OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments made between **1 October** and **31 December 2019**

Office of the Chief Coroner | 2019 (4)

Coroners' recommendations and comments

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

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

The 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 15 recommendations and/or comments issued by Coroners between 1 October and 31 December 2019.

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Recommendations and comments

1 October to 31 December 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

Kohai [2019] NZCorC 50 (16 October 2019)

CIRCUMSTANCES

Abraham Eparaima Kohai died on 14 October 2016 at Waikato Hospital of acute cardiac insufficiency due to a myocardial infarction in a background of cardiovascular atheromatous disease with an associated gastric ulcer.

Mr Kohai was serving a sentence in Springhill Corrections Facility, Hampton Downs, Te Kauwhata. In the weeks leading up to his death, Mr Kohai complained of stomach and chest pains and sought medical assistance. Mr Kohai was diagnosed with gastro-oesophageal reflux and provided with antacid treatment. An ambulance was called on the evening of 13 October after a deterioration in Mr Kohai's symptoms. In transit to Waikato Hospital, Mr Kohai went into cardiac arrest. Despite continuing efforts, his condition worsened, and he died the following morning.

The inquiry found that the failure by Department of Corrections Health Unit staff at Springhill Prison to provide adequate care to Mr Kohai contributed to his death.

The Department of Corrections advised the inquiry that as of April 2019, they had recently implemented a revised Health Care Pathway Policy.

RECOMMENDATIONS OF CORONER MATENGA

I. I have formed the view that the inability of the nurses involved in the care of Mr Kohai, to consult and record directly to the clinical record has contributed to the death of Mr Kohai. Pursuant to section 57A Coroners Act 2006 I recommend that the Department of Corrections conduct an urgent review of the staffing, resourcing and procedures of the Health Units at Springhill Correctional Facility to address the provision of laptops, tablets or other appropriate mobile devices which allow Health Unit staff to access a mobile patient management system.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of the names and identifying details of nurses A, B, C, D and E; and any photographs taken of Mr Kohai in the course of the inquiry, in the interests of decency.

Drug Overdose

Freeman [2019] NZCorC 53 (5 November 2019)

CIRCUMSTANCES

Priscilla Freeman, aged 44, of Christchurch died on the night of 9 April 2015 at Hanmer Springs. Her death was found to have been accidental and due to the use of a medicine which, although available legally in certain forms in New Zealand, was purchased online from overseas. It was not identified by Customs when it arrived by post in New Zealand. In addition, Mrs Freeman did not take medical advice before ordering and using the medicine. She thought she had purchased a product which was suitable for the medical purpose she intended but its concentration was far in excess of the versions which are available to consumers in New Zealand and its effect was therefore lethal.

COMMENTS OF CORONER ELLIOTT

I. The use of medical products purchased online from overseas without medical advice

The chances of death in similar circumstances may be reduced if medical advice is taken before using a medical product which has been purchased online from an overseas source. I therefore made a comment pursuant to section 57(3) of the Coroners Act 2006 that Mrs Freeman's death illustrates the risks of using medicinal products which have been purchased online from overseas without taking medical advice. Mrs Freeman died due to the use of a drug which, although available legally as a medicine in certain forms in New Zealand, was purchased online from overseas. The product which she purchased was not suitable for its intended purpose. In particular, the concentration of the drug was far in excess of the versions which are legally available to consumers in New Zealand. Its effect was therefore lethal. Mrs Freeman did not take medical advice before ordering and using the drug. Her death illustrates the risks of using medicinal products which have been purchased online from overseas without taking medical advice.

II. Supply of the product

Given that the product was classified under New Zealand law as a prescription medicine on importation and that prescription medicine may only be provided by a pharmacy on the prescription of a person authorised to prescribe, the operators of the website should not have supplied this product to Mrs Freeman. It should only have been supplied to a person who was authorised in New Zealand to prescribe medication. The operators of the website are based overseas. They did not respond when notified of my intention to make adverse comments about them.

III. Detection of imported medicines

I considered the possibility of making a recommendation relating to the detection of medicines by Customs. I make no recommendations given that I made the coronial comments above and the evidence from Customs that, due to the sheer volume of mail, it is impossible to intercept 100% of such products and that it is unfortunately inevitable that some will be missed.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of: (i) evidence and submissions in the inquiry; (ii) the applications which were heard on 21 March 2018; and (iii) the findings.

Fall

Te Amo [2019] NZCorC 55 (18 November 2019)

CIRCUMSTANCES

Te Hawiki Hona Kiri Te Amo of Christchurch died on 14 October 2018 at Waikato Hospital of a traumatic head injury following a fall from the roof of a building at Opotiki College on 13 October 2018.

On the evening of 13 October 2018 Mr Te Amo was with his brother and his cousin. The young men decided to go to the Opotiki College grounds and climb onto the buildings. Mr Te Amo and his cousin climbed onto the library building, making their way to the skylight in the roof. They then began kicking at the skylight.

Both young men fell through the skylight falling approximately 8 metres to the concrete floor of the library below them. Mr Te Amo landed first. His cousin landed on top of him and was able to walk to the library door, unlock it and turn on the light. The fall caused the traumatic head injury to Mr Te Amo which caused his death at Waikato Hospital the next day.

RECOMMENDATIONS OF CORONER MATENGA

I. Pursuant to section 57(3) Coroners Act 2006 I recommend as follows:

   a. The Opotiki College Board of Trustees either remove the skylight in the roof of the Discovery Centre Building, or otherwise comply with the Ministry of Education guidance as set out at: www.education.govt.nz/school/property/state-schools-design-standards/materials/roofing-materials ;

   b. I direct that a copy of this finding be distributed to all state funded schools in New Zealand.

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.

Tramping

Chee [2019] NZCorC 52 (24 October 2019)

CIRCUMSTANCES

Chien Han Chee of Motueka died between 11 July 2018 and 15 July 2018 on the Mt Robert ridgeline at Nelson Lakes National Park of hypothermia.

Mr Chee planned to hike to the Angelus Hut in the Nelson Lakes National Park. He was aware that he would be climbing in snow, and had bought new gear in Australia, including pants, and potentially new boots. A search and rescue operation was carried out after Mr Chee failed to make contact with friends, with his last text being sent on 11 July 2018.

Mr Chee's body was located off the track on 15 July 2018. The Mountain Safety Council reviewed the circumstances of Mr Chee's death. They considered that he was adequately equipped for a summer tramp in reasonable weather conditions, but not for the conditions he experienced. He had no emergency shelter, nor any emergency communications device. He had no navigation equipment.

He was lacking equipment typically required for travel above the snowline such as a helmet, ice axe and crampons and a snow shovel. The Mountain Safety Council observe however that this equipment would not have changed his circumstances, though it did illustrate his inexperience with New Zealand winter alpine conditions.

RECOMMENDATIONS OF CORONER ROBINSON

I. While the factors identified by the Mountain Safety Council and listed below ought to be well known, they bear repeating:

   a. Trampers should carefully consider the consequences of tramping alone. Those who choose to go solo should do so on trips that are well within their level of skill and expertise.

   b. Solo trips are not recommended for inexperienced trampers, above the bush line or in winter conditions.

   c. Trampers should source the latest weather forecast for the area they are going tramping, consider the impact the forecasted weather will have on their trip and be prepared to alter their plans to the conditions.

   d. Trampers should take adequate food supplies and eat regularly to ensure they maintain their energy levels. This is especially important in cold, wet or windy conditions when energy requirements are greater.

   e. Some type of emergency shelter should be carried on all trips. An emergency shelter is even more critical above the bush line where it is less likely a natural shelter will be found or built and exposure to wind chill is more likely (and often more severe).

   f. Trampers should carry reliable navigation equipment.

g. Trampers should carry an emergency communication device suitable for back country use.

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.

Medical Care

Graham aka Keehoma [2019] NZCorC 48 (3 October 2019)

CIRCUMSTANCES

Erueti James Keehoma, also known as the baby of Maria Graham, Baby Graham, or Baby G, died on 16 July 2016 at Middlemore Hospital of perinatal asphyxia associated with congenital infection.

Erueti was Ms Graham's second pregnancy and she did not seek antenatal care throughout. Erueti was born shortly after 2:20am on 16 July 2016 at Middlemore Hospital. He appeared healthy but his condition seriously deteriorated over the next 12 hours. Middlemore Hospital had a heavy workload over the weekend, with a heavy demand on staff numbers, skills and experience.

Despite various attempts at treatment and resuscitation, Erueti's condition declined and he died at 1:50pm on 16 July 2016.

COMMENTS OF CORONER SHORTLAND

I. It is very hard to pass judgement on a system and the hardworking dedicated professionals who care for mothers and babies. It was clear there were multiple systemic issues on the Birthing & Assessment, and Maternity Wards over the period in question, including staffing, communication and documentation issues. Further, a failure to escalate the care of Erueti Kerehoma at key demarcation points when there were clear warning signs.

II. I am conscious of the clarity which hindsight can bring to these situations, and the difficulty that can come with only seeing part of the clinical picture when handovers are not adequately performed or clinical records not available in an already stressed and understaffed environment.

III. There were multiple instances when individual results should have prompted the escalation of care i.e. frequent low temperature; high blood glucose at around 3.20am; ongoing low to very low oxygen saturations from 3.40am; elevated respiratory rate from 7.50am; Erueti not feeding until 9.40am; cyanosed at 9.45am; very high heart rate from 10.15am.

IV. There was no significant escalation of care until around 10.25am when the Neonatologist and neonatal clinical nurse specialist were called. Dr Bloomfield saw Erueti at 10.30am. In his report, he commented that:

> Although he [Baby Graham] did not appear too unwell his condition deteriorated rapidly, and he required a prolonged and ultimately futile resuscitation. There was no obvious cause for his collapse and death except to consider that he may have been hypoxic and slowly declining.

V. I acknowledge Dr Bloomfield's assessment of the situation. The sequence of events outlined in the SSE report showed that once care was escalated around 10.30am, everything possible was done to save Erueti, but ultimately it was too late.

VI. On the evidence available to me, I am not prepared to speculate on whether earlier intervention and escalation of care would have provided a different outcome. Nevertheless, it is worth noting the sentence in the SSE Report that reads: "Baby G died from congenital pneumonia and evolving sepsis, *a potentially treatable condition*" [emphasis added].

RECOMMENDATIONS ENDORSED BY CORONER SHORTLAND

I. The Counties Manukau Health SSE Report identified a number of key findings and recommendations. The key findings follow:

a. There was no newborn observation guideline and neonatal observation chart to record vital signs and determine an action pathway. This would have provided evidence to identify Baby G's deteriorating condition and escalate the concerns.

b. There was high acuity on both Birthing & Assessment and Maternity Wards. Twice the number of recommended inductions were booked. There was no escalation plan to manage the high acuity. The workload was not adequately matched to skill mix and experience.

c. There were major issues with communication and documentation. There was a confusing mix of hard copy and electronic (MCIS) clinical records. This hindered communication and contributed to the sequence of events.

d. The neonatal hard copy is filed within the maternal hard copy. This meant that once Ms G had gone to operating theatre, those caring for Baby G did not have the required clinical information available to them.

e. There is no easily identifiable neonatal problem list in MCIS or the hard copy clinical record. Staff were not sufficiently familiar with all aspects of MCIS.

f. Clinical handover was incomplete and not performed in accordance with CM Health's nursing policy and procedure.

g. Equipment for the monitoring and care of neonates in Birthing & Assessment and the Maternity Ward was not easily locatable.

h. There was no computer in the resuscitation bay (important if MCIS is the neonatal record).

i. The Neonatal management plan did not include a plan for reassessment.

j. No formal debriefing session was arranged for all caregivers involved in the care provision of Ms G and Baby G following this serious sentinel event.

II. The key recommendations and Counties Manukau District Health responses:

a. Develop a guideline for neonatal observations and detection of early warning signs, including use of pulse oximetry for at-risk infants. Provide a graphical chart to show trends in neonatal status for babies requiring monitoring. This should include guidance about when neonates should be referred for medical review and when to call a neonatal emergency code:

   The Neonatal Observations guideline was first issued in February 2017. It was last updated in July 2018.

b. Implement the neonatal observation guideline and chart. Audit the use of the guideline after its introduction:

   Counties Manukau Health (CM Health) piloted a Neonatal Early Warning Score Chart {NEWS} in November 2017. The purchase of pulse oximetry machines was not possible until early 2018 therefore the use of the chart was not fully implemented until July 2018. In addition to this, there is a national initiative to introduce a standardised NEWS chart across the country. This is currently at the consultation stage. CM Health is an active participant in this initiative and is providing input into the development of the national NEWS chart.

c. Increase the awareness of early presenting features of neonatal sepsis and the importance of responding to these quickly:

   Neonatal sepsis was highlighted as part of the introduction of NEWS. It is also covered as a topic in the "Care of the Newborn" workshop; for nurses new to the maternity services it is covered in the "Signs of the deteriorating neonate"; NEWS is one of the topics covered in the compulsory Midwives Annual Update; and neonatal sepsis is also covered in the "Recognising antenatal and Neonatal Risk" workshop.

d. Implement and validate the Assignment and Workload Manager {AWM}. Review escalation plan and ensure staff are familiar with the escalation plan:

   Following validation of the AWM a decision was made not to roll out AWM to maternity services. An organisational decision was made to implement a different system that is already in use at other New Zealand DHBs. This system, "Trendcare" is a workforce planning and workload management system that includes both an acuity tool and variance response management.

   CM Health is in process for the preparation of the roll out for Trendcare within the Care Capacity Demand Management programme. The scheduled time for roll out for the maternity area is April 2020.

e. Audit the assignment of workload and develop a plan to ensure individual workloads reflect staff skill mix and experience:

   As the implementation of AWM was not progressed an audit has not been completed.

f. Develop a system and processes so that staff receive adequate training to ensure proficiency with MCIS:

All new staff to maternity services are provided with training prior to being given access to MCIS. We have increased the number of staff in the MCIS Support Team by 1.3 FTE which gives us an increased capacity to provide ongoing and advanced training as required.

g. Develop a system so that neonates have their own clinical record separate from the maternal record. There should be one primary record for baby during their inpatient stay either electronic or hard copy:

We continue to have both an electronic and temporary hard copy file for neonates. If a baby is transferred to the neonatal unit, the hard copy clinical file becomes the primary record. If baby is discharged home from the postnatal ward the temporary hard copy file is scanned and placed in the MCIS baby record.

h. Develop a system so that the neonatal record has a readily visible problem list and care plan that can be used and referred to at handovers:

There is an ability to show a current problem list which is visible on the neonatal home page in MCIS. A management plan can be created but is not visible on the neonatal homepage.

Recently a small multidisciplinary clinical team visited the UK, with a Ministry of Health representative to meet with the MCIS vendor, Clevermed. The latest version of their system is used extensively throughout the UK and is much more developed and sophisticated than the version in use at Counties Manukau Health. We consider migrating to this advanced system is a matter of urgency for Counties Manukau Health and should also be implemented nationally.

i. Implement structured safety huddles across Women's Health on all shifts to foster collective situational awareness, establish shared decision-making with regards to risks and immediate escalation in the anticipated event of deterioration:

Structured daily safety huddles have been implemented on the maternity ward. On the Birthing and Assessment unit multidisciplinary formal structured handovers are held morning and late afternoon to facilitate collective situational awareness.

j. Audit current neonatal equipment levels and the placement and availability of equipment:

A review of the equipment required for neonatal support was conducted and new equipment purchased as required.

k. Provide dedicated neonatal observation carts with all necessary equipment and store these in clearly marked areas. Increase the number of overhead heaters:

Dedicated equipment stands have been introduced for easy 'grab and go' to the bedside.

l. Develop a system so that there is instant access to the MCIS programme via a computer on wheels when there is a resuscitation occurring in the neonatal resuscitation bays on the Maternity Wards:

Mobile computers are brought to the room whenever an emergency call bell is activated, or a neonatal resuscitation is in progress.

m. The neonatal management plan for babies with abnormal signs or results should include a plan for re-assessment, including the timeframe for review:

As identified on the CMH NEWS chart parameters for completing observations and for increasing the frequency of observations are outlined.

n. Review the current staff debriefing process following a critical incident and make recommendations for service improvement:

An organisation-wide debriefing programme/system is currently being developed by the Clinical Director for Patient Safety & Quality Assurance.

III. I acknowledge the initial SSE review and report conducted by Counties Manukau Health. It was open, honest and professional in identifying the issues and problems that lead to Baby Graham's death. The DHB has made honest changes to improve their service and systems.

IV. The findings adequately encompass the main issues that I perceive in this case, and the recommendations sufficiently address those findings.

V. As such, I am satisfied with the recommendations of Counties Manukau Health, and endorse them.

VI. A copy of these Findings, along with the SSE Report should be sent to the Child Youth Mortality Review Committee (CYMRC), the Perinatal and Maternal Mortality Review Committee (PMMRC), and the Ministry of Health.

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

Reed [2019] NZCorC 54 (13 November 2019)

CIRCUMSTANCES

Ada Reed of Holderthorpe died on 27 February 2017 at Oamaru Hospital of a subdural haematoma secondary to a fall. Mrs Reed was 85 years old and lived with her son, Robert, who cared for her as her mobility was limited. Robert was also responsible for administering Mrs Reed's medications and would go with her to medical appointments.

On 20 February 2017, Mrs Reed suffered a fall at home. There was some bruising around her eye and swelling, which was relieved by ice. Mrs Reed complained of some soreness and Robert administered paracetamol. That pain did not however appear to persist over the forthcoming days. Neither Robert nor his mother were overly concerned about the fall and were shortly due to attend the doctor for a repeat of her prescriptions. They agreed to wait until then to see about her eye.

There was no indication in her presentation over the subsequent days of any life-threatening condition developing. That can be gauged from the fact that it was originally intended that they would go to the general practitioner to obtain repeat prescriptions on the Friday but did not do so as Robert was tired from having worked overtime. He said that his mother was “still fine not to go”, and there was no immediate need to go to GP as they still had “all her major pills.”

Matters however changed when Robert went to get his mother out of bed at about 2:00pm on Sunday 26 February 2017. He described in his first statement to police that she started to mumble and was “really bedridden.” She was spilling water as he administered her medication to her. He described her as “all loose and floppy” and he had to do everything to get her out of bed and down to her chair in the kitchen.

An ambulance was called, and Mrs Reed was taken to Oamaru Hospital. However, her condition deteriorated and she passed away on 27 February 2017.

COMMENTS OF CORONER ROBINSON

I. It is well known within the medical profession that a subdural haematoma can result in the elderly from relatively minor trauma, and that the haematoma may develop over time without significant symptoms, potentially leading to death.

II. That is recognised by the development of protocols for the assessment of patients who present with minor head injuries. The well-known protocols include:

a. NEXUS II;

b. Canadian CT Head Rule;

c. NICE (National Institute for Health and Care Excellence) Guidelines; and

d. New Orleans Head Injury Guidelines;

e. Each of these protocols contains a list of criteria to assist clinicians in determining the nature of investigations required in patients who present with minor head injuries. For example, under the NEXUS II protocol, a CT scan of the head is not required if none of the following criteria are present:

f. Age greater than 65;

g. Evidence of significant skull fracture;

h. Scalp haematoma;

i. Neurologic deficit;

j. Altered level of alertness;

k. Abnormal behaviour;

l. Coagulopathy;

m. Recurrent or forceful vomiting.

III. Advanced age is a common criterion across the various protocols with patients aged over 65 with no other signs or symptoms being categorised as requiring a CT scan. Under the New Orleans protocol, a CT scan is mandated in patients aged over 60.

IV. My impression is that while the medical profession is aware of the need for radiological investigations in minor head injuries suffered by the elderly who display no significant symptoms, the need for medical assessment may not be well-known amongst the elderly or their caregivers.

RECOMMENDATIONS OF CORONER ROBINSON

I. The Accident Compensation Corporation, Ministry of Health and Health Quality and Safety Commission lead an initiative called “Live Stronger for Longer” which through a number of resources aims to prevent falls and fractures in the elderly. It centres around providing advice as to safety within the home, and facilitating “strength and balance” exercise classes to reduce the risk of falls. That material provides advice in the event of a fall, which includes “if you do manage to get up on your own, get medical help straightaway if you need it, and tell your doctor or health professional about the fall the next time you visit.”

II. The programme provides valuable advice to the elderly, but in my view could be improved by specific reference to persons aged over 65 seeking medical advice in the event that they suffer a head injury (even if minor), given the potential for the development of a subdural haemorrhage from minor trauma, as indicated by the circumstances in this case. Awareness of the need for such apparently minor injuries to be assessed by a doctor could be raised through the development of promotional material such as for display at medical practices.

III. I recommend to the Accident Compensation Corporation, Ministry of Health and Health Quality and Safety Commission that the “Live Stronger for Longer” programme included the specific advice contained above, and that consideration be given to an awareness campaign through provision of appropriate material to General Practices.[1]

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[1] As required by section 57B Coroners Act 2006, my draft finding, including my proposed recommendation was sent to the Accident Compensation Corporation, Ministry of Health and Health Quality and Safety Commission. By letter dated 2 July 2019, the Ministry of Health advised (inter-alia):

> I can confirm that the Ministry of Health accept your recommendations. The information and guidance for the "Live Stronger for Longer" initiative is soon to be refreshed. This includes revising the information that is directed to consumers and clinicians, as well as the associated publicity material. Your findings will be taken into account in this refresh. Raising awareness of the potential for serious consequences from what may appear to be a minor head injury in a frail older person will be addressed.

ACC replied by letter dated 15 July 2019 stating (inter-alia):

> ACC welcomes the recommendations. I am advised the "Live Stronger for Longer" programme is currently being reviewed and updated to include information pertaining to identifying and managing head injuries resulting from fall, and so the timing of the recommendations is opportune.

I thank them for their positive responses.

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

Case [2019] NZCorC 57 (2 December 2019)

CIRCUMSTANCES

Colleen Case, aged 83, died on 26 January 2018 at the intersection of Logistics Drive and Sawyers Arms Road, Christchurch, as a result of high energy impact injuries from a road vehicle crash.

Mrs Case was driving her 1997 Mazda Familia in a north-easterly direction along Logistics Drive. The intersection of Logistics Drive/Greywacke Road and Sawyers Arms Road are controlled by compulsory stop signs on Logistics Drive and Greywacke Road. Mrs Case failed to stop or slow for the compulsory stop sign on Logistics Drive and proceeded into the intersection at a speed of approximately 50 kilometres per hour. Her vehicle was struck by a Volvo truck and the force of the impact shunted her car across the intersection where the driver's side struck another car at the stop sign on Greywacke Road.

Serious Crash Unit reported that the road markings on Logistics Drive were worn and barely visible. The yellow limit line appeared to be non-existent from a distance of approximately 1.5 metres from the curb, the word "STOP" painted on the road was barely legible, and the narrow-painted median was non-existent in the area of the limit line. The stop sign on the pole approximately seven metres back from the limit line was visible.

Road markings at this intersection had previously been an issue, the police raising a concern on 6 January 2016, and a member of the public advising that the stop sign road marking had nearly completely faded on 16 June 2016. On or about 18 December 2017 the Council received advice from Police that the "give way" line markings at the intersection required repainting. The Council's call centre staff categorised the request as "normal" (not "urgent") and it was entered into the City Care system on 19 December 2017 as "to be programmed" for City Care to inspect and prioritise, meaning that it required inspection within 48 hours, with the work to be completed within five days. A contractor, City Care Limited, was to perform the work.

City Care assigned the request to its' road marking subcontractor, Fulton Hogan Limited. As it was the week before Christmas and as the job had not been highlighted as needing urgent attention, it was placed on the normal job schedule list which Fulton Hogan's crews continued to attend to after a two-week Christmas/New Year closedown period. The state of the markings was not properly assessed, nor remedied by the time of Mrs Case's crash.

Fulton Hogan received another tasking in relation to this intersection on 1 February 2018 when the word "stop" was found to be illegible. Given Mrs Case's death, Fulton Hogan had the further remarking work completed that day, even though the priority assigned by City Care to the referral was once again "to be programmed" (i.e. not urgent). While the issue was ultimately treated with urgency by Fulton Hogan, the way in which the matter was communicated underscores the need for a review of the applicable process.

Coroner concluded that the cause of the crash was likely inattention on the part of Mrs Case but did not discount the appearance of the intersection as being a factor. He was unable to establish, however, the extent to which the absence of road markings was a factor in the crash.

RECOMMENDATIONS OF CORONER ROBINSON

I. I do not propose to make any recommendations as to the intersection. Firstly, the key recommendations of the prior safety audit have been implemented, and secondly that on completion of the Broughs Road extension, turning movements at the Logistics Drive / Sawyers Arms Road / Greywacke Road intersection will be reduced, and Broughs Road will become the dominant traffic link.

II. It appears from the discussion above that some assumptions were made as to the priority to be afforded to the re-marking of the intersection once it was known to be faded. Both on 19 December 2017, and on 1 February 2018 the work was not prioritised as “urgent”, but as “to be programmed” when it would appear that road markings were faded such that a safety issue would have arisen.

III. I recommend that Christchurch City Council and City Care Ltd review their processes as to the assignment of priority for reinstating road marking, necessarily involving prompt inspection of the subject site in order that an informed decision can be made as to the priority to be assigned to the work.

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

Harley [2019] NZCorC 60 (6 December 2019)

CIRCUMSTANCES

On 23 May 2017 Richard Harley was travelling northbound on State Highway 1, driving up Saddle Hill, just out of Mosgiel, Dunedin, in his Toyota HiAce van. In the left on-ramp lane was a fully-laden log truck and trailer owned by Dunedin Carrying Company, travelling at about 40 kilometres per hour.

In the middle lane behind the Dunedin Carrying Company truck was a Volvo truck and semi-trailer going between 90 and 93 kilometres per hour. It slowed to about 40 kilometres per hour to allow the Dunedin Carrying Company truck to merge into the middle lane as the left on-ramp lane ended. Mr Harley was travelling behind the Volvo truck in the middle lane at about 94 kilometres per hour. He did not reduce his speed, but sought instead to overtake by changing into the right lane. He failed to notice a Toyota Corolla travelling in the right lane and his vehicle struck the Toyota Corolla. Following the collision, Mr Harley braked and swerved left. His vehicle collided with the steel trailer deck which intruded into the driver’s compartment and caused his fatal injuries.

Serious Crash Unit investigated the incident and noted that a compliant “rear underrun protection device (RUPD)” would likely have prevented the semi-trailer deck intruding. However, it also observed that a truck towing a semi-trailer is not required to be fitted with a RUPD.

RECOMMENDATIONS OF CORONER ROBINSON

I. I recommend that the Ministry of Transport consider amendment to the Land Transport Rules to require the fitting of a rear underrun protection device on semi trailers.

II. As is required by section 57B Coroners Act 2006 my draft recommendation was notified to the Ministry of Transport for comment. The Ministry responded:

> The Ministry is aware that some international research has suggested that front and rear underrun protection can have some safety benefits (particularly for occupants of light vehicles).
>
> However, previous research undertaken by the Ministry of Transport has also found that our heavy vehicle fleet has a number of unique factors that make it harder to extrapolate overseas experiences. In particular, our large forestry and dairy sectors mean a relatively large percentage of the heavy vehicle fleet is likely to be used for part of their journeys off road, where issues with ground clearance and the potential for damage in day-to-day use is much greater. This would make costs of installation and maintenance of the devices higher than in other jurisdictions.
>
> The Ministry is currently developing its work programme for the 2020/21 financial year. Consideration will be given to gathering further data on fitment and injury rates in New Zealand to better understand the potential safety impact of this technology as part of the ministry's ongoing research into improving the safety of the vehicle fleet.
>
> In addition, we are investigating whether other, newer technologies, such as automated emergency braking and radar to detect and potentially avoid collisions are likely to offer better long-term safety gains for all road users.

III. I thank the Ministry for its response. In the circumstances of this case, and noting the SCU investigator's advice that underrun protection would likely have prevented intrusion into the vehicle in this case (therefore likely preventing the death), I confirm my recommendation.

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

Rea [2019] NZCorC 61 (9 December 2019)

CIRCUMSTANCES

William Rea died on 3 December 2018 at State Highway 25A Kopu-Hikuai Road, Thames-Coromandel District of head and neck injuries resulting from a motor vehicle accident.

Mr Rea was the owner/operator driver for his haulage company, Heavy Haulage & Contracting, and had been contracted to transport heavy machinery from Maramarua in the Waikato to Whangamata in the Coromandel using a heavy truck and towing semi-trailer. On 3 December 2018, Mr Rea was at the loading site in Maramarua where he placed the cargo

(a forestry crane hauler pole) on the semi-trailer with the wider and heavier mass of the pole resting on the rear of the semi-trailer.

Mr Rea then began his journey to Whangamata. At about midday, he was travelling eastbound on State Highway 25A, approximately 3.7 kilometres east of Kopu when the accident occurred. He was turning around a sweeping right-hand curve when the trailer rolled to the left and left the road. The truck and trailer travelled approximately 15 metres into a gully, coming to a rest upside down. Mr Rea was critically injured in the crash and was pronounced deceased at the scene by attending ambulance staff.

As to the cause of the crash, there was no suggestion that any medical or alcohol/drug issues were a causative factor. Nor was the road/weather conditions or mechanical condition of the truck an issue. The primary factor was the way Mr Rea had placed the cargo on the rear of the trailer, which created an uneven and unsafe weight distribution that caused the trailer to veer off the road. The Coroner found that the hauler pole should have been loaded the opposite way, namely placing the heavier mass closer to and over the centre of the mass of the semi-trailer.

COMMENTS OF CORONER BATES

I. I refer to the Waikato Serious Crash Unit Report of Crash Analyst Constable Ian Cornelius. Having considered the causative factors of this crash he identified four recommendations. I agree with them. They are:

   a. Continued education regarding cornering speeds for trucks.

   b. Promotion of electronic rollover prevention warning systems for trucks, including rollover prevention programs.

   c. Further education and enforcement, on the importance of correct positioning of loads for trucks.

   d. Continued enforcement and education at roadside truckstops.

II. It appears Mr Rea's truck may have safely negotiated the corner where the crash occurred, at what he felt was a familiar and routine cornering speed, had the load on the semi-trailer been positioned differently.

III. There is a wealth of educative information available regarding rollover prevention for heavy goods vehicles, online and at no cost. Heavy vehicle rollover is not an unknown or uncommon occurrence. Experienced heavy truck drivers could reasonably be expected to be aware of such risks. Risk of this type may be mitigated through proper vehicle loading and weight distribution, combined with proper vehicle maintenance, driving at appropriate speeds, and taking account of environmental/weather factors.

IV. Mr Rea was an experienced heavy truck driver. He was familiar with the truck he was driving and the semi-trailer he was towing. He was familiar with the type of load he was carrying. He was aware of the alternative (reverse) manner of positioning that particular load on that semi-trailer. He was familiar with the roads he was travelling.

V. Comments Mr Rea made to his son during the transportation, via radio when queried about positioning of the load, indicate Mr Rea elected to load in that manner because it was easier, due to the way the hauler pole was found when he attended the pick-up site at Okaeria Road, Maramararua. It was loaded and placed

as it was found at the site to avoid Mr Rea having to remove the semi-trailer, turn everything around and back the truck up.

VI. I am satisfied that Mr Rea was aware of an alternative, and in all likelihood safer manner of loading the hauler pole for transportation, so that weight distribution would have less effect on vehicle handling. He made a decision not to load in that alternative manner.

VII. Continued education and enforcement regarding the correct loading of trucks is essential. When the opportunity arises, for example when an individual seeks approval to hold any of New Zealand classes 2, 3, 4 and 5 medium and heavy vehicle licences (including combination vehicles), particular attention should be drawn to the risk of rollover due to incorrect loading and weight distribution. It may be that further detail is required in the New Zealand Road Code for Heavy Vehicles and the accompanying study materials.

VIII. I have considered the official New Zealand Road Code for Heavy Vehicles; a document Mr Rea would need to be familiar with to hold New Zealand driver licence classes 2-5. There I find several references to the need to be aware of how the size, nature and position of the load will affect the handling of a vehicle. The code states that vehicles should be loaded to give correct axle distribution and an even weight distribution over its floor area. To maintain lateral stability, the centre of gravity of the load should be on, or as near as possible to the centreline of the vehicle.

IX. An essential requirement that must be satisfied when loading heavy vehicles is that the load must be distributed so that maximum stability is ensured when the vehicle is braked, accelerated or changes direction. Positioning of equipment, and any of its attached assemblies must be arranged so that the safe handling of the vehicle is not impaired.

X. The above information is clear but, in my opinion, brief, general, and somewhat scattered through the road code and associated documentation.

XI. The New Zealand Road Code for Heavy Vehicles is a comprehensive document containing vital information. It is clear and detailed in relation to many subjects, including legal requirements for properly and safely securing (restraining and/or containing) loads. Repeated reference is made to not overloading a vehicle or its individual axles. However, I was unable to locate any significant detail in relation to correct and safe load weight distribution, or educative examples or illustrations of situations where rollover may occur due to improper load weight distribution. The possible or likely impact on vehicle handling that may result from failure to properly distribute load weight was not borne out in any detail.

XII. The real risk of vehicle rollover in certain circumstances is not specifically addressed in the rode code. In my view it should be.

XIII. Continued enforcement and education at roadside truck stops is essential.

XIV. I am grateful for the response received from the New Zealand Transport Agency (NZTA) dated 14 November 2019, in response to my provisional findings. I note an intention by the NZTA to:

a. Improve the NZ Road Code for heavy vehicle drivers and the related theory tests.

b. Work with the Motor Industry Training Organisation (MITO) to improve the learning material and assessment criteria for heavy motor vehicle licencing courses, particularly in respect of highlighting the risks of improper weight distribution; and

c. Should the Land Transport Rule Driver Licencing Amendment (2019) proceed, the NZTA will also look at the possibility of incorporating elements of load restraint into the practical tests for heavy motor vehicles.

RECCOMENDATIONS OF CORONER BATES

I. Pursuant to Sections 57(3) and 57A of the Coroners Act 2006, I make the following recommendations in the belief that implementing them will reduce the chances of the occurrence of other deaths in circumstances similar to those in which this death occurred:

`a. That NZTA implement their intended responses, as detailed at paragraphs XIV (a) – (c) of these findings.

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

Seow [2019] NZCorC 56 (25 November 2019)

CIRCUMSTANCES

Kai Yuan Seow of Singapore died on 11 December 2017 on State Highway 6, Mahinapua of a head injury sustained in a motor vehicle accident.

Mr Seow was travelling with his partner on a flat, straight section of State Highway 6 in a Toyota Camry rental vehicle at approximately 108 kilometres per hour. As a result of becoming distracted, Mr Seow was not watching the road and the vehicle crossed the centreline into the path of an oncoming campervan.

COMMENTS OF CORONER ELLIOTT

I. I make the following comment pursuant to s 57(3) of the Coroners Act 2006:

Kai Yuan Seow died in a motor vehicle collision on State Highway 6, Mahinapua, on 11 December 2017.

Mr Seow's vehicle, which was travelling at 108km/hr, crossed the centreline into the path of an oncoming vehicle. The vehicle crossed the centreline because Mr Seow was distracted.

According to NZTA, driver distraction was a factor in 12 fatal crashes in 2018 and 155 serious injury crashes. Driving requires complete attention at all times. Driver distraction can have fatal consequences.

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.

Self-Inflicted

Dalton [2019] NZCorC 58 (3 December 2019)

CIRCUMSTANCES

Catherine Dalton of Dunollie, Runanga near Greymouth died between 15 February 2016 and 16 February 2016 at Dunollie, Runanga. Her death was self-inflicted.

Ms Dalton had a long history of mental health issues. Between 2011 and 2016, Ms Dalton lived between the West Coast and Auckland. In February 2013, while Ms Dalton was living on the West Coast, her GP referred her to the West Coast District Health Board (WCDHB) for a psychiatric assessment. She was invited for an appointment and blood tests by the Triage Assessment Crisis Treatment (TACT).

In October 2015, while living in Auckland, Ms Dalton was referred to Mental Health Services and then subsequently admitted to the Auckland Mental Health Inpatient Unit, Te Whetu Tawera (TWT) as a compulsory patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Ms Dalton was discharged from TWT on 8 January 2016 and referred to an outpatient treatment programme under a community compulsory treatment order where she was last seen on 20 January. At that point Ms Dalton had made plans to return to the West Coast, and the arrangements for the transfer of her care to the West Coast Mental Health Service was to be facilitated by Ms Dalton's keyworker. The keyworker was unsuccessful in making contact and as a result the WCDHB did not receive any notification from the Auckland District Health Board (ADHB) that she was returning to the West Coast, nor any information regarding her mental health at that time.

On 3 February 2016, Ms Dalton self-referred to the West Coast TACT team following a deterioration in her mental health. She was assessed by two nurses on 4 February 2016. A psychiatrist was not present as it was not considered necessary and no review by a psychiatrist was ever undertaken. Attempts were made to contact Ms Dalton's previous mental health service in Auckland and obtain further information prior to Ms Dalton's assessment, but this was ultimately unsuccessful. During the assessment, Ms Dalton told the nurses she had recently been admitted to a mental health service, but the nurses did not inquire further and therefore were unaware that she had been subject to a compulsory treatment order in Auckland. Ms Dalton was discharged to her GP and it was left to her to organise assistance for her mental health. Unfortunately, Ms Dalton's mental health referral from Auckland, and the true nature of her previous interaction with mental health services there, was not received by TACT until 22 February 2016, after her death.

As a result of Ms Dalton's death, the WCDHB conducted a serious incident review and produced a report. The reviewers concluded that, in hindsight, the decision to discharge Ms Dalton to her GP without review by a psychiatrist and before the review of information from Auckland was flawed. The reviewers also noted the failure to recall Ms Dalton for review after the information received from Auckland had been reviewed. The referral was not received from Auckland until three weeks after Ms Dalton had moved back to the West Coast and there was no clear pathway for receipt of the requested information and for the review and decision-making around that information.

COMMENTS OF CORONER TUTTON

I. The fact that Ms Dalton was not referred on 4 February 2016 for a review by a psychiatrist is troubling. Ms Dalton had been subject to a compulsory treatment order until 20 January 2016, following an inpatient stay of some weeks' duration.

II. The inaccessibility of relevant clinical information at the time of the assessment on 4 February 2016 was problematic. Dr Farrelly of the ADHB wrote that the plan was for transfer to the WCDHB, to be actioned by Ms Dalton's keyworker, "who was unfortunately unsuccessful in making contact with the West Coast service".

III. It is of concern that, despite attempts to obtain relevant documentation from Auckland, the assessing nurses were unaware that Ms Dalton had been an in-patient and subject to a compulsory treatment order very recently. It is of concern that their ability to access relevant records was limited to the West Coast, and only during the week, or to clinical files held in Greymouth. It is also of concern that the documents requested were not received before the assessment was conducted.

IV. I accept that attempts were made to obtain relevant documents from Auckland, but the reports I have received record that there were no entries in Ms Dalton's clinical records recording any attempt to communicate with Auckland DHB staff. Both nurses have acknowledged that, although Ms Dalton told them she had been admitted recently, they did not ask the reason for, or the duration of, the admission. They knew Ms Dalton had contacted the WCDHB MHS because she was feeling overwhelmed and that she had previously been cared for by WCDHB MHS. She told them she was experiencing suicidal thoughts.

V. The nurses who assessed Ms Dalton left it to her to contact her GP. The opportunity to assist Ms Dalton, at a time when she described feeling distressed and overwhelmed, was lost, ostensibly partly due to an inability to obtain relevant information held by another DHB.

VI. I agree with the finding of the WCDHB reviewers that, in hindsight, the decision to discharge Ms Dalton to her GP without review by a psychiatrist and before the review of information from Auckland was flawed.

VII. A further opportunity to assist Ms Dalton was lost when she was not recalled for review after the information received from Auckland had been reviewed.

VIII. In light of the information relating to Ms Dalton's recent mental health history available at the time of the assessment, and her presentation at the assessment on 4 February 2016, I consider the response of the WCDHB to Ms Dalton's approach on 3 February 2016 was inadequate.

IX. I accept that the WCDHB has made considerable efforts to improve the issues identified in its Serious Incident Review in relation to the death of Ms Dalton. It is to be hoped that the steps the DHB has implemented will ensure that those presenting with a history and presentation similar to those of Ms Dalton will be referred to, and seen by a psychiatrist, promptly, and treated appropriately.

Accessibility of information

X. Issues relating to the accessibility of information held by one DHB to staff of another DHB remain.

XI. I sought information from the Ministry of Health relating to "the accessibility of patient information held by one district health board to staff of another district health board treating that patient; for example, when a patient treated by one district health board moves to another area and presents at a hospital of another district health board".

XII. Dr Robyn Shearer, Deputy Director-General, Mental Health and Addiction, of the Ministry of Health, reported that electronic access to another district health board's medical records is not currently possible, outside of selected local regions, due to different operating systems. She stated that, accordingly, facilitation by DHB staff is required to transfer clinical information from Auckland DHB mental health services to WCDHB mental health services.

XIII. Dr Shearer reported that, where a patient has a planned transition to another service and agrees to the clinical information being shared, it would be expected that a referral be initiated from the outgoing service to the incoming service, including the transfer of relevant clinical information. However, where a person presented to mental health services without referral, but information was obtained that the person had recently been in the care of another service, then a formal request should be made to that service for clinical information. The urgency of the request would be relevant to the expected timeframe for provision of information. Dr Shearer reported that for instance, if the situation was urgent, a request for information might be by phone initially and then followed up by a written request. If the matter was urgent and life-threatening, it would be expected that some attempt be made to transfer at least summary information in an urgent manner to allow urgent treatment.

XIV. Dr Shearer stated that DHBs have been asked to improve access to clinical information by investing in regional capabilities supported by interoperability standards and good information governance practices. She stated that the Ministry of Health is working closely with DHBs to guide and monitor their digital health investments to ensure that information is increasingly able to be shared across a region and that all health data is interoperable and accessible.

XV. Dr Shearer wrote that, unfortunately, there is still variability between regions. For example, the Auckland metro area can access mental health files electronically among the three DHBs. The other regions are implementing electronic systems that mean records should be able to be shared between DHBs within the region in the next few years. In the meantime, if the information required cannot be accessed electronically by care providers, paper copies can be obtained by making a request to the hospital's Privacy Officer.

XVI. Dr Shearer reported that the Ministry of Health is developing a business case for developing an electronic health record that is accessible to providers, consumers and policy and service planners.

XVII. In respect of the disclosure of health information, Dr Shearer wrote that standard clinical practice is that a new service would request permission from the patient to obtain his/her records from the previous service, unless the patient refused. Pursuant to the Health Act 1956, health practitioners can obtain information from other health practitioners, although such a request may be refused if the agency believes, on reasonable grounds, that the patient does not want information to be disclosed.

XVIII. Dr Shearer wrote that the Health and Disability Sector Standards state that consumers experience a planned and coordinated transition, exit, discharge or transfer from services, and that the rates and quality

of inpatient transition discharge plans are slowly improving. She referred to the Health Quality and Safety Commission New Zealand “Connecting Care” project, the goal of which is to improve care transition for mental health consumers.

XIX. Unless or until accessibility of relevant clinical information between DHBs is increased, it appears a distinct possibility that, as in the case of Ms Dalton, information critical to appropriate assessment and care of a transferring patient, or a patient presenting for any reason at a DHB different from that from which they have received care and treatment previously, will not be available to treating clinicians.

XX. The risks arising from that inaccessibility are clear. It is to be hoped that the national health information platform referred to by Dr Shearer is implemented in a timely way to ensure such risks are reduced in future.

Note: Pursuant to section 71 of the Coroners Act 2006, the Coroner has authorised the partial publication of Ms Dalton’s name, address and occupation and the fact that the Coroner has found her death to be self-inflicted.

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

Hughes [2019] NZCorC 51 (22 October 2019)

CIRCUMSTANCES

Susan Elizabeth Hughes of Dargaville died on 14 March 2016 at Auckland City Hospital. Her death was self-inflicted.

Ms Hughes had a longstanding history of mental health issues and alcohol dependence. The latter had been in remission until the end of 2015.

Ms Hughes had been engaging regularly with Dargaville Community Mental Health Services (DCMHS) until 21 December 2015. She did not attend a scheduled appointment on 18 January 2016, although she was visited at home by a counsellor. She agreed to attend a review appointment on 22 January but did not attend or respond to attempts at contact. Despite many efforts, Ms Hughes did not engage again with DCMHS and her case was closed on 22 February (after consistent non-contact).

RECOMMENDATIONS OF CORONER MCDOWELL

I. As is usual in circumstances where a person dies at a time proximate to receiving mental health care, Northland DHB conducted a review of Ms Hughes' clinical care. The review identified two key care delivery problems.

II. First, there was limited access to psychologist expertise in the rural community where Ms Hughes lived (Dargaville). Specifically, neither 1:1 psychological support nor the Borderline Personality Disorder (STEPS) group was able to be delivered in Kaipara.

III. Secondly, documentation of interventions to maintain Ms Hughes' engagement with DCMHS and considerations for discharge were not reflected in the discharge documents. The review noted that Ms Hughes was discharged at a potentially risky period due to the breakdown of her relationship.

IV. The review commented and recommended as follows:

a. Workforce planning needs to consider 'talking therapies' capability in the region (there is no availability of psychology and DBT[2] trained staff or programmes in this rural area). This was referred to the Clinical Governance Group for consideration.

b. The 'Did Not Attend' Pathway (used in the Discharge Process) needs to cover those individuals at medium risk. Accordingly, the relevant document/process needs to have a middle column developed to cover those at medium risk.

c. The standard discharge documentation does not provide for: discharge planning; efforts to locate to be considered and documented; and medication compliance. Accordingly, the discharge document needs review to reflect discharge planning.

d. Staff were unaware of the Suicide Prevention Coordinator's access to networks for locating next of kin after death. Staff were to be reminded of this capability by email.

V. Ms Hughes withdrew from the mental health service in the months preceding her discharge (and death). During this time she struggled with the breakdown of her relationship and her relapse into alcohol consumption. I acknowledge DCMHS' efforts to contact Ms Hughes during this period and consider that the recommendations made by the review address the issues raised. If they have not done so already, I strongly urge the DHB to consider talking therapies capacity in the Kaipara region (as envisaged in its first recommendation).

VI. Noting the actions taken by the DHB no further recommendations and/or comments are required in the context of this case.

Note: Pursuant to section 71 of the Coroners Act 2006, no person may make public any particular of Ms Hughes' death other than her name, address and occupation and the fact that the Coroner has found her death to be self-inflicted.

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

Ngarimu [2019] NZCorC 49 (11 October 2019)

CIRCUMSTANCES

Hamuera Ngarimu, aged 30, of the Bay of Plenty, died on 14 February 2015 at Gisborne Hospital. He was a heavy user of cannabis and alcohol and his death was self-inflicted.

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[2] Dialectical Behaviour Therapy

RECOMMENDATIONS OF CORONER NA NAGARA

I. Pursuant to s 57A of the Coroners Act 2006 I recommend that Ngāti Porou Hauora and Te Runanga o Ngāti Porou continue discussions initiated in the context of this inquiry about how effective alcohol and drug services on the East Coast might be established.

II. In view of the meeting held with representatives of these agencies to discuss my observations and concerns following the hearing of evidence, and the acknowledgements made at that meeting as to the need for improved services, I consider that the recommendation is clearly linked to the factors that contributed to Hamuera's death, that it is based on evidence I considered during the inquiry, and that the agencies to whom this recommendation is directed do have an understanding of how it may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

Note: Pursuant to section 71 of the Coroners Act 2006, as originally enacted, the Coroner has authorised the partial publication of Hanuera's name, address and occupation, and the fact that the Coroner has found his death to be self-inflicted.

Note: An order under section 74 of the Coroners Act 2006 prohibits, on the grounds of decency, publication of photos of Hamuera taken in the course of the inquiry into his death.

Weather-Related

Butterworth [2019] NZCorC 62 (19 December 2019)

CIRCUMSTANCES

Trisha Butterworth died on 5 January 2018 at Amohia Street, Rotorua from multiples injuries and blood loss as a result of an oak tree having fallen on her car.

On that day Rotorua experienced significant adverse weather conditions with strong winds (up to 90 kph) and heavy rain. At 10.45am that day, Ms Butterworth was driving along Amohia Street and arrived at the intersection with Arawa Street. While she was stationary, an oak tree situated at the corner of Amohia Street and Arawa Street snapped at the main trunk, and the majority of it fell onto her vehicle, causing her death. When examined, it was found that there was substantial decay/rot in the trunk of the tree where it snapped.

The oak tree was planted in 1863 and was deemed a 'protected' tree under the notable trees register. In previous years, work was undertaken on the tree to ensure it was stable. At some stage (estimated to be in the 1950's), concrete was inserted into the trunk to fill a cavity. In March 2000, Arbor Care was involved with assessing the tree. In 2002, Wakeling & Associates recommended the tree's canopy be reduced over a period by 30% and also recommended further investigation of the fungal bracket and extent of decay near the base of the tree. This work was said to have been completed between 2001 and 2004 even though there was no documentation on the council records to confirm this. In 2007, another assessment of the tree was undertaken by Arbor Care Ltd. They acknowledged the tree was in a state of decline due to its age but gave it a low risk assessment. In May 2016, Treescape completed further redaction work on

the tree. In February 2017, Arbor Care conducted an analysis of the tree ('the tapping test') which did not raise any concerns. The test was standard practice and different from another form of analysis (a resistograph), the latter being considered more thorough and accurate but also costlier, and therefore rarely used in New Zealand. Had it been used, the decay would have been discovered. In September 2017, Treescape installed two cable braces to the tree to support it. A further brace was planned to be installed, but this did not occur due to bad weather conditions at the time and ultimately, was never done.

The police reviewed the steps taken by the Rotorua Lakes Council (RLC) to assess whether possible liability might attach to RLC or the arborists who analysed the tree prior to the accident. The steps taken by RLC were reviewed by Mr McBride, who was employed by an arboriculture consultancy firm. Key findings from his report were:

a. Significant wood decay was present; with a figure somewhere between 5% and 17.4% of the total trunk radius not being subject to decay.

b. Significant loading was placed on the tree during the storm. The cable braces may have minimised the tree's ability to dissipate the force of the weather, and possibly contributed to the accident.

Ultimately, the police concluded that there were no breaches of any Acts, Regulations or local Government Legislation, and therefore the death was not an offence.

An inquest was held on this matter and Ms Butterworth's family expressed concern that RLC had not taken adequate steps to manage the tree and determine whether it was dangerous or not. They submitted that had proper investigations into the tree been undertaken, with an appropriate exchange of information between arborists occurring, this accident would not have happened. The Coroner found on balance that RLC did not act unreasonably or negligently.

COMMENTS OF CORONER BAIN

I. In this case, a large historic tree which hung over a public footpath and part of a public road in a central part of Rotorua city fell unexpectedly on to a passing car causing the death of the driver occupant. It is reasonable to expect that the relevant authorities would take and continue to take all reasonable steps to prevent a tragedy such as this ever occurring. It is against this reality that the need arose for this enquiry to be opened and for this court to hear from all those connected and able to give relevant evidence, as it has done.

II. I have in this finding referred to the Police inquiry as to whether any criminal offence arose in respect of what has happened. I have also amplified the purpose of an inquest such as this which is a fact-finding exercise not a method of apportioning guilt.

III. The key cause of the tree falling was the rotten state of its trunk. This was exacerbated by the extreme wind conditions but, as noted in the submissions of the family, most trees in the city resisted those conditions.

IV. From there the submissions became focused on whether the extent of the decayed state of the trunk should have been discovered. If it was discovered, it is at least inferred that this would have resulted in remedial steps being taken including potentially the removal of the tree. In particular, the conclusion in the 2017 Arbor Care report to the Council (that the tree was low risk) might have been different.

V. There is also evidence which is accepted that if advanced tree inspection techniques (such as a resistograph) had been used the extent of the decay would have been discovered. The tapping test adopted by Arbor care in 2017 (tapping the trunk with a plastic mallet) would normally give some indication of decay but, it appears, in hindsight, that the presence of the concrete in the cavity affected the results of that test. The concrete and pumice installed many years earlier affected this normally acceptable standard test procedure.

VI. In response, the RLC referred to the fact that Arbor Care itself carried out a survey of the tree in 2000. It identified “a suspected hollow section" and the presence of fungal brackets which may have been an indication of decay. At the time however Arbor Care did not identify them as causes for concern or make any recommendation of further investigation. RLC say that Arbor Care could be assumed to have had that information from its 2000 inspection when it carried out its inspection in 2017. That, as I understand it, was not put to Mr Sale at the hearing because the evidence about the 2000 Arbor Care report was not included or identified as part of the bundle for the hearing.

VII. That in turn leads to the question of whether Arbor Care should have undertaken or recommended the expensive option of the high-level test for this tree. Submissions for the family have focused on what information the RLC had and what information was passed on to Arbor Care in advance of its 2017 inspection and report. It is the family’s submission that the Arbor Care report was flawed due to the Council’s failure to provide the necessary information and that no risk assessment was carried out on the most dangerous part of the oak tree (the trunk). The Court has considered these submissions carefully in reaching its conclusions. In fact Arbor Care did undertake an assessment of the trunk but using the accepted standard procedure (the tapping test).

VIII. In hindsight we know that the Wakeling report in 2002 specifically noted that "the Oaktree contained a large cavity, which was very deep filled with concrete and pumice". Further, "there may have been a decay pocket in the root system or in the heart of the Oakwood which could only be ascertained by a resistor or similar equipment mapping the decay". However, that report was not provided to Arbor Care. The family say the RLC should have given that report to Arbor Care before or as part of its instruction to Arbor Care to carry out its examination.

IX. It seems that the Wakeling identification of the large cavity deep filled with concrete and pumice went further than what the Arbor Care report of two years earlier identified. From the additional excerpts attached to the RLC’s supplementary submission, it is shown that in the 2000 report Arbor Care recorded a “suspected hollow section in lower base” but does not note the presence of concrete in the cavity as identified at that time. It appears that Arbor Care did the 2017 report at least without the information about the concrete presence which I don't think it can be denied may have led them, indeed I think probably would have led them, to carry out a more advanced inspection likely using a resistograph. We now know that the concrete negated the effectiveness of the tapping test which was carried out.

X. Having said that, the RLC received the 2017 report and accepted its findings and acted accordingly in respect of the work on the tree which was reasonable and appropriate. RLC in their submissions point to the breadth of their brief to Arbor Care for the 2017 report. It is implied that even though the RLC (through omission rather than deliberately) did not provide Arbor Care with the Wakeling report when it briefed Arbour

Care for the 2017 report, it was reasonable for RLC to expect that Arbor Care would nevertheless have discovered any serious flaw. It is accepted that Arbor Care undertook normal conventional practice in its investigation. However, that did not result in its discovery of the presence of the concrete. There was therefore no trigger to gear up to more intensive testing as I have accepted would have happened as in IX above.

XI. From this, there are however a couple of points which arise. Firstly, there are examples that the RLC records over a long period of years are not complete (perhaps they would be now with digital technology). This may have contributed to the fact that the old reports such as the Wakeling report were not identified as relevant to the Spencer Oak and given to Arbor Care when it was engaged in 2017. Secondly, I am confident that the staff of the RLC were experienced and committed to doing the best job they could. However, if those various reports and records were available, and they were considered by a qualified tree expert, then the issue of the concrete and pumice filled cavity, and the suggestion of a test using a resistograph, found in the Wakeling report on file, may have highlighted an issue with that expert which the RLC might have specifically raised with Arbor-care in in its 2017 brief.

XII. I am pleased to note that those matters have been recognised in the RLC's plans it is making for future management, keeping better records and engaging a fully qualified expert in this field for the future. That is acknowledged and appreciated as an appropriate outcome here.

XIII. I refer back to the conclusion that the primary cause of the tree falling was the decayed trunk in the heavy wind conditions. In Mr McBride's report, he adopted the view that the static cable bracing present within the tree crown may have minimised the trees ability to dampen the windy conditions and possibly contributed to failure. When the tree has static bracing, it develops less natural ability to resist the wind. This is a factor that should be identified as making a tree such as the Spencer Oak (at times having more or less static bracing) at greater risk of falling in high wind conditions compared to other trees which have not been braced.

XIV. To summarise the issues that have been identified and warrant comment, I note the need for full records to be kept and shared in respect of the management of trees by the council; the benefits of retaining expertise on RLC staff; the benefit of being aware of the advanced tree inspection technology available and when it should be used; the fact that static bracing may affect a trees natural resistance; and the need to ensure that, when expert inspections are called for, all historic data that has been gathered in respect of a particular tree should, as a matter of course, be made available to the report writer before the task is undertaken.

RECOMMENDATIONS OF CORONER BAIN

I. The Court proposes to adopt, a number of recommendations that have been put forward to it by the family of Mrs Butterworth. This is a tragic accident. The RLC are to be commended for their approach they have taken to meet with the family and to consider the various criticisms and adopt practices which are aimed at preventing a similar accident occurring under similar circumstances. This Court therefore recommends that:

   a. The RLC adopt a policy setting out how it manages the maintenance, management and risk assessment of trees.

b. The policy referred to above, should have that as overriding concern, the management of public health and safety risks, rather than prioritising the amenity or historical value of trees.

c. The policy should also:

i. Respond to and investigate complaints and concerns raised regarding public trees.

ii. Identify from its own investigations, and those initiated by public concerns, any trees which are dangerous.

II. Where a tree is identified as being immediately dangerous, the danger must be removed by taking any action necessary to do so, including preventing access to areas, carrying out maintenance on the tree, or removing the tree.

III. Any maintenance carried out on trees must have regard to the tree's health, expected lifespan, and the practicability of long-term maintenance required to ensure its safety.

IV. The RLC maintain a publicly accessible tree register which identifies assessments and maintenance carried out on individual trees, expert recommendations made regarding the trees, and whether those recommendations have been implemented.

V. That a suitably qualified individual with necessary training and expertise to be able to ensure compliance with the policy, engage tree contractors, and critically analyse the advice and recommendations received from tree contractors and arborists, be employed.

VI. The policy, and the RLC's adherence to it, shall be annually audited.

VII. It is noted by the Court that the RLC is currently complying with most of these recommendations, including in particular the recommendation in paragraph II above, and is close to full compliance.

Note: This finding is subject to prohibitions and restrictions on publication under section 74 of the Coroners Act 2006.

Workplace

Cutbush [2019] NZCorC 59 (4 December 2019)

CIRCUMSTANCES

Brogen Cutbush, died on 6 February 2019 in Hunter, Waimate of chest wall trauma and crush asphyxia as a result of a tree felling mishap.

Mr Cutbush and Mr Wilson were on the farm property on which they were employed. Mr Cutbush was not wearing safety gear and decided to fell a tree for firewood. He cleared the area to do so and started cutting a tree with a chainsaw. Mr Cutbush did not hear Mr Wilson's warnings that he was on the wrong side of the tree. Mr Cutbush turned his back on the tree and the tree followed him. He got tangled up in the fence and the tree landed on him. Mr Cutbush was unresponsive

when Mr Wilson removed him from under the tree. Emergency services attended but were unable to resuscitate Mr Cutbush.

Worksafe investigated the incident and noted that the tree stumps observed at the scene indicated poor tree-felling practices.

COMMENTS OF CORONER TUTTON

I. Worksafe has published a guide to safe manual tree felling, which it states is one of the most dangerous jobs in the forestry industry. The guide is available at: https://worksafe.govt.nz/topic-and-industry/tree-work/safe-manual-tree-felling/.

II. The guide stresses the importance of planning, sets out the five steps of a tree felling plan, and lists the seven main causes of harm.

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.

OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND