OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

# Recommendations Recap

A summary of coronial recommendations and comments made between **1 April** and **30 June 2022**

# Coroners' recommendations and comments

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

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

The Office of the Chief Coroner maintains a public register of these recommendations and comments and publishes summaries of those which are not prohibited from being published by order of court or law. Recommendations Recap includes all those recommendations and comments which have been summarised and published. This edition includes 42 findings with recommendations and/or comments issued by Coroners between 1 April and 30 June 2022.

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# Recommendations and comments

## 1 April to 30 June 2022

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

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

## Death in Custody

### Seller [2022] NZCorC 72 (5 May 2022)

**CIRCUMSTANCES**

Ricky Seller (also known as Richard William Galyer), aged 45, died on 30 November 2015 at North Shore Hospital, Auckland of sepsis, due to a perforation of the oesophagus during removal of objects due to the ingestion of sharp foreign bodies.

At the time of his death, Mr Seller was a sentenced prisoner residing at Auckland Prison. Being a death in official custody, an inquest was held under section 80 of the Coroners Act 2006.

During his incarceration, Mr Seller was a prolific self-harmer who spent significant periods in At Risk Units (ARU)[1] and Special Needs Units (SNU).[2] His self-harm attempts included ingestion of foreign objects. While Mr Seller received comprehensive psychological and forensic input during this sentence, he was not under the care of the Forensic Prison Team (FPT) at the time of his death. Mr Seller had been re-referred to FPT on 29 October 2015, however it was noted that his self-harming behaviour was related to a personality disorder, rather than a major mental illness, and prior FPT interventions had not improved his condition.

On 12 November 2015 Mr Seller was hospitalised for eight days following a self-harm incident in which he made multiple cuts to his arms and legs, and swallowed a number of objects. Following his discharge on 20 November 2015, he was placed in the ARU at Auckland Prison. On 23 November 2015 Mr Seller was relocated from the ARU to the SNU.

[1] A standalone unit for prisoners who are at risk and need constant monitoring. The only items prisoners have access to in their ARU cells are a gown, a blanket, a mattress and a television (with no remote control). Due to the glass doors, prisoners in ARU can be seen by staff at all times. Prisoners do not engage with each other in the ARU.
[2] Houses prisoners who are vulnerable and need some form of monitoring or additional care. Prisoners are observed on 15-minute or 30-minute cycles. Small groups of prisoners may be allowed to associate in SNU and they have more access to personal possessions.

Before a prisoner is moved from ARU to SNU a health nurse needs to undertake a risk assessment. Nurse Jiang performed the risk assessment on Mr Seller and concluded he was not at risk and could be placed where the Corrections Officer (CO) recommended. At inquest, Nurse Jiang accepted that on 22 November 2015 Mr Seller had told a CO that he would "go back to the old Ricky Seller" if management did not see him the following day. Nurse Jiang gave evidence that when she was completing her risk assessment on 23 November 2015, she had not seen the Corrections form recording this statement. She reported that if she had been aware of it, she would have had further discussion with her manager regarding the appropriateness of Mr Seller's transfer out of ARU.

While Mr Seller's file noted that he was not allowed to have certain objects in his room due to his self-harm risk, custodial staff were not alerted to this. Custodial staff do not have access to prisoner health records, and therefore need to be informed of particular prisoner risks via health alerts. It was accepted that such an alert should have been made in respect of Mr Seller when he relocated to SNU.

On 25 November 2015 Mr Seller was hospitalised following another self-harm episode in which he ingested a number of objects, which he obtained by asking another SNU prisoner. An oesophagus perforation occurred while Mr Seller was undergoing an operation to remove one of those objects. Despite medical care, Mr Seller's condition deteriorated and he died on 30 November 2015.

## RECOMMENDATIONS OF CORONER BELL

I. From my review of the evidence, the most significant issue that appears to arise is whether it was appropriate for Mr Seller to transfer out of ARU into SNU on 23 November 2015. As already discussed, I accept that such transfers are complex, particularly when the relevant prisoner has mental health difficulties, but not a major mental illness. However, it appears that in Mr Seller's case this decision, and its implementation, was made more complex by a lack of effective communication between custodial staff and health staff. In particular:

   a. Custodial staff were not formally alerted to the fact that Mr Seller was at risk of ingesting objects.

   b. Nurse Jiang was not aware of Mr Seller's comments to a CO, which may have impacted her risk assessment.

II. As noted above, it is not clear whether rectification of either or both of these issues at the relevant time would have resulted in a different outcome. Specifically, even if custodial staff were made aware of Mr Seller's risk of ingesting objects, the nature of SNU meant that they would not be able to constantly monitor him anyway. Therefore, while staff awareness may have been heightened, their ability to act on that awareness would have remained limited in the SNU environment. Similarly, while I accept that Nurse Jiang would have taken Mr Seller's 22 November 2015 comment into account during her risk assessment, had she been aware of it, the impact of this on her overall decision is now impossible to know.

III. I understand that decisions to transfer a prisoner out of ARU are now made by the multidisciplinary team, which includes custodial staff and a representative of the health team (among others). I am satisfied that this environment should lead to more effective information-sharing between health staff and custodial staff.

IV. Counsel for Waitematā District Health Board proposed the following as a possible recommendation;

*that the Department of Corrections and Auckland Regional Forensic Psychiatry Services work together to develop formal terms of reference for the HARAT meeting. The purpose of the terms of reference is to ensure that there is a structured and well-coordinated meeting, and information exchange, so that decisions about the appropriate placement of prisoners in secure units can be made. Such terms of reference ought to set out clearly the roles and responsibilities that each organisation has in setting the agenda for, and contributing to, the HARAT meeting.*

V. The proposed recommendation is supported by Corrections whose counsel advises that as at April 2022 work has commenced regarding the development of terms of reference. Counsel further advises that since the formation of the ISP Team at Auckland Prison, the HARAT and other multi-disciplinary meetings have improved coordination of treatment and team collaboration for people in Corrections' care.

VI. I support the above recommendation and formally record it as a recommendation.

VII. Counsel for Corrections also provided Corrections' Individualised Care Plan. Counsel submitted that Care Plan version 4 is the most comprehensive. The plan has been trialled which as at July 2021 revealed some difficulties. Corrections is in the process of completing work on privacy issues and the sharing of information between different Corrections' services to ensure there is no breach of confidentiality and health and well-being are focussed on. If the Individualised Care Plans have yet to be implemented, I urge Corrections to continue with the work on privacy issues and sharing of information.

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

# Drowning

## Boniface [2022] NZCorC 92 (16 June 2022)

### CIRCUMSTANCES

Jamie Stephen Boniface, aged 28, died sometime between 9 September 2018 and 12 September 2018 at the Jacobs River Estuary, Aparima River, from drowning.

On 9 September 2018 Mr Boniface and his friends, James Anderson and Nathan Gorton went fishing in the Riverton estuary in a motorised dinghy. The dinghy measured 3.5 metres and was piloted by Mr Anderson. The men were each wearing casual clothes and tall gumboots. They were not wearing life jackets, even though three life jackets were onboard.

The dinghy was observed by several witnesses from the shoreline as it travelled up the Estuary. Specifically, Peter Blackie explained that the dinghy appeared to be accelerating on the plane, when suddenly, it spun around 180° throwing the occupants into the water before capsizing.

After the dinghy capsized, all three men surfaced at about the same time and almost within arm's reach of each other. Mr Anderson said he could not see the life jackets at that time. Messrs Anderson and Gorton grabbed the front of the dinghy

which was above the water. Mr Anderson yelled at Mr Boniface to “get his gear off” and he and Mr Gorton removed some of their clothing. Mr Gorton removed his gumboots. At this time, Mr Boniface started to swim to the shore which was approximately 100 metres away.

Another witness heard a male yelling to Mr Boniface to take off his gumboots. She then saw Mr Boniface go under the water and not resurface. Mr Gorton tried to swim to Mr Boniface but the current was too strong and he lost sight of Mr Boniface. Mr Gorton eventually made it to shore. Mr Anderson remained with the dinghy and was assisted back to shore by members of the public. Mr Boniface remained missing until his body was located by divers on 12 September 2018. He was fully clothed but was not wearing gumboots.

The dinghy was inspected by Cory Ward who did not find any significant or obvious defects that could assist with determining the cause of the incident. Mr Ward noted that a long shaft outboard motor was fitted instead of a short shaft. The transom mount had been altered to support the long shaft outboard and a large crack was seen on the starboard of the mount. However, it could not be known whether the crack occurred prior to the incident.

## COMMENTS AND RECOMMENDATIONS OF CORONER MCKENZIE

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

   a. Be clearly linked to the factors that contributed to the death to which the inquiry relates; and

   b. Be based on evidence considered during the inquiry; and

   c. Be accompanied by an explanation of how the recommendation or comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

II. In considering recommendations and comments, I have turned my mind to the two broad stages of the incident: the boat doing the sudden turn which resulted in the men being thrown into the water and Mr Boniface’s chances of survival once in the water.

*Alcohol / drug use on the water*

III. Mr Anderson told Police he had consumed two beers on the boat. In considering whether any recommendations or comments are appropriate in this matter relating to the use of alcohol while on the water, I am mindful that I do not have formal evidence of the level of alcohol that Mr Anderson might have had in his system at the time of the incident. There is no evidence before me that his driving had come to the attention of the various people who saw the boat before the incident. Mr Gorton said he was not being foolish driving the boat. Mr Blackie said the driver was in control and on the tiller. I have not made an affirmative finding that Mr Anderson’s driving was affected by alcohol.

IV. Mr Gorton told Police he had consumed two beers. There is no evidence before me that his behaviour on the boat contributed to it doing the sudden turn.

V. I note that Mr Boniface had an alcohol level of 116mg/100mL in his blood and 154mg/100mL in his urine. For comparison purposes, the legal blood alcohol limit for a New Zealand driver 20 years old or over is 50mg/100mL. Mr Boniface also had indications of cannabis use in his system.

VI. Mr Boniface however was not driving the boat when it did the sudden 180° turn before capsizing. There is not otherwise evidence before me that Mr Boniface contributed to the boat doing the sudden turn (for example by suddenly moving and destabilising the boat's balance).

VII. I also do not have evidence as to whether the levels of alcohol and cannabis combined affected Mr Boniface's ability to swim to shore, though note the observations of the ESR in terms of the effects cannabis, and cannabis together with alcohol, can have. Mr Gorton speculated that they might have affected Mr Boniface's ability to swim and save himself, but I do not have direct evidence of this.

VIII. Finally, I do not have evidence before me that alcohol affected the rescue efforts of Messrs Gorton or Anderson in relation to helping Mr Boniface.

IX. In the light of all of these circumstances, I consider that I do not have an evidential basis upon which to make any formal recommendations or comments regarding the use of alcohol or cannabis while on the water. This is because I do not know whether use of these substances contributed to Mr Boniface's death by contributing to the boat suddenly turning or to lessening his chances of survival once he was in the water.

X. I observe too the existing public safety campaigns relating to alcohol use on the water.

*The long shaft outboard motor*

XI. Mr Ward observed that a long shaft outboard motor was fitted to the dinghy instead of a short shaft. The transom mount was altered to support the long shaft motor. A large crack was observed on the starboard side of the mount, but it is unknown whether this occurred before or during the incident. Mr Ward stated to Police "By having a long shaft outboard fitted it does mean that power head of the outboard is higher than the short shaft version and therefore can affect stability." Mr Gorton thought that it could be easy to lose control of the motor.

XII. I have no evidence before me that the long shaft outboard motor contributed to the boat doing the 180° turn. Mr Ward did not consider that stability would be affected "to the extreme of being the main cause of [the] boat lurching to one side while planning at speed …" Further, there is no evidence of the boat appearing to be unstable at earlier points in the trip, though I observe that the first manifestation of this could be the incident.

XIII. Accordingly, I do not make any recommendations or comments relating to the use of the long shaft outboard motor on the dinghy because I do not know whether this contributed to the incident.

*Wearing life jackets*

XIV. Mr Anderson's father provided the group with three life jackets before they left. The life jackets were not worn however and were recovered after the incident from having been stowed under the boat's bow plating.

XV. There are clear and publicly available safety campaigns relating to wearing life jackets while on boats. Further, the Southland Regional Council Navigation Safety Bylaws 2009 (Revised 2015) require the wearing of a properly secured personal flotation device on a boat that is 6m or less (the dinghy was 3.5m in length).

XVI. Alongside the existing public safety campaigns regarding wearing life jackets, I consider it is appropriate to comment that in my view it is reasonably possible that had Mr Boniface been wearing a life jacket his chances of survival would have materially increased: for example, he might have been able to remain with the boat until assistance arrived or it might have helped him make it to shore.

*Wearing gumboots*

XVII. The men were wearing gumboots. Mr Gorton removed his when he was in the water and it appears Mr Anderson may have done so too. One of them shouted to Mr Boniface to remove his gumboots and it appears he might have attempted to do so on the basis of Ms Wilkinson's evidence. When Mr Boniface was found, he no longer had his gumboots on.

XVIII. In my view it is reasonable to infer that if someone wearing gumboots falls into the water, their gumboots will fill with water and weigh them down. In many circumstances, particularly where the water is over the person's head and water conditions might be challenging such as due to the current or swell, I consider it possible that it would be difficult to remove gumboots in the water. This might increase the likelihood of drowning, may complicate rescue, or could result in another adverse outcome.

XIX. I am not aware of any public safety campaigns regarding wearing gumboots in boats of less than 6m. I have chosen this length boat because that appears to generally be the cut off length regarding life jackets (ie, the cut off point for what is considered to be a small vessel).

XX. Accordingly, in addition to Mr Boniface's family and Messrs Gorton and Anderson, I consulted Water Safety New Zealand, Maritime New Zealand, and the New Zealand Police's Dive Squad regarding a proposed recommendation that gumboots not be worn on boats of less than 6m. I did not receive any comments on the proposed recommendation.

XXI. Accordingly, pursuant to s 57A of the Coroners Act 2006 I recommend that gumboots not be worn on boats of less than 6m.

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

# Lane [2022] NZCorC 86 (7 June 2022)

### CIRCUMSTANCES

Keith Phillip Lane, aged 67, died on or about 15 February 2020 in the waters off Ponui Island, Auckland from saltwater drowning. Conditions that contributed to the death but did not directly cause it include ischaemic heart disease and alcohol consumption.

After competing in a yacht race on 15 February 2020, Mr Lane anchored in a bay off Ponui Island. After calling his wife and reporting feeling “exhausted” he took his motor-powered inflatable tender to a friend’s boat, before they travelled to a beach barbeque together. After leaving the barbeque, they returned to the friend’s boat. As they were disembarking the tender, it capsized and Mr Lane’s friend observed him treading water without issue, before he boarded the boat.

At around 10:30pm Mr Lane decided to return to his own boat. He took his tender out in the dark without a life jacket. His body was found the following morning at a nearby bay. Toxicology testing revealed the presence of alcohol in his blood at a level of 118 milligrams per 100 millilitres.

There are no eyewitness accounts as to the circumstances in which Mr Lane entered the water. Maritime New Zealand provided a report in relation to the accident, which identified the following likely contributing factors to Mr Lane’s entry into the water:

a) Considerable upper body strength is required to board a yacht from the water. Even though his yacht was fitted with boarding rungs, Mr Lane was fatigued and had been drinking alcohol. It was dark. These factors may have disoriented Mr Lane.

b) Mr Lane was not wearing a personal flotation device.

c) The average summer sea temperature in Auckland is 21 degrees Celsius. Hypothermia can onset when the core body temperature drops below 38 degrees Celsius.

d) Mr Lane was under the influence of alcohol. Alcohol impairs the ability to react, the ability to perform simple tasks, judgement and sense of direction. There is an increased risk of a person on a vessel ending up in the water and being unable to get to safety if they have consumed alcohol. Consumption of alcohol can increase the risk of capsize or overbalance. Further, once in the water, a person under the influence of alcohol can be more susceptible to hypothermia due to lower concentrations of blood going to the brain and muscles, contributing to loss of strength, heat and fluid.

These factors were accepted as contributing to the circumstances of Mr Lane’s death.

## COMMENTS OF CORONER HO

I. I do not consider it necessary to make any recommendations. Maritime New Zealand already promotes key safety messages on its website and through targeted campaigns which state the importance of wearing a correctly sized life jacket, carrying at least two forms of waterproof emergency communication and to avoid consuming alcohol prior to operating a vessel. It is incumbent on mariners to heed these messages. Mr Lane’s death demonstrates the fatal consequences that can otherwise occur.

II. I add for completeness that being able to tread water, like Mr Lane obviously could, does not replace the need to carry and wear a life jacket. Capsize and immersion events can happen rapidly and, even ignoring the other heightened risk factors in this case such as darkness, fatigue and alcohol intoxication, can overtake even the most competent swimmer. The best chance of survival comes with carrying and wearing life jackets in compliance with the relevant maritime rule and local authority bylaws.

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

# Matthews [2022] NZCorC 68 (29 April 2022)

### CIRCUMSTANCES

Scott Tamarakei Matthews, aged 36, died on 8 February 2021 at Motions Road Creek, Western Springs, Auckland of unintentional drowning.

In 2016, as part of his release from prison, Mr Matthews was required to attend alcohol and drug counselling. He did not do so and no further follow-up was undertaken.

At the time of his death, Mr Matthews was struggling with a personal crisis which had resulted in him relapsing into taking drugs. At around 5:36am, a member of the public saw Mr Matthews in the Jaggers Bush reserve area, breaking branches and yelling. The member of the public called Police, but no action was taken.

Other members of the public also saw Mr Matthews repeatedly launching himself into the Motions Road Creek. Despite concerns, Police were not called again until around 7:00am after which Police found Mr Matthews deceased in Motions Road Creek.

### COMMENTS OF CORONER TETITAHA

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

II. There was a need for the Police to consider the adequacy of the response to the 111 call made at 5:36am based upon the information they had at the time the call was received. There is little doubt that had the Police responded at 5:36am to the call they may have located Mr Matthews and prevented his death 2 hours later.

III. I do not agree with the Police stated justifications for their lack of action. The evidence provided by witnesses subsequent to the death would not have been available to Police at the time they received the 111 call. The unavailability of Police units to respond is a resourcing issue. Neither of these issues can be used to retrospectively justify the failure to respond to the 111 call at 5:36am. This is especially when the caller identifies someone who is distressed.

IV. I have been considering making a recommendation that the Independent Police Conduct Authority (IPCA) investigate this death including the adequacy of the Police response to the 111 call on 8 February 2021 at 5:36am.

V. These comments were directed to the Commissioner for Police and the IPCA.

VI. The circumstances of this death indicate that Mr Matthews might not have complied with his supervision conditions regarding attending alcohol and drug counselling in 2016 and no further follow-up by probation services was undertaken. Earlier intervention and follow up may have assisted Mr Matthews to avoid the drug taking that has led to his death.

VII. As I have noted in another decision, a vulnerable class of persons are those recently released from prison.[3] Community Corrections acknowledges the chief causes of prisoner and ex-prisoner deaths include substances abuse namely drug overdoses and accidental poisonings as well as suicide, homicide and accidents/injury.[4]

VIII. Community Corrections have provided information on changes they have made since 2018 regarding managing the risks of premature death of ex-prisoners with drug and alcohol problems. These changes have included an alcohol and drug strategy for 2021 to 2026 (the strategy). The strategy does not retrospectively address deficiencies in the past support of ex-prisoners.

IX. The likely effects upon Mr Matthews' death of the perceived deficiencies in alcohol and drug support at the time of his release from prison in 2020 should be noted. This may contribute to any future review of the strategy.

X. Given recent changes have been made by Community Corrections to prevent similar future deaths, I have no further recommendations to make on this issue.

XI. These comments were directed to Community Corrections.

## RECOMMENDATIONS OF CORONER TETITAHA

I. I had intended recommending this matter be referred to the Independent Police Conduct Authority (IPCA) for investigation. A draft of the recommendation was sent to the IPCA for comment.

II. The IPCA have advised they had already considered the matter, which I was unaware of from the information before me. The Police had notified the IPCA on 24 June 2021 whom referred the matter back to the Police to investigate. I was advised that a Police investigation identified inadequate service in managing the call, a breach in standard operating procedures and a failure to carry out duties. It further refers to appropriate employment outcomes with staff involved.

III. I subsequently sought a report from the Police on the outcome of their investigation. I also asked the Police to meet with the family to discuss the outcome of their investigation.

IV. Inquiries by my officers with the family have indicated there is no further action required. Given these responses, I have determined that no recommendations are required.

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

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[3] Inquiry into the death of Timothy Burns CSU-2018-AUK-000571.
[4] Community Corrections "An exploratory analysis into the mortality of offenders" https://www.corrections.govt.nz/resources/research/journal/volume_4_issue_2_december_2016/an_exploratory_analysis_into_the_mortality_of_offenders.

# McCracken [2022] NZCorC 70 (4 May 2022)

### CIRCUMSTANCES

Colin Lindsey McCracken, aged 51, died on 1 July 2021 at Little Bay near Waikawau in the Coromandel Peninsula of drowning.

Colin lived in Kaiaua. He worked as a fisherman and owned his own launch. On the evening of 1 July 2021 Colin was on a fishing trip with friends. The plan was to stay in the Peninsula for the night. Colin and his friends consumed several beers during the day. After dinner a dinghy attached to his fishing boat came adrift from the fishing boat, Colin decided to retrieve it. He took off his shirt and jumped into the water. He did not don a life jacket and the conditions were dark.

Colin's friend used a spotlight to assist with visibility as Colin swam toward the dinghy. However, shortly after Colin appeared to have gotten into difficulty and his friends could no longer hear him splashing in the water. Colin's friends lifted the anchor on his fishing boat to assist Colin. When they found Colin he was face down in the water and unresponsive. Despite Colin's friends administering CPR, he was unable to be revived.

### COMMENTS OF CORONER DUNN

I. I do not intend to make any specific recommendation in this inquiry. The general public are well aware of the many tragic cases of drowning that have occurred in New Zealand of recent times. Maritime NZ and Water Safety NZ both provide online advice about staying safe when boating including:

   a. Wear your life jacket.

   b. Take two waterproof ways to call for help.

   c. Check the marine forecast.

   d. Avoid alcohol.

II. There are obvious dangers of diving into seawater at night-time after consuming alcohol. This danger was aggravated by the lack of any lifejacket. Had Colin been wearing a lifejacket this tragic drowning may have been avoided.

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

# McIntyre [2022] NZCorC 89 (9 June 2022)

### CIRCUMSTANCES

Kristi Ann McIntyre, aged 41, died on 13 January 2020 at Oakura Beach, Taranaki of drowning.

Kristi and her husband were holidaying at a holiday park next to Oakura Beach where they set up a tent at a beach-front campsite. During the day of 13 January 2020 Kristi consumed approximately five vodka drinks at the campsite. At about 7:30pm she and her husband decided to go for a swim at Oakura Beach. On this particular evening, surfers at Oakura

Beach described the surf as “huge” with the waves around three metres in height. The swell was large and the water was noted to be “freezing”. Those who regularly go to Oakura Beach reported that there is often a strong rip that runs off the beach. As the conditions were unsafe for swimming that evening, Kristi and her husband got into difficulty while attempting to return to shore. At around 8:00pm a wave crashed over Kristi. Her husband then saw her floating face-down in the water and unresponsive. Despite extensive efforts by surfers and off-duty lifeguards, Kristi could not be revived.

### RECOMMENDATIONS ENDORSED BY CORONER DUNN

I. Water Safety New Zealand provides online advice about staying safe in the water, including:

**Be aware of the dangers**

- Check for safety signs, warning flags, currents and rips.
- Enter shallow and unknown water feet first.
- It may be easy getting into water, but can you get out?
- Your clothing in the water may drag you down.
- DO NOT enter the water after drinking alcohol or taking drugs.

**Know your limits**

- Challenge yourself within your physical limits and experience.
- Think about what you can and can’t do in the water.
- Being in the water will make you tired. Get out before you’ve reached your limit. Cold water will make it worse.
- Always know that the weather or water conditions are stronger than you.

II. I endorse the above advice and urge the public to only swim while sober, and to ensure water conditions are suitable for swimming before doing so.

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

## Miklus [2022] NZCorC 82 (24 May 2022)

### CIRCUMSTANCES

Denis Miklus, aged 67, died on 19 June 2018 at the Polynesian Spa, Hinemoa Street, Rotorua of drowning.

Mr Miklus was of Italian descent. He lived with his partner, Jany Toomaru, in Tahiti. In the 1990s he and his partner purchased a property in Hamurana, Rotorua and started holidaying in New Zealand, usually in the cooler months for around three months at a time. Mr Miklus was in good health and exercised regularly at the time of his death.

At approximately 11:43am on 19 June 2018 Mr Miklus attended the Polynesian Spa. There was no clear account of his movements while at the Spa complex. However, at around 1:00pm Mr Miklus was discovered alone, floating face down, in what is known as the 42° Priest Pool. Duty Manager, Kuljeet Kaur, was the first to observe him face down but assumed he was relaxing and did not want to interrupt him. Instead, she went to speak to a lifeguard and then came back to the Priest Pool to wait for Mr Miklus to surface. At this point she realised something was wrong and went back to the lifeguard for assistance.

The two of them removed Mr Miklus from the pool and commenced CPR. Emergency services also attended and continued resuscitation efforts. Unfortunately, Mr Miklus could not be revived and was pronounced deceased at the scene.

## RECOMMENDATIONS OF CORONER BATES

I. In the circumstances of this case I consider it necessary to make comments and recommendations pursuant to s 57(3) of the Coroners Act.

*Staffing and supervision*

II. There is no evidence that any member of Polynesian Spa staff observed or monitored Mr Miklus between 12:30pm and 1:00pm when he was in the 42° Priest Pool. An Adult Pools Lifeguard has the duty of providing constant supervision in the Adult Pools area. They also have a responsibility to remind bathers to adhere to the Bathe-Smart advice regarding regular breaks and hydration. There is simply no evidence that a Lifeguard was monitoring the Adult Pools area when Mr Miklus got into difficulty. Polynesian Spa were short-staffed on 19 June 2018, being one Lifeguard down, and were simply unable to provide their usual very high standard of supervision across all bathing areas at the Spa complex.

III. I recommend that Polynesian Spa give consideration to how, in the event of one or more rostered staff becoming unavailable, for whatever reason, they may ensure an appropriate level of bather supervision. This may involve closing or delaying the opening of certain areas of the Spa until replacement staff are on site. There should never be a ‘business as usual’ approach with a reduced number of staff available to supervise all areas and all bathers.

IV. The following question remains unanswered, why didn’t the person fulfilling the Duty Manager role the morning of 19 June 2018 address the staffing situation? Mrs Kaur, Duty Manager, started a 1:00pm shift and commenced her initial rounds of the Polynesian Spa complex. It appears she was unaware of the absence of a rostered Lifeguard, scheduled to be working from 8:00am to 3:30pm, and that there had been a period with no supervision in the Adult Pools area.

V. If Mrs Kaur been made aware there was an unsupervised period in the Adult Pools area she could have prioritised going there or sending another staff member there. She would have been able to consider whether any area of the Spa should be closed until appropriate cover was arranged. When she first

observed Mr Miklus face-down in the Priest Pool, human nature suggests she would have gone straight to him instead of first going to make an enquiry about it with another staff member.

VI. I recommend that Polynesian Spa review their duty handover process to ensure the Duty Manager coming on duty is immediately aware if there are, or there has been, a reduced number of staff.

*Polynesian Spa response*

VII. In response to a provisional copy of my Findings, Polynesian Spa maintain there was no short staffing on 19 June 2018 and in the event there had been, the Family Pool area would have been closed until suitable cover was in place, which is the Spa's standard practice.

*Immediate intervention when head or face submerged in thermal water*

VIII. At some pool complexes bathers receive advice against submerging their head or face in geothermal water due to a risk of amoebic meningitis. This particular risk is not present at the Polynesian Spa. The pathogenic protozoa that causes amoebic meningitis does not exist in all geothermal water. This hazard occurs wherever warm water is in contact with soil, or soil particles. All pools at Polynesian Spa are separated and isolated from soil contamination. Therefore, it is unnecessary to include a warning to bathers at the Polynesian Spa due to a risk of amoebic meningitis. However, that particular hazard is not the only reason bathers should be discouraged from submerging their head or face in higher temperature thermal pools.

IX. I acknowledge [Chief Executive] Mr Taljaard's evidence that bathers often wish to enjoy the pools while being left alone and not policed or interrupted. It can be a balancing act for staff. It should not be. The risk of annoying or interrupting a bather who may be relaxing or performing some type of exercise in higher temperature thermal pools is far outweighed by the need to ensure their safety at all times.

X. Therefore, I recommend implementation of a policy that all bathers are advised at point of contact with staff and through signage/safe bathing information, not to submerge their head or face in the higher temperature Pries Pools, due to the increased risk of heat exhaustion, dehydration and fainting.

XI. Additionally, I recommend implementation of a policy for immediate staff intervention when bathers are seen with their head or face submerged in higher temperature thermal pools. In the present case these are pools maintained at a temperature of 39° or higher. Whether or not a pool carries a risk of amoebic meningitis, high temperature pools fall into a special risk category, due to the increased possibility of heat exhaustion, dehydration and fainting. Staff must be proactive and should assume the person may be in difficulty or danger. Policy and training should require staff to intervene immediately; despite possible interruption of enjoyment if the bather is not in fact in difficulty.

*Monitoring bathers in the higher temperature pools*

XII. The New Zealand Aquatic Facility Guidelines for swimming pool supervision applies to thermal pools in general. However, it is recognised that, due to their make-up and character, some facilities may not be able to be fully compliant. Therefore, each Facility Manager, after taking into consideration all aspects of risk management, must decide on supervision levels having regard to the guidelines. Because all facilities are designed differently, there is no specific Lifeguard to customer ratio required.

XIII. The Lifeguard job description confirms the position objective includes monitoring and control and use of aquatic facilities and activities. Constant monitoring of the Adult Pools is essential and expected by way of constant roving patrols. However, as already noted, from some parts of the Adult Pools area at Polynesian Spa there is no clear line of sight to the Priest Pools and, as illustrated on 19 June 2018, a Lifeguard may at times be required to attend to other matters, such as customers using the Private Pools.

XIV. The Polynesian Spa Emergency Action Plan confirms that Adult Pools and Priest Pools are to be monitored by a Pool Attendant. There is no expectation that a Pool Attendant will always be monitoring the Priest pools or the Adult Pools generally. The Pool Attendant job description advises that, in addition to monitoring the pools and aquatic activities of customers, Pool Attendants are responsible for ensuring cleanliness, the setting up and safety of all areas and facilities and attending to customers and ensuring the facility is kept to a high level of cleanliness. It cannot be said that a Pool Attendant will be involved in monitoring bathers at all times. That is not their function.

XV. An examination of photographs of the Polynesian Spa landscape leads me to believe that a Lifeguard patrolling near the Main Adult Pool does not have an unobstructed line of sight to the Priest Pools at all times. Interruptions to line of sight include distance, changes in elevation, bushes, trees, large rocks, the columns and roofing of permanently installed shelters and, at times, steam rising from pools.

XVI. I recommend that, because of the increased risk of heat exhaustion, dehydration and fainting while using the Priest Pools, and because of obstructions to the line of sight between parts of the Main Adult Pool area and the Priest Pools, Polynesian Spa consider permanent placement of a Lifeguard or Pool Attendant with an unobstructed view of the Priest Pools. I accept this would require additional resourcing, would have financial implications and may not be practicable. However, a dedicated Lifeguard or Pool Attendant would ensure constant monitoring and opportunity, when appropriate, for bathers to be provided with safe bathing advice, encouraged to exit the pools for breaks and to hydrate, and not to submerge their heads or faces.

XVII. If a staff member is not permanently placed to observe the Priest Pools, I recommend that, as far as practicable, Polynesian Spa remove obstructions to the line of sight between the Main Adult Pool and Priest Pools. As already noted, those obstructions may include shrubbery, trees, large rocks, and the columns and roofs of permanent shelter structures.

*Polynesian Spa response*

XVIII. In response to a provisional copy of my Findings, Polynesian Spa advise that controlling the time bathers spend in pools is not physically possible, as customers actively move between the eight pools in the Adult Pools area. Keeping track of all of them is impossible. However, the safety message regarding regular breaks and drink water to hydrate and cool is conveyed to each customer at reception (as well as via signage). Polynesian Spa also point out that the Priest Pools are checked regularly as part of the roving patrols of the Adult Pools area and are visible from a number of points near the main adult pool.

*CCTV*

XIX. CCTV cameras are present at Polynesian Spa and their footage can be monitored. However, I understand it is not monitored constantly, and no person is assigned that role.

XX. Mr Taljaard confirmed the introduction of CCTV cameras was primarily to monitor the performance of team members going about their work duties, including Lifeguards. CCTV at Polynesian Spa is used as an aid to identify areas for further training and improvement, as opposed to watching for bathers who may be getting into difficulty, although instances of this could be observed.

XXI. In my view, increased monitoring of CCTV footage, in real time, lends itself to increased detection and prevention of health and safety incidents involving bathers.

XXII. I recommend that, if no staff member is permanently positioned to monitor bathers in the Priest Pools, Polynesian Spa install CCTV cameras to monitor them. Maybe this has been done already, as I understand further cameras were installed following Mr Miklus's death, although I'm unsure of their locations.

XXIII. I recommend that Polynesian Spa consider more frequent, if not constant, monitoring of CCTV footage in real time, to look for any bathers who may be getting into difficulty, or who may need reminders regarding safe bathing practices.

*Polynesian Spa response*

XXIV. In response to a provisional copy of my Findings, Polynesian Spa advise that the Lifeguard job description requires Lifeguards to continually move around the pathways so that they are not obstructed and can be proactive in checking on patrons.

*"Bathe-Smart" safety information*

XXV. Mrs Kaur gave evidence that when customers arrive at reception to purchase a ticket, they are given advice about the safe bathing message. The advice includes the need to drink water and take regular breaks by exiting the pools. The main message was to ensure they understood that dehydration could occur.

XXVI. Mrs Toomaru and Mr Miklus had attended the Polynesian Spa on a number of occasions. Mrs Toomaru does not recall ever being given those messages at reception. There may be some inconsistency in terms of safe bathing advice being delivered to customers at reception.

XXVII. I recommend that Polynesian Spa consider refresher training for reception staff, who are the first point of contact for bathers as they enter the complex, to ensure the safe bathing message is always delivered.

XXVIII. I recommend the safe bathing message at reception always includes a specific warning about the high temperature of the Priest Pools and a recommendation that bathers do not submerge their head or face in those pools. They should be advised that, if they do, they may be approached and spoken with by staff.

XXIX. At present the Bathe-Smart safety brochure provided by Polynesian Spa does not contain information about whether or not bathers should submerge their head or face in pools. I recommend that safety brochures, signage and other information available to bathers include advice against submerging one's head or face in higher temperature thermal pools. It should be explained that these pools carry an increased risk of heat exhaustion, dehydration and fainting, and that bathers observed to be submerging their head or face in the water may be approached and spoken with by staff.

XXX. Providing advice against submerging one's head or face in the Priest Pools is likely to reduce instances of this behaviour, thereby slowing the onset of heat exhaustion or dehydration. Crucially however, it would also provide a mandate to staff to immediately intervene with bathers engaging in the practice, without the need to pause and balance possible intrusion into their relaxation and privacy against the need to ensure safety and wellbeing. It would eliminate guesswork and delay and provide a consistency.

XXXI. Mrs Toomaru raised the possibility of including Bathe-Smart safety information on tickets and/or receipts issued to bathers at reception. I am unsure whether a ticketing system is still used. If it is, and if it is practicable, Polynesian Spa should consider this suggestion.

XXXII. Mrs Toomaru raised the possibility of placing signage with the Bathe-Smart message at eye level near payment stations at reception, so they catch the eye of bathers. The more the safe bathing message is repeated and the more visible it is to bathers, the greater the chance of it becoming ingrained and followed. I recommend that Polynesian Spa consider this suggestion.

XXXIII. Polynesian Spa is attended by a large number of tourists. English may not be their first language. Although perhaps not a factor in the present case, I recommend that signage and other material conveying safe bathing messages does so multilingually.

*Polynesian Spa response*

XXXIV. In response to a provisional copy of my Findings, Polynesian Spa advise the safety message regarding taking breaks and drinking water to hydrate and cool off is conveyed to each customer at reception. Mr Taljaard states that, when he is at work, he personally hears these messages given by reception staff.

*Competency qualifications*

XXXV. I recommend that Polynesian Spa review their process for ensuring the currency of qualifications required for each job position.

XXXVI. Ms Pablo's first aid certificate had expired. Although this did not factor into Mr Miklus's death, as a Pool Attendant Ms Pablo was required to hold a current first aid certificate. Ms Wilson was awaiting renewal of her PLPC, which is confirmation of competency to fulfil the Lifeguard role. Despite this, I accept Ms Wilson was an experienced Lifeguard able to fulfil this role.

*Response from Polynesian Spa*

XXXVII. In response to a provisional copy of my Findings, Polynesian Spa confirms that Ms Wilson was an experienced Lifeguard, previously certified and awaiting renewal. Lifeguard duties at Polynesian Spa do not require a Lifeguard to hold a current PLPC but they do require first aid certification, which Ms Wilson had. At Polynesian Spa PLPC certification is preferred, and Polynesian Spa have a policy of Lifeguards either being qualified, or in the process of becoming qualified.

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

# Pedersen [2022] NZCorC 74 (6 May 2022)

## CIRCUMSTANCES

Stuart John Pedersen, aged 58, died on 14 October 2019 at sea near the Bay of Islands from drowning.

Mr Pedersen was an experienced sailor who had a Yachtmaster qualification. On 8 October 2019, Mr Pedersen began sailing his 47-foot Bavarian Ocean Yacht back to Tauranga from Fiji. On the boat was his wife and two friends, who were also experienced sailors.

Mr Pedersen undertook extensive research into the weather for their trip, and the first six days were fine. However, reports predicted bad weather during the night of 13 October 2019 and the group prepared the boat for heavy weather protocols and changed their planned route. When the group undertook heavy weather preparation, storm shutters were not placed over the windows.

As they neared the entrance to the Bay of Islands on the morning of 14 October 2019, the boat experienced two knockdowns.[5] At around midday the boat experienced a third knockdown, during the which a wave broke the windows of the boat. As the boat began to fill with water, Mrs Pedersen used the radio to make a mayday call, alerting the coastguard that the group was abandoning the boat and that they had lost their life raft.

The group was in the water for approximately two hours before they were rescued by helicopter. Mr Pedersen was confirmed deceased.

Maritime New Zealand completed a report in relation to the accident, which noted that larger windows, as are commonly found on modern sailing vessels, can make the area around the windows more susceptible to failure. Under s 21 of the Maritime Transport Act 1994 pleasure vessels departing New Zealand are required to undergo a Category 1 inspection. The boat was inspected on 18 April 2019 for the purpose of a voyage to Tonga. It should be noted that inspections are only valid for one voyage from New Zealand and do not cover subsequent or return voyages.

During Category 1 inspections, inspectors refer to a Yacht Inspector's Manual, which incorporates the Safety Regulations of Sailing 2017-2020 (the Regulations) published by Yachting New Zealand. Under the Regulations, the boat was required to have storm coverings for all windows more than 1852cm2 in area, however these were not required to be fitted prior to departure. The boat's cabin windows were approximately double this size. Plywood storm covers were on board the boat, but to be effective they would need to have been bolted through the cabin. Mrs Pedersen advised that a drill was on board to secure the storm coverings.

Maritime New Zealand considered that, on the basis that appropriate storm coverings were on board the boat, the boat's windows were compliant with the Regulations, regardless of their size.

Maritime New Zealand noted that storm coverings should be secured prior to encountering heavy conditions, as the deck area of a yacht is a dangerous environment during heavy weather. To fit the plywood covers, significant damage would have been caused to the boat by drilling holes in the cabin top to pass bolts through. This would have considerably reduced the likelihood of the boat's crew fitting the covering in preparation for heavy weather.

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[5] A knockdown occurs when a vessel drops sideways from the top of a wave to the bottom of the trough, landing on its side.

Maritime New Zealand also noted that while the forecast was for gale force conditions, the boat encountered storm to violent storm conditions. Forecasts are issued with disclaimers that accuracy is not guaranteed, and a prudent mariner should always take this into consideration. However, there was nothing in the forecast on departure from Fiji, or during the voyage, indicating that the group could reasonably expect to encounter storm force conditions off the Northland coast.

A life raft was hired in Tauranga prior to departure for Fiji. Mr Pedersen constructed a new fibreglass cradle that was secured to the deck. It is likely that the life raft was washed from the deck by a wave action, or, alternatively, by the hydrostatic release unit being activated due to pressure generated during the final knockdown. In both scenarios, the life raft would have been inflated out of its container and broken free of the boat. This highlights the vulnerability of safety equipment stowed on an exposed deck during heavy seas.

Yachting New Zealand reported that there have been amendments to the Yachting New Zealand Safety Regulations 2021-2024, which now require storm coverings to be in place before a Category 1 certificate will be issued. As well, the revised manual used by Category 1 inspectors provides enhanced guidance on raft storage, drogues and sea anchors. The manual will be reviewed every four years to ensure consistency with Yachting New Zealand practice and the Regulations, and to reflect current industry best practice.

## COMMENTS OF CORONER BELL

I. From my review of the evidence, the boat sank after its windows shattered during a knockdown. This resulted in Mr Pedersen and his crew abandoning the boat and, tragically, Mr Pedersen's death. I accept that the boat's large windows may have been more susceptible to breaking and should have been covered in heavy weather. However, I imply no criticism of Mr Pedersen or his crew, who I accept were not alerted to the severity of the conditions until it was too late.

II. I am satisfied that this issue has been addressed by the amendment to the Regulations, which requires boats to have storm coverings fitted to windows with an area greater than 1852cm2 before they are granted a Category 1 certificate.

III. I am satisfied that regardless of whether the life raft was washed from the deck by a wave action, or, alternatively, by the hydrostatic release unit being activated due to pressure generated during the final knockdown, in either scenario, the life raft would have been inflated out of its container and broken free of the boat.

IV. In light of this, I make no recommendations.

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

# Suttie [2022] NZCorC 73 (5 May 2022)

## CIRCUMSTANCES

Martin Peter Suttie, aged 37, died on 12 July 2020 at the Buckler Burn mouth, Glenorchy, as a result of drowning. His death was an accident.

Mr Suttie was considered to be a careful and experienced angler, although not a strong swimmer. On 12 July 2020, while staying at a family holiday home in Glenorchy, Mr Suttie decided to go fishing at Lake Whakatipu with his partner's father, Robin Clifford.

Mr Suttie and Mr Clifford arrived at the Buckler Burn mouth at about 2:30pm. Mr Suttie set himself up in the centre of the gravel delta where the river enters the lake, while Mr Clifford was about 100 metres away from him at the north end of the delta. Mr Suttie was wearing his full fly-fishing kit, including waders.

After about 15 minutes, Mr Clifford looked up and could no longer see Mr Suttie. He then heard a shout over the noise of the river. He walked over to where Mr Suttie had been standing but could see no sign of him. Thinking that Mr Suttie must have crossed the river to the south and gone up a creek, Mr Clifford attempted to cross the river himself, but had to pull himself back up after sinking into soft sand and almost losing his footing.

Worried that Mr Suttie had been swept into the lake, Mr Clifford contacted emergency services. Searches by helicopter, LandSAR teams and the Coastguard that afternoon were unable to locate Mr Suttie. His body was recovered from the lake floor by the Police dive squad on 16 July 2020.

Constable Julian Cahill noted that the delta area at the mouth of the river is made up of gravel and sand which falls off very steeply into the lake. There is no signage advising of the conditions. Rainfall statistics for the area on the afternoon of 12 July 2020 showed that the Buckler Burn river was at about three times its normal flow.

There was no evidence that Mr Suttie had been behaving carelessly or recklessly on the day of his death. The Coroner concluded that he had misjudged the risk involved in attempting to cross the Buckler Burn and lost his footing. His fly-fishing kit and lack of swimming ability would have increased the peril he was in. The Coroner considered it likely that events unfolded so quickly that Mr Clifford would have been unable to reach Mr Suttie, even if he had seen Mr Suttie stumble.

## RECOMMENDATIONS OF CORONER CUNNINGHAME

I. As Constable Cahill pointed out, the Buckler Burn mouth area has no signs warning the public of the soft gravel or the steep bank.

II. The Queenstown Lakes District Council (QLDC) manages safety in the waterways in the area through its Harbourmaster. I wrote to the QLDC asking about the implications of installing signage in the area to warn the public of the risk.

III. The Monitoring, Enforcement and Environmental Team Leader, QLDC, advised that in considering the issue, concerns were raised that there are multiple areas around the Glenorchy Rivers and wider district that have similar concerns relating to the lakebed, and that if signage was to be installed in the Buckler Burn area, members of the public might conclude that the safety concerns are localised to that one area and that

unsigned areas do not have the same risk. Signposting all areas is not considered to be a practical option by the QLDC.

IV. The QLDC further advised that it may be more appropriate to include warnings about the specific dangers in the Council's waterways education communications and social media posts.

V. I agree that the size of Lake Whakatipu and the number of rivers that flow into it creating deltas means that it would not be practical to place signs in every area where there is a risk of soft gravel and steep banks. Some people may interpret the absence of signs elsewhere as an absence of risk, as predicted by the QLDC.

VI. Because the QLDC has the ability to educate the public about safely using the lake through its communication channels, I am satisfied that the risks involved in fishing or walking in river mouths in the region's lakes can be brought to the attention of the public so that as to prevent further deaths occurring in similar circumstances.

VII. Accordingly, I recommend that the QLDC updates any safety information regarding Lake Whakatipu, and in particular, the Glenorchy area, to warn users about the presence of soft sand and gravel, and steep drop offs into the lake, around river deltas. Anglers should be advised to use great care in these deltas, particularly after heavy rain. The QLDC should use its communication channels to disseminate this safety information.

VIII. I acknowledge the responsiveness of the QLDC, and its thoughtful feedback on the proposed recommendation.

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

## Taylor [2022] NZCorC 69 (2 May 2022)

### CIRCUMSTANCES

Sergeant Wayne Richard Taylor, aged 42, died on 13 October 2017 at Port Jackson of salt water drowning, associated with injuries sustained in a fall from a height.

On the morning of his death, Mr Taylor was one of several New Zealand Defence Force ("NZDF") soldiers taking part in a marine exercise in the Hauraki Gulf. The exercise included boarding a container ship from a rigid hull inflatable boat whilst the container ship was underway.

At approximately 6:00am, Mr Taylor was in the inflatable boat that was positioned alongside the moving container ship. Soldiers in the inflatable boat attached a portable ladder to a railing on the ship. While climbing the ladder, Mr Taylor fell. He struck the rear of the inflatable boat, before falling into the sea.

Colleagues quickly located Mr Taylor, floating face down and unresponsive in the water. They pulled him into the boat, where CPR and other medical aid were administered by a NZDF medic who transferred aboard from the nearby Safety

Boat. The inflatable boat then headed to a beach at Port Jackson to meet the Westpac Rescue helicopter. Resuscitation attempts at this time did not include defibrillation, because there was no portable defibrillator on board the Safety Boat.

The Coroner found that the maritime exercise was carefully planned and briefed. There was no evidence to suggest that there was a failure of equipment. All personnel involved were also appropriately trained. Mr Taylor was repeatedly described by colleagues as a diligent, highly competent soldier, particularly in the maritime environment. Colleagues also described him as the maintainer of safety standards with the unit.

The Police Northern Special Tactics Group inspected the ladder used during the exercise and found no fault. Furthermore, the portable ladders, their hooks, and the carabiner connecting the two had been serviced yearly by a civilian company and had current certification. In addition, the ladder was not overloaded.

It was noted that the rail bent and dropped approximately 30 centimetres as Mr Taylor climbed on to it. However, there was no evidence that Mr Taylor was thrown off balance when this occurred. In addition, the distance was unlikely to have been significant, occurring at a time when the inflatable boat and the container ship were both moving up and down in the sea swell. The soldiers who had climbed it before Mr Taylor described it twisting underneath them in a similar manner. The only difference was that when the ladder twisted as Mr Taylor climbed it, it trapped one of his feet.

The evidence suggested that Mr Taylor fell from the ladder because he found himself suddenly unable to hold on, rather than him letting go in a planned way. When Mr Taylor fell he struck his head, most likely on the rear of the inflatable boat. The Coroner found that it was highly likely Mr Taylor was unconscious when he fell into the sea and was, therefore, unable to avoid drowning.

## RECOMMENDATIONS OF CORONER KAY

I. Having given due consideration to all of the circumstances of this death, and pursuant to section 57A of the Act, for the purposes set out in section 4, I make the following recommendations:

   a. the NZDF medic on the Safety Boat comments that he had not taken a defibrillator with him on the exercise, as it was not normal to take one out “on the water.” I cannot say whether the outcome would have been different for Mr Taylor, had an AED been available, but such devices can be used in wet environments, and can greatly increase the likelihood of survival in a cardiac arrest situation. I recommend that the NZDF ensures that, where operational circumstances do not prevent it, an AED is part of the medical kits carried in maritime operations and exercises; and

   b. Mr Taylor was wearing a lifejacket that required him to manually inflate it, but he was unable to do so. I recognise that the safety of defence personnel who work in a maritime environment could be compromised by a lifejacket inflating when merely splashed with water. However, there are life jackets available that are designed to inflate when fully immersed in water and subject to water pressure, rather than when merely splashed by water – I recommend that the NZDF reviews the type of lifejacket used by its personnel, with a view to identifying a lifejacket that would satisfy NZDF operational requirements, and could self-inflate to assist an unconscious wearer.

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

# Upmanyu [2022] NZCorC 79 (13 May 2022)

## CIRCUMSTANCES

Upmanyu, also known as Upmanyu Sharma, aged 23, died on 20 January 2019 at Hunua Falls, Hunua Ranges Regional Park, Falls Road, Hunua, Auckland, as a result of accidental drowning.

On 18 January 2019, Upmanyu and two of his friends, drove from Wellington to Auckland for the weekend. At about 2:00pm on 20 January 2019, the group drove to Hunua Falls Lagoon at Hunua Ranges Regional Park. During the drive, Upmanyu consumed two small shots of whiskey.

After arriving at the Hunua Falls Lagoon, some of the group, including Upmanyu, decided to swim. Upmanyu had limited swimming skills. Nevertheless, he entered the waters of the lagoon and socialised with his friends. At one point, Upmanyu made his way to a rock ledge where he stood talking with a friend who took photographs of him with the waterfall in the background. Shortly afterwards, there was a break in their conversation and Upmanyu became submerged in the water. This was not witnessed and it was not clear if he stepped off the rock ledge into deeper water or slipped on the rock ledge and fell into the water.

Upmanyu did not resurface and his friends alerted other swimmers who tried to look for him; a buoyancy aid was also thrown into the water by a member of the public. Emergency services were called and, on their arrival, confirmed that Upmanyu had been submerged for approximately 20 minutes. Due to the time delay, depth of water, and risk of undercurrent from the waterfall, it was decided no Police staff would enter the water. A recovery operation commenced and Upmanyu's body was found on 21 January 2019 at a depth of 9.2 metres and approximately 10 metres from the rock ledge where he was last seen.

Auckland Council has responsibility for water safety in the Hunua Ranges and has since 2016 taken a number of steps to reduce the risk of drownings at the location.[6] Auckland Council made significant improvements and additions to the water safety signage in April 2017. A public awareness campaign, which included Hunua Falls, was also run in the summer of 2017 by Water Safety New Zealand, Surf Life Saving Northern Region, and Drowning Prevention Auckland. Since 2018 further safety work in relation to Hunua Falls has been undertaken. In particular:

*Information on Websites:*

- Hunua Falls was added to the searchable Safeswim website www.safeswim.org,nz prior to the 2020/2021 summer period. The Hunua Falls venue pin provides clear and detailed information about the water safety risks and hazards at the site.[7] The Hunua Falls page provides a warning that swimming is not advised and includes the following statement:

  > *"Swimming is not advised as there have been a number of fatal drowning incidents in the past. The pool is very deep and there are steep drop offs, so take care if you get your feet wet. The water is also cold and less buoyant, and you can get into difficulty more easily than you expect. Instead of swimming, take a picnic and relax by the water, or explore the Hunua Falls Loop Walk.. "*

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[6] A number of steps taken have been in collaboration with other agencies.
[7] The safety alerts and site hazards tabs on the Hunua Falls page of the Safeswim website provide detailed information about the dangers of swimming at Hunua Falls.

- Auckland Council's website also provides consistent messaging that swimming at the Falls is not recommended due to the safety risks at the site.

*Water Safety Project*

- Auckland Council, Drowning Prevention NZ ("DPNZ"), YMCA North and Water Safety NZ ("WSNZ") collaborated to develop and deliver a water safety project at Hunua Falls. During the 2019/2020 summer a 7-week pilot project was run at Hunua Falls to educate visitors on the dangers of swimming at this location by highlighting the specific hazards at the site and discouraging swimming. The project was delivered through the use of trained water safety ambassadors, on site during the peak summer period. The ambassador training included water rescues along with risk assessment and management skills specific to Hunua Falls. The role of the ambassadors included educating visitors on the dangers of swimming at the falls and gathering data about the public visiting the falls.

- A Hunua Falls Safety Report dated August 2021 was produced about this project and contained a number of recommendations. In response to the recommendations the following actions were taken:

    - Two water safety ambassadors were present at the falls for the period 20 December 2021 to 7 February 2022 from 11am to 6pm;

    - Auckland Council has commenced work with Safeswim to educate visitors of the dangers at the falls prior to and during their visit. This work is part of a wider project to promote and embed the Safeswim website as a ‘go to’ tool for information on water safety across the Auckland region;

    - Auckland Council has a noticeboard upgrade for its regional parks underway which includes consideration of QR codes on the boards linking to further information;

    - Education on the use of public rescue equipment is being incorporated into other water safety awareness initiatives such as the annual West Coast Rock Fishing Campaign;

    - Data gathered by the ambassadors is currently being collated with the report due in April or May this year;

    - Closer liaison with the Hunua Park rangers has occurred;

    - Other recommendations in the report (such as an electronic Safeswim sign at the falls) will be considered once the results of study undertaken by the ambassadors over last summer at re known.

*Other Actions*

- Auckland Council has engaged with the operators of Kokako Lodge which is an 80-bed outdoor education camp located near Hunua Falls. Council has provided education on freshwater safety and the specific hazards at the falls.

- In conjunction with WSNZ and DPNZ, Auckland Council is trialling the use of two smaller and lighter life rings at the falls which are expected to be easier for inexperienced users to throw and handle than the larger models.

## COMMENTS OF CORONER GREIG

I. Because of the safety work that has been undertaken and continues to be undertaken by Auckland Council (including in collaboration with Drowning Prevention NZ), YMCA North and Water Safety NZ) I do not consider it necessary to make recommendations on this matter.

II. Upmanyu had drunk some alcohol before going swimming. There is no suggestion from the evidence that he was intoxicated, but the evidence is that drinking alcohol before swimming increases a person's risk of drowning. The Water Safety Code for New Zealand includes the following advice: DO NOT enter the water after drinking alcohol or taking drugs.[8] I reiterate that advice.

III. I also reiterate the advice of Auckland Council that swimming at Hunua Falls is not recommended because of the many safety risks at the site.

Note: An order under section 74 of the Coroners Act 2006 prohibits making public any photographs of Upmanyu's body entered into evidence by the New Zealand Police, in the interests of personal privacy and decency.

# Drugs and Alcohol

## Asiata [2022] NZCorC 62 (14 April 2022)

### CIRCUMSTANCES

Peti Amani Asiata, aged 25, died on 12 October 2020 at Naenae, Lower Hutt. The cause of death was acute mixed drug intoxication (alcohol, THC and synthetic cannabinoid MDMB-4en-PINACA) and was the unintended consequence of recreational drug use.

On 12 October 2020, Peti was at a friend's house socialising. He had consumed alcohol, cannabis, and synthetic cannabis. At some point during the evening, Peti collapsed, which his friends attributed to his use of synthetic cannabis. When they later tried to awaken him, they found that he was unresponsive and called emergency services. However, despite efforts to resuscitate Peti, he passed away.

### COMMENTS OF CORONER RYAN

I. The evidence demonstrates that Peti collapsed after using synthetic cannabis and it was assumed that he was sleeping off the effects. Given the lack of consistency between the witness statements, I cannot discount the possibility that Peti's death could have been avoided had assistance been provided sooner. But there is also no evidence before me to suggest that earlier medical intervention may have prevented his death.

II. The New Zealand Drug Foundation states that it is unsafe to use synthetic cannabinoids, but users should treat the drug with extreme caution to avoid injury or death.[9] If an individual falls unconscious after using

[8] https://watersafety.org.nz/know%20before%20you%20go%20-%20the%20basic%20water%20safety%20code.
[9] https://www.drugfoundation.org.nz/info/drug-index/synthetic-cannabinoids/.

synthetic cannabis, they could die. People are often very "out of it" or unresponsive after using synthetic cannabinoids. They may collapse or “drop”, foam at the mouth or experience temporary paralysis. People providing assistance should place them in a stable side position if possible and continuously monitor their breathing.

III. The New Zealand Drug Foundation provides the following advice in the event that a person becomes unresponsive following the use of synthetic cannabis:[10]

a. Ask loudly if they are ok. Shake them gently.

b. If they are not responsive, dial 111 and request an ambulance.

c. Check they are breathing and place them in a stable side position.

d. If they are not breathing, start chest compressions.

IV. I endorse the New Zealand Drug Foundation’s advice. However, I do not consider there are any recommendations that could be made in this case for the purpose of reducing the chances of further deaths occurring in similar circumstances.

# Jones [2022] NZCorC 60 (11 April 2022)

### CIRCUMSTANCES

Calum Paterson Jones, aged 22, died on 1 September 2017 at Henderson as a result of synthetic cannabis toxicity.

Mr Jones had a history of drug use from the age of 13 years. He used cannabis from this time and started smoking synthetic cannabis around the age of 18. He developed an addiction to synthetic cannabis and struggled to combat it. Approximately 10 weeks prior to his passing, Mr Jones was motivated to stop using synthetic cannabis and was receiving treatment for this until the time of his passing.

At approximately 12:10pm on 1 September 2017, Mr Jones was found unresponsive in bed by his grandmother. Emergency services attended and confirmed that he had died.

Toxicology analysis confirmed the presence of the synthetic cannabinoid AMB-FUBINACA (and its metabolite, AMB-FUBINACA acid) in Mr Jones’ urine. The post-mortem examination found that Mr Jones’ heart was enlarged, and his lungs were congested and oedematous, in keeping with a drug-related death. No injuries were found. Dr Tse noted that Mr Jones’ obesity and enlarged heart may have contributed to his death.

### COMMENTS AND RECOMMENDATIONS OF CORONER BELL

I. Mr Jones was aware that consuming synthetic cannabis products could endanger his life. At the time of his death, he was participating in a rehabilitation programme to address his addiction. However, despite the

[10] https://www.drugfoundation.org.nz/news-media-and-events/how-to-help-someone-after-they-use-synthetic-cannabinoids/.

efforts of those caring for him, Mr Jones continued to use synthetic cannabis products. Unfortunately, his continued consumption of synthetic cannabis has resulted in his death.

II. The dangers of consuming synthetic drugs include:

a. It is promoted or sold as a form of synthetic cannabis, but there is no cannabis in the product.

b. The synthetic drug can be made to look like cannabis by using dried plant or other material, but it is saturated in a synthetic drug not THC (tetrahydrocannabinol) the active ingredient in cannabis.

c. The pharmaceutical agents from which synthetic cannabis was developed were attempts to create new medications to treat spasms and epilepsy but were found to be unsuitable and were discarded. The nature of the synthetic drug is unknown to the purchaser and unknown or poorly understood by the manufactures/distributors in New Zealand.

d. The synthetic drugs, AMB-FUBINACA and 5F-ADB, have been the cause or contributing factor in a number of deaths in New Zealand, and overseas.

e. The quantity and strength of AMB-FUBINACA and 5F-ADB is an unknown gamble which can have fatal consequences.

f. Individuals who fall unconscious after consumption of synthetic drugs can die if they do not receive timely and appropriate medical assistance; dying from cardiac event induced by consumption of the drug, or as a result of being comatose and asphyxiating on their own vomit, or they may suffer an hypoxic brain injury.

III. Due to the circumstances and cause of this death I repeat and adopt the recommendations made by Coroner Matenga in reliance on the expert evidence of Dr Quigley in the coronial inquiry into the death of McAllister, CSU-2017-HAM-000336:

*a. In order to prevent future deaths from synthetic cannabinoids, Dr Quigley suggested that an all-encompassing harm reduction approach which reduces demand, supply and easy access to treatment for those seeking assistance should be developed. He cautioned that any recommendations on increasing enforcement, targets manufacture, trafficking and supply, while not overly penalising users as this can create a barrier to those seeking medical attention, even in cases of emergency.*

*b. I agree with Dr Quigley, however I am unable to make any recommendations in this regard, as I have not heard any evidence. I am aware however, that Coroner McDowell is conducting a joint inquiry into deaths from synthetic cannabis which occurred in Auckland. I will refer this suggestion to Coroner McDowell to consider in the course of her joint inquiry. No recommendations will be made by me.*

*c. Dr Quigley submitted that efforts should be made to inform users of synthetic cannabis , their families and associates, of the dangers of synthetic cannabinoids and the need to get help immediately if someone collapses. I agree.*

IV. Dr Quigley's advice for the families or associates of synthetic cannabis users was that if a person who has used synthetic cannabis collapses, that person should be immediately shaken to attempt to rouse that

person. If the person rouses, that person should then be placed in the recovery position and a call for help should be made. If the person does not rouse, then call for help and commence chest compressions. The call taker who answers the emergency call for help will provide assistance. Do not delay.

V. Dr Quigley is a vocational specialist in Emergency Medicine, he has completed additional studies in clinical toxicology and conducted research in forensic toxicology. He is a recognised expert in emergency management and treatment of drug and alcohol presentations.

VI. I endorse Dr Quigley's advice.

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

# Fall

## Rowse [2022] NZCorC 83 (25 May 2022)

### CIRCUMSTANCES

Warren Noel Rowse, aged 70, died on 24 July 2020 at Wellington Hospital of traumatic brain injury which he sustained when he fell from a ladder on 12 July 2020.

On the afternoon of 12 July 2020, Mr Rowse was at home painting the walls inside of his garage. Sometime between 3:00pm and 3:30pm, Mr Rowse's wife, Jennifer Rowse, went out to the garage to ask if he would like a cup of tea. At the time, Mr Rowse was standing on the ground of the garage, finishing up. Mr Rowse told his wife that he would come inside soon.

Whilst inside the house, Mrs Rowse heard a loud crashing sound coming from the garage. She went inside to investigate and found Mr Rowse lying on the concrete ground of the garage with an unfolded ladder beside him. Mr Rowse had a cut on the right side of his head and blood was coming from his right ear and nostrils. Emergency services attended and Mr Rowse was taken to Nelson Hospital, where a computerised tomography scan showed extensive brain injuries. He received further treatment and was transferred to the Intensive Care Unit at Wellington Hospital. Unfortunately, Mr Rowse passed away on 24 July 2020.

Police concluded that Mr Rowse was attempting to finish a small section of the wall that remained unpainted. To reach this area, Mr Rowse climbed to at least the fourth rung from the top of the ladder which was approximately 2.02 metres above the concrete floor of the garage, the diagonal length of the ladder to the fourth rung was 2.15 metres. From that position, Mr Rowse either positioned the paint tin on the truss on which the ladder was resting or held the tin and then reached up with his left hand to finish the painting job. When Mr Rowse reached to his left to paint the unfinished area, the ladder slipped due to it not being supported and not having rubber feet which would assist in providing grip on the smooth concrete floor of the garage. As the ladder slid from beneath him, Mr Rowse fell to the concrete floor and sustained a head injury.

The Coroner found that Mr Rowse failed to follow at least three safe practices recommended by the Accident Compensation Corporation ("ACC") in its publication "Ladder Safety".[11] First, he failed to secure the ladder by using sandbags at the base of the ladder, having someone hold the ladder, or securing the ladder to the truss. Second, the ladder did not extend one metre above the landing place on the truss. Third, the ladder did not have slip-resistant feet.

### COMMENTS OF CORONER WRIGLEY

I. Given the role I have found safety failings played in Mr Rowse's death, by way of comment made pursuant to s57A of the Act, I reiterate the following advice ACC provides in relation to the safe use of ladders:

   a. If a ladder is broken or has loose or missing parts don't use it – it's really not worth the risk.

   b. Use a ladder with slip-resistant feet and ask someone to hold it steady. If that's not possible, then steady the ladder feet with sandbags or nail a solid piece of wood into the ground so that the ladder feet rest against this for support.

   c. Ensure the ladder extends one metre above the landing place (eg, roof line).

   d. If possible, tie a straight ladder to something stable as close to where it rests on the wall as possible to prevent movement.

II. I reiterate ACC's advice because, if drawn to public attention together with the circumstances of Mr Rowse's death, it may increase the likelihood that those who use ladders will do so safely and thereby reduce the chances of further deaths like his.

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

# Leisure Activities

## Mandik [2022] NZCorC 96 (29 June 2022)

### CIRCUMSTANCES

Petr Mandik, aged 50, died on 14 December 2019 at Aoraki/Mount Cook National Park as a result of injuries to his head, chest and neck which he sustained in a rockfall.

Mr Mandik lived in Switzerland and came to New Zealand to climb Aoraki/Mount Cook. He was an experienced mountaineer who was physically fit. After arriving in Christchurch, Mr Mandik drove to Aoraki/Mount Cook, arriving in the early evening of 13 December 2019. He intended to use Haast Ridge to gain access to Plateau Hut and then climb Aoraki/Mount Cook.

[11] Accessible at https://www.acc.co.nz/assets/injury-prevention/acc4407-ladder-safety.pdf.

The New Zealand Mountain Safety Council (MSC) provided a report in which they estimate that between 1:00 and 2:00pm on 14 December 2019, Mr Mandik was caught in a rockfall event while climbing the moraine of Tasman Glacier on Haast Ridge. On 19 December 2019 Mr Mandik was reported missing. On 31 December 2019 his body was located on Haast Ridge, partially covered in rocks.

## COMMENTS OF CORONER ELLIOTT

I. The authors of the MSC report said:

> Mountaineering is an inherently risky recreational pursuit, and it is often this balance between risk and reward that attracts and motivates climbers. It is impossible to remove all the risks from mountaineering, however there are ways to minimise or avoid most risks through having the right skills, experience and knowledge to make good decisions. MSC encourages those who have this necessary knowledge to undertake outdoor activities and in no way suggests people should not get involved in the pursuit.
>
> There are some learnings that can be taken away from this incident that are valuable for those alpine climbing in New Zealand, particularly those who come from overseas or are not familiar with the Southern Alps of the South Island. These are as follows:
>
> - New Zealand mountains punch above their weight in terms of technical challenges and ice and snow conditions compared to other mountains of the same altitude in areas such as the European alps. Do not make assumptions about a route or mountain due to its altitude, and do not underestimate the hazards and difficulties often encountered on the approach.
> - Rockfall is highly prevalent in the Southern Alps and is likely to get worse in the coming years due to climate change, particularly in Aoraki/Mount Cook National Park where glaciers are retreating rapidly. Be aware of this when planning your route and be vigilant on the trip. Talking to local guides will give good insight into latest trends or areas of concern.
>
> All climbers and backcountry trampers should apply the following lessons:
>
> - Leave detailed intentions of your plans with someone who can raise an alert if you do not report back on time. Before setting out on any trip in Aoraki/Mount Cook National Park, head into the DOC Visitor Centre in the village. You can leave your trip intentions, and the visitor centre staff will be able to provide local advice on your route plan and let you know about the current conditions. They'll also advise you about communication options, as some of the huts have radio systems. This is the best way to ensure someone will take notice if you aren't where you're supposed to be by a given time, and it also gives you a chance to gather info on the approach conditions, weather, and how many people to expect in the huts.
> - Climbers should always consider climbing with a partner. Climbing solo makes you much more vulnerable should you face difficulty, injury or any number of other scenarios on route. Apply an additional level of caution when planning on alpine climbing solo in New Zealand. Depending on the route this carries a significantly higher risk than climbing with a partner, particularly in glaciated areas.
> - Give yourself time. Avoid planning trips that place you under unnecessary and unrealistic time pressure. NZ has very dynamic weather and short settled periods. It is essential you have time to observe the

conditions and gather crucial observational information which will allow you to make sound decisions. It is important to be able to make critical decisions on your trip without unnecessary time pressure due to trying to squeeze a trip into a small window of opportunity.

- Be prepared to call for help. All alpine climbers should carry a PLB or satellite messenger device, particularly when travelling solo. This gives you the ability to signal for help in an emergency, and in the case of satellite messenger devices you can also communicate where necessary with the outside world.

II. The Department of Conservation made the following comments:

**Trip intentions**

Aoraki Mount Cook District is the only DOC district in the country that maintains a manual intentions system at the Visitor Centre. Visitors can leave their intentions at the Visitor Centre 24 hours, 7 days a week and these intentions are regularly monitored. Elsewhere around the country visitors are expected to leave details of their intended trip with trusted contacts.

Aoraki Mount Cook District has the only full-time professional Search and Rescue team in the country and this means they are in a position to initiate a formal search at short notice if required. Information about leaving intentions is available on the DOC website, Tourism New Zealand's website (newzealand.com) and the climbnz.org.nz website coordinated by the New Zealand Alpine club.

**Personal locator beacons**

Personal locator beacons have been available to hire in the Visitor Centre for at least ten years, and are also available to hire from several retail outlets in Christchurch, Wanaka and Queenstown.

The promotion of distress beacons (personal locator beacons) has been a key area of focus for DOC both through our own communication channels and in partnership with others. This has been part of our national programme of improvements in the way we provide information to visitors in a way that resonates, although we know that in the end people will make their own decisions.

…

**Influencing mountaineering trip planning decision making**

The mountaineering community, both international and within New Zealand, is relatively small and the Aoraki Mount Cook alpine rescue rangers are well connected, with extensive alpine climbing and rescue experience gained here and overseas. As set out above, the Visitor Centre is the key touchstone for providing real time advice to climbers. Many climbers make contact with the Visitor Centre before their trip either to leave intentions, get current information about weather and conditions, or for route planning. Our rescue rangers are available to go to the centre in person or talk to climbers over the phone to provide advice when requested.

The Aoraki Mount Cook Alpine Rescue Team recently set up an official Facebook page – DOC Aoraki Mountain Rescue – to share information to the mountaineering community about the team's work, to provide information about the current conditions and to raise skills. The page is growing a dedicated following and there is considerable

opportunity to expand our digital outreach and work with others to get key visitor risk management messages (such as good trip planning) across to the right audience.

It is an ongoing challenge to ensure that pre-visit information is current and accurately sets out the existing hazards. DOC has strong processes in places to manage its own communication channels and ensure current information can be accessed by those looking for it. We note that it is very difficult (almost impossible) to influence the information provided by third parties such as social media networks. DOC is constantly seeking to improve our visitor safety communications and works with others such as Mountain Safety Council, New Zealand Search & Rescue, and Tourism New Zealand to do this.

*Discussion*

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

**57A Recommendations or comments by coroners**

(1) A responsible coroner may make recommendations or comments in the course of, or as part of the findings of, an inquiry into a death.

(2) Recommendations or comments may be made only for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred.

(3) Recommendations or comments must—

(a) be clearly linked to the factors that contributed to the death to which the inquiry relates; and

(b) be based on evidence considered during the inquiry; and

(c) be accompanied by an explanation of how the recommendation or comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

IV. The effect of section 57A is that I only have the jurisdiction to make comments or recommendations in relation to factors that contributed to Mr Mandik's death.

V. Mr Mandik died as a result of being caught in a rockfall. It is likely that he died during or very shortly after the rockfall.

VI. The authors of the MSC report said that rock fall is very common in this area and almost impossible to predict.

VII. The Department of Conservation website states:

The majority of the park and surrounding terrain is serious avalanche country. The majority of the park is complex avalanche terrain, which demands respect from all who use it.'[12]

[12] Be Avalanche Alert in Aoraki/Mount Cook National Park - https://www.doc.govt.nz/parks-and-recreation/places-to-go/canterbury/places/aoraki-mount-cook-national-park/be-avalanche-alert-in-aoraki-mt-cook-national-park/.

VIII. The website also lists the area around Plateau Hut as an area of 'continuing rockfall risk.'[13]

IX. The authors of the MSC report noted that:

> …in recent years the use of helicopters and ski planes to access the area including Plateau Hut has become much more common due to faster travel times and being able to avoid the rockfall hazard on Haast Ridge. It is fair to say nowadays very few people walk in via Haast Ridge.

X. It is not possible to know whether Mr Mandik was aware of the risk of rockfall in that area. However, given that there are alternative means by which to reach Plateau Hut, the chances of deaths in similar circumstances may be reduced by increased awareness of the risk of rock fall in that area.

XI. I therefore make the following comments pursuant to s 57A of the Coroners Act 2006:

> On 14 December 2019, Petr Mandik was caught in a rockfall while climbing the moraine of Tasman Glacier on Haast Ridge in Aoraki/Mount Cook National Park. He died as a result of the injuries he sustained.
>
> The New Zealand Mountain Safety Council has advised that rock fall is very common in this area and almost impossible to predict and that the use of helicopters and ski planes to access the area including Plateau Hut has become much more common due to faster travel times and being able to avoid the rockfall hazard on Haast Ridge.

## Short [2022] NZCorC 56 (4 April 2022)

### CIRCUMSTANCES

Lance Phillip Short, aged 52, died on 26 January 2020 at Totara Park, 143 Redoubt Road, Flat Bush, Auckland of neck injuries consistent with a fall.

On 26 January 2020 Mr Short went mountain bike riding in Totara Park. That same morning, another rider located Mr Short's body in a ditch approximately two metres below a log bridge. Emergency services attended and confirmed that Mr Short was deceased.

Auckland Council provided a report to the inquiry, which confirmed that Mr Short had been riding along a Grade 2 track. The track contains two small bridges, the log bridge under which Mr Short was located, and a wider wooden bridge. The log bridge is an optional Grade 5 feature that requires riders to leave the main track. Grade 5 obstacles are described as "technically challenging". The log bridge is marked with a sign containing five Xs to indicate its difficulty. The sign is very clearly visible on approach to the bridge.

The Totara Park Mountain Bike Club undertakes minor repairs on the track and an external company carries out other, non-minor, track maintenance and repairs.

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[13] Plateau Hut - https://www.doc.govt.nz/parks-and-recreation/places-to-go/canterbury/places/aoraki-mount-cook-national-park/things-to-do/huts/plateau-hut/.

### COMMENTS OF CORONER BELL

I. I am satisfied that the log bridge at Totara Park Mountain Bike park is appropriately and clearly labelled as a Grade 5 obstacle, reflecting its challenging and dangerous nature. While it is located near a Grade 2 track, I accept that riders have to leave that course to access the bridge, and that there is an easier crossing very nearby.

II. I am also satisfied that the mountain bike park is appropriately maintained by the Totara Park Mountain Bike Club, and by an external company engaged by Auckland Council.

III. While I do not make any formal recommendations, I hope this tragic death can serve as a reminder of the need to exercise care when mountain biking and to pay attention to, and follow, the gradings of tracks and obstacles.

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

# Medical Care

## Akauola [2022] NZCorC 85 (31 May 2022)

### CIRCUMSTANCES

Neomai Moa Akauola, aged 83, died on 23 September 2021 at Auckland City Hospital of multiple intracranial haemorrhage and epidural haematoma with suspected underlying intracranial metastatic disease. Her supratherapeutic INR[14] (international normalised ratio), a result of her warfarin medication, was an antecedent cause of her death. While Mrs Akauola had a number of long-standing health conditions, she had been relatively independent, self-caring and active for her age. In 2016, Mrs Akauola was first diagnosed with acute decompensated heart failure and atrial fibrillation. At the time, she was commenced on warfarin, a blood thinner, as the best option for stroke prevention.

Approximately four weeks prior to her admission to Auckland City Hospital, Mrs Akauola's health deteriorated. She experienced unexplained back pain, nausea, vomiting and loss of energy. During a phone consultation on 10 September 2021, Mrs Akauola's general practitioner (GP) noted that she was prescribed warfarin but had not had an INR test since April 2020, when it was reported to be elevated at 3.3. Mrs Akauola's recommended range was between 2.0-3.0.

Mrs Akauola was referred to Auckland City Hospital later that day for specialist assessment. Upon admission, her blood tests showed her INR was above 10. She was given vitamin K and Prothombinex which was successful in reversing her supratherapeutic warfarin level. A computer tomography scan of Mrs Akauola's head and cervical spine identified the presence of haemorrhagic legions (bleeding in the brain). Her care was discussed with the neurosurgical team who advised they could not offer surgical intervention and her prognosis was poor. Following discussions with her family, Mrs Akauola was provided with palliative care. She passed away at the hospital several days later.

[14] An INR is a test that measures how long it takes blood to clot and is essential in warfarin dosing.

The Coroner sought expert advice from medical advisor, Dr Murdoch. Dr Murdoch reviewed Mrs Akauola's medical records and noted that three health professionals at her GP's clinic, Langimalie Clinic, continued to prescribe warfarin for her despite no further INR testing. She noted that on four occasions the health professionals ordered blood tests but none of them requested an INR test.

Dr Murdoch advised that it is very important for patients taking warfarin to have this monitored by regular INR blood tests, and to have the dose of warfarin adjusted according to the results, with the aim of keeping the INR result within a specified range. Dr Murdoch noted that if the INR values are greater than 3.0, the risk of bleeding is increased. In terms of any recommendations and comments, Dr Murdoch advised that a safety net which precluded the issuing of a prescription for warfarin without first checking INR would be ideal.

Dr Murdoch expressed concern about the safety of other patients on warfarin at Langimalie Clinic and believed that an urgent audit of all the patients on warfarin was necessary to check they were receiving appropriate monitoring.

Langimalie Clinic advised that as a result of the failure to monitor INR levels, clinical staff including doctors and registered nurse met to discuss procedure changes. The clinic immediately implemented changes involving their computerised practice management system and created an INR patient register. The register captures the patient's details with regard to medication dosage, date of INR results and the doctor's decision for the next INR testing event. The register is updated each time a doctor receives a new INR result from a registered nurse. On a daily basis registered nurses are tasked with contacting the patient with the updated dosing and testing orders. The INR register provides a visual alert for patients overdue for blood tests.

In addition to the above the practice appointed an "INR champion" whose responsibility includes weekly maintenance checks of this register and actively recalling and tracking those patients that remain overdue for their next INR test. Dr Murdoch considered that this proposed register would address the shortcomings she had identified.

## COMMENTS AND RECOMMENDATIONS OF CORONER MILLS

I. The failure by the successive doctors at the Langimalie Clinic to monitor Mrs Akauola's INR while continuing to prescribe her warfarin is very concerning. This continued over an 18-month period so was not an isolated event. No real explanation for this failure was provided other than a "breakdown in communication".

II. On admission to hospital Mrs Akauola's INR was above 10. Her target level was between 2 and 3. For patients on anticoagulant therapy such as warfarin, INR levels above 4.9 is considered to critically increase the risk of bleeding. INR higher than nine is associated with a high risk of bleeding.[15]

III. Dr Murdoch stated that monitoring INR is a fundamental aspect of prescribing warfarin. BpacNZ states[16]

> It is important that practices develop a standardised management protocol for all patients treated with warfarin, in order to optimise health outcomes, by achieving tighter control.

[15] https://www.medsafe.govt.nz/profs/datasheet/p/ProthrombinexVFinj.pdf.
[16] https://bpac.org.nz/bt/2010/november/inr.aspx BpacNZ delivers educational and continuing professional development programmes to medical practitioners and other health professional groups throughout New Zealand.

IV. I consider the obligation is on the prescribing practitioner and the GP Clinic to ensure that any patient being prescribed warfarin is also having their INR monitored. Practices should have clearly understood mechanisms in place to monitor patients treated with warfarin, in order to minimise the risks and maximise the benefits.

V. Langimalie Clinic were given the opportunity to comment on these findings and the adverse comments about the failure to monitor Mrs Akauola's INR. They advised that they accept the criticisms and have taken steps to address their failings. As set out above they have established an INR register and a recall process which places the responsibility for monitoring the INR levels on the prescribing doctor. Dr Murdoch confirmed that she considered the process Langimalie Clinic has established to be appropriate. Langimalie Clinic have also confirmed they will undertake an audit of all patients on warfarin to ensure appropriate monitoring is being undertaken. In light of those steps, I do not consider it necessary to make any specific recommendation directed at the Langimalie Clinic.

VI. I do however consider it appropriate to draw the importance of INR monitoring when prescribing warfarin to the attention of all general practitioners. While this may be basic prescribing practice, in busy practices it is understandable that, without adequate processes and procedures, it could be missed. Given the very serious consequences of failing to monitor INR for patients on warfarin I encourage all general practitioners to review their management protocols for patients prescribed warfarin or other anti-coagulants in order to optimise patient outcomes and minimise risks. Further guidance is available on BpacNZ.

VII. The Royal New Zealand College of General Practitioners have reviewed my draft finding and have endorsed my comments. I therefore direct that a copy of this decision be sent to the Royal New Zealand College of General Practitioners for dissemination amongst members.

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

## Davy [2022] NZCorC 61 (13 April 2022)

### CIRCUMSTANCES

Joyce Olive Caroline Davy died on 12 May 2019 at 12 Wakeman Street, Pahiatua of complications of Sheehan's Syndrome in the setting of recent colonoscopy and colonoscopic biopsy.

Mrs Davy had Sheehan's Syndrome for about 40 years. She took cortisone to keep her central nervous system functioning and prevent her from going into a coma.

On 10 May 2019 Mrs Davy went to hospital for a colonoscopy after a referral from her general practitioner. The results of the colonoscopy were normal and after the procedure Mrs Davy went out for lunch with her husband. During lunch she commented to him that she had some pain her stomach, but she was otherwise fine and laughing. They returned home later that afternoon. Mrs Davy went to bed early at about 7:00pm because she was tired.

The next day Mrs Davy was unwell with vomiting and diarrhoea. Mr Davy contacted the Healthline number that was provided with the colonoscopy discharge information and the Accident and Emergency Department for advice. Mrs Davy took three cortisones and spent the day in bed.

At around 6:45am on 12 May 2019 Mr Davy checked on his wife and found her unresponsive. She was unable to be revived.

Following Mrs Davy's death Dr James Irwin, a gastroenterologist employed by MidCentral District Health Board, prepared a report in response to the post mortem report and a number of questions in relation to Mrs Davy's procedure, including the pre and after care. The report noted that there was no documentation to demonstrate Mrs Davy's Sheehan's Syndrome was considered prior to booking the colonoscopy and no plan to manage her Sheehan's Syndrome for the colonoscopy. On reviewing Mrs Davy's case Dr Irwin concurred with the conclusion of the forensic pathologist, that Mrs Davy's death was probably due to an Addisonian crisis in the setting of Sheehan's syndrome and recent colonoscopy and colonic biopsy.

## COMMENTS OF CORONER FITZGIBBON

I. Joyce Davy was diagnosed with Sheehan's Syndrome in 1984 and was being treated with hydrocortisone and levothyroxine at the time of her death. As outlined by Doctor Amy Spark in the post mortem report, the condition affects the pituitary, and the body does not have the ability to naturally produce hormones such as cortisol to deal with stress. Mrs Davy went through a number of stressors in the days leading up to her death – bowel prep, multiple colonic biopsies taken, developed a small amount of infection associated with these biopsies, and developed diarrhoea and vomiting.

II. There was no pre or after care for the colonoscopy which considered Mrs Davy's condition. She was provided with the general instructions given to patients undertaking this procedure. Furthermore, Doctor Irwin says in his report that a colonoscopy for someone with Sheehan's syndrome is a higher risk procedure and if this was considered prior to booking the procedure it may have been decided for Mrs Davy to not undergo the procedure.

III. I provided a copy of my draft findings to MidCentral District Health Board and asked if they wanted to respond to my comment and if there has been any changes to their processes in relation to colonoscopies. A response was received on 13 April 2022 from Doctor Kelvin Billinghurst, Chief Medical Officer. MidCentral District Health Board has reviewed the pre and post procedure processes for colonoscopies which also includes gastroscopies and discussed the event with the Gastroenterology Department Consultant Doctor Irwin and the Clinical Nurse Specialist (CNS):

> The review reached confidence in the processes currently in place, having recently supplemented enhanced points of practice that:
>
> - Involves Patient participation: MDHB8147 V1 Routine Pre-Admission Questionnaire – this form is completed by the Patient and sent back to the Department.
> - Colonoscopy Patient Information Pamphlet: MDHB8197 is given to the Patients pre procedure.

- A new Policy that provisions areas of responsibility in the referral process: MDHB 8059 V1 Referral and Prioritisation Process V1 2022.
- The Gastroenterology Prioritisation Form (MDHB4659) was reviewed in 2021 that considers Patient requirements as the next step when the referral from the GP/NP has been received. This process is largely done by the Consultant.

IV. Doctor Billinghurst wanted to give assurance this case has been discussed in Doctor Review Forums and the Clinical Nurse Specialist will also present this case study to the Nurses as a learning teaching aid.

V. Due to the above actions undertaken by MidCentral DHB since Mrs Davy's death, I make no formal recommendations.

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

# Miscellaneous

## Colebrook [2022] NZCorC 63 (19 April 2022)

### CIRCUMSTANCES

Genevieve Maree Colebrook, aged 4, died on 24 August 2021 at Ngahinapouri, Hamilton. The cause of her death was complications of liver laceration with severe blood loss due to trauma from swing-set collapse with injury to upper abdomen and lower chest.

Genevieve's parents, Ian and Sarah Colebrook, had been dairy farming in Whangārei for a number of years. While there they purchased a heavy outdoor A-frame swing-set, which they had secured to the ground using metal pegs. The swing-set was a heavy piece of equipment which required two adults to move. It had two seats, one was made of red curved plastic and the other was a one metre disc with netting over it.

Ian and Sarah sold the farm and moved with their children to a 15 acre lifestyle block in Ngahinapouri. The swing-set was brought to the new home in July 2021 but was not secured into the ground as its permanent location on the property had not yet been decided. Ian noted that the swing-set sat on the lawn for several weeks, during which time it had worked its way into the ground about 75mm because of the wet weather and the swing-set's weight.

On 24 August 2021 Sarah was on the swing set with her children. Genevieve was swinging on the red plastic seat while Sarah sat on the disc seat holding her younger son. Sarah was intending to swing in the usual fashion of pushing her legs onto the ground so that she would go backward then lift her feet to swing forward. Genevieve was pushing and swinging herself at the time. Sarah's pushing back movement with her legs caused the swing-set to topple backward. The swing-set's legs came out of the ground and, due to the weight displacement, the frame toppled backwards. The top bar fell onto Genevieve's lower chest/upper abdomen. Sarah lifted the bar off Genevieve while Ian notified emergency services. Paramedics intubated and resuscitated Genevieve and, once stabilised, took her to Waikato Hospital. An

ultrasound examination showed evidence of intra-abdominal bleeding and Genevieve was immediately taken into theatre. Surgery revealed Genevieve's liver was shattered which caused uncontrollable internal bleeding. She went into hypovolaemic cardiac arrest and passed away while in theatre.

### COMMENTS OF CORONER HESKETH

I. I am conscious the swing set should have been secured to the ground with the pegs. That had been done when the family purchased the set some years beforehand and had it secured in one place on the farm.

II. However the family had not long moved to their new home and the swing set appears to have been one of the last items to have been transported down from Whangarei in July 2021. The set had been placed in the backyard on the lush Waikato lawn. The weight of the swing set and the softness of the ground caused the ends to sink into the ground 75mm. While that did not prevent the ends from coming out once someone was using the swings I am mindful that it takes two people to lift the set.

III. I am satisfied Sarah would not have thought the swing set would have shifted and given the circumstances I am satisfied this death has been the result of an accident as opposed to negligence.

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

## Te Moananui [2022] NZCorC 91 (10 June 2022)

### CIRCUMSTANCES

Vaughan William John Te Moananui, aged 33, died on 2 May 2015 at 107 Campbell Street, Thames, of gunshot injuries to the chest.

Vaughan had a long history of mental health difficulties which had led to inpatient psychiatric care on multiple occasions, with alcohol use being a consistent feature underlying his admissions. Vaughan's symptoms included paranoia and he was known to have armed himself for protection.

Vaughan was discharged from inpatient care at the Henry Rongomau Bennett Centre (HRBC) on 11 April 2014 but remained subject to a compulsory treatment order (CTO) administered by the Thames Community Mental Health Team (CMHT). He was identified as being at risk of mental deterioration if safeguards were not in place. Those safeguards included taking his prescribed medication (clozapine), being alcohol and illicit-drug free, and ensuring that he did not become isolated. From July 2014 and up until his death Vaughan was under the care of Psychiatrist X.

By December 2014 Vaughan had moved into a flat on his own and had unilaterally reduced his dosage of clozapine. Around early March 2015 he was injured in a fight at local tavern where he had been drinking, resulting in his admission to the emergency department (ED) at Thames Hospital. At a multi-disciplinary team (MDT) meeting on 26 March 2015, his suspected return to alcohol use was recorded as a serious early warning sign, but no plan or increased monitoring was put in place. Vaughan disclosed his alcohol use to his keyworker on 2 April 2015 and agreed to see his keyworker weekly thereafter, but no further contact took place. On 19 April 2015, Vaughan was injured in a motorcycle accident and

faced increasing financial pressure due to being unable to work. As the CMHT were not in touch with his employer, they were unaware of these issues.

On the evening of 1 May 2015, Vaughan became upset while drinking alcohol with others at his home address. He had a firearm and during a struggle with another man, shot the man in the lower leg. He later forced the injured man and his partner to stay in his lounge with him overnight. The next morning, the injured man and his partner managed to leave the address and make their way to hospital. Police were notified by the hospital but when they attended neither the injured man nor his partner identified Vaughan as the shooter.

On 2 May 2015, Vaughan's mother and stepfather visited him at his home and realised he had been drinking and was mentally unwell. They contacted the CMHT and several hours later arrangements were made for a mental health nurse to attend Vaughan's home accompanied by Police. Vaughan did not respond to knocks but it was suspected that he may still be at the property and potentially armed. The Armed Offenders Squad (AOS) and Negotiation Team were contacted and established a perimeter around the property.

However, Vaughan was not at home as he had been driven to an associate's address that morning, taking his firearm with him. He then went to his sister Genevieve's address, where he continued to drink alcohol and displayed concerning behaviour, including pointing his firearm at passing vehicles and at a man outside at a neighbouring property. He told his sister that he wished to die by being shot by the Police. It was clear to Genevieve and another person living at the address that Vaughan was in a paranoid and irrational state so they decided to contact Police.

As a result, members of the AOS made their way to Genevieve's home. Despite repeated requests, Vaughan refused to put down his firearm, telling the Police to shoot him. He began to walk towards the Police and the public street, raising his firearm as he did so. Police evaluated that they had no option other than to shoot Vaughan, and two officers fired a shot each which struck him. Vaughan was transported to hospital but passed away due to his gunshot injuries.

After two inquest hearings and further written submissions, the Coroner concluded that as a team, the CMHT had not functioned in an effective way to ensure that Vaughan was closely monitored and supported in the community. The Coroner also found that Vaughan's death was not at law a suicide, as he lacked the capacity to form the requisite intention to end his life.

## COMMENTS AND RECOMMENDATIONS OF CORONER ROBB

### Role of the CMHT

*Evidential Foundation*

I. In considering the making of any comments or recommendations I am mindful of the need to identify an evidential basis identifying the cause or contributing factor that I rely on as a basis for making any comment or recommendation.[17]

### Patient Confidentiality/Privacy

[17] Carroll v Coroners Court at Auckland [2013] NZAR 650.

II. An issue raised by Vaughan's whānau was their lack of knowledge about Vaughan's mental health condition and his medication. Vaughan's clozapine medication left him sedated at the level at which it was prescribed on his discharge from HRBC in April 2014. The whānau believe they had been provided with limited information about the effects of the medication and believe that they were required to try and get Vaughan up and working. His sedation was interpreted by some members of his whānau as laziness.

III. Families feeling that they are poorly informed about their loved one's mental health condition and how best they might support them or excluded from their care due to the perceived operation of the Privacy Act, are frequently raised by family in the course of coronial inquiries.

IV. Prior to discharge, progress notes record some information being provided to the whānau about Vaughan's medication. The keyworker believed information had been conveyed to the family about Vaughan's medication and its effects on him.

V. There was no whānau meeting in Thames after Vaughan had been discharged. It is also clear that there was no occasion when the psychiatrist had any direct contact with Vaughan's family and consequently no explanation from him in respect of the medication and its effects.

VI. While the keyworker believed he had a good relationship with the whānau, he also reported Vaughan as describing some stress within the household and a desire to move from the family home as a result. The whānau considered they had difficulty making contact with the keyworker and described feeling that the keyworker was essentially disinterested. He was concerned to hear that description of him at the Inquest.

VII. There is very limited documented contact between the whānau and the CMHT, and this has understandably left the whānau feeling that they were provided with no realistic opportunity to be involved in Vaughan's care.

VIII. I note that the Waikato DHB have considered this concern and have taken steps to prevent this by identifying the importance of establishing and maintaining a circle of care for clients. As part of that process the importance of whānau involvement has been specifically acknowledged and accepted.

**CMHT monitoring and support of Vaughan**

IX. In making the comments and recommendations that follow I begin from the position that Vaughan had an extensive mental health history that included some 18 inpatient admissions when he had become acutely unwell. He had been subject to both inpatient compulsory care and community compulsory care in the form of CTOs. On his discharge from a lengthy period of inpatient care on 11 April 2014 he remained subject to compulsory care in the form of a CTO. A crucial aspect of that community care was support and monitoring with the view to identifying and managing any risks of Vaughan again becoming acutely unwell. Vaughan had a history of both harming others and attempting to take his own life when acutely unwell. A characteristic connected to many of his periods of becoming acutely unwell to the extent that he required inpatient care was his alcohol consumption. He had struggled to manage his use of alcohol over many years.

X. The responsibility of the CMHT was to ensure that there was effective monitoring and support of Vaughan. Processes to ensure that there was effective identification of early warning signs of his deterioration, and in that context, whether he had returned to consuming alcohol was of the upmost importance.

XI. Predicting the precise outcome that unfolded on 2 May 2015 was not possible. However, when Vaughan was consuming alcohol the risk that he might harm himself or others was clear. Managing his risk of deterioration, identifying and appropriately responding to early warning signs, by appropriate and effective monitoring and support was the responsibility of the CMHT. If that monitoring and support proved to be ineffective then this was a contributing factor in Vaughan's ultimate deterioration and with that deterioration leading directly to his death, a contributing factor in his death.

XII. My focus as a coroner is to identify any way in which the risk of death occurring in similar circumstances can be reduced. An individual shortfall in monitoring has been identified as an issue in this Inquest. However, I am concerned to ensure that the processes and procedures of the CMHT are sufficiently explicit and robust as to guard against such an outcome as this in the future. I consider that there needs to be team responsibility which incorporates checks and balances and a greater level of specificity beyond a general expectation that applies to every patient, with protocols and procedures to manage high needs patients such as Vaughan.

XIII. I acknowledge the update provided by […] on behalf of the Waikato DHB, and the ongoing efforts to improve the care provided to patients in the community. I also note that there continue to be challenges around staffing and recruitment and the demand on the service to see people.

XIV. Vaughan's presentation has been described as complex. As the inquest evidence revealed, someone with his high needs and high level of risk would in the past have been managed by an assertive team. This was discussed by both the keyworker and [expert witness] Dr Syed, and the DHB provided an explanation as to why this manner of dealing with complex clients changed. I am not in a position to resolve the conflict in the view expressed by Dr Syed and the experience recounted by the Waikato DHB leading to the change. However, in the instance of Vaughan's care I consider he would have been assisted by clear identification or categorisation as being someone who was complex and high risk. An individual whose history revealed the likelihood that he would become unwell as he had in the past, and who required more intensive planning, wraparound support and in particular close monitoring. There did not appear to be a process for separating him out from other patients who may not have that history, complexity, and high risk of becoming acutely unwell.

XV. Classification of patients like Vaughan would also alert the MDT to the requirement for particular scrutiny when carrying out any review.

XVI. The focus should not be on risk identification as such, but on what constitutes good care, on identifying what will keep such an individual well. Identifying what their baseline wellness is and what needs to be in place to best keep them at that baseline wellness.

XVII. This is consistent with the approach advocated by [expert witness] Dr Chaplow: *to understand fully Mr Te Moananui as a person in order to understand who and what he was treating, gain his confidence and in conjunction with Mr Te Moananui and whānau, formulate and commit to an agreed treatment programme*

*covering biological, psychological, sociological and cultural/spiritual aspects of life. This would include meeting up with members of the whānau, discussions with sponsors (e.g., from the church), monitor progress, ensure the anxiety programme was progressing satisfactorily and ensuring Mr Te Moananui's predilection for alcohol and its use and abuse was being monitored*.

XVIII. For someone of Vaughan's complexity, protocols, and expectations for the keyworker as to close monitoring and engagement with whānau and others in his circle of care would have assisted. The approach to monitoring and engagement with those in the circle of care should not be triggered by an event or deterioration, but by recognition of a lengthy mental health history, the likelihood of deterioration having regard to that history, and an overriding aim to keep him as well as possible.

XIX. In my view the expectations on team members need to be prescriptive to incorporate those matters listed earlier in this Finding as **recommendations**, namely:

a. Identification of discharge requirements being incorporated into the ongoing plan following discharge from inpatient care. (For example, a drug and alcohol program being directed, coupled with a follow-up process to ensure that this is then done).

b. Identification of individuals who are high-risk of becoming acutely unwell, the reason they are high-risk, their risk factors should be listed (e.g. medication non-compliance, alcohol addiction, isolation), and the plan as between the psychiatrist and the keyworker that is to be followed should any early warning sign or risk be realised.

c. The level and requirements of monitoring should be specified in accordance with the identified level of risk and risk factors for any individual being cared for by the CMHT.

d. While the monitoring may be physically carried out by the keyworker there should be oversight of this by the lead clinician/psychiatrist.

e. Who the individuals or entities are within the client's circle of care should be specifically identified and the nature and level of communication with them should also be specified.

f. While the most direct contact with those in the client circle of care may be from the keyworker, there should be oversight of this by the responsible clinician/psychiatrist.

g. A requirement that prior to meeting and assessing a client the psychiatrist should review the progress notes and directly discuss the client with the keyworker, in doing so reviewing the nature and extent of monitoring and contact with those in the circle of care.

h. The psychiatrist should be provided with sufficient time resource to read progress notes and to undertake discussions with a keyworker and others in a client circle of care.

i. I also advocate a level of what I would describe as healthy scepticism in undertaking an assessment of an individual. While psychiatrists are experts in evaluating individuals face-to-face, there are limits on this based on the individual's willingness to be candid. I consider it is appropriate for a psychiatrist to consider the client's previous history, whether they are in anyway motivated to be less than candid

(such as multiple previous interactions with psychiatrists, and a very strong aversion to returning to inpatient care), and to check with the keyworker about the client's level of candour. This may logically occur as a debrief between the psychiatrist and the keyworker following each psychiatric assessment of the client.

XX. In response to these recommendations, the Waikato DHB advised that it continues to regard these expectations as fundamental and known by anybody that meets the requirement to be registered as a consultant psychiatrist or a mental health nurse in New Zealand. The DHB noted that none of the experts called in the inquest gave a contrary view. Despite this the DHB advised that it would consider whether it could set out these explicit requirements in orientation material for people working within the service.

XXI. I acknowledge that the psychiatrist felt resourcing did not allow him the time to review progress notes in respect of an individual prior to an assessment. Likewise, the keyworker pointed to resourcing issues. I also acknowledge that what I have outlined by way of recommendations may add additional resourcing strain to both a psychiatrist and keyworker's time. I understand that increased funding for mental health has been telegraphed by the present government and I hope that this will extend to entities such as the Waikato DHB in resourcing community mental health care. Whether this occurs in a practical sense is as yet unclear.

XXII. The DHB advised me that in addition to actual funding, the problem for resourcing in the mental health area is the availability of people to work in it. They explained that the situation could not be fixed by money alone and certainly not with the level of funding potentially being made available.

*Medical information to be provided to mental health team*

XXIII. In my draft finding I had proposed the following recommendation:

> Where any individual is receiving community mental health care from a CMHT, and that individual is treated in an ED, I recommend that details of that medical treatment should be provided directly to the CMHT as a matter of standard course. The CMHT can then determine the relevance of that medical information having regard to their knowledge of the individual's mental health care needs.

XXIV. In their response to the proposed recommendation the DHB advised of an initial attraction to the proposed recommendation, but after consultation with the various emergency departments within the Waikato region advised that there would be practical difficulties in implementing the recommendation. The advice was that the volume of people under the mental health team who present to emergency departments are so numerous that the volume of information going to the community mental health teams would be significant, with much of the medical information irrelevant to the patient's ongoing mental health care. Clinical review of the information and its significance would not be practically possible due to insufficient people available in the mental health teams to perform that role without compromising their care provided to others.

XXV. The DHB advised that the keyworker, in undertaking close monitoring of Vaughan, should have identified Vaughan's presentation at the emergency department and acted upon this.

XXVI. I acknowledge those practical difficulties limited by staffing and resources. I acknowledge that close and effective monitoring, resulting in the keyworker actually knowing what was happening for Vaughan in the community, should have meant that he was aware of Vaughan's presentation at the emergency department.

At that juncture the reason for the emergency department presentation, the significance of alcohol consumption in that presentation, and an action plan in consultation with the consultant psychiatrist and/or other members of the community team could have been undertaken.

Note: Orders under section 74 of the Coroners Act 2006 prohibit, in the interests of justice, decency and privacy, the publication of the names and any details likely to identify the following: any past and present Waikato DHB staff involved in the provision of care to Vaughan; Psychiatrist X; keyworker; and the Police officers that were in attendance at the time of Vaughan's death or otherwise involved in the investigation into the circumstances of his death, with the exception of Detective Inspector Smith.

# Motor Vehicle

## Charleston and McAlees [2022] NZCorC 90 (10 June 2022)

### CIRCUMSTANCES

Terry Jonathon Charleston, aged 34, and Rebecca Collen McAlees, aged 24, died on 25 December 2020 at Clevedon-Kawakawa Road, Clevedon, Auckland of multiple injuries sustained in a single motor vehicle crash in which Mr Charleston was the driver.

On the evening of 25 December 2020, Mr Charleston was driving his Holden Commodore (the Holden) east along Clevedon-Kawakawa Road near Clevedon, heading towards Kawakawa Bay. His partner, Ms McAlees, was in the front passenger seat.

At approximately 7:30pm, the Holden's rear left wheel dropped off the road surface onto a gravel shoulder while exiting a right hand bend. The vehicle rotated across both lanes and left the road on the right side, proceeding through a drainage ditch and vegetation before colliding with a power pole and landing on its roof. As neither Mr Charleston nor Ms McAlees were wearing seatbelts, they were both thrown from the vehicle and died at the scene.

The Coroner found that at the time of the crash, Mr Charleston was speeding and driving dangerously whilst impaired by the effects of alcohol and methamphetamine. His driver's licence was suspended at the time of the crash and had been suspended multiple times in the past. Mr Charleston's vehicle was modified in such a way that the handling and suspension of the vehicle would have been "stiffer and less forgiving than standard".

### COMMENTS OF CORONER GREIG

I. Serious Crash Unit Investigator Constable Popping expressed the opinion that earlier targeted intervention in relation to Mr Charleston's poor driving behaviour by Police and/or partner organisations may have prevented the crash, commenting that an educational/training component following multiple driver licence suspensions may be beneficial. He noted that there is currently no score or measure for Police to predict the likelihood of drivers being involved in serious or fatal crashes other than their demerit point history. However, he advised that demerit points are not accrued for certain high risk activities such as failing to wear a seatbelt, failing to comply with red traffic signals and court offences for drunk or otherwise impaired

driving, but are accrued for some offences which have "little to no bearing on road safety such as operating an unlicensed motor vehicle".

II. He also commented that increasing enforcement officers' awareness of the provisions of section 80 of the Land Transport Act 1998, where a general penalty of disqualification may be imposed if offences involve road safety could also be beneficial.

III. The issues raised by Constable Popping in the Crash Analysis Report are important as they look to possible solutions for preventing deaths in similar circumstances in the future – in particular how to deal proactively with drivers who repeatedly exhibit poor driving behaviour. The matters raised require the consideration and expertise of the New Zealand Police and the agencies it partners with as they work to achieve zero road deaths and serious injuries by 2050.[18]

IV. I advised New Zealand Police that I proposed to recommend that New Zealand Police (in conjunction with partner agencies which they identify as appropriate) conduct a review of how best to:

a. identify high risk drivers/repeat offenders; and

b. improve and manage the risks they pose to themselves and other drivers; and as part of such review, consider the suggestions made in the Crash Analysis Report of Constable Jeremy Popping of Counties Manukau Serous Crash Unit into the deaths of Terry Jonathon Charleston and Rebecca Colleen McAlees as to how this may be achieved.

**Response from New Zealand Police**

V. I received a response on behalf of New Zealand Police from Senor Sergeant Chris Whitehead, Manager: Operational Support (relieving), National Road Police Centre to my proposed recommendation.

VI. Senior Sergeant Whitehead considered the suggestions made by Constable Popping (set out […] above) and, provided information in relation to each, including, where relevant, work New Zealand Police is currently undertaking with its partners on these matters. His response is set out below, with each suggestion from the Crash Analysis report in italics above the response.

*Earlier and targeted intervention for those drivers who display poor driving behaviours and [that] educational/training referral may be beneficial.*

"There are limited educational/training courses available for addressing poor driving behaviours in New Zealand. One example is 'The Right Track'[19] (Te Ara Tutuki Pai) programme, an initiative delivered by Eduk8 Charitable Trust. Entry to this programme includes self-referral and Justice sector referral. Notably the Trust website outlines a history of positive outcomes for participants. The efficacy of post-licence training and education programmes, including those targeted at traffic offenders in improving driver safety is questionable. A recently published guide on road safety interventions by the Global Road Safety Facility of the World Bank concluded that post licence training

[18] https://www.beehive.govt.nz/release/govt-launches-road-safety-campaign-target-zero-road-deaths.
[19] https://therighttack.org.nz/.

and education is in effective and may be harmful (Turner et al., 2021).[20] A New Zealand study in 2010[21] identified that people who undertook graduated driver license education programs and received a subsequent time period discount, had a higher level of involvement in crashes than individuals that gained their full licence after the full term."

*There is no score or measure for Police to predict the likelihood of drivers being involved in serious or fatal crashes other than demerit point history.*

"Whether demerit point history can reliably predict future crash involvement is uncertain. One predictor of the likelihood of a driver's future involvement in a severe crash is repeated or high-end drink driving offending. Others include previous crash involvement, licence suspension or disqualification history. Driving under the influence of alcohol and methamphetamine has the highest risk estimate for severe crash involvement (20 to 200 times higher than baseline risk). The use of alcohol and methamphetamine is known to be associated with increased risk taking, high speed and dangerous driving. Alcohol and methamphetamine also impair driving performance and negatively affect cognitive functions, motor function, mood, time estimation, and balance. The risk of severe crash involvement following consumption of drugs and alcohol was rated as 'extremely high' in a report on driving under the influence of drugs and alcohol commissioned by the European Commission and published by the European Monitoring Centre for Drugs and Drug Addiction (Schultze et al., 2012).[22]

Severe crashes involving repeated alcohol and drug impaired driving can be reduced through driver remediation, rehabilitation and where applicable, addiction treatment programme completion. Availability of addiction services and completion of programmes was amongst the key recommendations in the European Commission's report on driving under the influence referred to above. A current programme called 'One for the Road' is operated by Harmony Trust in Auckland and shows good promise. However referral requirements to such programmes must be made by the courts. Addiction treatment services for at risk drivers needs to be readily available and adequately resourced to meet demand."

*Demerit points are not accrued for certain high-risk activities such as failing to wear a seatbelt, failing to comply with red traffic signals and court offences for drunk or otherwise impaired driving, but are accrued for some offences that have no bearing on road safety.*

"The Ministry of Transport is currently carrying out a Road Safety Penalties review. The review aims to ensure that road safety penalties imposed reflect the risk of harm caused by each offence, act as an effective deterrent for high-risk road user behaviours, and support compliance, while supporting equitable outcomes. This review is a priority action under the Governments 'Road to Zero' strategy as the road safety penalties system describes the mechanisms which detect, enforce, and penalise traffic offences, and is the primary tool we have to directly reduce high risk driving behaviours on New Zealand roads. Police and partner agencies have been consulted on the proposed changes. It is intended that the draft changes are presented to Cabinet in June 2022 with a round of public consultation scheduled for July and August 2022."

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[20] Turner,B.,Job, S., & Mitra, S.(2021).Guide for Road Safety Interventions Evidence of What Works and What Does Not Work. Washington D.C., U.S.A.: World Bank.
[21] Lewis-Evans, B. (2010). Crash involvement during the different phases of the New Zealand Graduated Driver Licensing System (GDLS). Journal of Safety Research, 41(4), 359-365. https://doi.org/10.1016/j.jsr.2010.03.06.
[22] Schultze,H., Schumacher,M., Urmeew,R., et al (2012). *Driving under the influence of drugs, alcohol, and medicines in Europe – findings from the DRUID project.* https://orbit.dtu.dk/en/publications/driving-under-the-influence-of-drugs-alcohol-and-medicines-in-eur.

*Increased awareness amongst Police officers of Section 80 of the Land Transport Act 1998, where a general penalty of disqualification may be imposed if offences involve road safety could be beneficial.*

"A penalty of disqualification may be imposed on conviction of a Land Transport Act 1988 offence relating to road safety. There is an opportunity for New Zealand Police to be more proactive in placing repeat road safety offenders before the court and seeking a section 80 driver licence disqualification as opposed to simply writing another infringement notice if applicable. The National Road Policing Centre acknowledges the proposed recommendation and will work closely with the Police Prosecution Service to increase awareness and application of this existing road safety tool and consider additional policy development to support this activity into the future."

**Overall response to recommendation**

VII. Senior Sergeant Whitehead advised that in late 2021, New Zealand Police introduced the 'Road Policing Control Strategy' which is an overarching framework to achieve safer roads. He stated: "This framework is evidence based and supports the wider government strategy – Road to Zero. By focusing on an intelligence and evidence led approach to informing our road policing deployment strategies, we are constantly evaluating, reviewing, and informing our road policing deployment strategies. Police evaluates our own intelligence, reviews international best practice, and is aware of and agile to the changing environment and road safety risks evident on New Zealand roads. By deploying our resources based on real time intelligence, we intend to focus on high-risk offenders, locations and enable our people to make a positive impact when opportunities are presented."

VIII. The response of New Zealand Police makes clear that the suggestions made in the Crash Analysis report into the deaths of Terry Charleston and Rebecca McAlees have been considered and that there are steps in place, or about to be put in place, that will address the points made, save for one suggestion that is not supported by evidence. The response also shows that the review I proposed to identify high risk drivers/repeat offenders and improve and manage the risks they pose to themselves and other drivers is encapsulated in the approach adopted in the Police's Road Policing Control Strategy introduced in 2021 – which dovetails into the wider government strategy – Road to Zero. Senior Sergeant Whitehead has advised that is the Police's intention to focus on identifying high risk drivers and to make a positive impact in this regard by deploying Police resources "based on real time intelligence."

IX. On the basis of the response from New Zealand Police, and for the reasons outlined above, I make no recommendations on this matter.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Mr Charleston and Ms McAlees taken during the investigation into their deaths, in the interests of decency and personal privacy.

# Fox [2022] NZCorC 88 (9 June 2022)

### CIRCUMSTANCES

Howard Christopher Fox, aged 34, died on 20 June 2021 at Riverhead Road, Auckland, of multiple blunt force injuries as a result of a motor vehicle collision.

Mr Fox was serving a sentence of home detention. He was also disqualified from driving until May 2024, having previously been convicted and sentenced for driving in a dangerous manner.

On 20 June 2021, Mr Fox was driving a Subaru Impreza on Riverhead Road, Auckland, when he overtook a car and a horse float by entering the opposite lane. The road had a sweeping right-hand bend with a speed limit of 60km/h. Mr Fox lost control of his car, colliding into two power poles and a boundary fence. He suffered serious injuries and died at the scene.

Toxicology results identified the presence of methamphetamine in Mr Fox's blood. The Police Serious Crash Unit (SCU) investigated the crash and calculated that Mr Fox was travelling at a speed of 119 to 124km/h when he left the road. The SCU concluded that the two main reasons for the crash were the excessive speed and the illegal drugs in Mr Fox's system.

### COMMENTS OF CORONER HO

I. It is seldom safe to drive at double the speed limit and particularly so where the speed limit is, such as in this case, fixed at a low base. It is also unsafe to drive while under the influence of drugs such as methamphetamine and cannabis. These messages are well publicised and it is incumbent on drivers to heed these messages for the safety of themselves and other road users. I do not make any recommendations under s 57A.

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

## Harmer, Haami-Harmer and Tapiata Harmer [2022] NZCorC 59 (8 April 2022)

### CIRCUMSTANCES

Chante Alissa Harmer, aged 30, died on 1 April 2019 at the intersection of Hepburns and Mitcham Roads in Ashburton of high energy impact injuries to her chest, abdomen and pelvis as a result of a vehicle collision.

Te Awanuiarangi Shayelous-Jay Matenga Haami-Harmer, aged 17 months, died on 1 April 2019 at the intersection of Hepburns and Mitcham Roads in Ashburton of high energy impact injuries to his head and spleen as a result of a vehicle collision.

Wysdom Amara Francis Tony Jame Tapiata-Harmer, aged 8 months, died on 1 April 2019 at Ashburton Hospital of an injury to her head as a result of a vehicle collision.

On 1 April 2019 Ms Harmer was driving a Holden Astra on Hepburns Road towards the intersection with Mitcham Road in Ashburton. There were three other passengers in her vehicle, including Wysdom and Te Awanuiarangi. The speed limit in that area is 100km/hr and there was a Give Way sign on Hepburns Road. Without braking, Ms Harmer's vehicle entered the intersection and travelled into the path of a Ford Ranger utility travelling on Mitcham Road. Ms Harmer braked, but this did not prevent the collision. Ms Harmer and Te Awanuiarangi died at the scene. Wysdom was transported to Ashburton Hospital where she died a short time later.

The Police Serious Crash Unit (SCU) investigated the collision. It found that there were no signs along Hepburns Road warning of the presence of the impending Give Way sign. The Give Way sign also blended into the background and was difficult to see when observing from a distance. There were hedges on the southern side of Hepburns Road which at least partially obscured the view of Mitcham Road for traffic travelling east on Hepburns Road.

The Coroner concluded that the crash was caused because Ms Harmer did not obey the Give Way sign as she did not see the sign, the intersection or the approaching Ford Utility in sufficient time to stop. The Coroner concluded that it was more probable than not that the reason Ms Harmer did not see the Give Way sign was that it blended into the background and was difficult to see. In addition, she did not appreciate that she was approaching an intersection or that there was a danger with an oncoming vehicle.

The *Land Transport Rule: Traffic Control Devices 2005* (the TCD Rule) sets out the legal requirements for signs and markings on roads in New Zealand. Waka Kotahi produces manuals to assist road controlling authorities to apply the TCD Rule. The Manual of Traffic signs and Markings (the Manual) applied in this case. The Manual provides guidance on whether a Give Way or Stop sign is the appropriate sign to place at an intersection. It provides that, if a Give Way sign is not clearly visible to an approaching driver for a distance of at least 120 metres, a warning sign should be provided.

Since this crash, Ashburton Council has installed a Stop sign at this intersection. In addition, there is another sign 200 metres back, warning of the impending Stop sign. The Council's position is that a Give Way sign satisfies the requirements of the Manual and that the use of a Stop sign exceeds these requirements.

## COMMENTS OF CORONER ELLIOTT

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

> Chante Alissa Harmer, Wysdom Amara Francis Tony Jane Tapiata-Harmer and Te Awanuiarangi Shayelous-Jay Matenga Haami-Harmer died after Ms Harmer drove along Hepburns Road and travelled into the intersection with Mitchams Road.
>
> The crash occurred because Ms Harmer did not give way at the intersection. She did not give way because she did not perceive the Give Way sign, the intersection or […] approaching vehicle in sufficient time to stop. Ms Harmer did not perceive the Give Way sign because it blended into the background and was difficult to see.
>
> This crash illustrates the danger that drivers on long, straight rural roads may not identify the presence of an intersection in sufficient time to stop. Drivers should be alert to the possibility of intersections on rural roads and pay close attention to signs and road markings warning of an approaching intersection.

## RECOMMENDATIONS OF CORONER ELLIOTT

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

*Ashburton District Council*

a. In addition to the existing Stop sign which is situated on the left-hand side of Hepburns Road, Ashburton District Council should also place a Stop sign on the right-hand side. Both Stop signs should be 1015x1015.

b. Ashburton District Council should:

i. Conduct a review of the 79 similar intersections to assess whether the existing combination of road signs and markings are adequate for the purpose of providing the safest possible environment for road users. Although the provisions of the Manual should be considered, those assessing the intersections should note the issues identified in these findings and consider whether additional precautions should be taken such as those which are now in place at the Hepburns Road/Mitcham Road intersection.

ii. Implement the additional safety features identified in the review.

*Waka Kotahi*

II. Waka Kotahi should:

a. Conduct a review of international, national and regional practice of the use of traffic signs and markings that relate specifically to controlling risks at rural crossroads. This should include consideration of the issues identified above in relation to warning signs.

b. Identify any changes to the TCD rule, TCD manual that would improve safety rural crossroads and take appropriate steps to implement these changes.

c. As part of its research study of rural crossroads, Waka Kotahi should identify those authorities who are responsible for rural crossroads which are subject to the same potential risks as those identified in this case and provides advice about how to address these risks.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of two witness' names and any particulars likely to identify them, as well as medical evidence, in the interests of justice and privacy.

# Johnson [2022] NZCorC 93 (17 June 2022)

### CIRCUMSTANCES

Richard James Johnson, aged 45, died on 11 July 2017 at Christchurch of crush/compression impact injuries to his chest and spine as a result of being struck by a vehicle.

On 11 July 2017, at around 9:30pm, Mr Johnson was crossing the road outside his home when he either collapsed unconscious or tripped and fell on the roadway. While he was lying on the road, he was struck by a car. The driver of the car did not see Mr Johnson lying on the road as the weather was poor and Mr Johnson was wearing dark clothing. Sadly, Mr Johnson died at the scene.

Although Mr Johnson was an alcoholic, the Coroner noted that in the time leading up to his death, he had been making efforts to reduce his drinking. In the past, his alcoholism had led to Mr Johnson suffering from seizures. The Coroner noted that post-mortem toxicology revealed a trace amount of alcohol in Mr Johnson's blood and urine, which may be due to means other than deliberate ingestion.

## COMMENTS OF CORONER HESKETH

I. Some comment needs to be made about the dangers of alcohol. Alcohol, like many other drugs, is a sedative. Generally, it relaxes the body and induces calm. Over time, the brain adapts to frequent heavy doses. Its neurotransmitter system recognises the sedation and goes into a hyperactive state to overcome the effects of the alcohol so it can continue to function at normal levels. When the body suddenly stops its intake of alcohol, the neurotransmitter system continues working in overdrive. This is referred to as 'neurotransmitter rebound' and can lead to convulsions, where the person has an epileptic seizure, and cardiac arrhythmias, where the heart goes into a spasm and doesn't pump blood efficiently. Other common symptoms include nausea, sweating, dysphoria, and delirium tremens.[23]

II. Overuse of alcohol and un-maintained withdrawal from its use by someone who is addicted to it can create real dangers to the individual's health. Addiction involves a hijacking of the survival mechanisms in the brain. People with drug addiction continue to use the drug as if their lives depend upon it. Body and brain get their wires crossed, so people in withdrawal can feel like they are going to die if they don't get enough of the drug they 'need'.[24]

## RECOMMENDATIONS OF CORONER HESKETH

I. People who are addicted to alcohol can seek help from the Ministry of Health website and various agencies set up to assist. The Ministry of Health aids those seeking help with alcohol and drug addiction as follows:

a. Alcohol Drug Helpline -0800 787 797 (https://alcoholdrughelp.org.nz/)

b. Alcohol.org.nz (http://www.alcohol.org.nz)

c. Like a Drink (http://www.likeadrink.org.nz/)

d. Living sober (http://www.livingsober.org.nz/)

e. Whaiora Online (https://www.whaioraonline.org.nz/login)

f. Community treatment services (/your-health/services-and-support/health-care-services/help-alcohol-and-drug-problems/community-services-alcohol-or-drug-treatment)

g. Live-in treatment services (/your-health/services-and-support/health-care-services/help-alcohol-and-drug-problems/live-services-alcohol-or-drug-treatment)

h. Help for families, whānau can be found at (/your-health/services-and-support/health-care-services/help-alcohol-and-drug-problems/help-families-whanau-friends)

i. There are a number of independent agencies that also help:

i. Salvation Army (Addictions, Supportive Accommodation & Reintegration Service Enquiries – 0800 530 000

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[23] https://www.drugfoundation.org.nz/matters-of-substance/archive/november-2011/mythbusters-death-by-withdrawal.
[24] Ibid.

ii. Higher Ground -09 834 0042

iii. Community Alcohol Drug Services (CADS) – 0800 845 1818

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

# Roberts [2022] NZCorC 80 (16 May 2022)

### CIRCUMSTANCES

Jack Steven Roberts, aged 18, died on 18 February 2018 on Pareora Gorge Road, near Maungati, Canterbury. The cause of death was multiple injuries due to a motor vehicle collision.

At 4:00pm on 17 February 2018 Jack and his friend, Harry Campion, were drinking at the Cave Pub. They left at around 6:30pm to go to their friend's home. After a while, they went back to Craigmore Station and then returned to their friend's home at around 10:00pm where they continued drinking. Jack and Harry decided to stay at their friend's home for the night and sleep in a caravan that was on the property. Both were happy with this arrangement. However, at some point they left the caravan to drive back to Craigmore Station in Harry's Subaru. Harry could not remember why they left but told Police it was Jack's decision because he wanted to charge his phone.

At 2:00am on 18 February 2018, members of the public found a Subaru station wagon on its roof in a paddock off the side of Pareora Gorge Road. Jack was upside down in the driver's seat, with his seatbelt on. Harry was found lying in the paddock.

The Canterbury Police Serious Crash Unit (SCU) investigated the cause of the crash. The SCU concluded that the Subaru travelled south along Pareora Gorge Road towards Jack and Harry's home at Craigmore Station. About ten kilometres from Otama Road and about eight kilometres from Craigmore Station, the Subaru failed to take a sharp bend in the road. The SCU calculated the speed at 74kph as the Subaru left the bank, with a total speed of 138kph prior to braking as the Subaru came around the bend. The Subaru's speed was too fast for it to stay on the road round the bend.

The SCU report noted that there were no barriers on the corner where the Subaru left the road. While Armco barriers on that bend would not have prevented the Subaru from leaving the road, they would "almost certainly have lessened the severity of the outcome." There were also no speed warning markings on that bend and the SCU report opined that, had they been in place, they would have been able to warn drivers that the bend is much tighter than it first appears.

### COMMENTS OF CORONER JOHNSON

I. Police advised me that there have been previous crashes in the same area of Pareora Gorge Road where the Subaru failed to take the bend. Police suggested that a review of the road should be conducted.

II. I therefore recommended to the Waimate District Council that it reviews the area of Pareora Gorge Road where the Subaru failed to take the bend, with a view to

a. installing speed advisory signs, or revising the posted speed limit; and

b. installing Armco barriers on the side of the bend to reduce the chances of future deaths occurring, if other drivers also fail to safely negotiate this bend.

III. Waimate District Council responded as follows, advising me of the work that has already had done and what it is still doing to try to ensure that other drivers safely negotiate this bend on Pareora Gorge Road.[25]

> The crash occurred on the section [of] Pareora Road where the road climbs 100 metre(sic) above the Pareora River to avoid the Pareora Gorge. The alignment of this section is winding with 64 curves over a length of 4.5km. The operating speed of these curves ranges from 25 to 75 kph. This section of road is out of context with the balance of the route which is generally flat with higher speed curves. Each end of this section of road has winding road warning signs in place.
>
> . . .
>
> Council has installed speed advisory and chevron signs.
>
> . . .
>
> Council will programme the installation of a Road Safety barrier at the crash site to protect road users.

IV. Waimate District Council has also advised that:

> The old drink-driving slogan promoted a few years ago "rural people die on rural roads", is unfortunately still too true. It is an ongoing issue that is challenging to resolve because of the set culture in the rural space
>
> Our Council delivers safety education through collaboration with two other districts, Timaru and Mackenzie District Councils recognised as South Canterbury Road Safety. There is currently one road safety coordinator who promotes safer road use in our region. He will continue to address crash issues of young farmworkers using the district's roads.

V. I endorse the steps that have already been taken by Waimate District Council to install speed advisory signs and the safety education that it delivers together with Timaru and Mackenzie District Councils. I also endorse the upcoming installation of a road safety barrier at the crash site. I consider that these measures will go a long way to prevent further deaths occurring on that stretch of Pareora Road.

VI. I will send a copy of these Findings to media outlets in the hope of raising awareness that rural people are still dying on rural roads, and (yet again) the dangers of driving after drinking.

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

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[25] Report to the Coroner dated 2 May 2022 from Waimate District Council.

# Singh [2022] NZCorC 95 (23 June 2022)

## CIRCUMSTANCES

Maria Jose Singh, aged 22, died on 12 April 2018 at 10 Manurewa Grove, Wainuiomata. Her death was the result of injuries to her head, chest and pelvis which she sustained when a vehicle she and her sister Gurpreet were attempting to manually push uphill rolled backwards and she got dragged beneath it.

At about midday on 12 April 2018 Maria and Gurpreet were attempting to jumpstart a 2008 Ford Falcon sedan ("the Ford"). They were attending to this at the top of the steep driveway at 10 Manurewa Gove, Wainuiomata. After Maria had rolled the Ford down the driveway slightly by releasing its handbrake, the sisters placed a cobble stone under the rear right wheel as a chock. They then positioned another vehicle nearby in order to jumpstart the Ford.

However, the leads were too short and the sisters decided to manually push the Ford up the driveway so that it would be closer. Maria released the Ford's handbrake and took up position at the rear left wheel. The sisters then began to rock the Ford back and forwards. Consequently, the Ford rolled back over the cobblestone. Gurpreet was knocked to the side but Maria, who tried to keep pushing the Ford by herself, got caught by the rear left wheel. She was dragged down the driveway until the Ford crashed into a fence and remained trapped underneath. Emergency services arrived and attempted to save Maria but she passed away at the scene.

This inquiry has had the benefit of expert advice from Dr Timothy Stevenson. He provided calculations which, while involving a number of assumptions, usefully illustrate the clear inadequacy of the single cobblestone Maria and Gurpreet used as a chock. Dr Stevenson calculated that a single 40mm tall cobblestone would deliver a restraining force of approximately 230 kg. When on a slope of 30%, the downhill force acting on the Ford is equivalent to 501 kg, which far exceeds the 230 kg restraining force offered by the cobblestone. By comparison, a single chock 165 mm tall (25% of the diameter of the Ford's tyre) would provide a restraining force of 709 kg. The low height of the cobblestone is a key feature of its inadequacy as a wheel chock.

The Coroner found that factors contributing to this tragic incident included the inadequacy of the wheel chock (the cobblestone) being used to secure the Ford on the steep driveway and the steepness of the driveway.

## RECOMMENDATIONS OF CORONER WRIGLEY

I. For reasons explained below, I make the following three recommendations under s57A of the Act:

   a. Waka Kotahi/New Zealand Transport Agency ("NZTA") should consider making publicly available, including adding to the Road Code, authoritative information regarding the correct use of wheel chocks; and

   b. Until further research indicates otherwise, the following guideline should be followed when circumstances call for the use of wheel chocks:

      i. An appropriate wheel chock must:

         1. Have an angled face of between 35° and 45° that is placed against the tyre;

         2. Be a minimum of 25% as tall as the tyre it is placed against/under;

3. Have a width that is at least 3/4 of tire tread width; and

4. Not deform when in use;

ii. Two wheel chocks should be placed under the lower portion of the two wheels on the vehicle's most downhill (lower) axle, when securing a vehicle on a slope; and

iii. Be aware that if the gradient is over 30% or the road surface is slippery (for example, due to ice or loose gravel), wheel chocks may not have enough resistance to secure the vehicle.

c. Advice regarding the use of wheel chocks at www.drive.govt.nz should be removed or updated to ensure the advice given is consistent with the guidelines above.

II. Doctor Stevenson conducted a review of wheel chock selection and usage guidelines in New Zealand. He found advice on the website drive.govt.nz operated by NZTA and the Accident Compensation Corporation that wheel chocks should be used when changing a wheel.[26] The advice includes "Do this using wedge blocks (or any available blocks of wood or rocks …)". In Dr Stevenson's opinion this advice could easily lead to an unsafe situation: a situation like that which occurred in this case where a "rock" was used as a wheel chock. On its website NZTA recommends the use of wheel chocks when securing a light trailer. No other relevant advice regarding the use of wheel chocks is provided on NZTA's website or in the Road Code. WorkSafe New Zealand has on its website advice about the use of wheel chocks when loading and unloading vehicles and when performing maintenance on a tractor.[27] Aside from that noted, none of these online guidelines specify the requisite dimensions of a wheel chock to effectively prevent a passenger vehicle or trailer from moving.

III. In summary, Doctor Stevenson found there was poor availability and inconsistency of publicly accessible and authoritative information regarding the safe specifications and use of wheel chocks in New Zealand. Most of the available information targets operators of commercial and heavy vehicles and trailers.

IV. Doctor Stevenson identified various international guidelines or standards regarding the use of wheel chocks and provided a review of SAE Standard J348:Wheel Chocks produced by the SAE International.[28] Aside from some "quirks" in the SAE Standard J348, Dr Stevenson considers it provides useful and appropriate guidance on the use of wheel chocks for passenger vehicles. The SAE Standard J348 is not publicly available in New Zealand. The guidelines specified at [para I b. of this summary] above are based upon Dr Stevenson's advice for such guidelines and derived largely from the SAE Standard J348 with some modifications made for the purpose of simplifying interpretation and implementation.

V. I have found that use of an inadequate wheel chock was a key contributor to Maria's death. It is apparent that Maria and Gurpreet lacked knowledge about what would serve as adequate wheel chocks. I consider that the inclusion of wheel chock guidelines in the New Zealand Road Code which is used to educate new

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[26] https://drive.govt.nz/get-your-restricted/skills/bonus-skills/changing-a-tyre/.
[27] https://www.worksafe.govt.nz/topic-and-industry/vehicles-and-mobile-plant/site-trafficmanagement/managing-work-site-traffic-gpg/ and https://worksafe.govt.nz/dmsdocument/152-safe-use-of-tractors-on-farms.
[28] SAE International is a global association of more than 128,000 engineers and related technical experts in the aerospace, automotive and commercial-vehicle industries. It provides a forum for companies, government agencies, research institutions and consultants to devise technical standards and recommended practices for the design and construction of motor vehicle components.

drivers, and the easy public availability of wheel chock guidelines from an authoritative source may increase the likelihood that members of the public will select and use effective wheel chocks when required, thus reducing the chances of further deaths like Maria's.

VI. Prior to finalising these findings, I provided WorkSafe and Waka Kotahi – NZ Transport Agency with an opportunity to comment upon my recommendations at [I above]. In response, Allison Houston, Manager, Victim Services and Coronial Services, of WorkSafe observes that Maria's death did not involve a work-related accident and asserts that my recommendation does not include any actions for WorkSafe. For these reasons Ms Houston advises that WorkSafe has "no further comment to make regarding this matter" and identifies Waka Kotahi NZTA as the most appropriate agency to comment upon the proposed recommendations. Ms Houston goes on to state that:

> WorkSafe does acknowledge the observations noted under para [II] and [III] about current industry-specific guidance on the use of wheel chocks are not intended to be used as general guidance.

VII. Michael Aitken, Manager, Operational Policy and Standards responded on behalf of Waka Kotahi – NZ Transport Agency. His response included the following:

> Waka Kotahi is currently undertaking a review of the New Zealand Road Code with the intention of making it a more user friendly guide for those progressing through the graduated driver licence system (GDLS). The focus of the review is to streamline the Road Code by removing information not directly related to road rules and road user behaviour, as such it is unlikely that information on the use of wheel chocks will be added. However, Waka Kotahi will look to update its website regarding the use of wheel chocks use, along with any other important road safety information.

VIII. In response I refer to Dr Stevenson's observation that a paragraph on appropriate wheel chock selection and usage could be added to the section in the Road Code addressing parking on a steep road.[29]

# Sullivan [2022] NZCorC 58 (7 April 2022)

### CIRCUMSTANCES

Kyle William John Sullivan, aged 19, died on 27 July 2018 on a section of Devon Road, State Highway 3, near Brixton, of multiple injuries sustained in a vehicle collision.

On the afternoon of 27 July 2018, Kyle was the driver and sole occupant of a Toyota Sprinter sedan travelling in a north-easterly direction on State Highway 3, Devon Road. On the crown of a railway overbridge, known as 'Big Jim's overpass', Kyle crossed the centre line and collided with an oncoming Holden Commodore vehicle. Kyle died from his injuries at the scene.

[29] https://www.nzta.govt.nz/roadcode/general-road-code/road-code/about-driving/stopping-and-parking/how-to-park-safely/.

Toxicological analysis found alcohol in Kyle's blood at a level of 156 milligrams per 100 millilitres. For comparison purposes, the legal blood alcohol limit for a New Zealand driver 20 years or over is 50 milligrams per 100 millilitres. Kyle's blood sample also tested positive for cannabis.

The Serious Crash Unit (SCU) conducted an investigation into the circumstances of the crash and found that the likely cause of the collision was the level of impairment Kyle would have experienced as a result of having alcohol and cannabis in his bloodstream, which may have caused him to overreact when his car initially drifted onto the grass verge. The SCU also noted that both Kyle and the driver of the oncoming Holden Commodore vehicle held learner driver licenses and were driving in breach of their license conditions. Specifically, they did not have a fully licenced supervisor accompanying them.

### COMMENTS OF CORONER KAY

I. Having given due consideration to all of the circumstances of this death, I make the following comments:

   a. there is sound reasoning behind the requirement for individuals with learner licences to have an appropriately qualified supervisor with them when they are driving. Such drivers may have a level of self-confidence that does not match their limited driving experience and skills (including assessment of driving-related risk); and

   b. it is well recognised that driving whilst under the influence of alcohol and/or cannabis increases the risk of harm to the person affected by those substances, and to others (including other road users and pedestrians), and should not be done.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Kyle entered into evidence for this inquiry, on the grounds of decency.

# Self-Inflicted

## Chen [2022] NZCorC 55 (31 March 2022)[30]

### CIRCUMSTANCES

Shiyu Chen, aged 22, died on 20 August 2020 at Central Auckland. The circumstances of his death amount to suicide.

In the months leading up to his death, Shiyu had lost significant sums of money through gambling, which had caused him a great deal of distress. Although he had been offered help with his gambling by various agencies he chose not to engage. While Shiyu's partner had raised concerns with him about his gambling, and encouraged him to stop, he appears to have kept the true extent of his addiction and his distress hidden from her.

### COMMENTS OF CORONER MILLS

[30] This finding was issued on 31 March 2022 but could not be published in the previous edition of Recommendation Recap.

I. Having given due consideration to all of the circumstances of this death, I make these comments in the hope that if drawn to the public's attention, they may help prevent further deaths occurring in similar situations.

II. These comments are not meant in any way as a criticism of any of Shiyu's friends or family, as they appear to have been unaware of the extent of his harmful gambling. It is, however, unfortunate that Shiyu declined help when initially offered and that no one appears to have encouraged Shiyu to seek further help when his gambling began to cause him harm.

III. Shiyu was one of many whose gambling went from being "entertainment and recreational" to being "harmful". Understanding and recognising the signs of problem or harmful gambling may not be well known. The Ministry of Health identify the following as warning signs that could point to a problem with your gambling or the gambling of someone you know:[31]

a. spending more time or money than you planned;

b. making excuses or being secretive with friends or family about how much time and money you're spending gambling;

c. feeling guilty or worried about how much you're gambling;

d. you or your family going without;

e. thinking that you can gamble your way out of debt;

f. losing interest in your friends, family or other activities; and

g. borrowing or taking money from your friends, family or a workplace.

IV. It is important to know that there is a range of services and support for people with a harmful or problem gambling habit. The nationwide 24 hour Gambling helpline service is available on **0800 654 655** or text **8006** and https://gamblinghelpline.co.nz/. It offers a range of free services. In addition, there is a range of population specific helplines including:

a. Māori Gambling Helpline

0800 654 656

b. Vai Lelei Pasifika Gambling Helpline

0800 654 657

c. Gambling Debt Helpline

0800 654 658

d. Youth Gambling Helpline

[31] https://www.health.govt.nz/your-health/healthy-living/addictions/harmful-gambling.

0800 654 659

e. Asian Hotline (Problem Gambling Foundation)

0800 862 342

f. The Salvation Army Oasis Centres (Public Health and Intervention Services)

0800 53 00 00

g. Problem Gambling Foundation of New Zealand (Public Health and Intervention Services)

0800 664 262

V. There are also a number of services in each region that provide localised support for harmful gambling. These can be found on https://www.health.govt.nz/your-health/healthy-living/addictions/harmful-gambling/find-service-near-you.

VI. The Problem Gambling Foundation also provide guidance about how to support someone who has a problem with their gambling and offers advice on:

a. talking to them about their gambling;

b. not giving or loaning money; and

c. becoming knowledgeable about problem gambling and encouraging the person to seek help.

d. More information about how to support someone who has a gambling problem and how to talk to them can be found on https://pgf.nz/concerned-about-someone/how-to-talk-to-someone-about-their-gambling

VII. I encourage anyone who is concerned about their gambling or the gambling of a friend or loved one to consider seeking help for that person prior to the problem reaching a crisis point. I make these comments in the hope that greater awareness about harmful gambling and the help available may help prevent further deaths in similar circumstances to that of Shiyu.

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

## Dryson [2022] NZCorC 76 (11 May 2022)

### CIRCUMSTANCES

Phillip William Dryson, aged 42, died on 22 September 2018 at Auckland in circumstances amounting to suicide.

My Dryson had a history of mental illness and was under the care of a private psychiatrist since 1993. He was initially diagnosed with obsessional thinking and mild depression. He had expressed suicidal ideation from the age of 15 and

was treated with antidepressant medication. At the time of his death, Mr Dryson had been residing with his flatmate in Auckland.

On 14 February 2018, Mr Dryson was briefly admitted to the Te Whetu Tawera Inpatient Unit, Adult Acute Mental Health Unit, Auckland District Health Board (ADHB) after displaying concerning behaviour in public. He was discharged back home on 16 February 2018 with follow up arranged by the services.

On 20 March 2018, Mr Dryson's flatmate contacted ADHB Mental Health Service informing them that Mr Dryson had expressed suicidal thoughts over the past fortnight and had been displaying impulsive thoughts while under the influence of alcohol. A plan was made during that call to contact the Urgent Response Services (URS) if Mr Dryson did not return home by the end of the evening shift. No contact was made, and the matter was closed by the ADHB.

On the evening of 21 September 2018, Mr Dryson's flatmate considered him to be in a depressed state as he was exhibiting concerning behaviour. Some time after midnight, on 22 September 2018, the flatmate contacted the Mental Health Crisis Line and spoke with the operator who took her details and passed them on to a triage clinician at the URS. A short time later the triage clinician from ADHB rang back. During the phone-call, Mr Dryson and the flatmate got into a physical altercation resulting in the phone being cut off. The triage clinician immediately phoned 111 when the phone went dead.

As a result of the altercation, Mr Dryson's flatmate fled their property. Shortly after, Mr Dryson was found deceased.

## COMMENTS OF CORONER HESKETH

I. I need to determine whether there are any comments or recommendations I can make concerning this death that may, if drawn to public attention, reduce the chances of death in similar circumstances.

II. Mr Dryson's flatmate was also critical of the procedure in place should a friend or family member ring the Mental Health Crisis Line in an emergency seeking assistance. The procedure currently is:

   a. A phone call is made to the Mental Health Crisis Line 0800-800-717.

   b. The call is answered by an ADHB switchboard operator who records the caller's name, the phone number they are calling from and the client details.

   c. The ADHB operator explains to the caller that their details will be passed onto the URS team, a member of which will then call that caller back when they are available.

   d. The operator then conveys the caller's details to the URS. This system is in place as the URS are a small team and they get numerous calls daily (sometimes a hundred or more). The URS staff aim to return calls within 10 minutes of the notification but during high volume periods that time frame is not always met.

III. As had occurred in this case in the early hours of the morning of 22 September 2018, the ADHB operator ended the call once they obtained sufficient detail from Mr Dryson's flatmate. The information was then passed to the URS team, a member of which called her back.

IV. There is nothing stopping the caller ringing 111 themselves and I envisage there will be many occasions when a call is made to the Crisis Line and things will escalate while the caller is talking to either the operator or a triage staff member. It would appear sensible in a situation of escalating violence for the caller to either dial 111 themselves or they could request the person they are speaking with to do so.

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

# Hayman [2022] NZCorC 57 (5 April 2022)

### CIRCUMSTANCES

Cecile Ruth Hayman, aged 32, died on 15 January 2019 at Mount Eden, Auckland. The circumstances of her death amount to suicide.

Ms Hayman had a history of depression for which she had sought medical attention and which had been treated with venlafaxine. She had stopped taking antidepressants on or about 10 November 2018.

### COMMENTS OF CORONER TETITAHA

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

II. Withdrawal from venlafaxine can be associated with severe symptoms,[32] including suicidal ideation.[33] Discontinuation effects are well known to occur with antidepressants, and sometimes these can be protracted and severe.[34]

III. It is recommended that withdrawal from venlafaxine be tapered gradually and the patient monitored. The period required for discontinuation may depend on the dose, duration of therapy and individual patient. In some patients, discontinuation could take months or longer.[35]

IV. There was evidence Ms Hayman had been prescribed antidepressants including venlafaxine for severe depression for 5 years or longer. She had been prescribed 150 mg tablets of venlafaxine up and until 17 October 2018 when this was substantially reduced to 37.5 mg.

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[32] Symptoms include agitation, anorexia, anxiety, confusion, dry mouth, fatigue, paraesthesias, vertigo, hypomania, nausea, vomiting, dizziness, convulsions, headache, diarrhoea, sleep disturbance, insomnia, somnolence, sweating and nervousness. Medsafe website online https://www.medsafe.govt.nz/profs/Datasheet/e/Efexorxrcap.pdf.
[33] The Primary Care Companion for CNS disorders 2000; 13 (5) Peters, J M.D., Sandsone, RA M.D. A case of into dose discontinuation symptoms with venlafaxine extended release citing Stone T.E., Swanson C., Feldman M.D. Venlafaxine discontinuation syndrome and suicidal ideation: a case series. J Clin Psychopharmacol. 2007;27(1):94–95 online version https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3267502/#bib13.
[34] See above note [33].
[35] See above note [33].

V. Ms Hayman then stopped taking venlafaxine a little over 3 weeks later on or about 10 November 2019. She subsequently exhibited symptoms of aggression and hostility resulting in criminal charges of assault on Police.

VI. The evidence indicates that her behaviour that gave rise to the one of the principal stressors namely criminal offending may have resulted from her abrupt withdrawal from venlafaxine. If she had had better support with her withdrawal including education and monitoring, the incident that became a source of stress leading to her death might have been avoided.

VII. There is merit in reviewing the best practice guidelines for medical practitioners treating patients seeking to withdraw from long term antidepressant use such as Ms Hayman. Reviewing a patient's wellbeing in the three month period following withdrawal from long term use may capture any behavioural changes before they became problematic and/or provide support to ensure self-harm is avoided including referrals to mental health professionals.

VIII. These comments were provided to the Ministry of Health, New Zealand Medical Council and Ms Hayman's medical practice. The Ministry replied stating "the Coroner's draft findings in this matter are outside the scope of what they can comment on".

IX. The New Zealand Medical Council provided the below reply:

> The Council publishes standards and guidance material for medical practitioners, but these are high level and broad so that they cover the range of scopes of practice and roles that medical practitioners undertake. For example, Good Prescribing Practice (2020) outlines what good prescribing practice involves, and the legal requirements doctors must comply with. The Council does not issue specific clinical management guidelines such as those referred to in the proposed recommendation. As a result, this recommendation would be better directed at the Ministry of Health or a relevant medical college such as the Royal New Zealand College of General Practitioners and/or the Royal Australian and New Zealand College of Psychiatrists.

X. Having considered the replies received, I see little point in recommending better treatment plans for patients.

XI. However, I am aware the Ministry is currently reviewing the patient education materials available to prevent opioid overdosing. Similar materials could be made available for patients withdrawing from long term antidepressant use such as Ms Hayman. The material could cover the risks and how to manage withdrawal from the patient's perspective including direction to accessible resources. These resources could be made available to patients through medical practitioners and drug and alcohol counsellors or online.

XII. The evidence shows Ms Hayman was unaware of the risks of withdrawal despite any adherence to specific clinical guidelines by her medical practitioner. She also could not access counselling assistance when sought. She blamed the effects of the withdrawal for her subsequent behaviour. She required better patient guidance to manage her health.

XIII. If she had been able to access educative materials on the risks of withdrawal and how to manage withdrawal, she may not have been subjected to the stressors that led to her death. This death may have been avoided.

XIV. The Ministry has replied to the comments and a draft recommendation, advising it is unaware of any plans to develop further information or guidance for patients prescribed antidepressants. It referred to a data sheet published by Medsafe[36] which gives guidance to medical practitioners, including information for patients and caregivers.

XV. There is little to show that this data sheet is available or being made available to patients withdrawing from antidepressants. There is no evidence of it being provided to Ms Hayman. It also presumes the patient knows how to find this information and has access to resources such as the Internet. This data sheet is also written in technical language that would not be able to be easily read by the average person.

XVI. It is concerning the lack of readable information being made available to patients prescribed antidepressants. According to one source, in 2018 approximately 9% of people in New Zealand aged 18 years and older (approximately 300,000) were dispensed a SSRI anti-depressant[37] and 45,000 New Zealand patients were prescribed venlafaxine.[38] Given the large numbers being prescribed antidepressants, there is a need for readable education material about the safe use of antidepressants to be produced.

### RECOMMENDATIONS OF CORONER TETITAHA

I. In view of the above, I make the following recommendations pursuant to section 57A of the Coroners Act 2006:

II. The Ministry of Health consider producing education materials for patients such as Ms Hayman seeking to withdraw from long term use of antidepressants. The materials could cover the risks and how to manage withdrawal including where to access support and assistance.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Ms Hayman taken during the inquiry, in the interests of decency.

## Henry [2022] NZCorC 84 [26 May 2022)

### CIRCUMSTANCES

Carolyn Patricia Henry, also known as Carolyn Patricia McKinlay, aged 49, died at Tarewa Road, Whangārei, on or about 17 July 2017 in circumstances amounting to suicide.

Carolyn was diagnosed with schizophrenia as a young adult and went on to have frequent contact with mental health services during her life. At the time of her death, she was subject to a compulsory community treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

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[36] https://medsafe.govt.nz/profs/Datasheet/e/Efexorxrcap.pdf.
[37] BPAC NZ website "SSRI use in New Zealand: your prescribing data" online article https://bpac.org.nz/2019/ssri.aspx#:~:text=SSRI%20use%20nationally%20has%20increased,a%20SSRI%20(Figure%201).
[38] NZ Herald article "patient say generic PHARMAC under division of antidepressant been the vaccine left them depressed, anxious" online https://www.nzherald.co.nz/nz/patients-say-generic-pharmac-funded-version-of-antidepressant-venlafaxine-left-them-depressed-anxious/SWRMDDR3CDKSDBLSZKCMZ72QPA/.

Carolyn was receiving support from a mental health nurse every two weeks in the months leading up to her death. Her last face to face contact with her nurse was on 3 or 4 July 2017. She appeared to be compliant with her medications and no concerns for her mental state were noted.

Northland District Health Board (DHB)'s Serious Incident Review records that Carolyn called her nurse on 17 July 2017 asking for her broken television to be fixed. The nurse attended the following day, but Carolyn did not appear to be at home. Carolyn did not respond to several follow up phone calls and knocks on her door over the following weeks.

On 11 August 2017, Carolyn's pharmacy advised the community mental health team that she was three days overdue to collect her medication. A social worker requested Police assistance to gain entrance to Carolyn's flat, where Carolyn was found deceased.

Carolyn's family raised concerns about the frequency with which she had contact with mental health staff and the timing of their communications with her in the last few weeks of her life. The Coroner concluded that Carolyn likely died on or about 17 July 2017 and that the lack of direct contact between Carolyn and her mental health team during late July and early August 2017 did not have any impact on her death. The Coroner further noted that Carolyn had no history of suicidal thinking or attempts, and that there was nothing in particular that would have alerted mental health staff that she was at specific risk of suicide in the period before she died.

### COMMENTS OF CORONER ANDERSON

I. As outlined above, I have formed the view that there are no clear indications that Carolyn's death was preventable. However, I note that Northland DHB has made a number of changes since Carolyn's death. These changes include the establishment of a Clinical Nurse Coordinator Role and a Clinical Pharmacist Role and improvements to the daily handover process. I do not consider that any additional recommendations are required in the circumstances. However, I note that service and quality initiatives of this nature must be sustained and enduring in order to provide ongoing improvements in the care that is provided.

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

## Inglis [2022] NZCorC 66 (28 April 2022)

### CIRCUMSTANCES

Clinton Douglas Inglis, aged 34, died on 27 August 2019 at Glen Eden, Auckland, in circumstances amounting to suicide.

Mr Inglis was reported to have struggled with his mental health over the years, and had attempted to end his life multiple times. He was diagnosed with schizoaffective disorder in 2016 and, following his last period of inpatient care in early 2019, remained subject to a Community Treatment Order under the Mental Health Act up until his death. Although he had generally appeared to be improving over this time, he began displaying symptoms of paranoia and erratic mood in the days prior to his death.

On the evening of 26 August 2019, Mr Inglis spoke of wanting to end his life to a relative who was flatting with him at the time. His flatmate tried to reassure Mr Inglis, but did not realise the extent of Mr Inglis' depression. The following morning, Mr Inglis again expressed suicidal ideation to his flatmate and on the phone to his sister, who contacted other family members asking if they could check on him. In further phone calls with Mr Inglis, his sister reassured him that his uncle would be over to see him soon. Mr Inglis appeared alright to his flatmate and others at the property, although he was noticeably quiet. He left the house briefly at about 3:00pm, saying he was going to the shops, but did not appear to be carrying anything with him on his return.

When Mr Inglis' uncle arrived at the property shortly before 4:00pm, he found Mr Inglis unresponsive in his bedroom. Emergency services attended but were unable to revive Mr Inglis.

## COMMENTS OF CORONER BELL

I. I make no recommendations however I make the following comments which are not intended in any way to be a criticism of any person. Having regard to the factors in this case I would urge all persons who:

   a. are aware of a person who has expressed suicidal thoughts and may be taking steps to act on those thoughts; or

   b. become aware that the person has so acted;

   c. to call emergency services as soon as possible, so that the best opportunity for successful intervention is given.

II. Every instance of a threatened suicide must be taken seriously.

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

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

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

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. The death may be described as a suicide. An order under section 74 of the Coroners Act 2006 prohibits the making public of the photographs of Mr Inglis entered into evidence, in the interests of personal privacy and decency.

# Lilley [2022] NZCorC 81 (25 May 2022)

## CIRCUMSTANCES

Ronald Thomas Lilley, aged 55, died on 23 June 2018 at the Southland Waterski Club, Invercargill, in circumstances amounting to suicide.

About two months prior to his death, Mr Lilley had sought help for his low mood and was prescribed antidepressants. Mr Lilley's mental health at first appeared to stabilise, but after expressing suicidal ideation on 6 June 2018, he was assessed by clinicians from the Southland Mental Health Emergency Treatment Team. A plan was made for community-based follow-up and treatment.

An appointment at the Brief Intervention Service on 11 June 2018 was cancelled due to staff illness. Mr Lilley was offered an appointment on 28 June 2018 but said that this was too long for him to wait, as he had "had enough of everything at the moment".

On 13 June 2018, Mr Lilley saw a consultant psychiatrist who diagnosed him with endogenous Major Depressive Disorder. Mr Lilley continued having thoughts of ending his life when he was alone, but identified his family relationships as strong protective factors. He was prescribed additional antidepressant medication and his sleep medication switched, to reduce his poor energy and daytime sedation. When Mr Lilley was reviewed again on 19 June 2018, he reported that his energy levels and mood had improved. He told the psychiatrist that he did not have any suicidal thoughts or plans.

On 23 June 2018, Mr Lilley appeared to have gone to work as normal but never arrived. He was subsequently found deceased.

Mr Lilley's family raised some concerns regarding his medical care in the period before his death, including the extent to which Southern District Health Board (SDHB) clinicians involved them in his care. While clinicians had sought permission from Mr Lilley to speak with his wife, he did not wish for his wife to be contacted. The SDHB accepted that contact with Mrs Lilley would have provided more useful information about Mr Lilley and his progress, and would have better equipped his family to monitor and participate in his treatment. It was noted that staff were aware of the usefulness of family involvement, but also had to balance this against their obligations under the Privacy Act and Health Information Privacy Code.

The Coroner noted that the primary responsibility for addressing these issues lay with the Ministry of Health rather than the SDHB. *He Ara Oranga, the Report of the Government Inquiry into Mental Health and Addiction*, was published in November 2018. The report addressed this issue and made the following recommendations:

> **Support families and whānau to be active participants in the care and treatment of their family member**
>
> 23. Direct the Ministry of Health to lead the development and communication of consolidated and updated guidance on sharing information and partnering with families and whānau.
>
> 24. Direct the Ministry of Health to ensure the updated information-sharing and partnering guidance is integrated into:
>
> - training across the mental health and addiction workforce

- all relevant contracts, standards, specifications, guidelines, quality improvement processes, and accountability arrangements.

These recommendations were accepted by the Government. In response to the Coroner's queries about their implementation, on 11 March 2022 the Ministry of Health advised:

- Updated Mental Health Act guidelines were released in September 2020 setting out best practice for engaging with family and whānau. A training package to support the implementation of the new guidelines is planned for roll out in the second half of 2022.
- Updated Health and Disability Services Standards, focusing on person and whānau centred approaches, including involvement of whānau, information sharing and supported decision-making, went live on 28 February 2022.
- Opportunities to improve and develop guidance on information sharing and partnering with family and whānau will continue to be considered as part of the wider health system reforms and establishment of new system arrangements. There are currently workplace development activities underway to promote whānau involvement and engagement.
- The implementation of both recommendations is therefore ongoing and does not have an 'implementation completion date'.

## COMMENTS OF AND RECOMMENDATIONS OF CORONER ELLIOTT

I. Even though the Ministry of Health has undertaken some action, it appears that recommendations 23 and 24 have not been fully implemented. In particular:

a. The recommendations were made in *He Ara Oranga* in the context of the following comments:

> As with any legal framework, guidance is crucial if the intent of legislation is to translate into good practice by the people at the front line. A variety of information is available, including extensive guidance from the Privacy Commissioner as well as guidance from the Royal Australian and New Zealand College of Psychiatrists, Ministry of Health, and Health and Disability Commissioner. This is a problem in itself – different messages from different organisations can cause confusion.
>
> We consider these guidance documents should be combined into consolidated, updated guidance that key agencies endorse. The Ministry of Health should lead a process to develop this guidance, involving people with lived experience, families and whānau, the Privacy Commissioner, the Royal Australian and New Zealand College of Psychiatrists, the Health and Disability Commissioner, the Children's Commissioner and other interested parties.
>
> The starting point should be that family and whānau can be involved in treatment and care, subject to the wishes of the individual patient. This should be supported by service cultures that promote connection and whanaungatanga. Some people may decide to give full access to their family or whānau, others may authorise access only to information about medication and discharge, and some may refuse to allow any access. In addition, family and whānau should be given the opportunity to provide information relevant from their perspective about their family member, recognising the valuable role that contextual information plays in improving outcomes.

The new guidance should also be built into relevant contracts, standards, specifications, guidelines, quality improvement processes and accountability arrangements.

b. It appears that the Ministry of Health has thus far not taken steps to combine the existing guidance 'into consolidated, updated guidance that key agencies endorse,' nor has it 'led a process to develop this guidance, involving people with lived experience, families and whānau, the Privacy Commissioner, the Royal Australian and New Zealand College of Psychiatrists, the Health and Disability Commissioner, the Children's Commissioner and other interested parties.'

c. Given that the Ministry of Health has not led the process of developing 'consolidated, updated guidance that key agencies endorse,' it follows that it has not implemented recommendation 24, which required the integration of this guidance into training, contracts, standards, specifications, guidelines, quality improvement processes, and accountability arrangements.

d. Even though Ministry of Health has taken some action in relation to matters involving the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992, this relates to only a portion of all cases.

II. I therefore proposed to make some comments and recommendations about this. Pursuant to sections 57B and 58 of the Coroners Act 2006, I gave the Ministry an opportunity to be heard.

III. Kiri Richards, the Acting Deputy Director-General, Mental Health and Addiction, provided the following further response:

> I want to acknowledge the tragic death of Mr Lilley and extend my sincere condolences to his family and whānau.
>
> I also acknowledge that extensive work has happened since 2018 to improve mental health and addiction services and support for tāngata whaiora and their whānau, including the work described in the Ministry's response dated 11 March 2022 to the request for comment under Section 120 of the Coroners Act 2006.
>
> **Recommendation 23 from *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction***
>
> In the response dated 11 March 2022, we provided evidence of work already underway in relation to recommendation 23 from *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (*He *Ara Oranga).* The letter stated that much of this work is ongoing, and that to give effect to the intention of the recommendation will require continuous improvement, therefore there is no fixed completion date for our work in response.
>
> The Government's response to *He Ara Oranga* noted the need to prioritise and sequence actions. One of the initial priorities identified in the Government's response to *He Ara Oranga* was the repeal and replacement the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act). As such, this has been a priority focus for the Ministry. The Ministry recently undertook a significant public consultation process to hear New Zealanders' views on what new mental health legislation in New Zealand could look like. The Ministry will use the public's feedback to develop policy recommendations to the Government by the end of 2022. The Government's policy decisions will then shape the new mental health legislation.

As outlined in the response dated 11 March 2022, the Ministry has ensured the intention of recommendation 23 is reflected in the priority work to support the repeal and replacement of the Mental Health Act. Updated Mental Health Act guidelines were released in September 2020 and set out the best practice for engaging with family and whānau. A copy of these guidelines can be found online here, with a whole chapter (Chapter 5) devoted to this guidance: Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 | Ministry of Health NZ

The Ministry also has broader work underway to improve the experiences of tāngata whaiora and their whānau with mental health and addiction services. This includes participation in the Key Performance Indicator programme (www.mhakpi.health.nz/) and various programmes through the Health Quality & Safety Commission (www.hqsc.govt.nz/). These programmes aim to gain insights from people with lived experience of services and their whānau, what works well and where improvements can be made.

I also want to provide assurance that people with lived experience and their whānau are involved in how we design and deliver mental health and addiction policies and services. We do this through our Lived Experience and Clinical Advisory team, which has strong relationships with lived experience and whānau networks and sits within the Ministry's Mental Health and Addiction Directorate.

**Recommendation 24 from *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction***

As outlined in the response dated 11 March 2022, the Ministry contracts four national mental health and addiction workforce development centres to provide leadership and to develop and implement programmes to grow and support the workforce: Te Pou, Te Rau Ora (Māori workforce), Le Va (Pacific workforce) and Whāraurau (Infant, Child and Adolescent Mental Health and Addiction workforce).

Further to our initial comments on recommendation 24, the four workforce centres coordinate and deliver training that supports and incorporates family and whānau involvement in the care and support of people accessing services. Further examples of programmes the workforce centres deliver, specifically Te Rau Ora, include:

Whare Tukutuku, an integrated model of prevention which focuses on creating a future workforce that is whānau-centred and community focused

- a whānau workforce programme being developed and implemented which is informed by the outcomes of the Māori Whānau Carers survey
- training and support for mental health and addiction providers to use the outcome measurement tool Hua Oranga, which considers views from stakeholders including whānau.

I would also like to highlight that the Ministry funds Māori, Pacific and Rainbow competency training, which includes consideration of whānau and family involvement.

***Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing***

I would also like to reiterate the strategic importance of *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing (Kia Manawanui)* released in 2021, as the Government's 10-year strategy and action plan for transforming New Zealand's approach to mental wellbeing.

It takes forward the Government's response to *He Ara Oranga,* including recommendations 23 and 24, and sets the direction for long-term transformation. While good progress has been made, we know more work is needed to better support New Zealanders' mental wellbeing. Building on the progress already underway, *Kia Manawanui* sets out the sequenced actions we will take.

Efforts to improve mental health and wellbeing, including for mental health and addiction service users and their whānau, will be supported by the health and disability system reforms. The objectives of the reform include common areas of focus on equity; partnering with Māori; greater access to care in the community and early intervention services; person and whānau-centred care; and consistent, high-quality care everywhere.

I hope this information is helpful, and once again I extend my sincere condolences to the whānau and friends of Mr Lilley.

IV. I have considered the further information provided by the Ministry of Health. Although the Ministry has referred to the need to prioritise work relating to the Mental Health (Compulsory Assessment and Treatment) Act 1992, it has not explained why that work has precluded it from fully addressing recommendations which have been accepted by the Government. For example, there was no reference to any lack of resources or explanation about why work relating to the Mental Health (Compulsory Assessment and Treatment) Act 1992 precludes the other work set out in the recommendations.

V. *He Ara Oranga* was published in November 2018. It is unsatisfactory that, after more than three years, these important recommendations have not been fully implemented.

VI. The recommendations are specific, tangible and capable of completion by a fixed date. It is therefore concerning that the Ministry of Health has decided that there will be no 'implementation completion date' for them.

VII. I will make a recommendation pursuant to section 57A that the Ministry should take immediate action to implement recommendations 23 and 24 and that it commits to a fixed date for doing so. My reasons for this are:

a. *He Ara Oranga* was published in November 2018, over three years ago.

b. Recommendations 23 and 24 are directed to a particular issue, namely the need for consolidated, updated guidance that key agencies endorse in relation to the application of the Privacy Act and Health Information Privacy Code. The discussion which precedes these recommendations shows that they were directed to the tension between a patient's right to privacy and involvement of the family.

c. The report states that guidance about this issue is crucial and that, while a variety of information is available, this is a problem in itself because different messages from different organisations can cause confusion- hence the need for consolidated, updated guidance which key agencies endorse.

d. This is an issue of very long-standing concern in the mental health system.

e. In relation to the treatment provided to Mr Lilley, Dr Mason accepted Dr Chaplow's statements regarding the Privacy Act and Health Information Privacy Code and that contact with Mrs Lilley would

have provided more useful information about Mr Lilley and his progress and would have better equipped the family to monitor and participate in his treatment.

f. The availability of such guidance may reduce the chance of further deaths in similar circumstances because mental health care is likely to be enhanced where all available information has been obtained by the practitioners and where the patient's family is in the best position to monitor and participate in the treatment.

g. Even though the Ministry of Health has taken some action in relation to matters involving the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992, this relates to only a portion of all cases.

h. The ongoing work which the Ministry of Health intends to do does not appear to incorporate the process specifically identified in recommendations 23 and 24 of *He Ara Oranga*.

i. Recommendations 23 and 24 were specific, tangible and capable of completion by a fixed date.

j. The Ministry has not fixed a completion date for implementing the recommendations.

VIII. I therefore make the following recommendation to the Ministry of Health pursuant to section 57A and comment pursuant to 58 of the Coroners Act 2006:

> Recommendations 23 and 24 of the *He Ara Oranga, the Report of the Government Inquiry into Mental Health and Addiction* relate to important and long-standing issues. The Inquiry's recommendations were made in November 2018. The Government accepted them. However, the Ministry of Health has still not fully implemented them.
>
> Mr Lilley's death illustrates the importance of these recommendations. Their implementation may save lives. It is unsatisfactory that, after more than three years, the Ministry of Health has not fully implemented these important recommendations. The Ministry of Health should take immediate action to fully implement the recommendations and commit to a date by which this is to be completed.

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

## Miller [2022] NZCorC 87 (7 June 2022)

### CIRCUMSTANCES

Gloria Whoi-Ran Ka Miller, aged 44, died on or about 27 January 2019 at 245 Glamorgan Drive, Torbay, Auckland in circumstances amounting to suicide.

Gloria was originally from South Korea. She moved to New Zealand when she was 29. She married a New Zealand doctor Chris Miller and had two young children.

Following the birth of her first child in 2005 Gloria experienced post-natal depression and was prescribed medication. In February 2009 Gloria was referred by her general practitioner to Waitematā DHB's Asian mental health services in the context of her presenting with mild depressive symptoms. She was prescribed anti-depressants and sleeping medication following this contact.

Asian mental health services worked with Gloria for eight months. A cultural support co-ordinator contacted Gloria and visited her at home to have time for emotional support and to encourage her potential. She was discharged from the service in November 2009 after her mental condition became more stable.

Gloria was seen by her general practitioner for a number of visits over the years and was diagnosed with chronic depression in 2016; the management plan was long-term antidepressants.

On 26 January 2019 Gloria's husband and their children travelled to their bach in Algies Bay for a long weekend while Gloria stayed at home. After arriving at the bach Dr Miller texted Gloria and told her that she was welcome to join them. This prompted an argument over text.

On the evening of 27 January 2019 Gloria sent a friend a text message indicating she was done with life. The friend thought that Gloria might have been intoxicated because of a high number of errors in the message, and replied the next day. Gloria did not respond.

Mr Miller returned home on 28 January 2019 and found Gloria deceased.

## COMMENTS OF CORONER HO

*Care provided to Gloria*

I. Dr Miller has expressed concerns that New Zealand's mental health system is overly "bicultural" giving minimal regard, resources and priority to the cultural context of mental health for people of Asian origin. He notes that mental unwellness is generally seen as of great shame and humiliation in Korean culture and informs a reluctance of those who are mentally unwell to seek help. He acknowledges that the Asian mental health service at Waitematā DHB was beneficial for Gloria in that they understood Gloria's cultural background and encouraged her to take steps that improved her mood. However, he says that this service was relatively unknown, difficult to locate and appeared under-resourced and that Gloria did not have ongoing follow up with them. He cites instances after she was discharged of her stopping her mood medication.

II. Issues of resourcing are a matter for the relevant district health board to determine. It would not be appropriate for me to opine on how government should best allocate scarce resources among competing priorities. I do however endorse the proposition that as the cultural mix of New Zealand's population changes the delivery of health services must also change to reflect the different needs of people from varying cultural backgrounds. This is particularly acute in the space of mental health where, as Dr Miller has observed, there may be stigma or barriers particular to people from certain cultural backgrounds.

III. I do not identify any issue with the specific decision by Asian mental health services to discharge Gloria in November 2009. At the time Gloria had made significant progress and she agreed to the discharge. Gloria regularly saw her GP after she was discharged and it was always open for her GP to re-refer her if it was

considered this was necessary. Gloria's medical notes record that the importance of complying with her medication was discussed.

*Organisations providing assistance to Gloria*

IV. Dr Miller says that he encouraged Gloria to seek help and asked for help from multiple medical and social services. He alleges that one local service refused to take him seriously and he was the subject of allegations of psychological abuse from that service. That allegation does not contain specifics about the individual(s) involved nor does it contain specifics of the service in question such as the branch and location. As the allegation is untested it would not be appropriate for me to make any further comment.

V. It is important that all organisations and services which deal with mental health issues take patient concerns seriously and respond in an appropriate manner without resorting to inflammatory language.

*Final text message to friend – a missed opportunity?*

VI. Dr Miller's view is that the recipient of Gloria's text message on Sunday evening ought to have contacted the Police at the time she received it. While that would have been prudent, I disagree that the message was so clear that an outsider should have immediately and objectively concluded that Gloria was at immediate risk of harm. Dr Miller's view is naturally informed by the circumstances of his marital relationship and more recently the messages he exchanged with his wife over the weekend. Gloria's friend did not have any of this context. In isolation, I do not regard the message as sufficiently indicative of suicide such that Gloria's friend turned a blind eye to an obviously imminent risk.

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

## Patterson [2022] NZCorC 64 (27 April 2022)

### CIRCUMSTANCES

Zak Ian Patterson, aged 18, died on 4 September 2019 at Stratford, Taranaki, in circumstances amounting to suicide.

The Coroner noted that Zak's sexuality appeared to be a stressor for him. He had told only a few close friends that he was gay and had not come out to his family, although had previously discussed questioning his sexuality with his mother. A female friend had told him that the male friends he grew up with would not accept him. In addition, it seemed that he had developed feelings for a male friend which were not reciprocated. The Coroner considered it likely that Zak would have felt isolated and strained by the burden of hiding his sexuality.

### COMMENTS OF CORONER DUNN

I. LGBTIQ+ New Zealanders are on average twice as likely to experience depression, anxiety and suicidal thoughts compared to those who are heterosexual.[39] There is a clear link between sexual orientation and self-harm, suicidal ideation and attempting suicide. [40] It has been reported that secondary school students who identify as LGBTIQ+ have an increased risk of depression, self-harm and suicidality, and experience more difficulty getting help for emotional worry.[41]

II. For young people struggling with their sexuality, there is always hope. There are several organisations that offer assistance to members of the LGBTIQ+ community who are seeking support. These are:

   a. Rainbow Youth – www.ry.org.nz

   b. 0800 OUTLINE – www.outline.org.nz

   c. Inside Out – www.insideout.org.nz

III. I note also that it can be difficult for parents to know how to support children who may be questioning their sexuality. Guidance for parents and family members can be found here:

   a. www.outline.org.nz/parents

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

# Rakete [2022] NZCorC 77 (12 May 2022)

### CIRCUMSTANCES

Dorothy Ann Rakete, aged 28, died on 19 January 2019 at 25 Heybridge Street, Manurewa, Auckland, in circumstances amounting to suicide.

Ms Rakete, her partner and their children moved address several times in the months before January 2019, at which point, they were staying with Ms Rakete's mother and grandparents. However, this living arrangement was temporary and the family were due to move out of Ms Rakete's grandparents' address at the end of January.

At around 7:00pm on 19 January 2019, Ms Rakete and her partner began to argue. During the course of the argument her partner decided to leave with the children. At this point, Ms Rakete started to make threats of self-harm. However, her partner explained that she would often voice these threats when they argued. Ms Rakete's partner returned home at around 9:30pm to find her unresponsive. Despite efforts to resuscitate Ms Rakete she died at the scene.

### COMMENTS OF CORONER GREIG

[39] https://www.otago.ac.nz/news/news/otago713774.html.
[40] Adams, J., Dickinson, P. and Asiasiga, L. (2012) Mental health promotion and prevention services to gay, lesbian, bisexual, transgender and intersex populations in New Zealand: Needs assessment report. Auckland: Te Pou.
[41] https://psychiatry-training.wiki.otago.ac.nz/images/e/e7/Lucassen11.pdf.

I. Ms Rakete's apparently repeated statements that she was going to kill herself when she and her partner argued, and he habitually went out following or during the argument, were ignored because "nothing happened." They were not treated as a signal that she may truly be thinking of ending her life. There is no evidence that her statements were ever taken seriously or that any steps were taken to encourage her to get help. It appears that important family members such as her grandmother and mother were not aware that she had made threats to end her life. Ms Rakete had not seen her general practitioner in relation to thoughts of suicide, nor had she ever been seen by mental health services. Her death is a tragic reminder that if someone has thoughts or feelings about suicide it is important to take them seriously. Good practical information for what to do when a person is distressed or showing suicidal behaviours (e.g., attempted suicide, self-harm and suicidal thinking) is contained in a Mental Health Foundation suicide prevention factsheet: https://mentalhealth.org.nz/conditions/condition/suicide-worried-about-someone.

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

## Rau [2022] NZCorC 94 (22 June 2022)

### CIRCUMSTANCES

Tira Junior Rau, aged 18, died between 22 and 23 October 2019 at Port Waikato in circumstances amounting to suicide.

Mr Rau was a promising rugby league player, He played for Runway Bay under 18 and under 20 in Australia and was pursuing a career in professional rugby league.

In the months leading up to his death, Mr Rau faced some health challenges including previous attempts at self-harm. In September 2019, he returned with his mother to live at the whānau home located in Waikato. Mr Rau seemed to be happy and healthy, keeping in contact with his family in Australia and looking at buying a return ticket. However, on 23 October 2019, Mr Rau was found deceased by a member of his family.

### COMMENTS OF CORONER TETITAHA

I. I make the following comments pursuant to sections 4 and 57A of the Coroners Act 2006.

II. There is a higher rate of mental illnesses amongst elite athletes which may be offset by pressures to succeed, full instabilities, and approaching retirement or transitioning from sports.[42] Elite athletes may also struggle with a perceived stigma that having a diagnosable mental illness is detrimental to the sporting careers, and subsequently risk not seeking effective support for treatment toward recovery.[43]

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[42] Rice, S. M., Purcell, R., De Silva, S., Mawren, D., Mcgorry, P. D., & Parker, A. G. (2016). The mental health of elite athletes: A narrative systematic review. *Sports Medicine*, 46(9), 1333–1353. doi:https://doi.org/10.1007/s40279-016-0492-2.
[43] Bauman, N. J. (2016). The stigma of mental health in athletes: Are mental toughness and mental health seen as contradictory in elite sport? *British Journal of Sports Medicine*, 50(3), 135–136.

III. Rugby league players are not exempt from mental illness. On average 2.5 players in every run-on rugby league team will experience depression.[44] Academics have commented upon rugby league's "club culture" including "a harsh, unsupportive psychological environment combined with expectations of manliness resulting in a culture of silence in the face of personal difficulties."[45]

IV. Whānau referred to Mr Rau's refusal to access available assistance when exhibiting self-harming behaviour in the Gold Coast. This might indicate the issues referred to above and the need for educational strategies to elicit positive changes in behaviour toward mental illnesses, communicating needs and help seeking behaviour including how to proactively seek support from mental illnesses through increased mental health literacy amongst the players and their supports.[46] Incorporating an ethnic-cultural understanding of well-being is vital in connecting to relevant support structures and systems.[47]

V. I sought comments from New Zealand Rugby League (NZRL) regarding details of any mental health support provided to players at all levels both regional representative as well is top tier players.

VI. At the regional representative level, NZRL has a well-being team that conducts a presentation in the early stages of the team's formation including a discussion on mental health service support available for each member of the team. Several of the regional teams have NZ sports chaplains with the specific task of mental and spiritual support. If regions request an additional workshop, they receive education on how to spot the signs of mental distress, respond and refer to help. This was undertaken with 4 regional representative teams this year.

VII. In 2021 in partnership with Le Va,[48] NZRL produced a mental health roadshow that delivers interactive and educational workshops for Rangatahi and parents called the "Wellbeing Waka" which is developing "Wellbeing champions" in each area. These champions provide welding support networks for the communities when the roadshow ends. These champions have training opportunities for toolkits to deal with potential crises or matters of need regarding mental health, suicide prevention and overall well-being. Le Va provides access to free of charge counselling services to all rugby league whānau.

VIII. The elite Kiwi and junior Kiwi players who go to individual clubs have well-being managers attached to their "top 30" players. There are mandated periodical wellbeing plans to be completed with each player. NZRL use Le Va's tool to assess mental health risk for individual players who join in NRL or Australian state cup side from New Zealand. If the tool reveals any red flags, this is followed up by the NZRL and NRL club wellbeing managers.

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[44] NRL website Well-being and Education https://www.nrl.com/wellbeing-and-education/healthwise/mental-health/depression/
[45] Brownrigg, A., Burr, V., Bridger, A., & Locke, A. (2018). 'You shut up and go along with it': An interpretative phenomenological study of former professional footballer's experiences of addiction experiences of addiction. *Qualitative Research in Sport, Exercise and Health*, 10(2), 238–255.
[46] Sebbens, J., Hassmén, P., Crisp, D., & Wensley, K. (2016). Mental Health in Sport (MHS): Improving the early intervention knowledge and confidence of elite sport staff. *Frontiers in Psychology*, 7(June), 1–9. doi:https://doi.org/10.3389/fpsyg.2016.00911.
[47] Marsters, C., & Tiatia-Seath, J. (2019). Young Pacific male rugby players ' perceptions and experiences of mental wellbeing. *Sports*, 83, 7. Retrieved from https://www.mdpi.com/2075-4663/7/4/83.
[48] Le Va a charitable organisation supporting Pacifica families and communities to achieve the best health and well-being outcomes. https://www.leva.co.nz/.

IX. This year NZRL endeavoured to train as many staff and investors as possible in either the “mental wealth project” or the life keepers (suicide prevention) program. Staff are trained to spot the signs of distress and respond. In time this will become a prerequisite for coaches to complete.

X. NZRL have 2 full-time and 2 part-time workers dedicated to their well-being department. The Wellbeing manager has a direct report line to the CEO.

XI. The NZRL are thanked for their response. I support and endorse NZRL’s proactive stance on the mental health and well-being of their players. If Mr Rau had access to these resources in 2019, this death may have been preventable.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Rau taken during this inquiry, on the grounds of decency.

## Speedy [2022] NZCorC 78 (12 May 2020)

### CIRCUMSTANCES

Michael Weston Speedy, aged 60, died on 11 August 2019 at his family farm in Ngatea in circumstances amounting to suicide.

At the time of his death Mr Speedy managed three farms owned by his family.

In May 2017 a commercial property that the Speedys owned burnt down in a suspect arson. As a result Mr Speedy was experiencing difficulties with the local Council and their insurance claim. Additionally, the spring of 2017 had been a difficult one for farming. These issues caused Mr Speedy much anxiety for which he sought professional help via his general practitioner (“GP”).

Following his death, Mr Speedy’s family raised a number of concerns with the Coroner regarding difficulties they experienced accessing appropriate and timely mental health support due to Mr Speedy’s rural location.

Dr Scott, from Mr Speedy’s GP practice, advised that primary level mental health services are limited due to the area’s rural location. Primary health organisations (“PHOs”) include GP practices and are funded by the Waikato District Health Board (“DHB”). Four funded sessions of counselling may be requested at this level and there are some small non-governmental organisations (“NGOs”) providing specific services in Thames. However, once a patient is referred to secondary care they can no longer access services provided by the PHO or NGOs as they are considered to be under the secondary care team. There are some private options in the area, including referrals to a psychiatrist or a psychologist, but there are no comprehensive services required to provide a complete mental health support package.

Dr Scott also advised that referral to a secondary service usually occurs because a patient’s symptoms have become too severe for general practice to handle, and specialist services at a higher level are required. For psychiatry care, a referral to secondary care is done to access advice around more complex medication regimes, but also to access support services such as psychology, social worker, etc that are not available in general practice or primary care.

Finally, Dr Scott reported that by April 2022 the practice would be provided with a health coach with a mental health focus, and a health improvement practitioner with a clinical psychology background. These are both new roles within the practice that have been funded by the DHB. It is likely these services will not be accessible by those under secondary care, as with other primary care roles. However, Dr Scott hoped that accessing this new primary level care sooner will reduce the requirement to use secondary care.

### COMMENTS OF CORONER BATES

I. I am heartened by the information provided by Dr Scott, noted in the previous paragraph. The DHB-funded initiative of introducing into a rural GP practice specialists such as a health coach with a mental health focus and a health improvement practitioner with a clinical psychology background is to be commended. Although the addition of these resources at primary care level has come too late for Mr Speedy and his family to benefit from them, my sincere hope is that other rural families are able to benefit and that mental health concerns are able to be identified and explored at a much earlier stage. I encourage the spread of this type of primary care initiative to other rural locations, backed by DHBs as in this case or through an additional government funding stream.

II. There is much in the media at present regarding funding of and access to mental health services generally, and in particular services that may be utilised by those in rural areas and in the farming sector, such as Mr Speedy and his family. Improved access for patients and their families to appropriate mental health support is an area requiring constant attention, investment and improvement at primary and secondary levels.

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

## Walkley [2022] NZCorC 67 (28 April 2022)

### CIRCUMSTANCES

Luke Josip Walkley, aged 17, died on 11 October 2019 at Auckland Central. The circumstances of his death amount to suicide. On occasion Luke would express thoughts of self-harm to his friends.

### COMMENTS OF CORONER BELL

I. One role of the Coroner is to make comment or recommendations that may prevent deaths in similar circumstances in the future. In this case the issue of how best to deal with a person talking of taking their own life requires comment. However, in making these comments, I intend no criticism of Luke's friends or anyone else Luke may have had contact with and expressed thoughts of self-harm to. This is not a circumstance most people are faced with, particularly young people. Knowing how best to respond if confronted with such a situation is important.

II. There are key things to bear in mind. The first is that if someone expresses thoughts and feelings about suicide take them seriously. Urge the person to obtain help and if you are concerned, get help immediately, by contacting a doctor or mental health service. If you need to, call emergency services on 111. If the

person is feeling unsafe, or you think they are at high risk, do not leave them alone. People in this situation need someone with them.

III. I note the Ministry of Health gives the following advice for people who are concerned about suicidality in others, and includes specific resources for those concerned about young people: https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal

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

# X [2022] NZCorC 75 (10 May 2022)

### CIRCUMSTANCES

X, a 14-year-old male, died on 25 June 2019 in circumstances amounting to suicide.

X was experiencing several stressors in his life, including continuing difficulties with his schoolwork and with his whānau and other relationships. He had attempted to end his life on two occasions in the previous 18 months.

On the day of his death, X had been visibly distressed after his girlfriend ended their relationship via text message. X replied with messages saying that he was going to end his life, and also communicated to another friend his intentions to self-harm. While alone at home for a short time, he took steps to end his life.

Post-mortem toxicology testing confirmed the presence of THC, the active constituent of cannabis, in X's blood. X's mother told Police that she was aware that he used cannabis, and various cannabis-related items were found in his bedroom. While the frequency of X's cannabis use could not be ascertained, the Coroner considered that it was a potentially relevant factor in his death.

### COMMENTS OF CORONER BORROWDALE

I. Youth suicide in New Zealand is a health issue of the deepest concern, and one that does not lend itself to a simple solution. I make the following comments under section 57A of the Coroners Act 2006, for the purpose of reducing the chances of further suicide by young people in circumstances similar to those in which X died.

II. It appears from X's medical records that he received appropriate and supportive mental health care and counselling following his first suicide attempt in December 2017, and over the following 18 months until his death by suicide in June 2019

III. It is not apparent that X's health support included any substance-use counselling or other attention.

*Guidance for young people on suicide risks*

IV. On the day of his death, X expressed suicidal intentions to his girlfriend and to another friend. I acknowledge that it must have been very difficult for these young people to know how to respond. It appears that they

both pleaded with X not to act on his impulses towards self-harm, and one friend promptly alerted X's mother to the danger he was in. Tragically, X did not share his suicidal intentions with his mother or brother that afternoon and, when left alone for a short time, took the steps that ended his life. X's impulsive acts that day left no opportunity to obtain for X the urgent help that he needed.

V. I endorse the Ministry of Health's published advice to anyone worried about someone who may be suicidal:[49]

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

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

c. The website contains information about what to do if you think someone needs urgent help, which I repeat here:

> If someone has attempted suicide or you're worried about their immediate safety, do the following:
>
> - Take them seriously. Thank them for telling you, and invite them to keep talking. Ask questions without judging.
> - Call your local mental health crisis service or go with the person to the emergency department at the nearest hospital.
> - If they are an immediate danger to themselves or others call 111.
> - Remain with them and help them to stay safe until support arrives.
> - Try to remain calm and let them know that you care.

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

> For counselling and support – these are free and generally available anytime:
>
> - Lifeline – 0800 543 354
> - Samaritans – 0800 726 666
>
> For children and young people:
>
> - Youthline – 0800 376 633, free text 234 or email talk@youthline.co.nz (for young people, and their parents, whānau and friends)

[49] https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal.

- What's Up – 0800 942 8787 (for 5–18 year olds; 1 pm to 11 pm)
- The Lowdown – visit the website, email team@thelowdown.co.nz or free text 5626 (emails and text messages will be responded to between 12 noon and 12 midnight)
- SPARX – an online self-help tool that teaches young people the key skills needed to help combat depression and anxiety.

*Comments on youth suicide and cannabis use*

VI. X was a young teenager who had a history of experiencing moderate depression, with feelings of intense isolation and sadness. X was known to smoke cannabis with some regularity, and he had smoked cannabis immediately prior to his death.

VII. X's cannabis use was not unusual within his age-group. Cannabis use amongst New Zealand's young people is commonplace, although reported to be declining.[50] A major study in 2011 reported that nearly 80% of young people had used cannabis before the age of 21.[51] Many New Zealanders appear to regard cannabis use as innocuous.

VIII. It is not possible to particularise what causative effect or contribution X's cannabis use made to his suicide. However, I have derived help from considering medical research on whether there is an identified association between youth cannabis use and suicidality.

IX. The public may benefit from knowing about the accumulating evidence that cannabis use by teenagers is associated with an increased risk of mental health problems and suicidal ideation.

X. A recent large-scale study of Americans aged 18-35 years old, over the period 2008 - 2019, was supplemented by national data on cannabis use by those aged 12 years and over. The study found that cannabis use was associated with increased risks of suicide, suicide planning and suicide attempt. Even people who used cannabis non-daily were more likely to have suicidal ideation, and to plan or attempt suicide, than those who did not use the drug at all.[52] The association held true regardless of whether the cannabis user was also experiencing depression. The major longitudinal Christchurch Health and Development Study (**CHDS**) has reported in these terms:[53]

> Until relatively recently, cannabis has been viewed as a relatively harmless drug that has few adverse effects. However, in the last two decades there has been an accumulation of evidence suggesting that cannabis may have multiple harmful effects with these effects being particularly marked for adolescent users. It is believed that the

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[50] Ball et al "Adolescent cannabis use continues its downward trend, New Zealand 2012-2018" *New Zealand Medical Journal* Vol 133 No 1510, 21 February 2020.
[51] "Cannabis Use in Adolescence" D Fergusson and J Boden, Chapter 20 in *Improving the Transition – Reducing Social and Psychological Morbidity During Adolescence – A report from the Prime Minister's Chief Science Advisor*, May 2011 (**CHDS study**) at p260: https://dpmc.govt.nz/sites/default/files/2021-10/pmcsa-Improving-the-Transition-report.pdf.
[52] Study by researchers of the National Institute on Drug Abuse, part of the US National Institutes of Health, reported 22 June 2021: https://nida.nih.gov/news-events/news-releases/2021/06/cannabis-use-may-be-associated-with-suicidality-in-young-adults and https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2781215?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jamanetworkopen.2021.13025.
[53] CHDS study at 258.

greater vulnerability of adolescent users may be due to the biological effects of cannabis on the developing adolescent brain.

XI. The study described the following documented adverse effects:

- Increased risks of psychosis and psychotic symptoms
- Increased risks of other mental disorders, including suicidal thoughts
- Increased risks of other illicit drug use
- Increased risks of school dropout and educational under-achievement
- Increased risks of motor vehicle accidents

XII. A 2014 analysis of adolescent studies that included the CHDS and the Victorian Adolescent Health Cohort Study (**VAHCS**)[54] reported a "direct relation" between cannabis use and suicidal ideation. Its study found strong effects for daily users of cannabis. Adolescents who were daily cannabis users before age 17 years had odds of suicide attempt that were seven times higher than for those young people who had never used cannabis. Those who used cannabis weekly or more were four times more likely to attempt suicide. Those who used cannabis monthly or more were over twice as likely to attempt suicide. The analysis acknowledged that the "mechanisms" behind these associations were less well understood, but emphasised that the developing adolescent brain "*is vulnerable to the effects of cannabis.*"

XIII. These studies, and others like them, are a vital contribution to suicide prevention efforts. We cannot know what contribution X's cannabis use may have made to his mental health or his suicide. But on the basis of these studies, and many others like them, I am not prepared to assume that X's cannabis use played no part at all in his tragic death.

XIV. I encourage the caregivers and guardians of youngsters who use cannabis to make themselves aware of its risks, and of the avenues for help and support in reducing their children's cannabis use.

*Recommendations*

XV. In light of these comments, I do not consider it necessary to make any recommendations pursuant to s 57(3) of the Coroners Act 2006.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. Orders under section 74 of the Coroners Act 2006 prohibit making public any photographs of the deceased entered into evidence during this inquiry, on the grounds of personal privacy and decency; and making public the names of, and any particulars likely to lead to identification of, the deceased and each of his parents. For the avoidance of doubt, identifying details include the college that the deceased attended, his hometown and place of death.

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[54] Silins & Ors "Young Adult Sequelae of Adolescent Cannabis Use: An Integrative Analysis" *Lancet Psychiatry* 2014: 1: 286-293, https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(14)70307-4/fulltext.

# Sudden Unexpected Death in Infancy (SUDI)

## Veamatahau [2022] NZCorC 65 (27 April 2022)

### CIRCUMSTANCES

Ofa Ki Muli Veamatahau, aged seven weeks, died on 1 January 2022 at Mt Wellington, Auckland from Sudden Unexpected Death in Infancy associated with unsafe sleep.

At around 3:00am on 1 January 2022, baby Ofa was fed by her mother, Lisa. Lisa noticed that Ofa was shivering and wrapped her up. Ofa was sleeping with Lisa on a king sized mattress. At around 7:00am, Ofa was found unresponsive by Lisa. Sadly, efforts to revive Ofa were unsuccessful.

Ofa was co-sleeping with her mother on the same sleep surface, which is a risk factor for Sudden Unexpected Death in Infancy (SUDI). A sleeping adult has no knowledge or control of their movements during sleep and so co-sleeping increases the risk of asphyxiation or smothering of a child. This is why it is recommended that parents who wish to sleep next to their baby, including for bonding reasons, should put the baby in their own separate and delineated sleeping surface on the bed such as a pēpi-pod or wahakura.

The Coroner identified two other potential SUDI risk factors:

a. Sleep surface: the king size mattress was a new, firm innerspring mattress. However, Ofa was sleeping on an improvised topper made up of a folded over queen sized blanket which was likely to be a softer sleeping surface than the mattress itself.

b. Overheating: while Lisa said that Ofa was shivering at 3:00am, when she added an extra blanket, Ofa was already in a muslin swaddle over a long-sleeved onesie, tights and socks. This meant Ofa was covered in three to four layers on an Auckland summer's evening. No windows were open in the house.

### COMMENTS OF CORONER HO

I. It is clear from the evidence that Lisa and Salesi are loving parents to their children, as are many others who in the past have made the same tragic decision to co-sleep with an infant. As has been outlined, I am satisfied that the safe sleeping message was advised to the parents. Indeed, upon post-natal visits to the address Lisa's LMC [lead maternity carer] witnessed safe sleep practices being observed. In a SUDI liaison interview conducted after Ofa's death Lisa said that Ofa would sleep in her bassinet in the lounge half the time and with her in the bed the other half. The family liked to sleep in the same room so if Ofa was in the lounge the family would also sleep in the lounge.

II. Considerable effort has been made in New Zealand to promote the message that every sleep for a baby should be a safe sleep. That is for every sleep, babies up to one year of age should be put to sleep on their backs, in their own sleeping space (being a firm, flat surface with no pillow) and with their face clear.

III. Ministry of Health guidelines were published to reduce the sudden unexpected deaths of infants. The key focus was to target the two key modifiable risks for SUDI: exposure to tobacco smoke during and following

pregnancy in the home and in the car; and unsafe co-sleeping in the bed with baby. Despite the admirable aim of these guidelines, research studies have expressed concern at the level of awareness of these commonly promoted healthy sleep messages.[55] Specifically, studies have exposed a lack of understanding by some of the importance of the safe sleep practices due to conflicting experiences within families, which become barriers to implementing the messages:

a. Safe sleep messages generally had higher awareness than messages promoting quality sleep. Why a message was important was not always communicated or understood.

b. Families were exposed to messages through multiple sources, which were often conflicting. Family seemed to be one of the most trusted sources.

c. Barriers to implementing messages were interconnected with determinants of health, inequities of social, cultural, collective and economic realities for Māori whānau and Pasifika family.

d. Caregivers did not always implement sleep advice due to these factors. As a result, experiences of self-doubt, judgement and pressure were common.

IV. It is important that the safe sleep message be consistent and not conflict with other advice. Any barriers that exist through inequities in social, cultural, collective and economic disparity must be addressed through appropriate funding levels to ensure the importance of the safe sleep message is consistently communicated, understood and disseminated. It is essential that parents understand the difference between safe *bed-sharing* with an approved separate sleep safe device, such as a wahakura or pēpi-pod and the dangers of *co-sleeping* without such a device.

V. In a previous coronial finding I addressed a situation where a mother had declined a pēpi-pod after giving birth because she already had a bassinet at home. My view remains that the best solution to avoid co-sleeping deaths is by issuing all new parents with a pēpi-pod at birth:

> To the extent that baby['s] death resulted from co-sleeping with his mother, and therefore could have been prevented by the use of a pēpi-pod or wahakura, I do not regard it as sufficient that new parents are simply "offered" such a device at birth. Many new mothers are tired and overwhelmed after giving birth. They do not want to make another decision. If there is to be a serious public health desire to reduce deaths of babies from SUDI caused by co-sleeping, there must be commensurately serious attempts at ensuring that simple steps which can prevent such deaths are routinely taken before they are needed. One possible course of action is to automatically give each new mother a pēpi-pod after birth rather than ask if they would like one. My research shows that the cost of a basic pēpi-pod, albeit in 2016, was $100 each[56] and in the year to September 2021 there were 59,382 live births registered in New Zealand.[57] An annual cost of $6 million appears to be a small price to pay to ensure that babies do not unnecessarily die from co-sleeping.

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[55] Perese, I., Warwick, K., Pio, F., McLeod, D., & Salter, T. Malatest International. (2020). Māori whānau and Pasifika family experiences of sleep health messages. Wellington: Te Hiringa Hauora/Health Promotion Agency.
[56] https://www.stuff.co.nz/national/health/82801474/government-uturn-on-funding-pepipods-could-save-dozens-of-babies-lives#:~:text=Mitchell%20told%20the%20New%20Zealand,would%20be%20about%20%24100%20each.
[57] https://www.stats.govt.nz/information-releases/births-and-deaths-year-ended-september-2021.

I recommend that the Ministry of Health consider automatically issuing all new babies with a pēpi-pod or wahakura at birth.

VI. Lisa said that she was offered a pēpi-pod but declined because she already had a bassinet. It is unclear whether the difference between a pēpi-pod and a bassinet was explained to her. Lisa also said in interview that she had co-slept with her other three children; if this had been ascertained prior to Lisa being discharged home with Ofa she may have been identified as more at risk of co-sleeping with Ofa and therefore identified as someone who would have benefited from a more fulsome explanation of the purpose of a pēpi-pod and the dangers of sharing a bed with her infant baby without one. Even if my recommendation of pēpi-pods universally being issued is not taken up, checking with mothers about previous co-sleeping practices would at least provide a more targeted marker of those babies who might be at risk of co-sleeping and therefore who would benefit from a wahakura or pēpi-pod being provided.

VII. I direct a copy of these findings to be sent to the Ministry of Health, the Child Youth Mortality Review Committee, and Change for our Children, all of which are actively involved in working to strengthen and promote consistent safe sleep messages.

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

# Workplace

## McLean [2022] NZCorC 71 (4 May 2022)

### CIRCUMSTANCES

Benjamin Henry McLean, aged 63, died on 15 April 2020 at Makarewa of multiple traumatic injuries and blood loss after being gored by a stag.

Mr McLean and his partner, Binita Kumar, owned a 10-acre farm at Makarewa where they kept deer, pigs, sheep, alpacas, goats, chicken and ducks. Mr McLean was known to treat his animals like pets. Two red stags were kept at the farm. The bigger of the two was named Robert and had been bottle reared by Mr McLean and Ms Kumar. Robert was about four years old and had not had his velvet antlers cut that season. Mr McLean had separated the two stags because they were fighting due to the rutting season, or “roar”, as it is commonly known. Robert was put in a paddock with three red deer hinds. The paddock was fully fenced with two-metre high deer fencing and two gates.

Ms Kumar did not go into the paddock to feed Robert because she was scared of him. She had told Mr McLean they should sell him but Mr McLean reassured her that he would be safe because the stag knew him well, and he always took a long fluorescent coloured fiberglass stock stick into the paddock with him. Ms Kumar, as well as Mr McLean’s colleagues, had told him not to go into the paddock with stags during the roar.

On 15 April 2020 Mr McLean went out to the farm at 11:00am. He had not arrived home by 2:30pm when Ms Kumar left for work. Mr McLean’s colleagues became concerned when he did not arrive for his shift. They went to his farm and while

searching the property, heard a stag roaring. They could see something blue and orange at the other end of Robert's paddock and went to investigate. They found Mr McLean pushed up against the fence, with serious injuries and ripped clothing. Because of the stag, the colleagues thought it was too dangerous to enter the paddock. One of them managed to reach through the fence in order to check Mr McLean for a pulse. He could not find one.

During investigation, the Police identified rut marks in the grass near Mr McLean's body, and the broken tip of an antler near him. Robert's antlers had blood on them.

In 2015 WorkSafe New Zealand produced a guideline for safe deer handling (the Guideline). The Guideline was prepared with assistance from a sector working group which included representatives from Deer Industry New Zealand, Federated Farmers of New Zealand. It applies to anyone handling deer.

The Guideline states that it applies "to anyone handling deer" and notes:

> From late January onwards, the nature (temperament) of stags tends to change with a move toward increased aggressiveness. By the beginning of March (beginning of the rut) they can be very dangerous and unpredictable. As such, antlers should be removed early, before they are "hard Antler' … to ensure the safety and welfare of the deer and their handlers.
>
> To ensure stags are handled as safely as possible, a rigorous culling policy for poor temperament, aggression, flightiness or unpredictability should be practised.
>
> When entering a paddock with a rutting stag inside, use a vehicle that will provide protection from an attach, eg a cabbed tractor. Two people should be on hand.
>
> Hand-reared deer can be the most dangerous, and should not be kept in hard antler.
>
> Never work with stags on your own, or enter a paddock with stags on foot during the rut.

The New Zealand Deer Farmers Association (NZDFA) and Deer Industry New Zealand (DINZ) also provide advice to farmers regarding the safe handling of deer. The DINZ "Deer Hub" website includes the following information:

> Stags with hard antlers or buttons present a very significant hazard to people especially if they have little fear of people.
>
> Tame stags can become very dangerous. All stags can be dangerous during the rut, but tame animals may be even more dangerous due to a very low flight distance created, for example, by having become accustomed to human contact whilst being hand fed.

There was no evidence that Mr McLean was aware of the advice in the Guideline and that he knew he was not following best practice in terms of his interactions with his stags.

### RECOMMENDATIONS OF CORONER CUNNINGHAME

I. The Guideline sets out clear advice about the safe handling of stags. It is freely available through WorkSafe's website. I do not consider it necessary to make any recommendations pursuant to s57A of the Act about the safe handling of stags.

II. Mr McLean and Ms Kumar were not professional farmers. They may not have considered the farm to be a "workplace", as defined by s20 of the Health and Safety at Work Act 2015 (HSWA). Whether or not deer-owning hobby farmers or lifestyle block come under the jurisdiction of the HSWA, the Guideline is pertinent to them. It is reasonable that individuals who own stags follow the recommendations in the Guideline.

III. In these circumstances, it is appropriate to make a recommendation in order to promote the advice in the Guideline among the rural community, and particularly among those New Zealanders who keep deer on lifestyle blocks. I have considered how New Zealanders like Mr McLean might best be advised about the existence of the Guideline, so that they can take best practice into account when managing stags.

IV. DINZ and DFNZA are focussed on farmers and industry stakeholders. Federated Farmers of New Zealand Inc (Federated Farmers) has 13,000 members, which includes not only farmers, but lifestyle block owners. Among Federated Farmers' many initiatives is the "Friday Flash" newsletter which goes to around 11,000 people every week.

V. In taking into account the requirement that any recommendations must be clearly linked to the factors which contributed to Mr McLean's death, I am mindful that he would not have identified as a deer farmer or a member of the deer industry. I therefore decided to direct a recommendation that Federated Farmers disseminates information about Mr McLean's death as set out above, along with a link to the Guideline to its members, with a particular focus on its lifestyle block owner membership, in order to promote awareness among the community.

VI. I consulted with Federated Farmers in accordance with s57B of the Act.

VII. Federated Farmers advised that the organisation was happy to use its communications channels to promote the Guideline and the need to take care with handling stags, and noted that its expansion into the lifestyle farmer market allows it to specifically target these members. Federated Farmers suggested that the messaging be timed for summer since the roar for farmed deer is over for the year, and in summer it is still possible to remove the velvet antlers from stags. This suggestion is practical.

VIII. Federated Farmers also advised that lifestyle block owners may face additional challenges managing the risk of stags in hard antler because they may not be equipped with deer handling facilities that allow a veterinarian to remove antlers, and their small number of paddocks can make it difficult to separate stags and put them in separate paddocks.

IX. Finally, Federated Farmers suggested that these findings be provided to DINZ and DFNZA so that safety messages can be more widely shared.

X. Having considered the feedback from Federated Farmers, I make the following recommendation:

a. That over the 2022-23 summer period, Federated Farmers disseminates information about Mr McLean's death summarised at paragraphs [45] to [49] [of the finding], along with a link to WorkSafe's guideline for safe deer handling to its members, with a particular focus on its lifestyle block owner membership.

b. That the Ministry of Justice provides a copy of these findings to DINZ and NZDFA for their information.

XI. I thank the team at Federated Farmers for their advice and for their willingness to work with the Court to prevent further tragedies.

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

OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND