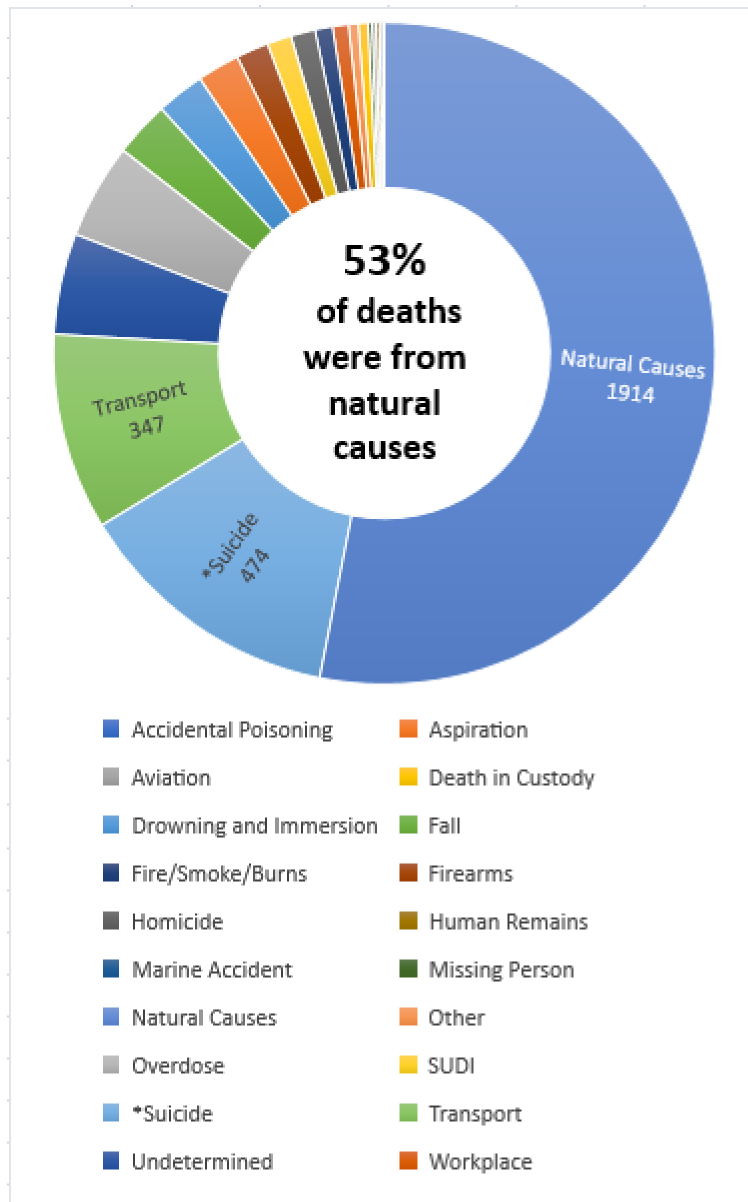


Year in review	2018-2019	2019-2020	CHANGE	% CHANGE
Number of deaths reported	5545	5198	(347)	(6.26%)
Number of deaths coroners took jurisdiction	3800	3603	(197)	(5.18%)
Coronial cases closed	1745	1595	(150)	(8.60%)
Coronial cases on hand (30 June)	4665	5245	580	12.43%
Average days for case closure	450	519	69	15.33%

NATIONAL STATISTICS

In 2019-2020, coroners took jurisdiction over 3,603 deaths. Of these, most deaths were due to natural causes, followed by suicide and then transport deaths.

Cause of death 2019-20	Deaths
Accidental Poisoning	3
Aspiration	75
Aviation	7
Death in Custody	17
Drowning and Immersion	85
Fall	98
Fire/Smoke/Burns	31
Firearms	57
Homicide	43
Human Remains	6
Marine Accident	5
Missing Person	7
Natural Causes	1914
Other	17
Overdose	168
SUDI	43
*Suicide	474
Transport	347
Undetermined	178
Workplace Accident	28
Total	**3603**



13%	Suicide	**Less than 5%:** Firearms, Fall, Drowning and Immersion, Undetermined
10%	Transport	**Less than 1%:** Accidental Poisoning, Aspiration, Aviation, Death in Custody, Drowning and Immersion, Fire/Smoke/Burns, Homicide, Human Remains, Marine Accident, Missing Person, Other, Workplace Accident
5%	Undetermined	

Notes:

The cause of death categories is a broad description. Where there are multiple causes of death, one major cause category is used. For example, death in custody must be recorded as the primary category even if the death was a result of suicide or natural causes.

Suicide reporting

Last year, approximately 654 New Zealanders took their lives. As part of the collective effort to reduce Aotearoa New Zealand's rate of suicide, the Chief Coroner releases the national provisional suicide statistics each year. A full report is available on the Coronial Services website at coronialservices.justice.govt.nz

It is important to note that the Chief Coroner's data is provisional. It includes all active cases before coroners where intent has yet to be established. Therefore, some deaths provisionally coded as suicides may later be determined not to be suicides.

In Aotearoa New Zealand, the legal position is that a person dies by suicide if their death was self-inflicted with the intention of taking their own life and knowing the probable consequence of their actions. The coroner must be satisfied there is clear evidence inferring an intention to end one's life.

Provisional Suicide statistics: Men-Women

PROVISIONAL SUICIDE RATE 2008-2020

By sex

Rate per 100,000 people

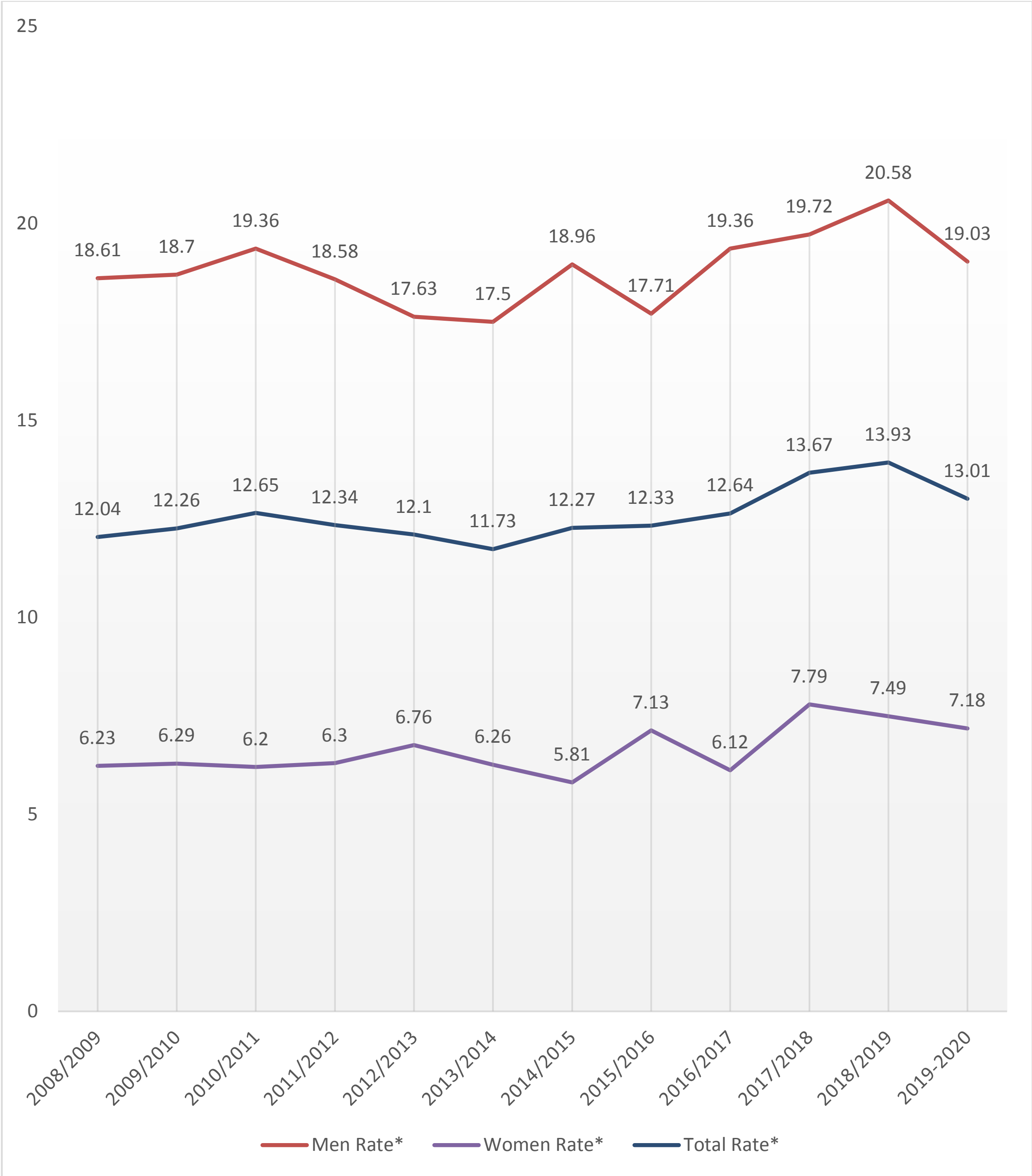
Year	Men		Women		Rate	Total	
	Number	Rate*	Number	Rate*	(Men:Women)	Number	Rate*
2008/2009	394	18.61	137	6.23	2.87 :1	531	12.04
2009/2010	401	18.7	140	6.29	2.85 :1	541	12.26
2010/2011	419	19.36	139	6.2	3.01 :1	558	12.65
2011/2012	405	18.58	142	6.3	2.85 :1	547	12.34
2012/2013	388	17.63	153	6.76	2.54 :1	541	12.1
2013/2014	385	17.5	144	6.26	2.67 :1	529	11.73
2014/2015	428	18.96	136	5.81	3.14 :1	564	12.27
2015/2016	409	17.71	170	7.13	2.41 :1	579	12.33
2016/2017	457	19.36	149	6.12	3.06 :1	606	12.64
2017/2018	475	19.72	193	7.79	2.46 :1	668	13.67
2018-2019	498	20.58	187	7.49	2.66 :1	685	13.93
2019-2020	**471**	**19.03**	**183**	**7.18**	**2.57:1**	**654**	**13.01**

Notes:
1. Male and female populations come from Stats NZ's national population estimates as published at the end of each financial year.
2. The per 100,000 population rates for the male and female groups have been calculated using the male and female populations respectively.
3. Information about the estimated population of New Zealand can be found at https://www.stats.govt.nz/indicators/population-of-nz

PROVISIONAL SUICIDE RATE 2008-2020

By sex

Rate per 100,000 people



Year (1 July to 30 June)

Notes:

1. *Male and female populations come from Stats NZ's national population estimates as published at the end of each financial year.*
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Provisional Suicide statistics: By sex and age

PROVISIONAL SUICIDE RATES 2019-2020

By sex and age

Rate per 100,000 people

Age Group (Years)	Men		Women		Total	
	Number	Rate*	Number	Rate*	Number	Rate*
10-14	2	1.16	4	2.46	6	1.86
15-19	36	22.35	23	14.97	59	18.69
20-24	40	22.61	20	12.23	60	17.77
25-29	63	33.91	17	9.33	80	22.21
30-34	57	32.88	12	6.57	69	20.46
35-39	40	25.32	11	6.62	51	16.36
40-44	36	24.64	8	5.17	44	14.90
45-49	42	26.90	15	8.89	57	17.50
50-54	33	21.56	15	9.08	48	15.32
55-59	41	26.66	14	8.45	55	17.39
60-64	26	18.68	13	8.69	39	13.97
65-69	15	12.51	9	7.03	24	9.96
70-74	15	14.44	7	6.31	22	10.78
75-79	7	9.98	4	5.10	11	7.69
80-84	11	24.87	7	12.93	18	19.48
85-90	5	20.89	3	9.11	8	14.25
90+	2	16.72	1	4.61	3	9.31
Total	**471**	**19.03**	**183**	**7.18**	**654**	**13.01**

Notes:
1. Male and female populations come from Stats NZ's national population estimates as published at the end of each financial year.
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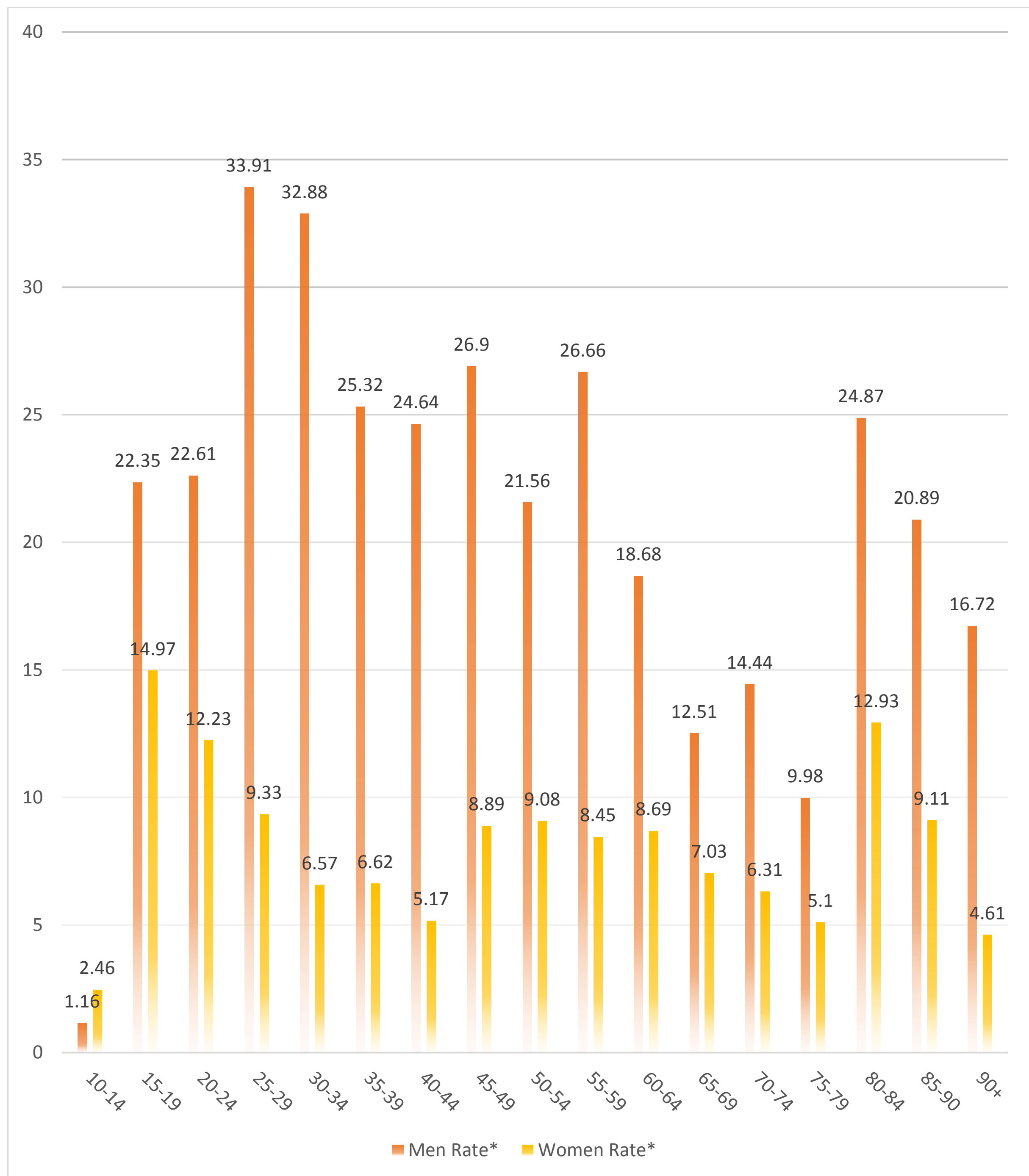
PROVISIONAL SUICIDE RATES 2019-2020

By sex and age

Rate per 100,000 people



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Provisional Suicide statistics: Ethnicity

PROVISIONAL SUICIDE RATE 2008-2020

By ethnic group

Rate per 100,000 people

Year	Asian		Māori		Pacific		European and Other	
	Number	Rate*	Number	Rate*	Number	Rate*	Number	Rate*
2008-2009	10	2.82	95	16.81	26	9.81	400	13.00
2009-2010	22	6.21	105	18.58	31	11.69	383	12.45
2010-2011	19	5.36	101	17.87	22	8.30	416	13.52
2011-2012	19	5.36	132	23.34	31	11.69	365	11.24
2012-2013	28	7.90	105	18.58	24	9.05	384	12.48
2013-2014	22	4.67	108	18.06	26	8.81	373	12.96
2014-2015	16	3.40	130	21.74	27	9.15	391	13.58
2015-2016	39	8.28	129	21.57	24	8.13	387	13.44
2016-2017	27	5.73	130	21.73	27	9.15	422	14.66
2017-2018	41	8.69	142	23.72	23	7.77	462	13.94
2018-2019	36	7.63	169	28.23	34	11.49	446	13.46
2019-2020	**56**	**7.91**	**157**	**20.24**	**27**	**7.07**	**414**	**12.08**

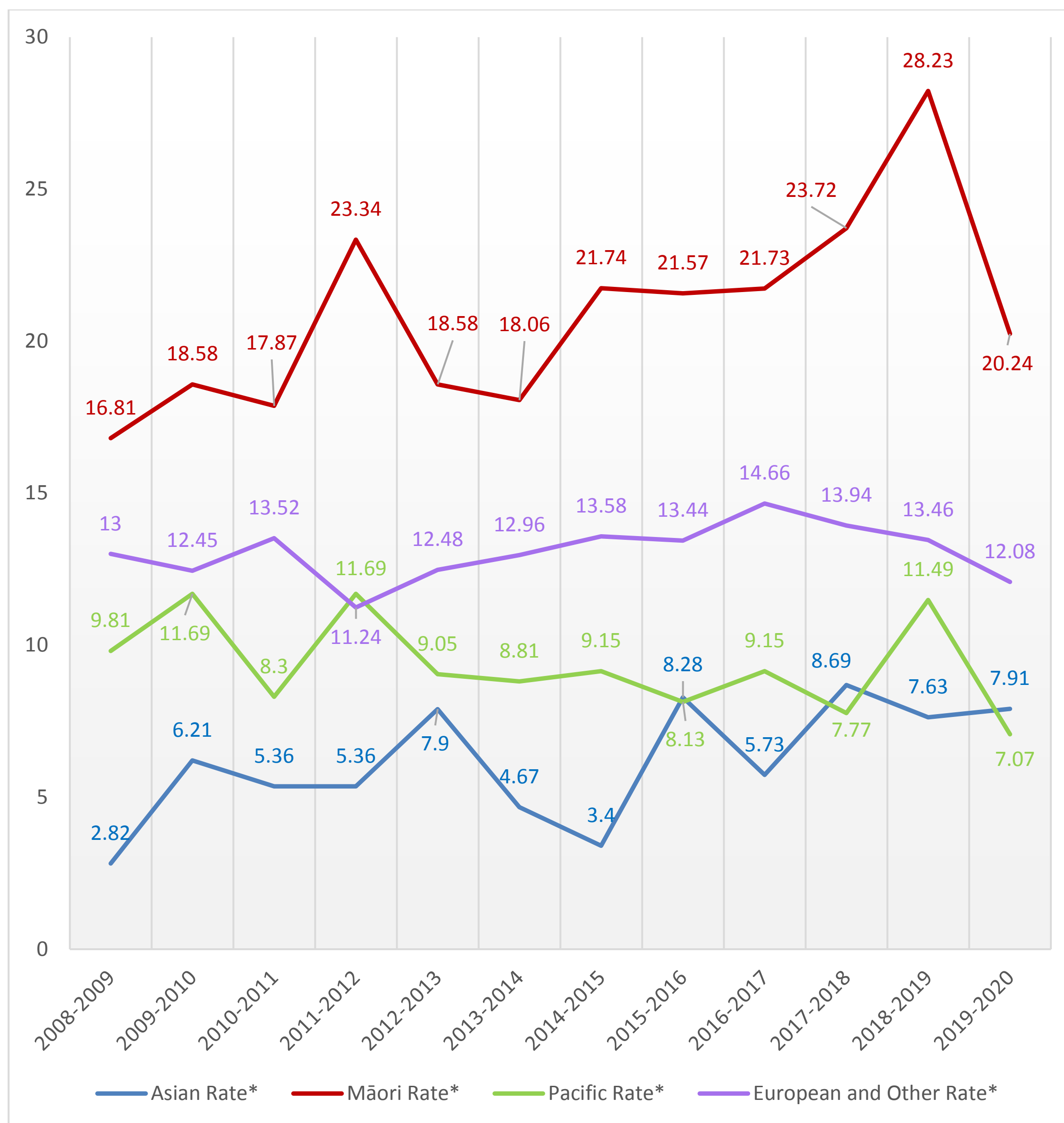
Notes:

1. Ethnicity count is based on information reported to the Coroner and may differ from that held by other agencies, such as the Ministry of Health.
2. The 2018/2019 rates differ from those previously published as they have been updated to reflect 2018 census data, which was not available when the 2018/2019 rates were first published.
3. The per 100,000 population rates have been calculated using Stats NZ's population information as published in the 2006, 2013 and 2018 censuses. 2006, 2013 and 2018 census information is available at http://archive.stats.govt.nz/Census.aspx
4. The per 100,000 population rates have been calculated using each ethnic group's population respectively.
5. 'European and other' includes, but is not limited to: New Zealand European, European, Middle Eastern, Latin American, African and 'not elsewhere defined'.
6. The small numbers for Asian and Pacific peoples mean data may be more susceptible to fluctuation.

PROVISIONAL SUICIDE RATE 2008-2020

By ethnic group

Rate per 100,000 people



Year (1 July to 30 June)

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CORONERS AS AT 30 JUNE 2020

Office of the Chief Coroner
Judge D Marshall

Whangarei
Coroner T Tetitaha
Coroner A Mills

Auckland
Coroner S Herdson
Coroner K Greig
Coroner D Bell
Coroner M McDowell
Coroner H McKenzie
Coroner J Anderson

Hamilton
Coroner M Robb
Coroner M Bates
Coroner L Dunn

Rotorua
Coroner D Llewell
Coroner B Hesketh
Coroner H Wrigley

Hastings
Coroner T Fitzgibbon

Palmerston North
Coroner R Kay

Wellington
Coroner P Ryan
Coroner B Windley
Coroner M Wilton
Coroner M Borrowdale

Christchurch
Deputy Chief Coroner A Tutton
Coroner S Johnson
Coroner M Elliot

Dunedin
Coroner D Robinson
Coroner A Cunninghame

Contact the Coronial Offices

For more information
The Office of the Chief Coroner
Email: OfficeoftheChiefCoroner@justice.govt.nz

Report a death to the Coroner
National Initial Investigation Office (NIIO)
Phone: 0800 266 800
Email: NIIO@justice.govt.nz

Media liaison
Email: media@justice.govt.nz
Phone: 04 918 8836

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coronialservices.justice.govt.nz

MINISTRY OF JUSTICE
Tāhū o te Ture

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