



OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments
made between **1 July** and **30 September 2019**

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 20 recommendations and/or comments issued by coroners between 1 July and 30 September 2019.

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

Contents

Recommendations and comments	4
1 July to 30 September 2019	4
Death in Custody.....	4
Dalton [2019] NZCorC 37 (30 July 2019)	4
Drowning.....	6
Buckley [2019] NZCorC 45 (22 August 2019)	6
Hodges [2019] NZCorC 36 (19 July 2019)	7
Jentsch [2019] NZ CorC 38 (2 August 2019).....	8
Power [2019] NZCorC 28 (3 July 2019)	9
Hunting.....	10
Leech [2019] NZCorC 40 (9 August 2019)	10
Medical Care	11
Gilbert [2019] NZCorC 47 (30 September 2019)	11
Mitchell [2019] NZCorC 29 (8 July 2019)	13
Motor Vehicle	14
Mosaferi (A and R) [2019] NZCorC 41 (9 August 2019)	14
Neems [2019] NZCorC 32 (16 July 2019)	15
Wano [2019] NZCorC 44 (16 August 2019)	16
Product-Related	18
Wylie [2019] NZCorC 30 (11 July 2019).....	18
Self-Inflicted	20
Carter [2019] NZCorC 42 (12 August 2019)	20
Day [2019] NZCorC 39 (7 August 2019)	21
Hart [2019] NZCorC 31 (12 July 2019).....	22
Naidoo [2019] NZCorC 35 (17 July 2019)	23
Roberts [2019] NZCorC 33 (16 July 2019)	23
Thomas [2019] NZCorC 34 (16 July 2019).....	25
Sudden Unexpected Death in Infancy (SUDI).....	27

Pakuivi [2019] NZCorC 43 (12 August 2019)	27
Workplace	28
Rowberry [2019] NZCorC 46 (10 September 2019)	28

Recommendations and comments

1 July to 30 September 2019

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

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

Death in Custody

Dalton [2019] NZCorC 37 (30 July 2019)

CIRCUMSTANCES

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

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

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

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

COMMENTS OF CORONER RYAN

- I. A draft of proposed recommendations was provided to the ADHB to enable submissions to be made on those recommendations. Submissions have been received from counsel for the ADHB. The submissions indicate that

it is already standard practice for the mental health service to offer a letter of introduction for patients who inform the staff of their intention to travel. The implication is that such a protocol is not required.

- II. The ADHB submissions also referred to potential breach of a patient's right to privacy if the patient's consent is not given for such a letter, and the heavy burden it would place on the mental health service to obtain knowledge of foreign mental health systems to be able to inform patients and their families.
- III. The submissions go on to note that modern methods of communication easily allow for transfer of information to foreign mental health services as the need arises. The ADHB suggests that the concerns intended to be addressed by the proposed recommendations would be better dealt with by discussions between the service and the patient and family about the risk of relapse while travelling overseas and therefore the desirability of the travel.
- IV. I have given consideration to the submissions, but do not consider the matters raised override the potential benefit for having a formal policy. Clearly any such policy would note the limitations on knowledge and would address the patient privacy issues covered in counsel's submissions.
- V. In my view the lack of a policy covering the situation faced by ADHB staff and Mrs Wilson when discussions were being held regarding Mr Dalton travelling to Samoa contributed to a misunderstanding between the parties. As a result, Mrs Wilson believed arrangements were being made which in fact was not the understanding of the ADHB staff.
- VI. I do not consider my proposed recommendations impose a duty upon the ADHB to research any foreign mental health service to ascertain the level of care that service can provide to travelling patients, nor to pre-determine where and how information on a patient might have to be sent. But it is not unreasonable to expect the ADHB mental health service to discuss with a patient and their family the possibility that mental health services in the proposed country of travel may have limitations. If a patient requires information to be sent to a foreign country due to a relapse there, that service would of course contact the ADHB for information.
- VII. I am therefore satisfied that the recommendations set out below are appropriate, particularly as they are not prescriptive.

RECOMMENDATIONS OF CORONER RYAN

- I. I make the following recommendations pursuant to section 57A of the Act:
 - a. That the Auckland District Health Board should consider developing a protocol covering the actions by ADHB Mental Health Services when a client of the Service is about to travel to another country.
 - b. Such a protocol should address (inter alia) the following issues:
 - i. The circumstances in which the ADHB should provide the client and/or the family with a letter outlining in brief the client's mental health history and current treatment regime, to provide a colleague in a foreign mental health service with some immediate information about the client if required.
 - ii. The circumstances in which the ADHB should communicate with the mental health service in the country to which a client of the ADHB is about to travel, to provide information to that

service about the client instead of or beyond what might be contained in the letter proposed in (i) above, and (in appropriate cases) to discuss whether the local mental health service has the resources to cope with that client if required.

- iii. The understanding of the client and/or the family that the mental health service of the country to which the client is travelling may have limited resources if the client's mental health deteriorates, so that the client and the family can make a fully informed decision on whether to travel.
- II. This recommendation is directed to the Chief Executive Officer and the Chief Medical Officer of the Auckland District Health Board.
- III. The purpose of this recommendation is to encourage the development of a protocol which clinicians can follow to:
 - a. Assist families to determine whether it is appropriate for a family member with mental health issues to travel overseas.
 - b. Facilitate the immediate or early transfer of information to the mental health service of another country where a client of the DHB is travelling to, thereby ensuring the best opportunity for optimal psychiatric care if it is required.
- IV. Such a protocol would also cause clinicians to consider whether they should pre-empt the possibility of the patient requiring psychiatric care in another country by discussing the patient with the mental health service in that country before the patient arrives there.
- V. This Court has no jurisdiction in Samoa and therefore it is not appropriate for any recommendations to be made relating to factors identified within Samoa that have contributed to Mr Dalton's death. Instead I will provide a copy of my Finding to the Attorney-General of Samoa in the hope that any lessons that can be learned from the distressing circumstances of Mr Dalton's death will be taken on board.

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

Drowning

Buckley [2019] NZCorC 45 (22 August 2019)

CIRCUMSTANCES

Andrew John Buckley was found dead on the ocean floor near Stephens Island, Marlborough, on 28 February 2017. He was last seen by his diving buddy on 25 February 2017, while ascending to the surface during a scuba dive. At that point

he had under 50 bar of oxygen in his dive cylinder. When found, Mr Buckley was missing his dive mask, his knife and one fin. His dive belt was on his body.

Mr Buckley's diving equipment was examined and tested by the Police National Dive Squad (PNDS). PNDS observed that Mr Buckley's dive cylinder was empty and its valve open. The valve was tested and found to function correctly with no evident leaks. PNDS also examined Mr Buckley's weight belt and found that it would have made him negatively buoyant. PNDS concluded that Mr Buckley did not have enough oxygen in his cylinder to complete the ascent with two decompression stops he had to undertake. His death therefore occurred while he was ascending, after he breathed his dive cylinder empty.

