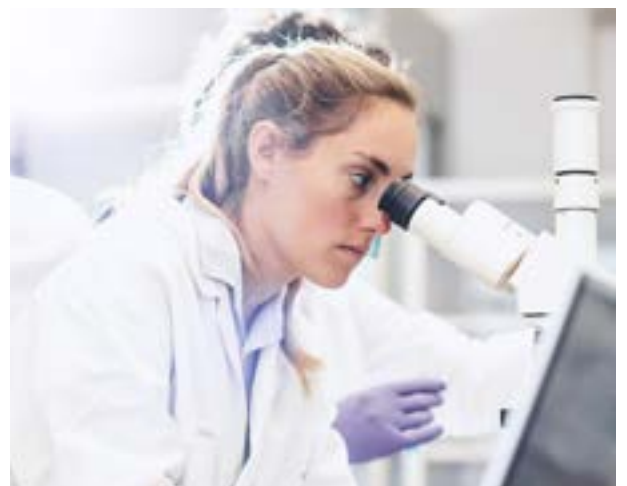


Annual Report 2016 to 2017

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



A photograph of a man and a woman standing on mossy rocks in a lush forest, looking at a waterfall. The woman is in the foreground, wearing a black t-shirt and grey shorts, with her back to the camera. The man is standing next to her, wearing a maroon t-shirt and khaki pants, with his arm around her shoulder. They are both looking towards a waterfall in the background. The scene is filled with green foliage and a stream of water flowing over rocks.

**Providing answers
for families**



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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 nuīnga 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.

Introduction

Welcome to the second annual report of the Chief Coroner

The coroners of New Zealand are dedicated to investigating deaths, so that individual causes of death can be established and lessons learned to prevent similar deaths occurring in the future. There is a coroner on duty every day and every night of the year. The duty work is carried out in addition to a large workload of active investigation files, chambers findings and inquests. I am honoured to be the Chief Coroner of New Zealand. This is my second Annual Report.

In February 2017, I had the pleasure of attending the swearing-in ceremony for Deputy Chief Coroner Brandt Shortland. This was held at the Māori Land Court in Whangarei. Coroner Shortland was appointed for 5 years under a new provision of the Coroners Act 2006¹. Find out more about Coroner Shortland on page 5.

Coroner David Robinson was sworn in as the Coroner in Dunedin in April 2017. Coroner Robinson has spent much of his legal career practising in Dunedin, so he comes to the role with much local knowledge and a desire to service his community. Read more about Coroner Robinson on page 6.

One of the functions of the Chief Coroner is to establish, and help maintain, relationships between coroners and other people carrying out functions and duties within the coronial system. I am assisted by the coroners in carrying out this function. We make many presentations to key groups each year. It is a way of promoting understanding of the coronial system and obtaining feedback and suggestions for improvement. Some of the groups we have spoken to this year are listed on page 29 of this Annual Report.

This year has been a busy one, with an increase from last year in the number of deaths over which coroners took jurisdiction. At the beginning of 2018 we hope to have in place additional legal resources to assist coroners with their high workload.

I hope you enjoy reading this overview of coronial work for the period 1 July 2016 to 30 June 2017.



Her Honour Judge Deborah Marshall
Chief Coroner

DECEMBER 2017



¹ Section 105A of the Coroners Act 2006 came into force on 21 July 2016

Coronial Services of New Zealand Purongo O te Ao Kakarauri

The New Zealand coronial bench consists of 17 coroners and one Chief Coroner. They are supported in their roles by the Ministry of Justice's Coronial Services Unit and operate throughout 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 Whangarei, Auckland, Hamilton, Rotorua, Hastings, Palmerston North, Wellington, Christchurch and Dunedin.



BACK ROW LEFT TO RIGHT: **Coroner Shortland, Coroner Devonport, Coroner Scott, Coroner Ryan, Coroner Windley, Coroner Bain, Coroner Greig, Coroner Matenga, Coroner Tutton.** FRONT ROW LEFT TO RIGHT: **Coroner Bell, Coroner Elliott, Coroner McDowell, Judge Marshall (Chief Coroner), Coroner na Nagara, Coroner Johnson, Coroner Robb.**
ABSENT: **Coroner Herdson, Coroner Robinson.**

Coroners' contributions



DEPUTY CHIEF CORONER BRANDT SHORTLAND

E ngā mana, E ngā reo, E ngā hau i wha, Tēnā koutou e whoa ma.

The 2016 amendment to the Coroners Act 2006, introduced the position of Deputy Chief Coroner. It is envisaged the role of Deputy Chief Coroner will provide support for the Chief Coroner and thereby provide support to the coronial bench as a whole.

As this is a relatively new role it has been a year of pioneering. Working out what other projects and responsibilities the Deputy should fulfil. How to balance the Deputy responsibilities with case management and NIIO roster duties. Who should take some of that load? I am confident these challenges will be answered as the role evolves.

In the first year of this new position, I have been involved in several projects concentrating on providing support to the bench and the CSU service. These have included reviewing and restructuring the kōiwi tangata (human remains) process involving police and our NIIO operation. With the heightened issues around cultural sensitivity, health and safety issues, and police involvement – it was necessary to re-establish a workable process relating to the locating, and respectful treatment, of human bones.

We have also developed a NIIO/Coroners Log for common use between NIIO and the Duty Coroner. The objective was to develop consistency when recording the details of reportable deaths to assist NIIO, the Duty Coroner and ultimately the Coroner who manages the file. The log was designed to allow NIIO and the Duty Coroner to provide shared information for each case. I would like to acknowledge Coroner Katharine Greig who pioneered the concept and Coroner Peter Ryan who designed the template and Merelyn Redstone, Manager of the NIIO service, for their input into this project. I consider the liaison between coroners and NIIO an important relationship. It ensures good communication exists for the efficient running of the duty service.

A big part of the role is to provide pastoral support to the bench. It has been a tough year for many. I consider the Deputy Chief role includes providing as much support as possible. One of the projects for 2018 is to put in place an effective support process when coroners have been the subject of a complaint. Ensuring there is a clear process is important for all involved, especially if a complaint matter progresses to the Judicial Conduct Commissioner. As judicial officers, we have an interest in the aims of the Office of the Judicial Conduct Commissioner and its process which, as set out on its website, is intended to help maintain public confidence in the judicial system, and to protect its impartiality, integrity and independence.

I would like to acknowledge the support given to me in 2017 from the bench, case managers, managers and from our many stakeholders. Maintaining stakeholder relationships and working with community groups also remains a priority. I look forward to further developing the role in the years ahead.

Ngā mihi koutou

Brandt Shortland

Deputy Chief Coroner



Coroners' contributions

CORONER DAVID ROBINSON

I was appointed a coroner to be based in Dunedin in April 2017. It is a privilege to be able to serve in this role in my home town.

Coming from a litigation background, I find it refreshing to be discharging a role that is primarily about seeing what can be learnt from tragic circumstances, rather than the traditional litigator's role which is about identifying who is to blame for a particular event.

The Coroners Act 2006 is specific that it is not our function to enquire into civil, criminal or disciplinary liability. To do so would distract from the key role of identifying the cause and circumstances of a death and making recommendations to avoid a recurrence.

It is the ability to draw positives from the loss of life, and to provide comfort and understanding to the bereaved that I find so fulfilling about this role.

I cannot speak highly enough of my colleagues on the coroners' bench for the skill and dedication they bring to their roles. Mention must also be made of the dedicated Ministry of Justice staff who support our work, often dealing with the bereaved in the very earliest stages of an inquiry when emotions are rawest, doing so with professionalism and respect.

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 respectively in sections 3 and 4 of the Act.

The coronial process is an inquisitorial, fact-finding jurisdiction that is informed by family 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 the making of specified recommendations or comments to help reduce preventable deaths.

Reportable deaths

The coronial system in 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 in around 3,200 deaths. Sections 14 and 15 of the Act state that a death must be reported if:

- the body is in 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 that was medically unexpected
- the death occurred while the person concerned was affected by anaesthetic and that was medically unexpected
- the death of a woman that occurred while the woman was giving birth
- the death occurred in official custody or care
- the death in relation to which no doctor has given a death certificate.



Timaru Courtroom

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 a 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 ensure unnecessary and costly post-mortems are avoided. 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 or wait for more investigations, or 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 are able to ask relevant questions. After the inquest, written findings are issued and in some cases the coroner might make recommendations or comments to help prevent similar deaths in the future.

Coronial investigations and court operations

Coronial findings

An inquiry is a legal investigation into a death; it is not a trial. The role of a coroner is not to determine civil, criminal or disciplinary liability. Rather, it is to establish the cause and circumstances of a death and identify any lessons that can be drawn to prevent similar future deaths. In some cases, such as death from natural causes, a coroner may make a finding without opening an inquiry.



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
- accompanied by an explanation of how recommendations, if drawn to public attention, 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 20 working days to respond.

In accordance with section 7 of the Act, the Chief Coroner maintains a public register of coroners' recommendations or comments. This 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.

DEATH BECAUSE OF CARDIAC ARRHYTHMIA DUE TO STRESS ASSOCIATED WITH A PHYSICAL ASSAULT IN THE CONTEXT OF CARDIAC SARCOID INVOLVING THE CARDIAC CONDUCTION SYSTEM

Dudley (Coroner Matenga)²

The coroner made the following recommendations that:

- the West Auckland High School develop a programme for Year 9 students to learn how to perform CPR and use an AED and incorporate such training into the current Year 9 camp program which already incorporates basic first aid training, and reinforce such training at annual presentations
- the Ministry of Education develop a guideline for all schools across New Zealand to provide schools with an overview of the various issues that should be considered when purchasing an AED, including but not limited to, appropriate training.

In response, the West Auckland School said:

In response [to] the recommendation of Coroner Matenga, the West Auckland High School will be incorporating training about how to perform CPR and use of an AED, as part of the basic first aid training that is given to Year 9 students. The school intends to reinforce such training through annual presentations at school assemblies, aimed at educating and refreshing these skills.

See over the page for the Ministry of Education responses (two letters):



10 May 2017

Coroner Gordon Matenga
219 Collingwood Street
HAMILTON

c/- Jennifer.Chalken@justice.govt.nz

Dear Sir

Thank you for your email, dated 19 April, with your draft findings into the death of Stephen Eruwera Dudley attached. Thank you, too, for your invitation to comment on the draft findings. I would like to accept that invitation and comment briefly on the recommendations.

Recommendation 1. (56.1 The West Auckland High School discussed in this finding develop a program for Year 9 students to learn how to perform CPR and use an AED and incorporate such training into the current Year 9 camp program which already incorporates basic first aid training, and reinforce such training at annual presentations).

State schools are individual Crown entities that are governed by their own Boards of Trustees. This means that, while the Ministry of Education can provide guidance and support and provides a broad and empowering curriculum framework, decisions about teaching and learning for individual schools are made by their Principal and Board.

Health Education/Hauora is the only learning area of the curriculum around which schools need to consult their communities. After consultation each school's Board will decide how the Health curriculum is developed and implemented. This means a range of views can be heard on what community members consider are important issues in the health teaching and learning programme.

There is scope at different levels within the Health curriculum for schools to incorporate teaching on first aid. For instance at Level 5 of *the New Zealand Curriculum* students are expected to learn about safety management and investigate and practise safety procedures and strategies to manage risk situations.

We are aware that schools use external providers to support teaching and learning in the health curriculum. For example, in 2015/16 St John Ambulance [schools programme](#) trained 33,000 school children in first aid and 115 first aid clubs were created. In addition St John Ambulance provides a range of free resources including lesson plans to schools on the teaching of first aid.

In summary, while the Ministry can produce guidelines to support schools, in this specific matter the school Board of Trustees is the entity that needs to respond to this recommendation.

Recommendation 2. (56.2 *The Ministry of Education consider developing such a program - as recommended in paragraph 56.1 - for implementation across all High Schools in New Zealand*).

As explained above, given the respective responsibilities of Boards of Trustees and the Ministry of Education, it would be inappropriate for the Ministry to take this action, particularly in relation to the compulsion implied in the recommendation.

Recommendation 3. (56.3 *The Ministry of Education develop a guideline for all schools across New Zealand to provide schools with an overview of the various issues that should be considered when purchasing an AED, including but not limited to, appropriate training for staff and students*).

The Ministry does not usually develop guidelines on single issues such as the purchase of an AED. However, we would be able to include guidance on this in our Health and Safety information/guidelines, and also in our Education Outside the Classroom guidance. Such guidance could include material about ensuring staff and students know where an AED is located and when and how to use it. Given your recommendation, we will prioritise this work.

Thank you again for the opportunity to comment on you findings in this most tragic case.

Yours sincerely



Susan Howan
Associate Deputy Secretary
Sector Enablement and Support
Ministry of Education



23 August 2017

Coroner Gordon Matenga
219 Collingwood St
Hamilton

cf- Jennifer.Chalken@justice.govt.nz

Dear Coroner Matenga

Following the release of your findings into the death of Stephen Dudley, recommending the Ministry of Education develop guidance for schools on Automated External Defibrillators (AED), the Ministry has developed the attached guidance for schools.

We have worked alongside the Red Cross, Ministry of Health and St John to develop the initial draft. We also approached the New Zealand Resuscitation Council (NZRC) as subject matter experts following recommendation from the Ministry of Health.

Our Officials subsequently attended the NZRC's biannual working group meeting in July 2017. We presented our approach, initial draft and our communication plan to deliver guidance to schools. The NZRC agreed to provide further content and to ensure the guidance was medically correct and user appropriate.

Following substantive feedback and input from the NZRC the final draft was submitted to the Red Cross, Ministry of Health, St John and NZRC for sign out and endorsement. Endorsement was given and the resource is expected to be released in late August 2017.

The resource will be featured in the Education Gazette, the Ministry's Health and Safety Webpage and emailed to all schools and board chairs through our School Leaders Bulletin.

Kind regards

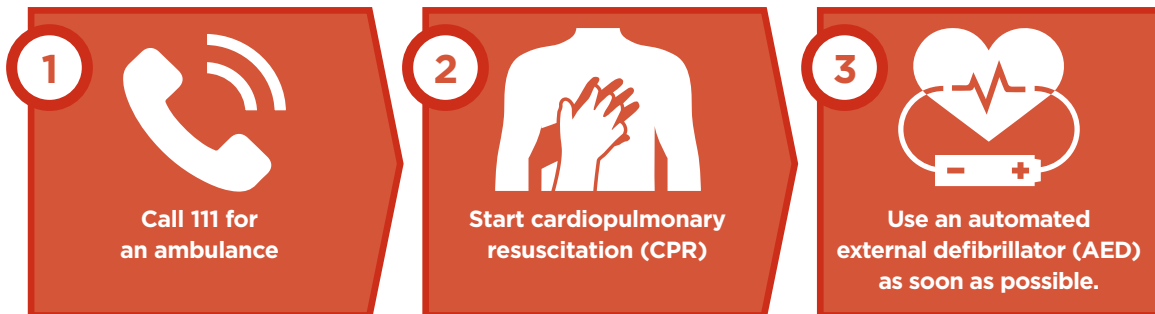


Katrina Casey
Deputy Secretary
Sector Enablement and Support

AEDs in schools

Cardiac arrest can affect all adults and children without warning – so it may occur at your school or during an offsite school event. In a cardiac arrest, the heart suddenly and unexpectedly stops beating. This poses an immediate threat to a person’s life How would your school respond? How would your staff and students respond in an emergency?

The first aid treatment for cardiac arrest is an easy three steps:



An AED, also known as a defibrillator, delivers a safe electric shock to try and restart the heart. AEDs are very easy to use and increase the chance of a person surviving a cardiac arrest from around 15% to around 40%. CPR temporarily maintains circulation of blood and oxygen until a defibrillating shock can be delivered from an AED.



Red Cross AED

In a cardiac arrest, a person’s chance of survival decreases by approximately 10 percent for every minute that the person goes without CPR and a defibrillating shock. The sooner they receive CPR and a defibrillating shock, the more likely they are to survive.

Considerations for schools:

1. Should my school purchase an AED? Have this discussion with your board and health and safety committee.
2. If there is an emergency do my staff and students know first aid including how to do CPR and how to use an AED, if we have one onsite?

3. Do we have a clear and simple plan to access the AED?
4. Is first aid, including CPR and using an AED, being taught in my school to students? Is adequate training around first aid provided to my teaching staff and volunteers?
5. Does my school plan ahead for EOTC activities and emergencies that could happen?
6. Have we recently invited the local ambulance crew to visit our school and to engage with students?

Should my school purchase an AED?

A child or an adult may have a sudden cardiac arrest at any time while at school. An AED is a life-saving device that can be used by anyone, even by untrained people. All that is required is to turn it on and follow the voice prompts. For those that are hearing impaired a step by step user guide is included with all AED devices.

Some schools have already taken steps to purchase or start fundraising efforts to purchase an AED. The decision to purchase an AED is the responsibility of the

Board of Trustees and should be considered by reviewing the schools health and safety policies and relevant workplace regulations.

Many schools provide additional services to the community, such as facilities for meetings, sports, and support for people during natural disasters and civil emergencies. As part of your school planning for these services and events you should consider the benefits of your school holding an AED.



Do my staff know how to do CPR and use an AED?

All schools have staff trained in first aid including how to perform CPR and use an AED. Formative, practical training is best, but other training (such as video-based training and e-learning) can facilitate basic training,

ensuring that staff are trained without the need to necessarily attend face to face training.



Schools should have a clear and simple plan to access their AED.

Your school's AED should be in a known place that is central and easily accessible in an emergency. The physical location of the AED in your school should be clearly marked with standard AED signage. There also needs to be a known process for getting the AED if someone collapses.

In New Zealand, apps such as AED Locations are now being used to map the location of AEDs nationwide. We recommend that AEDs be registered here. These apps are freely available to anyone with a smartphone.



First aid, including CPR and defibrillation, should be taught to students as part of health education.

Training in first aid including CPR is known to increase bystander CPR rates and to improve the outcomes of people who have a cardiac arrest. CPR is a very

easy skill and children readily share their knowledge and enthusiasm with others, and can be taught at age-appropriate stages.



Is first aid, including CPR and using an AED, being taught in my school to students and is adequate first aid training provided to my teaching staff and volunteers?

The policy statement Kids Save Lives has been endorsed by the World Health Organisation (WHO) and supported by resuscitation councils worldwide, including the New Zealand Resuscitation Council. "By introducing just two hours of CPR teaching per year for all children over 12, the WHO believe that cardiac arrest survival rates would improve and in turn lead to improved global health." (Kids Save Lives, 2015).

There are more than 2,000 out-of-hospital cardiac arrests in New Zealand every year, of which only

approximately 15 percent will survive (St John, 2016). Training in first aid including CPR is an essential life skill because it saves lives. The New Zealand Resuscitation Council, Red Cross, St John and Ministry of Education and Ministry of Health encourage all teachers, caregivers, and boards of trustees to support initiatives to include age appropriate first aid, including CPR, training in their school's curriculum.



Does my school plan ahead for EOTC activities and emergencies that could happen?

Taking students outside the classroom to learn has been part of schooling in New Zealand for generations. Education Outside the Classroom (EOTC) continues to be a key component of school life in New Zealand. EOTC can range from a museum or marae visit to a sports trip or a school camp.

Schools are expected to have policies in place about a range of events including all major issues such as traumatic incidents. As part of this planning process schools are also expected to have undertaken a risk assessment of all EOTC events before actually taking students to any event.

A traumatic incident during an EOTC activity can be a stressful experience for a school and its community because it is usually sudden and unexpected. A planned response with procedural steps to follow can do much to lessen the impact and accelerate recovery.

When finalising your procedures for off-site EOTC events, the Person In Charge of the EOTC activity should check with the EOTC provider what their emergency processes are, ask if staff are trained in first aid and inquire if there will be an AED readily available.

When school staff, volunteers and students arrive onsite they should be given a health and safety induction which should include emergency processes and where any first aid supplies (including AED) are kept.



For further information about safety management planning for EOTC events is available on

<http://eotc.tki.org.nz/EOTC-home/EOTC-Guidelines>

Have we recently invited the local ambulance crew to visit our school and to engage with students?

You may like to consider inviting your local ambulance crew, and other emergency service personnel, to visit your school or speak at assembly. Many schools use such visits as a method to engage students and the community in their local curriculum. The emergency

services could provide engaging contexts for learning areas like health and physical education, social studies and science as well as the development of key competencies. Students could be empowered to act in an emergency.



Community stations and AED Locations

Across New Zealand there are thousands of AEDs that are available for use. Some of these are located at private businesses, schools or at defibrillator stations in community hubs. Community AEDs may be installed in an outdoor secured cabinet with secured access. They may be registered with 111 or an ambulance service, who ensure the AED is able to be used when needed. When 111 is called, the operator can alert the caller that there is an AED located nearby.

AEDs are placed in areas where members of the community gather such as around libraries, schools, shops and sports grounds. Providing 24/7 AED access in public places increases the chances of survival for people who have a cardiac arrest. For every minute defibrillation is delayed, the chances of survival drops by around 10%.



What does the Health and Safety at Work (General Risk and Workplace management) Regulations 2016 say?

The Regulations place a duty on a Person Conducting a Business or Undertaking (PCBU/Board of Trustees) to provide first aid. This duty is set out in Regulation 13 and covers the provision of adequate first aid facilities, first aid equipment and trained first aiders.

It is the responsibility of the Board, as PCBU, to assess the circumstances and risks arising from their work and school, and decide what is appropriate.



To find your nearest AED visit: www.aedlocations.co.nz

Basic Life Support

D

Dangers?

R

Responsive?

S

Send for help

A

Open Airway

B

Normal Breathing?

C

Start CPR

30 compressions : 2 breaths

D

Attach Defibrillator (AED)
as soon as available, follow prompts

Continue CPR until responsiveness or normal breathing return



January 2016



NEW ZEALAND
Resuscitation Council
TUSKAKALOUKA AOTEAROA

DEATH BECAUSE OF TOXAEMIA SECONDARY TO MEGACOLON AND PARALYTIC ILEUS, IN THE CONTEXT OF CLOZAPINE TREATMENT FOR SCHIZOPHRENIA

Warburton (Coroner Windley)³

The coroner made the following recommendations:

- MedSafe update the current clozapine data sheet to reflect the key findings related to CIGH in the Every-Palmer 2016 Study and issue a prescriber update
- All District Health Boards:
 - review and, where appropriate, update their clozapine protocols and guidelines to ensure the risk of CIGH reflects the current state of knowledge as informed by the Every-Palmer 2016 Study, particularly in relation to CIGH prevalence, risk factors, consideration of prophylactic prescribing of maintenance laxatives (if not mandated as routine treatment), procedure for regular physical health checks undertaken by GPs and the need for high levels of suspicion when clozapine patients are unwell, particularly where gastrointestinal symptoms are identified
 - ensure there are effective mechanisms and processes in operation to ensure clozapine patients' GPs are aware of their clinical responsibility to undertake regular physical health monitoring of those patients
 - ensure there are effective mechanisms and processes to ensure adequate and ongoing education of clozapine patients' clinicians, the patients themselves, and their families and caregivers (where appropriate) as to the risk of CIGH, possible signs and symptoms to be alert for, and the importance of early medical attention if they are unwell
 - remind all clinical staff involved in the care of clozapine patients about the need to record bowel habit inquiries in the patient's clinical records
 - consider implementation of a clozapine red-flag alert feature in electronic patient records systems (such as in effect under the Porirua Protocol) to alert healthcare providers not familiar with the patient of the need for a high index of suspicion where a clozapine patient is unwell, especially where gastrointestinal symptoms are present.

- The Ministry of Health considers the feasibility and utility of an evidence-based national protocol on clozapine prescribing and risk management:

- PHARMAC Gastrointestinal Subcommittee and Psychiatric Subcommittee consider broadening the eligibility criteria for accessing macrogol to include clozapine use
- Novartis New Zealand Ltd ensure that the information it produces, including the Clozaril datasheet, the Patient Information Pack, and the GP Referral Pack reflects the current state of CIGH knowledge as informed by the Every-Palmer 2016 Study.

In response, the Southern District Health Board, the Hutt Valley District Health Board and PHARMAC said:



Southern District Health Board
Dunedin Hospital
201 Great King Street
Private Bag 1921
DUNEDIN, 9054

Chief Executive Officer
Phone 03-476 9456 Fax 03-476 9450

31 May 2017

The Hon Justice Marshall
Chief Coroner
C/- Ms Tanya Botha
Legal and Research Counsel to the Office of the Chief Coroner

Email: Tanya.Botha@justice.govt.nz

Dear Judge

Re: Warburton [2017] NZCorC 4 (26 January 2017)

I would like to update you on Southern DHB's progress with regard to the recommendations made by Coroner Windley in her Finding related to the death of Daniel James Warburton. The relevant recommendations for Southern DHB are as follows:

All District Health Boards:

- *review and where appropriate update their Clozapine protocols and guidelines to ensure the risk of CIGH reflects the current state of knowledge as informed by the Every-Palmer 2016 Study, particularly in relation to CIGH prevalence, risk factors, consideration of prophylactic prescribing of maintenance laxatives (if not mandated as routine treatment), procedure for regular physical health checks undertaken by GPs, and the need for high levels of suspicion when Clozapine patients are unwell, particularly where gastrointestinal symptoms are identified;*
- *ensure there are effective mechanisms and processes in operation to ensure Clozapine patients' GPs are aware of their clinical responsibility to undertake regular physical health monitoring of those patients;*
- *ensure there are effective mechanisms and processes to ensure adequate and ongoing education of Clozapine patients' clinicians, the patients themselves, and their families and caregivers (where appropriate) as to the risk of CIGH, possible signs and symptoms to be alert for, and the importance of early medical attention if they are unwell;*
- *remind all clinical staff involved in the care of Clozapine patients about the need to record bowel habit inquiries in the patient's clinical records;*
- *consider implementation of a Clozapine red-flag alert feature in electronic patient records systems (such as in effect under the Porirua Protocol) to alert healthcare providers not familiar with the patient of the need for a high index of suspicion where a Clozapine patient is unwell, especially where gastrointestinal symptoms are present.*

The Coroner's Finding was distributed to Mr Craig MacKenzie, Chair of the Medicines Management Committee, and also to the Mental Health Addictions and Intellectual Disability Directorate leadership team.

In response to the recommendations above, Professor Paul Glue and colleagues have written a research protocol (copy enclosed) for a three-phase mixed methods study entitled "Clozapine and constipation: how often are laxatives co-prescribed, and can this be improved?".

This study aims:

1. To estimate the proportion of patients taking clozapine who are co-prescribed laxatives in Southern DHB;

-
2. To evaluate the effectiveness of informing prescribers and pharmacists about the Porirua protocol, comparing the proportion of patients taking clozapine who are co-prescribed laxatives in Dunedin and Invercargill.

Professor Glue's team has collaborations with Alesha Smith and Natalie Medicott from The School of Pharmacy. These collaborations will assist in access to the Pharms database, and resulted in excellent suggestions around Continuing Medical Education (CME) creation and distribution for the Dunedin-based pharmacists and physicians.

The Medicines Management Committee, in collaboration with the Chief Medical Officer, shall continue its oversight of the implementation of the recommendations.

Yours sincerely



Chris Fleming
Chief Executive Officer

Encl. *Protocol Clozapine and constipation: how often are laxatives co-prescribed, and can this be improved?*



Lakes District Health Board
Corner Arawa and Ranolf Streets (Pukeroa Street)
Private Bag 3023, Rotorua Mail Centre
Rotorua 3046, New Zealand
Telephone 07 348 1199
www.lakesdhb.govt.nz

01 June 2017

Coroner B Windley
c/o Tanya Botha
Legal & Research Counsel to the Office of the Chief Coroner
Coronial Services Unit
Specialist Courts

REF: CSU-2015-CCH-282

Dear Ms Windley,

In response to the recommendations for DHBs detailed in the Coroner's report into the death of Daniel Warbuton, Lakes DHB has the following processes in place:

- The local Clozapine protocol and guidelines and Metabolic Monitoring Procedure do not currently specifically mention CIGH but will be altered to do so. However, the type of physical monitoring that is required for all patients on certain antipsychotics, including Clozapine, includes specific monitoring of bowel function which has been emphasized to all staff.
- Lakes DHB does not generally have any patients on Clozapine being managed by GPs. However, the Senior Leadership Team of the MH&AS will ensure that a copy of the Everey-Palmer 2016 Study is sent to all GPs within our district via the GP liaison.
- All patients on Clozapine within secondary care MH&AS have metabolic monitoring and physical health checks relating to potential side effects of their medication carried out within the Mental Health and Addictions Service. There are specific Metabolic Monitoring Clinics in place to cater for this.
- It is an expectation of the DHB that Lead Clinicians and prescribers will provide ongoing education to patients, families and caregivers around the signs and symptoms of physical side effects of Clozapine. Whilst this has been focussed more specifically on constipation, the same process would also pick up CIGH. The requirements for regular bowel monitoring and physical monitoring of other side effects of Clozapine amongst other medicines are regularly reviewed by the MH&AS Continuous Quality Improvement team and updates provided to all clinical staff. We will further update these requirements with specific mention of CIGH and disseminate this via the service.
- At the April meeting of the MH&AS CQI team, it was agreed that an alert will be placed on the national medical warning system for local patients who are on Clozapine or Lithium in order to alert any DHB staff caring for these patients to be aware of this in regards to providing potential cause for presenting physical symptoms. The organizational procedure for this process is currently under review and this expectation will be included in the updated version.

We trust that these actions already do and will further minimise risk of complications arising from CIGH or Clozapine induced constipation.

Yours sincerely

Dr Sharon L Kletchko, MD FRCPC FRACP FACEM
Quality, Risk and Clinical Governance Director

31 May 2017

Tanya Botha
Legal and Research Council to the Office of the Chief Coroner
Coronial Services Unit
Specialists Courts
Tanya.Botha@justice.govt.nz

Dear Tanya

Thank you for your email received on 22 May 2017 regarding the Findings and Recommendations of Coroner Windley in relation to the death of Daniel James Warburton.

The recommendations included in Coroner Windley's findings noted that:

(6) All District Health Boards:

- review and where appropriate update their Clozapine protocols and guidelines and ensure the risk of CIGH reflects the current state of knowledge as informed by the Every Palmer 2016 Study, particularly in relation to CIGH prevalence, risk factors, consideration of prophylactic prescribing of maintenance laxatives (if not mandated as routine treatment), procedure for regular physical health checks undertaken by GPs, and the need for high levels of suspicion when Clozapine patients are unwell, particularly where gastrointestinal symptoms are identified;
- ensure there are effective mechanisms and processes in operation to ensure Clozapine patients' GPs are aware of their clinical responsibility to undertake regular physical health monitoring of those patients;
- ensure there are effective mechanisms and processes to ensure adequate and ongoing education of Clozapine patients' clinicians, the patients themselves, and their families and caregivers (where appropriate) as to the risk of CIGH, possible signs and symptoms to be alert for, and the importance of early medical attention if they are unwell;
- remind all clinical staff involved in the care of Clozapine patients about the need to record bowel habit inquiries in the patient's clinical records;
- consider implementation of a Clozapine red flag alert feature in electronic patient records systems (such as in effect under the Porirua Protocol), to alert healthcare providers not familiar with the patient of the need for a high index of suspicion where a Clozapine patient is unwell, especially where gastrointestinal symptoms are present.

Hutt Valley DHB's 'Clozapine Initiation & Monitoring Pack' contains the 'Porirua Protocol' for managing/preventing constipation. The pack also recommends that every time a team member looking after a patient taking Clozapine sees the patient, they ask about the patient's bowel habits.

A recently developed 3DHealthPathways guide 'Clozapine Monitoring in Primary Care Pathway' is due to go live shortly. At the start of the pathway, there are two 'red flags' - Neutropenia and infection, and Serious constipation. The pathway also includes a link to the Porirua Protocol for constipation. The 3DHealthPathways guides are aimed at primary care/GPs. Information regarding Clozapine effects, adverse effect, including constipation is sent to GPs for whom patients under their care are prescribed Clozapine treatment by a Hutt Valley DHB psychiatrist. The letter to the GP also provides contact information if questions around Clozapine treatment arise.

Hutt Valley DHB also has a three page Appendix (7) in the HVDHB Clozapine policy devoted to managing constipation.

The policy for 'Transferring Clozapine Clients to GP Care' is currently undergoing review; this will include 3DHB (Capital and Coast DHB, Hutt Valley DHB and Wairarapa DHB) aspects for use. Constipation has a special mention within the transfer of care document as an area of particular concern, referencing the work by Dr Lucy Palmer et al.

Constipation in patients who receive Clozapine treatment is an area both inpatient and community Mental Health nurses and psychiatrists show an interest in, understanding of and give appropriate attention to. In particular the Mental Health inpatient unit gives bowel habit much attention.

I am confident that Hutt Valley DHB has appropriate systems and processes in place relating to Coroner Windley's recommendations to reduce the risk of Clozapine-induced gastrointestinal hypomotility.

Yours sincerely



Dr Ashley Bloomfield
Chief Executive
Hutt Valley District Health Board

2 June 2017

Tanya Botha
Legal & Research Counsel, Office of the Chief Coroner

Via email: tanya.botha@justice.govt.nz

Dear Tanya

Coroner Windley's Findings relating to the death of Daniel James Warburton

Thank you for your email regarding this Finding, and the opportunity for us to respond to the recommendation that Coroner Windley made to PHARMAC. The recommendation relating to PHARMAC was:

PHARMAC Gastrointestinal Subcommittee and Psychiatric Subcommittee consider broadening the eligibility criteria for accessing Macrogol to include Clozapine use.

The recommendation is currently under consideration.

Macrogol 3350 is fully funded, however there are certain clinical criteria a patient must meet in order to receive this funded medicine. This is called a Special Authority, whereby the prescriber applies online for a patient to receive the medicine subsidised. The Special Authority for Macrogol 3350 requires people who have problematic constipation to have previously trialed other oral medicines first, including lactulose.

The Gastrointestinal Subcommittee of the Pharmacology and Therapeutics Advisory Committee (PTAC) reviewed the Coroner's report and recommendations at its March 2017 meeting. As a laxative, this medication is appropriately reviewed through this subcommittee. While PHARMAC's subcommittees make recommendations, they do not make decisions about funding which are made by the PHARMAC Board or its delegate.

The Subcommittee discussed the recommendation, reviewed published studies, and arrived at a formal recommendation to PHARMAC regarding widening access to macrogol 3350. The minutes of the Subcommittee's discussion and recommendation are currently being reviewed by the members of the Subcommittee. When the minutes are finalised, they will be published on our website www.pharmac.govt.nz.

If, following the Subcommittee's recommendation, PHARMAC were to decide to widen access, we would not be able to provide a definitive timeframe for when this might occur. This is because the relative priority of funding one medicine compared with other medicines can change over time.

Details like the relative health benefits, the amount of funding available, the success of negotiations with the suppliers and/or new clinical data, and the mix of other funding applications being considered at any one time, are all examples of factors that may change the relative priorities of funding choices.

Yours sincerely

A handwritten signature in black ink, appearing to read 'J Wyeth', written in a cursive style.

Dr John Wyeth
Medical Director

DEATH BECAUSE OF COMPLICATIONS OF A CRUSH INJURY SUSTAINED IN A QUAD BIKE CRASH

Cameron (Coroner Ryan)⁴

The coroner made the following recommendation:

- All organisations involved in promoting the safe use of quad bikes, including Federated Farmers New Zealand and WorkSafe New Zealand, should continue in their efforts to reduce the chances of further deaths occurring in similar circumstances to this one, including:
 - stressing to all quad bike operators that it is essential they maintain air pressure in the tyres on the bikes in accordance with the manufacturer's recommendations at all times when using the bikes; and
 - encouraging all riders of quad bikes to carry a personal locator beacon when riding in isolated areas with little or no cell phone coverage.

See next page for WorkSafe response:

23 December 2016

Coroner Ryan
Coronial Services Unit
Auckland

Email: Lynda.Marks@justice.govt.nz

File Ref: 5578809
CSU 2015 PN000451

Dear Coroner Ryan,

Thank you for providing WorkSafe with the opportunity to make a submission on the draft Finding for the Inquiry into the death of Kenneth Francis Cameron.

WorkSafe notes your recommendations:

That all organisations involved in promoting the safe use of quad bikes continue in their efforts to reduce the chances of further deaths occurring in similar circumstances to this death including:

- (a) Stressing to all quad bike operators that it is essential they maintain the air pressure in the tyres on quad bike in accordance with the manufacture's recommendations at all times; and*
- (b) Encouraging all riders of quad bikes to carry a personal locator beacon when riding in isolated areas with little or no cell phone coverage.*

Promoting the safe use of quad bikes remains an important part of improving safety on New Zealand's farms. WorkSafe's expectations regarding the matters above are set out in the *WorkSafe Guidelines for the Safe Use of Quad Bikes*, which are available on our website. These expectations align with the primary duty of care placed on persons conducting a business or undertaking (PCBUs) by section 36 of the Health and Safety at Work Act 2015 (HSWA).

WorkSafe releases regular communications about the safe use and maintenance of safe quad bikes. A press release in early November advised farmers to make sure that quad tyres have tread depth in line with manufactures instructions and that they are correctly inflated. WorkSafe is currently investigating ways for farmers to access more useable tyre pressure gauges than those provided with the vehicles.

The Health and Safety at Work (General Risk and Workplace Management) Regulations 2016 places a duty on PCBUs to manage risks to health and safety of workers who perform remote or isolated work, this requires the provision of a system of work that includes effective communication with workers. WorkSafe has been engaging with farmers to make them aware of the risks of working alone and possible ways to manage the risk. There are a number of communication systems available for people working alone on farms. These include two-way

radios, personal locator beacons and other real-time locating systems. WorkSafe advises farmers to consider the risks specific to their property and work when selecting an appropriate communication system.

Farm Angel is an example of a real-time locating system that is currently in use on LandCorp farms. It is a satellite and cellular enabled system that detects accidents and raises automatic panic alerts. It also allows users to send messages when they are out of cell phone reception. It lets farmers track where and how quad bikes are being used on the farm. LandCorp has given WorkSafe permission to access the data from the Farm Angel system. We will use this data to gain a better understanding of quad bike use and incident causation, so we can better target our future interventions.

In conclusion there are a range of communication and location technologies available for use by farmers and farm workers, these include but are not limited to personal locator beacons. WorkSafe will continue to promote the use of these technologies to ensure that workers doing remote or isolated work have an effective means of communication.

Yours sincerely,



Phil Parkes
General Manager, Better Regulation



Presentations by Coroners throughout New Zealand

Coroners spend many hours in and out of business hours presenting to various stakeholders and agencies. The following are some of the groups coroners have presented to from 1 July 2016 to 30 June 2017.

- Police DVI training
- Youth Parliament
- Road Controlling Authorities Forum
- Medical staff of Southern Cross Hospital
- Waikato Child and Youth Mortality Review Committee
- Te Runanga O Kirikiriroa presentation on suicide
- NZ Society of Forensic Dentists
- District Community Law Centre Hamilton
- First year doctors at Waikato Hospital
- Iwi Consultation Hui
- Medical referees
- NZ mortuary technicians
- Te Hunga Roia Māori O Aotearoa (Māori Law Society)
- TV1 Marae programme
- Gisborne and Hawkes Bay Hospital
- Youth Forensic Course
- Grand round, Auckland District Health Board
- AUT Law School
- AUT midwifery students
- South Canterbury District Health Board
- College of Intensive Care Medicine
- Annual Medical Law Conference
- Women in Law Committee, Hamilton
- Clinical nurse specialists, Middlemore Hospital
- CEO Lecture Series, North Shore Hospital
- CVICU Auckland Hospital

Performance measures

From 1 July 2016 to 30 June 2017...

5534

deaths were reported to the
National Initial Investigation Office

Coroners took jurisdiction over

3422

Compared
to 2015/16
this is an
increase of

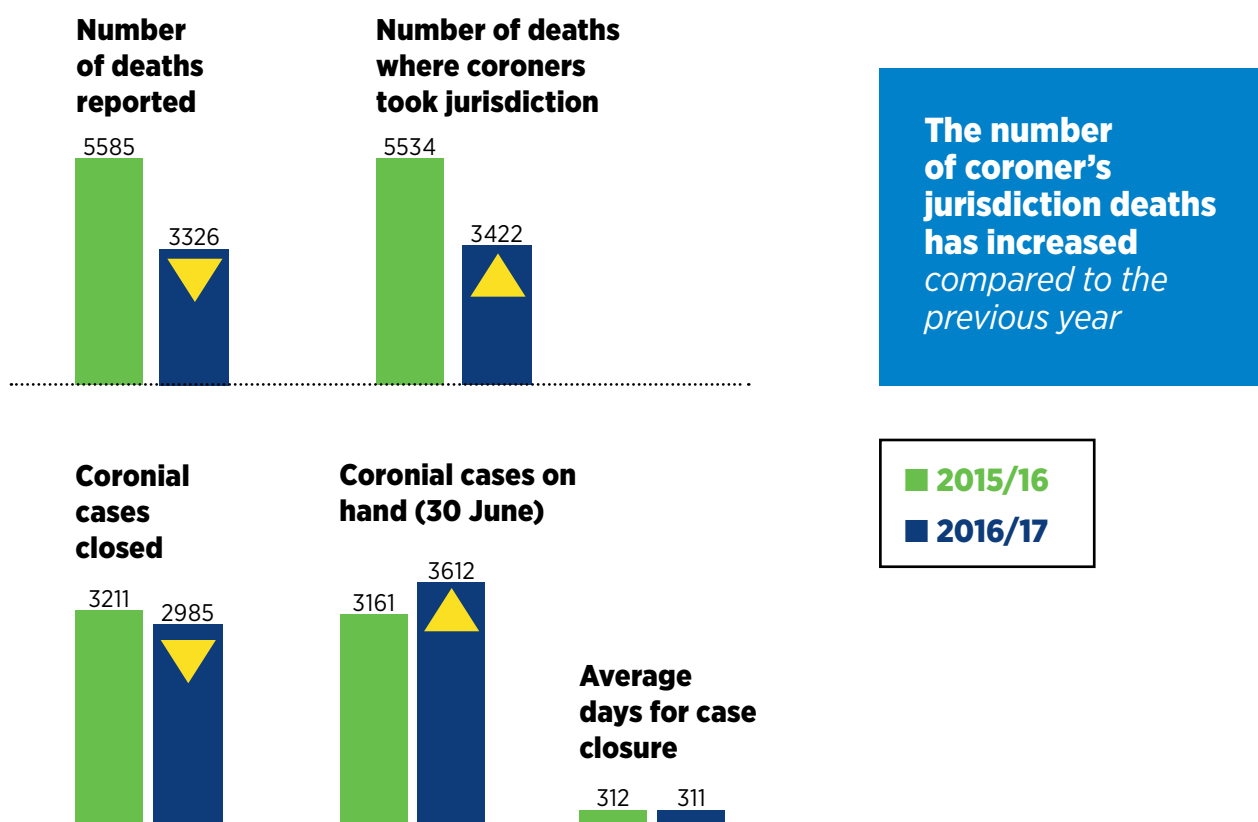
96

Closing a case took
ON AVERAGE
311 days

THIS IS APPROXIMATELY THE SAME AS THE PREVIOUS YEAR

Year in review: 2016-2017

During the 2016/17 year, 5534 deaths were reported to NIO. Of these, coroners took jurisdiction over 3422 deaths. As of 30 June 2017, coroners are investigating 3612 deaths. For the financial year, coroners have closed 2985 cases, 226 less than the previous year. On average, it took 311 days to close a case, which is a reduction of 1 day when compared with last year.



The number of coroner's jurisdiction deaths has increased compared to the previous year

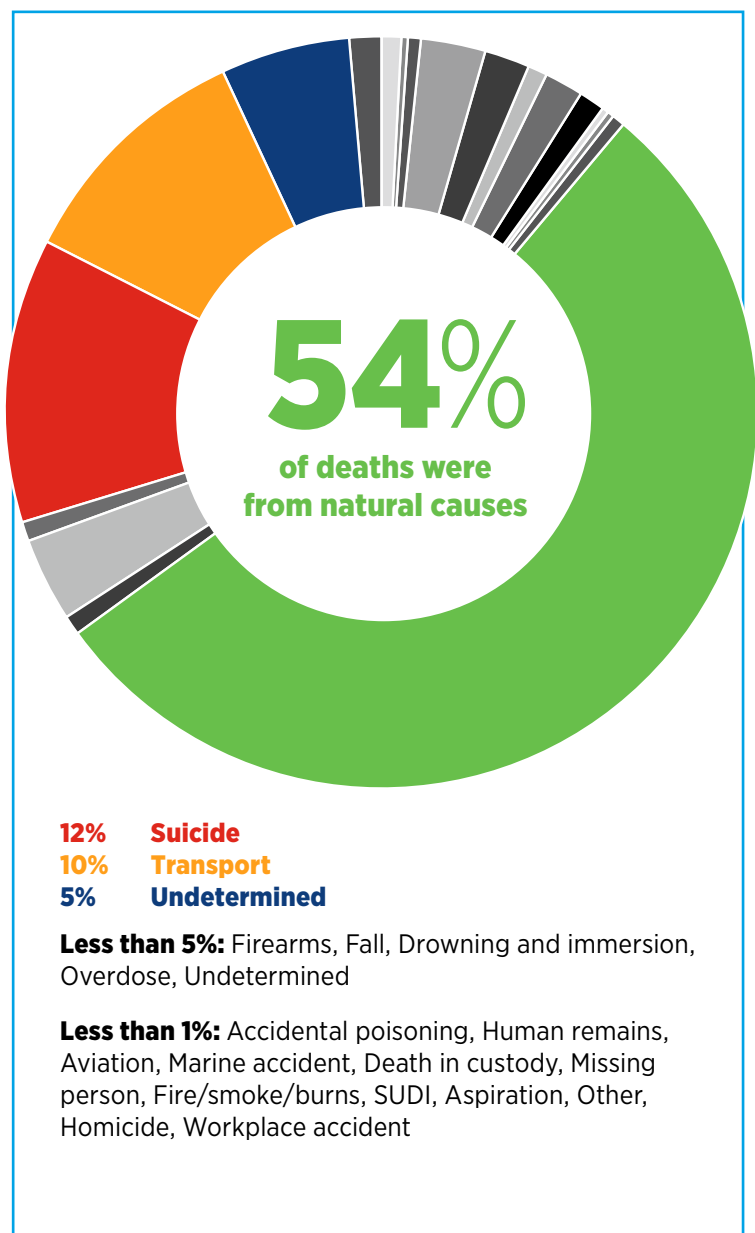


Year in review	2015/16	2016/17	CHANGE	% CHANGE
Number of deaths reported	5585	5534	(51)	- 1%
Number of deaths coroners took jurisdiction	3326	3422	96	2.88%
Coronial cases closed	3211	2985	(226)	-7.04 %
Coronial cases on hand (30 June)	3161	3612	451	14.26%
Average days for case closure	312	311	(1)	0.33-%

National statistics

In 2016-2017, coroners took jurisdiction over 3422 deaths. Of these, 1843 (54%) deaths were from natural causes. The second highest category was suicide. Deaths by suicide accounted for 419 deaths (12%), followed by transport deaths, 359 (10%).

Cause of death 2016-17	Deaths
Accidental poisoning	2
Aspiration	32
Aviation	12
Death in custody	17
Drowning and immersion	91
Fall	74
Fire/smoke/burns	25
Firearms	57
Homicide	40
Human remains	3
Marine accident	12
Missing person	17
Natural causes	1843
Other	34
Overdose	123
SUDI	31
*Suicide	419
Transport	359
Undetermined	186
Workplace accident	45
Total	3422



*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 as a result of suicide or natural causes.

Enhancing suicide reporting

Last year, approximately 606 New Zealanders took their lives, which is the highest number of suicides since these statistics began in 2007. As part of the collective effort to reduce New Zealand's rate of suicide, the Chief Coroner releases her 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 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 from which an intention to end one's life can be inferred.

Provisional suicide statistics: By sex

PROVISIONAL SUICIDE RATE 2007-2017

By sex

Rate per 100,000 people

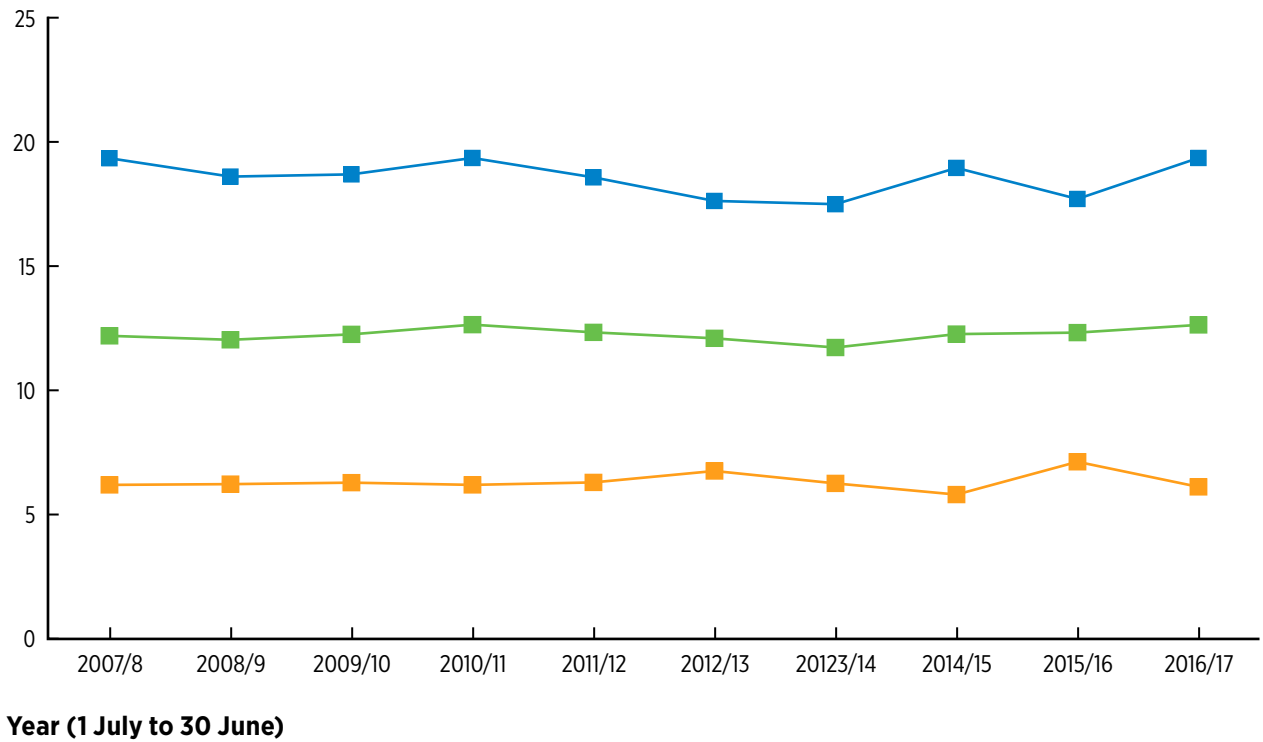
Year	Men		Women		Rate (Men:Women)	Total	
	Number	Rate*	Number	Rate*		Number	Rate*
2007/2008	405	19.35	135	6.2	3.00 :1	540	12.2
2008/2009	394	18.61	137	6.23	2.87 :1	531	12.04
2009/2010	401	18.7	140	6.29	2.85 :1	541	12.26
2010/2011	419	19.36	139	6.2	3.01 :1	558	12.65
2011/2012	405	18.58	142	6.3	2.85 :1	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

Note: The per 100,000 population rate shown has been calculated following Statistics New Zealand annual population estimates for the 2017 year.

PROVISIONAL SUICIDE RATE 2007-2017

By sex

Rate per 100,000 people



Provisional suicide statistics: By sex and age

PROVISIONAL SUICIDE RATE 2016-2017

By sex and age

Rate per 100,000 people

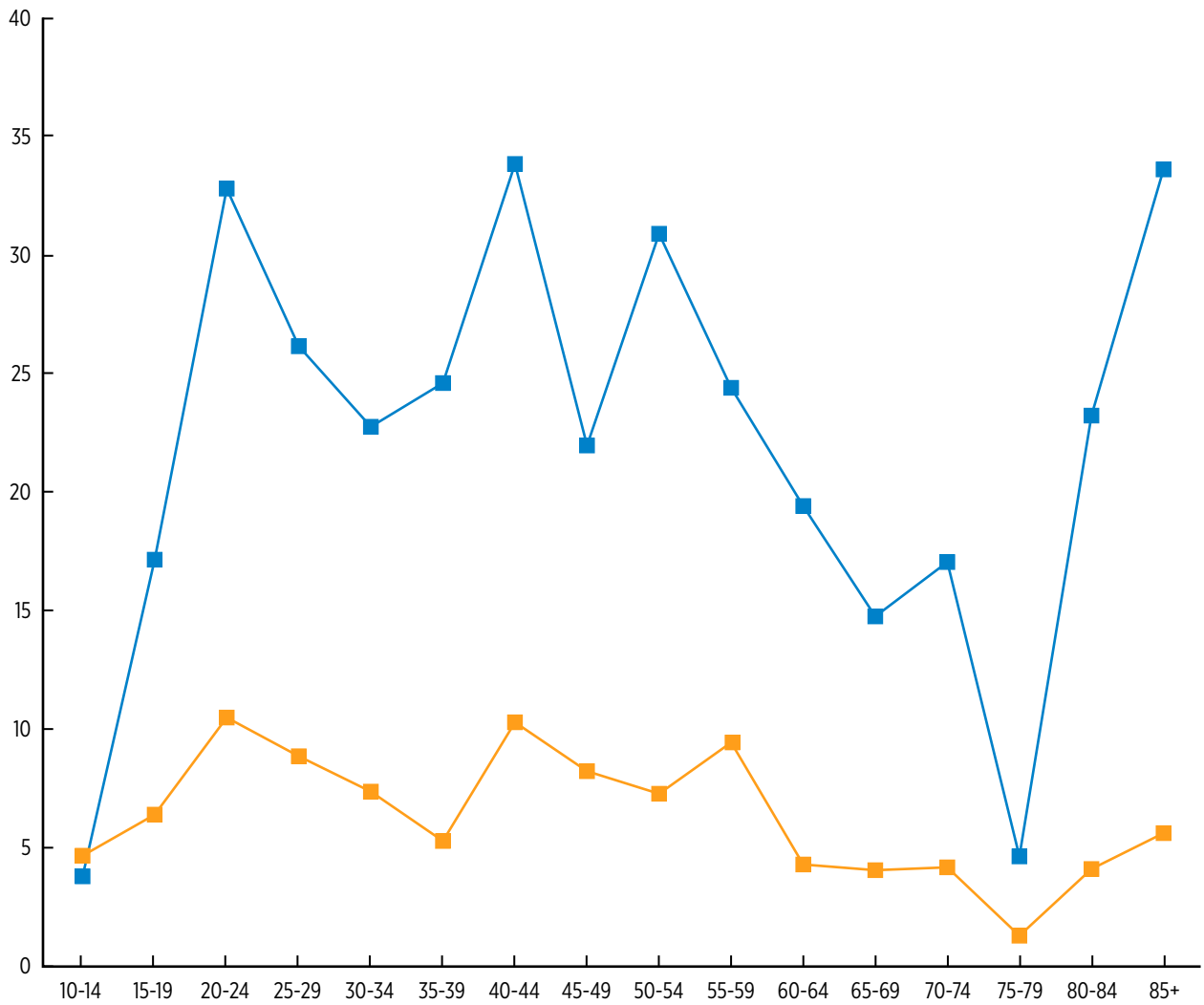
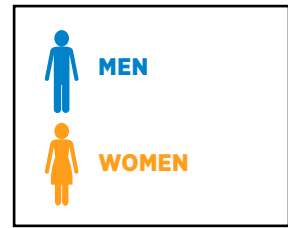
Age Group (Years)	Men		Women		Total	
	Number	Rate*	Number	Rate*	Number	Rate*
10-14	6	3.89	7	4.76	13	4.31
15-19	28	17.23	10	6.49	38	12.01
20-24	61	32.86	18	10.58	79	22.20
25-29	48	26.22	16	8.95	64	17.69
30-34	35	22.83	12	7.46	47	14.96
35-39	34	24.67	8	5.38	42	14.65
40-44	48	33.90	16	10.38	64	21.64
45-49	34	22.04	14	8.32	48	14.88
50-54	47	30.96	12	7.37	59	18.76
55-59	36	24.47	15	9.53	51	16.75
60-64	25	19.49	6	4.39	31	11.71
65-69	17	14.84	5	4.15	22	9.36
70-74	15	17.13	4	4.27	19	10.48
75-79	3	4.73	1	1.39	4	2.96
80-84	9	23.30	2	4.20	11	12.76
85+	11	33.67	3	5.71	14	16.43
Total	457	19.36	149	6.12	606	12.64

Note: The per 100,000 population rate shown has been calculated following Statistics New Zealand annual population estimates for the 2017 year.

PROVISIONAL SUICIDE RATE 2016-2017

By sex and age

Rate per 100,000 people



Provisional suicide statistics: By ethnic group

PROVISIONAL SUICIDE RATE 2007-2017

By ethnic group

Rate per 100,000 people

Year	Asian		Māori		Pacific		Other	
	Number	Rate*	Number	Rate*	Number	Rate*	Number	Rate*
2007/2008	21	5.93	87	15.39	24	9.05	408	13.26
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

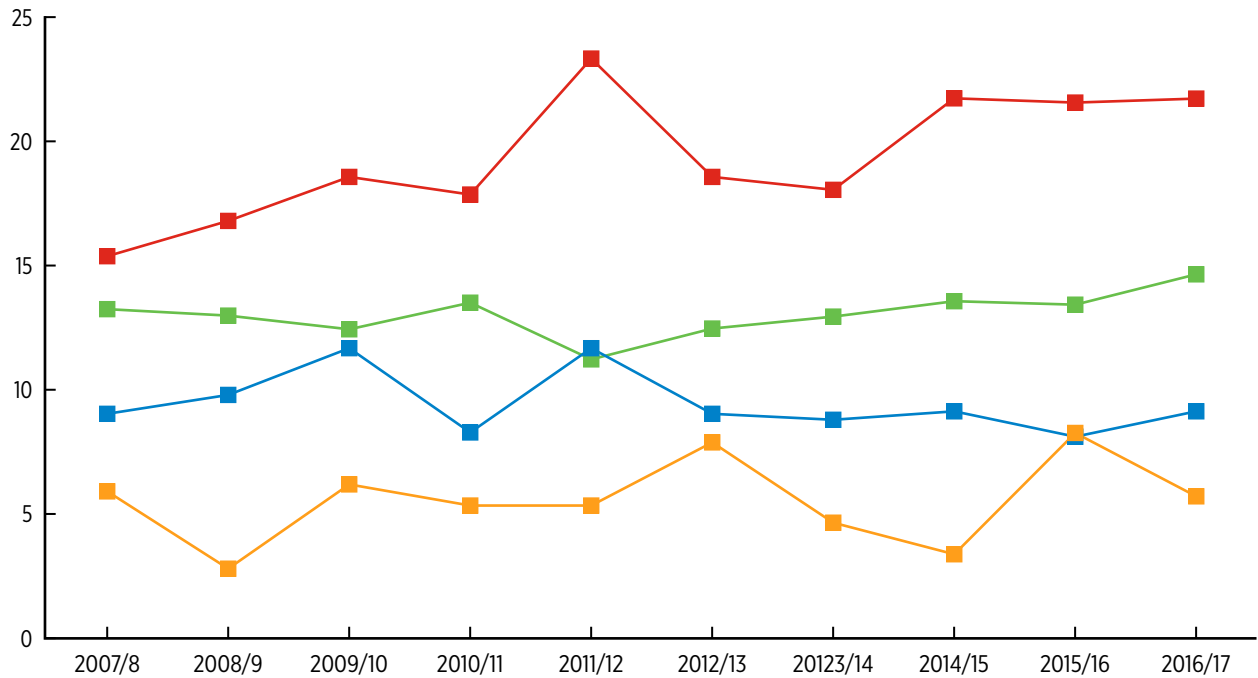
Note: The per 100,000 population rate shown has been calculated using Statistics New Zealand annual population information as published following the 2006 and 2013 censuses.

The table shows provisional suicide deaths by ethnicity between July 2007 and June 2017. The small numbers and volatile nature of this data for Pacific and Asian peoples makes reliable estimation of the patterns very difficult and may be misleading.

PROVISIONAL SUICIDE RATE 2007-2017

By ethnic group

Rate per 100,000 people



Year (1 July to 30 June)

Note: The per 100,000 population rate shown has been calculated using Statistics New Zealand annual population information as published following the 2006 and 2013 censuses.

Ethnic groups have been classified in the following groups: Māori, Pacific peoples, Asian, European and other (including European, Not elsewhere classified and New Zealand European).

The small numbers and volatile nature of this data for Pacific and Asian peoples makes reliable estimation of the patterns very difficult and may be misleading.



Coroners

Office of the Chief Coroner

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Whangarei

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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

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