COMMENTS OF CORONER ELLIOTT

- I. It appears to be necessary to continue to emphasise the need to adhere to safe practices when diving. I therefore make the following comments pursuant to section 57A of the Coroners Act 2006:
 - a. Andrew Buckley drowned on 25 February 2017 while diving in the water near Stephens Island, Marlborough.
 - b. Mr Buckley began his ascent to the surface alone but the oxygen in his cylinder ran out and he did not reach the surface.
 - c. The following factors collectively contributed to the unsuccessful ascent:
 - i. The duration and depth of the dive, given the amount of air he had.
 - ii. The amount of weight on his weight belt, which affected his buoyancy.
 - iii. The fact that he did not abandon his weight belt when in difficulty when doing so would have made him more buoyant.
 - iv. Ascending to the surface alone.
 - d. Mr Buckley's death highlights the importance of scuba divers checking their weighting and buoyancy, monitoring their air supply and diving with a buddy for the whole dive.

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

Hodges [2019] NZCorC 36 (19 July 2019)

CIRCUMSTANCES

Michael John Hodges of Dunedin died on 3 February 2017 in the water at Sandfly Bay, Dunedin. The cause of his death was drowning following a shallow water blackout.

Mr Hodges was an experienced freediver and on 3 February 2017 was fishing and diving with his friends at Sandfly Bay, Dunedin. At approximately 6.30pm, the group wanted to move to another point in the bay but found that the anchor was stuck. Mr Hodges dove down to release the anchor. He returned to the surface but then disappeared.

COMMENTS OF CORONER ELLIOTT

- I. Michael Hodges died in Sandfly Bay, Dunedin, on 3 February 2017. Mr Hodges had been freediving with four companions. He dived alone to free an anchor and then returned to the surface. He then lost consciousness as a result of shallow water blackout.
- II. The weight on Mr Hodges belt was such that he was negatively buoyant and he descended beneath the water when he became unconscious. None of Mr Hodges' companions were in the water keeping watch for him. Mr Hodges drowned.
- III. Mr Hodges' death illustrates the importance of freedivers weighting their belt such that they are neutrally buoyant at a minimum depth of 10 metres, and therefore positively buoyant at lesser depths, as well as the importance of following the 'one up/one down' principle under which another diver on the surface monitors the submerged diver, and maintains visual contact with the point of descent until the diver resurfaces and then maintains visual contact with the diver once they have surfaced.

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

Jentsch [2019] NZ CorC 38 (2 August 2019)

CIRCUMSTANCES

Carolin Klara Emma Jentsch died on 14 December 2016 at Hukatere Beach, Pukenui, from accidental drowning.

Ms Jentsch was a tourist from Germany, sight-seeing in Northland. On 14 December 2016, she went swimming with some friends on Hukatere beach. After about 10 minutes it was noticed that Ms Jentsch and two others were about 50 meters off the beach and seemed to be panicking and going under the water. Several rescue attempts were made, and Ms Jentsch was found behind the breaking waves. Despite attempts at resuscitation, Ms Jentsch was sadly unable to be revived.

Hukatere beach is situated partway along Ninety-Mile Beach, 31 kilometres north of Ahipara. It is an area with only a few permanent residents, with one vehicle access track onto the beach and two pedestrian access tracks from the two accommodation providers in the area. The beach is characterised by a wide, gently sloping beach face with the near-shore zone having multiple shore-parallel sand bars separated by deep gutters and troughs. Inshore holes are present throughout the near-shore zone. The area is exposed to considerable wave energy, and strong rip currents, particularly during outgoing tides. The area is not patrolled by surf lifeguards, with the nearest surf lifeguarding service 34 kilometres to the south at Ahipara Beach.

Photographs taken on the day of Ms Jentsch's drowning show that it was a moderately fine day. However, a local resident, who knows the beach well, said that the sea conditions were very rough. The waves were about 2m high and

breaking to over 100m offshore. Hukatere Beach is described as being notoriously dangerous for swimming in these kinds of conditions. There are known holes off shore and a severe tidal rip. High tide had been at roughly 10am, with low tide expected at about 4.20pm. Accordingly, it was an outgoing tide when the women went swimming.

Various witnesses to this inquiry commented on the lack of signage warning of the dangers of swimming in this area.

COMMENTS OF CORONER MCDOWELL

- I. I am aware of one other drowning at Hukatere beach, which occurred two years before Ms Jentsch's death.¹ In the finding relating to that death Coroner Greig noted the isolation of Hukatere beach and that swimming conditions there can be treacherous. On 11 December 2017 she made a specific recommendation to the Far North District Council (FNDC) that it facilitate the erection of water safety signage which meets the requirements of the combined Australian/New Zealand standard, at the road entrance to Hukatere Beach. FNDC indicated its intention to do so.
- II. I have received confirmation from FNDC that water safety signage was installed at Hukatere beach on 19 December 2018. That signage warns of strong currents/rips, large waves, and that the beach is not patrolled by lifeguards, among other things. I commend the Te Oneroa-a-Tōhe (90-mile beach) board for its actions in this respect.
- III. I note further that Water Safety New Zealand (WSNZ), the national agency that works with the water safety sector to reduce the incidence of drowning and injury in New Zealand, has confirmed its ongoing education campaigns targeted to high risk groups. WSNZ advised my inquiry that between 2008 and 2017, 82% of people who died by drowning in New Zealand were born in New Zealand. Of the non-New Zealanders who drowned in that period, 3% were tourists. A copy of my finding will be sent to Water Safety New Zealand for its information.

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

Power [2019] NZCorC 28 (3 July 2019)

CIRCUMSTANCES

Zachary Orland Mark Power of New Plymouth died between 13 and 15 November 2017 at Ohariu Bay, Makara, Wellington of probable drowning due to a shallow-water blackout while free-diving alone.

On 13 November, Zachary Power (aged 24 years) went free-diving off Makara beach near Wellington. He failed to return to his partner's address in Wellington that evening. Following an extensive search, Mr Power was located deceased by the Police National Dive Squad (PNDS), 18 metres offshore from Ohariu Bay, Wellington on 15 November.

The Police National Dive Squad (PNDS) provided a report on Mr Power's death which raised two possible scenarios that could explain what happened. First, he may have panicked, possibly believing he was running out of air, and rushed to

¹ In the matter of an inquiry into the death of Jarod Lineses, CSU-2015-WHG-000001, 11 December 2017.

the surface. Given that Mr Power was an experienced diver, this was considered unlikely. The second scenario was that Mr Power may have experienced a shallow-water blackout. PNDS defined this as a loss of consciousness caused by a reduction of oxygen to the brain. This occurs in free-diving and spear fishing where breath-holding divers descend for a period of time. Then, during their ascent, changes in pressure combined with reduced oxygen, starve the diver's brain causing them to black out. Shallow water-blackout occurs without warning, making it impossible for a diver to abandon their weight belt.

Mr Power was free-diving alone, contrary to best practice for any form of diving. He was also carrying excess weights, and failed to jettison his weight belt when he got into difficulty, most likely because he was acutely incapacitated.

The PNDS report referred to several recommendations for free-divers. These included:

- (a) Always dive with a buddy and constantly monitor each other. Employ the 'one-up, one-down' system.
- (b) Free-divers should constantly review and adjust their weight in relation to the dive they are conducting. Ideally, free-divers should manage their weight to maintain a neutral hover point in the water approximately 30% to 40% of the depth they will dive.
- (c) Although it is not recommended by Police to dive alone, if the individual is free-diving alone, they should be marked or tethered to a surface float to show their approximate position underwater. If this is not possible, then always have someone on the surface watching the diver's movement so that they will be able to assist when needed.
- (d) Divers should abandon weights when they start to get into difficulty.
- (e) Take regular breaks on the surface even if only to reassure the person on the surface monitoring you.
- (f) Know your limitations and do not take any unnecessary risks.

COMMENTS OF CORONER RYAN

- I. I have considered whether recommendations or comments are appropriate in this inquiry pursuant to s 57(3) of the Coroners Act 2006. I do not consider there are any formal recommendations I could usefully make, although I endorse the recommendations contained in the PNDS report and encourage free-divers to adhere to them.
- II. I note the efforts being made by Leon Power and interest groups to raise public awareness of appropriate safety measures for free-divers, and commend these efforts.

Hunting

Leech [2019] NZCorC 40 (9 August 2019)

CIRCUMSTANCES

Gordon Douglas Leech died on 2 April 2018 while hunting. He was fatally shot in the chest by another hunter, Mr McCreedy, from a distance of 40-50 metres. Mr McCreedy immediately called the Police. A helicopter arrived at the scene and resuscitation attempts were made. However, Mr Leech could not be revived. Mr McCreedy was later dealt with by the Courts.

COMMENTS OF CORONER BAIN

- I. This is a tragic hunting accident. It reinforces the need for hunters to properly identify their target.
- II. This matter has been dealt with by the Court at length, with all the material facts and the errors that were made.
- III. There is a major issue here of failing to identify a target. This aspect was dealt with by this Court into the death of James Wilson Dodds in 2013.
- IV. The Firearms Safety Code stresses the need to identify a target when hunting and sadly that very much applies to this tragic death.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs forming part of the evidence, as well as addresses, telephone numbers, and e-mail addresses of persons who have provided signed statements, in the interests of personal privacy and decency.

Medical Care

Gilbert [2019] NZCorC 47 (30 September 2019)

CIRCUMSTANCES

Arohaina Teiria Gilbert, aged 25, suffered from acute bronchitis. On 28 February 2018 she was referred to General Surgical Outpatients at Wairoa Hospital by her then GP after presenting with breathing difficulties and an enlarged neck swelling. Following a CT scan on 23 March, she was diagnosed with goitre (swelling of the neck due to an enlarged thyroid gland). This was causing compression on Ms Gilbert's trachea. Appointments in the following days indicated the swelling was increasing and interfering with her breathing, although there was good air entry into the lungs, and no increased heart rate. Thyroid tests were ordered.

Ms Gilbert was triaged by the General surgical team on 28 March 2018 and was prioritised as "urgent" (to be seen within six weeks). An outpatient appointment arranged for 9 May 2018 was cancelled when the surgeon was required to attend another patient. The appointment was rescheduled for 30 May 2018. Ms Gilbert saw another GP on 11 May 2018, who was very concerned that two and a half months after Ms Gilbert's initial referral, and six weeks after her CT scan, she had not been seen by Hastings hospital. Ms Gilbert's condition was deteriorating. That same day the GP spoke to a surgeon over the phone and arranged for Ms Gilbert to be seen by the surgeon on 16 May and operated on the next day.

On 14 May 2018, Ms Gilbert was having increasing trouble breathing and an ambulance was called. On arrival at Wairoa Hospital Ms Gilbert was unresponsive. She could not be revived and was pronounced deceased. The post mortem revealed

that the cause of Ms Gilbert's death was asphyxia due to respiratory compromise, with underlying thyroid gland, large multinodular goitre, compressing the trachea, and with recent chest infection. Ms Gilbert's morbid obesity was considered to be a contributing factor in her death.

Hawkes Bay District Health Board (HBDHB) asked Mr Simon Harper, Consultant Endocrine and General Surgeon at Wellington Regional Hospital, to provide an opinion regarding the management of Ms Gilbert's case. Mr Harper reported that in a very small percentage of patients with benign multinodular goitre (in the region of 0.69%) the presentation can be with acute airway compromise, noting that this is one of very few true emergencies to present to an endocrine surgeon. Having reviewed Ms Gilbert's CT scan, Mr Harper noted that the surgical referral by the GP, received by HBDHB on 1 March 2018, was triaged on 28 March 2018. Mr Harper considered this interval appeared unduly long. Noting the GP's call and what she reported to the surgeon on 11 May, Mr Harper considered that it was reasonable for the surgeon to arrange to see Ms Gilbert on 16 May, with a plan for surgery the day after.

HBDHB also commissioned an Adverse Event Review, which concluded that the system for management of surgical referrals and access to general surgical clinics led to a delay in timely surgical review and treatment for Ms Gilbert. There was a delay to triage Ms Gilbert's referral. The Endocrine Surgical triage criteria failed to acknowledge that some non-malignant (benign) cases can be life-threatening. Ms Gilbert was given an urgent triage prioritisation (to be seen within six weeks) which was consistent with the triage criteria, rather than a higher prioritisation (i.e. immediate – to be seen within two weeks) which was restricted to patients with high suspicion of cancer. The process for obtaining a clinic appointment was cumbersome and had insufficient quality assurance and monitoring. The Reviewers noted that the first planned review appointment (9 May 2018) was postponed due to competing need for the surgeon to undertake a cancer operation, and insufficient alternative clinics. They considered that, although Ms Gilbert was reviewed by her GP two days prior to her collapse and death, there was nothing in that assessment, or the subsequent conversation between the GP and the surgeon, to indicate acute admission was required, rather than what was arranged.

RECOMMENDATIONS ENDORSED BY CORONER ROBINSON

- I. The Reviewers have recommended that patients presenting with neck masses with potential airway compromise be added to the "immediate" (to be seen within two weeks) category on the surgical triaging form. They also recommended a review of the referral system and processes and the development of a new process to ensure timely triage occurs with checks in place to alert and escalate if delays occur. The Reviewers also recommended that surgeons' timetables and resourcing be reviewed to ensure sufficient clinical non-contact time is available for referral triaging, and that where an appropriate applicant exists, locums employed should have the surgical subspecialty skills required to fill the position they are covering. As an adequate clinic availability led to failure to provide an appointment date within the specified timeframe for Ms Gilbert, the Reviewers recommended review of the current clinic availability and waiting times and compare it to referral demand.
- II. I consider that the recommendations by the Adverse Event Reviewers are appropriate. Given that, I consider it unnecessary for me to make recommendations. Effectively, the management of surgical referral of Ms Gilbert's multinodular goitre as urgent, rather than immediate, and cancellation of the general surgical clinic scheduled for 9 May 2018 led to a delay in timely surgical review and treatment for Ms Gilbert. I consider that Ms Gilbert's death could reasonably have been avoided had there been more prompt surgery review at a surgery clinic, and had surgery been undertaken.

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

Mitchell [2019] NZCorC 29 (8 July 2019)

CIRCUMSTANCES

Trevor John Mitchell of Owaka died on 22 July 2016 in a helicopter en route to Dunedin Public Hospital of effects of massive trauma consistent with “run-over” injury producing numerous fractures of the thoracic cage and extensive bleeding into the lungs.

Mr Mitchell, aged 48, was working on a rural farm with a friend, William Scoles, to cut and remove firewood. They had done this several times in the past. Mr Scoles was cutting the tree and Mr Mitchell was driving the farm’s tractor unit, a 1961 International TD5 crawler. It appears that Mr Mitchell was driving the tractor unit with a log in tow and was carrying out manoeuvres to shorten the chain between the towed log and the tractor. The tractor unit then started to roll down the hill. Mr Mitchell tried to regain control of the moving tractor unit which may have resulted in him slipping or falling and being run over by the tractor unit. The accident was not witnessed and Mr Scoles found Mr Mitchell shortly after lying injured in a paddock.

Mr Scoles called emergency services at 2:27pm. At 2:39pm, the call-taker attempted to identify the exact location of the accident but this proved difficult due to its remoteness. At 2:39pm, the call-taker contacted Heli Otago and requested a helicopter. A helicopter was available but there was no crew as the primary helicopter and crew were attending another incident. Due to the difficulty in locating the scene of the accident, Police Search and Rescue (SAR) were notified at 2:41pm to assist as per the Letter of Understanding between Police and St John. Police were advised that a helicopter was on standby and looking for appropriate crew.

At 2:45pm, Police communications contacted the Officer in Charge of SAR who advised that this would be a medical response, not a SAR response as there was sufficient information to locate Mr Mitchell. Clinical Support at the Clinical Communication Centre contacted Mr Scoles at 2:45pm to clarify location details and provide information to help assist Mr Mitchell. A helicopter was dispatched at 2:56pm.

At 3:07pm, Police sent a ‘Mobile Locate’ to Mr Scoles’ cell phone. As a result, his GPS location was established. This was relayed to St John and helicopter crew. They arrived at the location at 3:34pm.

RECOMMENDATIONS OF CORONER ELLIOTT

- I. I make the following recommendation to St John and Police:

In cases where Emergency Services have been notified by mobile phone of an accident in a remote but unidentified location, ‘Mobile Locate’ should be used immediately to identify the exact location from which the call has been made.

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

Motor Vehicle

Mosaferi (A and R) [2019] NZCorC 41 (9 August 2019)

CIRCUMSTANCES

On 30 March 2018, a Nissan Navara motor vehicle was travelling south on State Highway 1. A Kenworth truck towing a trailer was travelling south behind the Nissan, followed by a Toyota motor vehicle, and behind that was another Kenworth truck towing a trailer. The southbound Easter traffic was heavy and there was a line of traffic preceding the Nissan. The traffic slowed and the driver of the Nissan adjusted his speed accordingly. The driver of the Kenworth failed to notice the slowing traffic and had to swerve into the opposing lane to avoid a rear end collision. The driver in the Toyota was in the process of adjusting speed while the driver of the following Kenworth truck failed to stop short of the Toyota, colliding with the rear of the vehicle.

As a result, the Toyota was pushed forward into the rear of the trailer being towed by the Kenworth truck and the rear of the Nissan. Four-year-old Arteen Mosaferi, who was seated in the rear right of the Toyota on a booster seat, sustained injuries and died at the scene. Two-month-old Radeen Mosaferi, who was seated in the rear left of the Toyota and in an appropriate baby capsule was also injured and died two days later in Starship Hospital.

The driver of the rear Kenworth truck, Mr Barber, was following too close and unable to stop. According to the serious crash analysis report, fatigue and distraction may have been contributing factors. Mr Barber was charged with and pleaded guilty to careless driving causing death, as well as falsifying a logbook entry, exceeding work hours and failing to have mandatory rest. The company he worked for, Dynes Transport, also pleaded guilty to two counts of allowing the vehicle to be used in respect of which a logbook was falsified. WorkSafe decided not to prosecute Dynes Transport as a result.

RECOMMENDATIONS ENDORSED BY CORONER BAIN

- I. WorkSafe, from their investigation, made a number of recommendations to the Coroner. They are set out below:
 - a. Support the introduction of electronic logbook systems so real time monitoring of drivers can be achieved by the heavy motor vehicle transport industry;
 - b. Ensure transport operations/routes are researched, scheduled and resourced, so far as reasonably practicable, so drivers can comply with work and rest time legal requirements;
 - c. Introduction of an automated braking system (autonomous emergency braking) to heavy motor vehicles.
- II. It is recommended that these be forwarded to the appropriate authorities and in particular the Minister of Transport for them to be considered for implementation.
- III. Having read the traffic crash report and the WorkSafe report and considered all the material, it is the Court's view that it appears that an offence has been committed under the Health & Safety and Work Act 2015.

Accordingly, pursuant to s146(1)(b), the certificate of Findings is signed, and this is forwarded to WorkSafe so that consideration for a prosecution may commence.

Note: An order under section 74 of the Coroners Act 2006 prohibits, in the interests of personal privacy and decency, the publication of the photographs forming part of the evidence, as well as the addresses, telephone numbers and email addresses of persons who provided statements in evidence.

Neems [2019] NZCorC 32 (16 July 2019)

CIRCUMSTANCES

Carla Lynne Neems of Whataupoko, Gisborne died on 2 May 2017 outside 33 Russell Street, Whataupoko, Gisborne of massive head injuries sustained in a pedestrian v truck incident.

Carla, aged six years old, was coming home from her school (a distance of 450m) on a push scooter. She was accompanied by two other children earlier in the journey but they parted ways and she continued alone. Carla was not wearing a safety helmet.

As far as can be determined, when Carla crossed Russell Street to access the driveway to her home, she was struck by a refuse truck owned by Waste Management Limited that was collecting rubbish. Carla (or her scooter) was struck by the mid-front of the truck, causing a slight dent to the number plate. Tragically, Carla was then struck by the left rear wheel of the truck and died instantly from a massive head injury. The truck driver was unaware that he struck Carla.

COMMENTS OF CORONER SCOTT

- I. The two methods of protecting Carla in ascending order were firstly to have the truck fitted with proximity audio alarms and secondly, to have her accompanied by a responsible adult.

RECOMMENDATIONS OF CORONER SCOTT

- I. Evidence from the Area Manager of Waste Management Ltd was that the company now recognised the desirability of having audio alarms and because Hino trucks were not fitted with them, they were going to be replaced on a rollout basis commencing in the South Island with Mercedes trucks that do have an audio alarm. While that is positive, the company needs to do more.
- II. It is my recommendation that the company proactively investigate the retrofitting of audio alarms to its present fleet. I am aware that backing cameras can be retrofitted and I would be surprised if audio alarms cannot be, although the company may need to do some investigation to determine that. It is my recommendation that the company proceed to do so with the aim of retrofitting such alarms over the next six months. That would make a similar tragedy highly unlikely. Drivers will also need to be directed and trained to stop immediately and investigate if such audio alarms sounded. An alternative (or an addition) to these alarms would be to fit a front view camera. However, I am cautious about "driver overload" - giving the driver one more active thing to do risks the possibility of error and might be counter-productive. Therefore, I do not recommend front view cameras unless as an alternative if it proves impossible to install audio alarms.

- III. Meantime, there is one simple and obvious thing that the company can do to make the process of refuse collection safer - although it may not make it safer for young unaccompanied children - put signage on the trucks. Something along the lines of, "Caution I stop often and am often driven from the left," - or similar. I recommend that the company undertakes such signage work - again within six months.
- IV. I also make the point however that the WorkSafe inspector indicated that he had received no particular training in investigation or report writing - he was a former police officer - and that he had no particular expertise in the subject he was investigating. There may be room for WorkSafe to address these issues - particularly with training in investigation and report writing and perhaps in the selection of inspectors to inspect and report on events within their particular field of expertise. That of course depends on the pool of available inspectors. I make a recommendation about this.

Wano [2019] NZCorC 44 (16 August 2019)

CIRCUMSTANCES

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

RECOMMENDATIONS OF CORONER WINDLEY

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

- II. NZTA subsequently provided a further response advising:

We are now aware that the Coroner has been advised that the Horowhenua District Council are only accepting responsibility to repair existing fencing and are not accepting responsibility for the installation of new fencing along the railway lines in the subject location. We were not aware of the position of the Horowhenua District Council until being advised by the Coroner.

In light of this new information we are now in the process of assessing whether there is a need to change our regulatory response. ...

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

KiwiRail can confirm that vegetation along the area of the rail corridor in question is being cut back to 5 meters off rail. This work has started and is expected to be completed within a week.

Once that work is completed, fencing contractors ... will erect fencing² as identified by the Blue line [refer Image 2] ... This is new fencing and will be installed from the 90km NIMT mark to the first level crossing (South Lane) and then on to Bath Street (approximately 1.3km north of the yard) as per the plan. It is anticipated that this work will begin the week of 19 August 2019.

KiwiRail is committed to erecting the fencing as described above.

- IV. The need for agencies with safety responsibilities for areas in and around railway lines to work collaboratively and effectively with a focus on enhancing safety is self-evident. I consider KiwiRail to have now given a clear and firm undertaking to promptly undertake what is a fencing project of some scale, independent and irrespective of any licensee obligations upon HDC.
- V. KiwiRail's engagement with the safety issues raised in my inquiry, and planned practical improvements in response to my recommendations, demonstrate a recognition and commitment to improving rail safety. However, as these are still planned works, I cannot yet be satisfied that the safety risk identified has been mitigated such that my proposed recommendations are no longer necessary.
- VI. I should note that it is not lost on me, or any of the organisations I have engaged with in relation to this inquiry, that Rail Safety Week 2019 has focussed its public campaign on near miss incidents between people and trains, and vehicles and trains,³ of which there were in excess of 400 last year. Implementing these planned improvements are practical means by which rail safety will be immediately enhanced and the chances of serious injury or death markedly reduced at this location. The potential future development of a shared pathway/cycleway through Levin may incidentally provide a rail safety solution along a much greater area of Levin's rail network in the longer-term.
- VII. I therefore confirm my final recommendations as follows:
 - a. That **KiwiRail** complete the work outlined in its undertakings to my inquiry to:
 - i. identify and implement means by which members of the public can be physically excluded or discouraged from accessing the railway yard at this specific location, specifically by erecting or supplementing fencing, and erecting signage warning of trains and directing pedestrians to the level crossing; and
 - ii. ensuring planting in close proximity to the track in this location is trimmed back to allow for greater visibility for train drivers to identify any risks including the presence of any person.
 - b. That the **NZTA**, in its capacity as the safety regulator, closely monitor the pace and extent of progress towards full implementation of KiwiRail's above undertakings to my inquiry, and if it should become necessary, give consideration to the exercise of its regulatory powers to drive forward implementation of these safety improvements.

² Being wire mesh fencing 1.8 metres high.

³ See www.nearmisses.co.nz

VIII. Upon issuing this Finding my jurisdiction in relation to this matter ends. Unfortunately, in New Zealand, there is no mandatory requirement under the Coroners Act 2006 for organisations to report on the action that has been, or will be taken, in response to a coroner's recommendation.⁴ Notwithstanding this, I invite KiwiRail and NZTA to provide to the Chief Coroner an update as to progress with safety improvements at this location **within three months** of this Finding.

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

Product-Related

Wylie [2019] NZCorC 30 (11 July 2019)

CIRCUMSTANCES

Albert Wylie of St Albans, Christchurch died between 22 February and 23 February 2015. The cause of his death was carbon monoxide poisoning due to accidental inhalation of fumes from an LPG heater.

Mr Keith Rodgers of Energy Safety, part of WorkSafe New Zealand, examined the heater.

Coroner Windley was satisfied that a fault with the heater produced excessive carbon monoxide that was unable to be sufficiently dissipated due to the confined space and lack of ventilation in Mr Wylie's unit, ultimately leading to Mr Wylie's death from carbon monoxide poisoning.

COMMENTS OF CORONER WINDLEY

- I. In his report, Mr Rodgers stated that both causal factors identified in this fatal accident: a fault in the heater, and the failure to use it within ventilation guidelines, can be managed by the end-user. He recommended that cabinet heaters such as this only be used in larger rooms and not in bedrooms or bathrooms. Further, that they be serviced regularly, preferably at the beginning of each heating season. The challenge, in his view, lies in raising public awareness of these important safe operating practices.
- II. Since Mr Wylie's heater was supplied for sale in 2009, new regulations have been implemented for all gas appliances imported or manufactured in New Zealand. The Gas (Safety & Measurement) Regulations 2010 require that before they are supplied, all gas appliances must comply with a gas appliance certification regime. The European Standard EN 449 for flueless LPG heaters is the standard that includes cabinet heaters.

⁴ Supplementary Order Paper No 146 to the Coroners Amendment Bill proposed amendment to the Coroners Act 2006 to introduce a new section, section 57C, which would require Government agencies to respond to coroner's recommendations describing the action taken, or planned to be taken, as a result of the coronial recommendations, within 60 days (clause 30). The explanatory note records this proposed amendment was in recognition of the critical role coroner's recommendations have in understanding the causes of, and preventing further, deaths. The ability for agencies to ignore coronial recommendations was identified as undermining this role. This proposed amendment was not carried through to the Coroners Amendment Act 2016.

- III. Since April 2011 cabinet heaters have also been subject to additional controls as a 'Declared Article' requiring an approval from WorkSafe. Prior to this, the obligation on the supplier was to make a supplier declaration that the appliance was safe. Now, as part of the WorkSafe approval, the supplier must provide:
- a. Evidence of certification to the European Standard (EN 449)
 - b. A test report that demonstrates the appliance meets the requirements of EN 449
 - c. Evidence of satisfactory combustion performance on NZ LPG or its equivalent gas type
 - d. Evidence that that the product will be sold with the marking required by NZS/AS 3645 (Essential requirements for gas equipment) being:
 - i. permanent label on heater with health warning, minimum room size, positioning and ventilation requirements, and gas flare up warning;
 - ii. removable notice on a prominent position on the outside of the heater or external packaging with safe operation advice including: health warning, recommended leak tests, positioning and ventilation requirements, minimum room size, recommended annual servicing.
- IV. Mr Rodgers noted that Energy Safety had previously worked with the gas industry to produce swing tags detailing the safety information. These tags were attached to LPG cylinders when consumers refilled their cylinders at a service station with an LPG filling facility. However, Mr Rodgers noted such service station facilities are now less common and the current trend is for consumers to use a swap system where they bring an empty cylinder in and pay for a pre-filled full cylinder. There are also a variety of retailers who operate a swap system. Mr Rodgers suggests these changes make it more difficult to provide safety information at the point of LPG cylinder refill sale.
- V. A website for gas safety that details safety messages relating to cabinet heaters⁵ has been developed by the gas industry and the government agencies involved in gas safety. WorkSafe has also produced a webpage that details cabinet heater safety.⁶ This webpage emphasises the following safe operating practices:
- a. have adequate fireguards;
 - b. check connections on LPG heaters for leaks;
 - c. ensure heaters are used in well ventilated areas; and
 - d. have heaters serviced regularly.

⁵ LPG association "LPG Safety – Safe and efficient use of LPG" GASNZ <http://www.gasnz.org.nz/lpg-association-of-new-zealand/lpg-safety> .

⁶ WorkSafe "Cabinet heater safety" <https://worksafe.govt.nz/managing-health-and-safety/consumers/gas-2/cabinet-heater-safety/> .

- VI. I endorse these safety messages and efforts to increase public awareness. On the basis of Mr Rodgers' analysis, if Mr Wylie's LPG heater had been used in an appropriately sized and ventilated space, it is possible his death may have been avoided, or his outcome may have been improved. I note that Mr Wylie's heater was found to have a warning plate advising end-users not to use the heater in a bedroom or similarly confined space and to ensure the room is well ventilated when the heater is in use.
- VII. In light of the approval requirements applicable to all gas heaters supplied for sale since 2011 which mandate detailed labelling and warnings, and the clear safety messages and practices publicised by WorkSafe and the LPG industry, I do not consider that there are any further comments or recommendations which I can make, pursuant to section 57A of the Coroners Act 2006, that could reduce the chances of further deaths occurring in similar circumstances.
- VIII. That said, Mr Wylie's death in circumstances where important safety messages were displayed on the heater, but for whatever reason, were not heeded, highlights the need for ongoing publication and reminders of these safety messages, in particular at the start of each winter season. Families and caregivers of the elderly and those with cardio-respiratory vulnerabilities can also play an important part in avoiding harm caused by unsafe operation of LPG heaters.
- IX. In addition there are likely to be a number of LPG heaters still in use in New Zealand households that were supplied prior to the implementation of the current legislative and compliance framework. Strict adherence to the safe operation practices described above, including regular servicing, is essential to avoid potential harm to end-users.

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

Self-Inflicted

Carter [2019] NZCorC 42 (12 August 2019)

CIRCUMSTANCES

Craig Carter of Christchurch died on 3 March 2016 of self-inflicted injuries. Mr Carter had previously suffered from anxiety and depression and had engaged in self-harming behaviour.

COMMENTS OF CORONER ROBB

- I. It is worth reinforcing that where one becomes aware of a person having engaged in self-harm, even if it is perceived to be attention seeking, it would be prudent to seek assistance from mental health professionals. The self-harm could be symptomatic of something more serious, or that some intervention is warranted.

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death.

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

Day [2019] NZCorC 39 (7 August 2019)

CIRCUMSTANCES

Brendon Day of Palmerston North died on 20 April 2018 of self-inflicted injuries amounting to suicide.

On 31 March 2018, Mr Day and his family were alerted to Mr Day becoming the subject of a social media post by a person under the Facebook profile, Palmy Creep Catchers'. A Google search of Stuff brings up an article about a 21-year-old man who pleaded guilty to charges under the Harmful Digital Communications Act 2015. This man styled himself as the 'Palmy Creep Catcher', a vigilante paedophile hunter, who would film his targets and upload the videos to the Internet.

Mr Day was identified in a post using his Facebook profile page and name, and his newly updated LinkedIn page identifying him by age and occupation. Mr Day told his family that his Facebook and LinkedIn pages had been hacked, and that this was a case of mistaken identity. He spoke to many people who contacted him after they became aware of the social media posts. Mr Day made a statement of complaint to Police, who were investigating the actions of the Palmy Creep Catcher. Eventually, Facebook shut down the page.

After these posts, Mr Day's family said he was stressed and obviously upset. He lost weight and became paranoid that people were looking at him and judging him as a result of those posts.

COMMENTS OF CORONER RYAN

- I. I make the following comments pursuant to section 57(3) of the Coroners Act 2006:
 - a. The precipitating event which appears to have been responsible for Brendon taking his own life was the social media postings by 'Palmy Creep Catchers'. Despite laying a complaint with Police over these postings, and eventual removal of the Facebook page, Brendon felt that he could not move on with his life, as he would always be identified as the subject of those posts. It is significant that the man behind this Facebook page pleaded guilty to charges under the Harmful Digital Communications Act.
 - b. This case is a salient reminder that the public should be aware of the harm that can be caused to the emotional and mental well-being of people who are the subject of social media posts, implying they are involved in criminal behaviour. This can occur despite the denial of culpability by the subject person, the involvement of Police laying charges under the Harmful Digital Communications Act, and the removal of the posts from social media sites.
 - c. Once a post is uploaded, the damage is done. Therefore, people need to consider very carefully before posting anything on social media.

- d. This case also highlights the need for robust legislation controlling and regulating social media posts, to prevent harm to people who may be the subject of such posts.

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death. Pursuant to section 71(3)(b) of the Act, the death may be described as a suicide.

Hart [2019] NZCorC 31 (12 July 2019)

CIRCUMSTANCES

Neil Lionel Hart of Kaikohe died between 9 and 11 April 2016 at his home address in circumstances amounting to suicide.

At the time of his death, Mr Hart was under the care of the Northland District Health Board Mental Health Services. He sent text messages to his social worker indicating that he was going to self-harm on 9 April 2016. His social worker was not utilising her work phone as it was the weekend. The messages came to her attention in the morning the next day, 10 April. The social worker rang the Mental Health Services' Crisis on-call number to ask that someone check on Mr Hart as soon as possible. She followed up two hours later and was told the Crisis Team had been unable to get hold of Mr Hart. The social worker tried to call Mr Hart directly and further visits were made by members of the Mental Health Services in the afternoon and evening. There was still no response.

The social worker went to Mr Hart's address around 9:30am on 11 April 2016. She entered the living room and found Mr Hart clearly deceased.

RECOMMENDATIONS OF CORONER GREIG

- I. I recommend that Northland DHB Mental Health Service:
 - a. review and, if necessary, amend its policies to ensure that staff are aware of the steps that should be taken if there are concerns for a patient's safety (including when it is appropriate to contact the Police);
 - b. undertake any necessary consultation with the New Zealand Police to ensure that there is a clear understanding around the respective roles of each organisation in such circumstances;
 - c. ensure that staff are aware of the expectations in this regard.
- II. Northland DHB has advised that it accepts these recommendations.

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

Note: Section 71 of the Coroners Act 2006 applies in this case. Accordingly, no person may, unless granted an exemption under section 71A of the Coroners Act, make public the method or suspected method of a death, or any details that suggest the method or suspected method of the death. See section 71 for the full restrictions.

Naidoo [2019] NZCorC 35 (17 July 2019)

CIRCUMSTANCES

Mekellan Naidoo of East Tamaki, Auckland died on 18 January 2017 at his home in circumstances amounting to suicide.

Mekellan was aged 17 years and completed Year 13 at the end of 2016. He planned to go to Auckland University in 2016 to study primary teaching.

On 17 January 2017 Mekellan received his NCEA results and discovered that he had not met the entry requirements for his university course. He did not tell his parents his results but did advise his friends. He was clearly upset and grappling with the implications of his results and whether he would get into university and, if not, what his options were. He made contact with the university to find out whether he had been accepted and what he might have to do if not. He also contacted teachers from his school to find out whether he could make up the credits he required.

Mekellan was discovered deceased the following night.

COMMENTS OF CORONER GREIG

- I. Mekellan's tragic and untimely death highlights that the period around receiving NCEA results can be a time of heightened vulnerability for students, especially if the results received are not as they wish. This is something that everyone involved needs to be aware of, and alert to. It is important that processes are in place to ensure that students have clear information on how to access promptly both emotional support and practical advice about options moving forward, if required.
- II. The evidence is that both Mekellan's school and NZQA were aware of the need to support young people practically and emotionally and had processes in place. Tragically, although Mekellan was able to seek advice to sort out his options moving forward, he did not feel able to indicate to anyone how he was feeling.
- III. Since Mekellan's tragic death, both his school and NZQA have strengthened further the information provided to students.
- IV. Given the evidence, I do not consider recommendations are necessary in this case. A copy of these findings will be sent to the Chief Executives of the Ministry of Education and the Tertiary Education Commission to highlight the issues identified in these findings.

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

Note: Section 71 of the Coroners Act 2006 applies. This prohibits any person from making public the method of Mekellan's death or any detail that suggests the method.

Roberts [2019] NZCorC 33 (16 July 2019)

CIRCUMSTANCES

Maryanne Huia Roberts of Meadowbank, Auckland died on 28 October 2016 at her home in circumstances amounting to suicide.

COMMENTS OF CORONER WINDLEY

- I. Social media provided the platform for Ms Roberts to be instantly exposed to what I take to have been accusations and vitriolic comments of other users. While the specific social media content is not available to my inquiry, it appears to have been a source of significant upset and distress to Ms Roberts. The pervasive nature of social media and potential harm from cyberbullying is well recognised. I do not consider there are any recommendations I can make, pursuant to Section 57A of the Coroners Act 2006, to reduce the chances of future deaths in circumstances similar to Ms Roberts.
- II. Given the circumstances of Ms Roberts' death as I understand them to be, it is appropriate to reiterate existing advice and safety messages in relation to social media and online bullying. Netsafe notes that online bullying can take many forms including: name calling online, repeated unwanted online messages, spreading rumours or lies, fake accounts used to harass people, excluding people from social activities, embarrassing pictures, videos, websites, or fake profiles.
- III. Every situation of bullying is different. Netsafe offers the following advice that may help in situations of online bullying:
 - **Don't reply:** Especially to messages from phone numbers, profiles or people you don't know.
 - **Don't attack the person back:** Avoid giving the bully the satisfaction of a reaction.
 - **Have a conversation:** If it's safe, try talking to the person privately about what they've said or done to work things out.
 - **Get support:** Talking to friends or whānau can make you feel better – or you can reach out to Youthline, Lifeline or others.
 - **Save messages and images:** Take screen shots of the bullying in case you need evidence later. Find out how here.
 - **Cut off the person bullying you:** Block their phone number, or block them on social media.
 - **Report it:** If the online bullying is happening on social media, you can find out how to report it below.
 - **There is an NZ law to help:** The Harmful Digital Communications Act aims to help people dealing with online bullying, abuse and harassment.
 - **Get help:** Contact Netsafe for help. We can help with any of the above, tell you if there's anything you can do to stop the abuse and let you know how to stay safe.
- IV. The Facebook Safety Centre (<https://www.facebook.com/safety/tools/safety>) includes the following advice on sharing, blocking and reporting:

Sharing

We ask people to consider their audience when sharing on Facebook. It's important to be thoughtful about how and what you share. We make it easy for everyone to decide who can see the content they share, and we have policies that prohibit hateful, violent or sexually explicit content.

Before you share, ask yourself:

- Could somebody use this to hurt me?
- Would I be upset if someone shared this with others?
- What's the worst thing that could happen if I shared this?

Always remember that the things you share with your friends can end up being shared with others.

Blocking

You can block someone to unfriend them. This will prevent them from starting conversations with you or seeing things you post on your profile. In addition, people you block can no longer tag you, invite you to events or groups or add you as a friend. Blocking is reciprocal, so you also won't be able to see things they post or start conversations with them. When you block someone, we don't notify them.

To block someone, click  in the top right of any Facebook page, click "How do I stop someone from bothering me?", enter the name or email address of the person you want to block and click "Block".

Reporting

Facebook includes a link in nearly every piece of content for reporting abuse, bullying, harassment and other issues. Our global teams work 24 hours a day, 7 days a week, to review things you report and remove anything that violates our Community Standards. To report a post, click in the top right of the post and choose the option that best describes the issue, then follow the on-screen instructions. Learn more about reporting other types of content.

If you've reported something, you have the option of checking the status of your report from your Support Inbox. Only you can see your Support Inbox. We don't include any information about the person who filed the report when we contact the person responsible.

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

Note: Section 71 of the Coroners Act 2006 applies in this case. Accordingly, no person may, unless granted an exemption under section 71A of the Coroners Act, make public the method or suspected method of a death, or any details that suggest the method or suspected method of the death.

Thomas [2019] NZCorC 34 (16 July 2019)

CIRCUMSTANCES

Awhina Dolly Thomas of Waimuku died between 15 and 17 April 2016 of self-inflicted injuries.

COMMENTS OF CORONER MCDOWELL

- I. In her joint inquiry into the deaths of four young people in Flaxmere by suicide,⁷ Coroner na Nagara specifically commented on the risks implicit for young people exposed to family violence, noting expert advice which commented that exposure to such violence can have a significant and measurable negative effect on children's functioning including emotional, behavioural, cognitive and general health function, as well as their social competence, school achievement and psychopathology. They are more likely than their peers to suffer the effects of depression, anxiety, fear and low self-esteem and have an increased risk of suicide.

[...]
- II. I adopt Coroner na Nagara's comments from the Flaxmere inquiry: "What seems to me to be vital...is ensuring that all agencies in a position to see that young people exposed to numerous risk factors are struggling (as evidenced by, for example, truancy, disciplinary problems at school, alcohol and drug abuse, youth offending, roaming at night) are able to alert other agencies to any concerns so that action can be initiated and coordinated. The primary sources of this information would be the school and the police, followed by general practitioners, the DHB (either via the Emergency Department or the Mental Health Service), and CYFS".
- III. In 2016 some regional multi-agency Children's Teams were set up as part of the Children's Action Plan (an inter-agency collaboration involving different agencies directed at vulnerable children). As at May 2019 five teams have been set up, with a further three to be implemented in the near future.⁸ The focus of these teams is the coordination of the various agencies involved in a child or young person's care (up to the age of 18 years) to create a single plan and help support children who are at risk of abuse or neglect. The focus is on agencies sharing information and working together to improve outcomes for children. The teams will look at (among other things) children who are living in homes where family violence is present, children who have difficulty attending school or engaging when present, children with social or behavioural problems, and children with unaddressed health issues.⁹
- IV. The issues to be addressed by the Children's Teams would, in theory, have possibly identified Awhina as a young person at risk, and possibly have addressed some of the issues that were present for her.
- V. However, it is not clear whether suicide prevention is an express focus or goal of the teams. While I do not propose to make any specific recommendations or comments in this respect, a copy of this finding will be sent to the Ministry of Health and Oranga Tamariki (the lead agencies in respect of the Children's Teams) for their consideration of the issues raised and specifically whether the Children's Teams should have a specific objective of assessing suicide risk factors, if they do not already do so.

⁷ A joint inquiry into the deaths of L Ngatuere, J Staples, E Karangaroa-McKenzie, and D Whaanga, CSU 2013-Has-139, 221, 224, and 2014-Has-167, 6 May 2016.

⁸ www.health.govt.nz/our-work/life-stages/child-health/childrens-action-plan-programme

⁹ www.orangatamariki.govt.nz/working-with-children/childrens-teams

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death.

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

Sudden Unexpected Death in Infancy (SUDI)

Sudden Unexpected death in Infancy (SUDI) is an ongoing issue in New Zealand and Coroners continue to endorse the advice of the Ministry of Health. SUDI findings are also referred to the agencies responsible for SUDI prevention strategies.

Pakuivi [2019] NZCorC 43 (12 August 2019)

CIRCUMSTANCES

Caesar Pakuivi died on 22 September 2017 at Papakura, Auckland of an unascertained cause.

Caesar was 3 weeks old, and when found deceased, had been sleeping on a couch. The pathologist was unable to determine the exact cause of his death, due to an absence of information about the exact positioning of Caesar on the couch, and a description of the couch and bedding.

The coroner was satisfied Caesar's mother had been given and was aware of the safe sleeping message. This had been confirmed in a visit from a community midwife. On the night of his death, the family were staying at a cousin's place, and Caesar was sleeping on a two-seater couch pushed up against a double bed.

COMMENTS OF CORONER MCDOWELL

- I. In the past, coroners have made many recommendations to agencies to ensure that the safe-sleeping message is consistent between health professionals, and appropriately given to new parents. It is an important message, as it is effective in preventing infant death.
- II. The current advice repeats the message that every sleep for an infant should be a safe sleep. This means that, for every sleep, infants up to one year of age should:
 - Be put to sleep on their backs
 - Be in their own sleeping space (a firm, flat and level surface with no pillow)
 - Have their face clear, so their breathing cannot become obstructed
 - Have someone looking after them who is alert to their needs and free from alcohol or drugs, and
 - Have clothing and bedding that keep them at a comfortable temperature (20 C ambient temperature).
- III. A baby's bed is safe when it has a firm and flat mattress, and where there is nothing in the bed that might cover the baby's face (no pillows, toys, loose bedding or bumper pads).
- IV. As has been outlined, I am satisfied that Caesar's mother was advised on multiple occasions of the safe sleeping message, and that it was consistently given. However, I am also unable to determine the role that the sleeping

environment played in Caesar's death. In the circumstances of this case, further recommendations or comments are not called for, although I observe that, ordinarily, a couch is not an appropriate sleeping environment for an infant, and every sleep needs to be a safe sleep for an infant (including those times where they are sleeping away from their normal sleeping environment).

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

Workplace

Rowberry [2019] NZCorC 46 (10 September 2019)

CIRCUMSTANCES

Mr Rowberry was a truck driver working in a quarry. On 16 October 2017, he arrived at the quarry in an articulated truck to drop off a load of gravel. Once at the drop-off point he reversed and the trailer jack-knifed and stopped where he intended to unload the gravel. The ground the trailer was on was uneven. Mr Rowberry raised the trailer unit up and it toppled over, landing on Mr Rowberry's side of the truck and crushing him. This was either caused by it reaching its maximum height or, once the trailer was raised, the gravel not emptying in the unit, and Mr Rowberry jerking the truck backwards in an attempt to dislodge the gravel.

The accident was fully investigated by WorkSafe NZ who concluded that Mr Rowberry omitted to ensure his truck was correctly and safely positioned during the tipping operation, due to an action error, specifically a Lapse. According to WorkSafe NZ, a Lapse is typified by a person omitting to perform a required action due to a short-term memory lapse, often made by experienced, highly trained and well-motivated staff. As a result, WorkSafe NZ made a number of recommendations but decided to take no further action.

RECOMMENDATIONS ENDORSED BY CORONER BAIN

- I. WorkSafe have recommended a number of preventative measures which this Court adopts. They are as follows:
 - a. Employed full time driving assessor (shortly prior to the event) to formalise training.
 - b. Full induction day, rather than arrive inductions. Every Tuesday new employees go to an induction day.
 - c. Re-induction of new employees is to be part of the process.
 - d. An alert sent to drivers about tipping operations.
 - e. The company design and implement a warning/interlocking system to prevent similar future events.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs, addresses, telephone numbers, and e-mail addresses in the interests of personal privacy and decency.



OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND