



OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments
made between **1 January** and **31 March 2020**

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 13 recommendations and/or comments issued by Coroners between 1 January and 31 March 2020.

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.

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Recommendations and comments

1 January to 31 March 2020

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

Evans [2020] NZCorC 12 (4 March 2020)

CIRCUMSTANCES

Nicholas Julian Evans died on 18 June 2015 at Whangarei Base Hospital of septic shock due to pneumonia complicating chest drain insertion for spontaneous pneumothorax.

Mr Evans was a prisoner transferred from Mount Eden Corrections Facility to Northland Regional Corrections Facility on 29 May 2015. During this transfer, Mr Evans did not report any health concerns. However, when Corrections officers opened his cell the next morning, they found him in considerable pain. He was reviewed at the prison's health centre and administered a Tramadol injection before being taken to Broadway Health Centre in Kaikohe. The doctor there recommended that Mr Evans be taken to Whangarei Base Hospital virtually immediately.

Mr Evans was given more pain relief then transferred back to the prison. After a 55-minute reshuffle of staff and completion of appropriate paperwork, Mr Evans was transported to Whangarei Base Hospital where he was admitted at 3:00pm.

All the appropriate assessments including chest X-rays were made at the Emergency Department. It was determined Mr Evans had presented with a tension pneumothorax on the right-hand side with a completely collapsed right lung. It was considered at that stage that the pneumothorax was spontaneous. The appropriate treatment for this (chest drains insertion) was undertaken. Blood cultures were done and no organism was grown from them.

Further chest X-rays showed poor expansion of the right lung in spite of the chest drains. A second chest drain was inserted under aseptic conditions in an effort to facilitate the re-expansion of the right lung. Mr Evans' condition further worsened and he developed pneumonia. On 4 June 2015, Mr Evans was moved to the Intensive Care Unit and found to be in septic shock and in type 1 respiratory failure. He was placed on a ventilator and put into a medically-induced coma to assist with his breathing and treatment. Vancomycin was added to his treatment on 5 June to treat methicillin-resistant staphylococcus aureus.

Despite a slight improvement over the next few days, Mr Evans then developed severe Adult Respiratory Distress Syndrome (ARDS). There was very little improvement for the next 10 days other than more complications including cuts in his right internal jugular vein. The ARDS became progressively worse despite full attempts to provide oxygen and a full ventilator service. Mr Evans did not respond. After discussions with hospital staff and family, the decision was made to palliatively treat Mr Evans and he died on 18 June 2015.

RECOMMENDATIONS OF CORONER SHORTLAND

- I. In the context of delay in getting Mr Evans to Whangarei Base Hospital for the earliest possible treatment, it was apparent the procedure of returning to the prison first to change-out staff and then complete paper work was an issue in this inquest.
- II. It is accepted the Department of Corrections have robust standard procedures for prisoners requiring hospitalisation.
- III. At issue is whether the Department of Corrections have the flexibility in their robust processes to respond to unfolding medical emergencies like in Mr Evans' circumstances on 30 May 2015, when he should have been taken immediately to hospital from Broadway Health.
- IV. The decision to take Mr Evans to Broadway Health in the first instance was reviewed by Ms Sergeant's report. There was an inference Mr Evans should have been transported by ambulance.
- V. Associate Professor Garrett talked about "Windows of opportunity to medically treat" referring to medical attention as soon as possible.
- VI. The recommendation is to invite the Department of Corrections to look at flexibility in their Standard of Procedures (SOP's) in responding to medical emergencies and urgent transportation to hospital. To avoid any unnecessary delays. To avoid what happened on 30 May 2015 for Mr Evans. To resource such a process appropriately.

Leisure Activities

Brookes [2020] NZCorC 2 (13 January 2020)

CIRCUMSTANCES

Neil Robert Brookes was found dead on the seafloor off Motunau Beach, North Canterbury on 6 March 2017. He was last seen by his diving companions on 5 March 2017, when he surfaced during a scuba dive. When found, Mr Brookes' mask was lying on the seabed next to his hand.

Mr Brookes' diving equipment was examined and tested by the Police National Dive Squad (PNDS). PNDS observed that Mr Brookes' 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 Brookes' weight belt and found that it would have made him negatively buoyant. After examining the buoyancy compensatory device, the PNDS found that it would have been at its limit to

provide any buoyancy for Mr Brookes as it was not a correct fit and because of the amount of weight carried on the weight belt and the full catch bag.

PNDS further considered that Mr Brookes used some unsafe diving practices: possibly breathing his dive cylinder empty; not wearing a watch or time piece while diving; carrying a very large amount of buoyancy weight and not recognising that this was unnecessary; not abandoning his weight belt when in trouble; attaching a catch bag directly to his dive equipment; and not diving with a dive buddy. The probable cause of Mr Brookes' death was drowning following possible cerebral arterial gas embolism in out of air ascent while scuba diving, complicated by loss of mask and regulator, overweighting by lead and crayfish, and separation from diving buddy.

COMMENTS OF CORONER ELLIOTT

- I. Constable Clayton-Greene suggested a number of recommendations to avoid future deaths in similar circumstances for recreational divers:
 - Divers monitor their air supply and end a dive on 50Bar.
 - Divers should wear a watch or other timing device to assist in planning their dives.
 - Divers maintain and adjust correct buoyancy and weight.
 - Divers abandon their weights when in difficulty.
 - Dive with a buddy for the duration of the dive.
 - Divers should hold or carry their catch bag in their hand and not attach it to their dive equipment.
 - Divers have their dive equipment serviced annually by a qualified technician.
 - Divers discuss what to do in an emergency.
- II. Diving deaths are a regular occurrence in New Zealand. A number of diving deaths have been subject to a Coronial inquiry and a number of recommendations have been made.
- III. Recommendations were made in relation to the 2011 death of Neville Poole.¹ Mr Poole died in similar circumstances while diving for scallops in Allom Bay. The following recommendations were made in relation to Mr Poole's death:
 - Dive with a buddy.
 - All dive equipment should be well maintained and serviced every year.
 - Equipment should be checked before all dives (for example, by checking for leaks).

¹ Issue 7 Recommendations Recap: Coronial Services 1 July to 30 September 2011 - CSU-2011-AUK-000117 (2013 NZ CorC 96).

- If a fault is found in a piece of dive equipment the dive should be cancelled until the fault is fixed or the faulty equipment replaced.
- Divers should practise emergency drills.
- If a diver begins to feel unwell or stressed during a dive, the dive should be aborted.
- Divers should plan to be on the surface with 50 bar or 500psi still in their cylinder, and they should monitor their air during the dive.
- If the diver has an extended break from the sport, they should do a refresher course.
- Divers should always carry a knife when diving.
- Divers should never attach a catch bag to their body.

IV. There has also been media coverage of diving deaths. For example:

All four people who died off Wellington's south coast this summer [of 2015/2016] were scuba divers with varying degrees of experience, whose deaths were not yet fully understood, Adams said.

"There's certainly no one thing going wrong in any of these cases."

However, there were common factors among the tragedies from which others could learn, he said.

Running out of air was one common theme, as was divers being weighed down with catch bags they had clipped to themselves.

"We're seeing a lot of fatalities with the diver still having their weight belt on," Adams said.

If people got into trouble underwater, they should not be afraid of ditching expensive gear to resurface at a safe rate. "You are dealing with your own life, your own well-being."²

V. 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:

Neil Brookes died on 5 March 2017 in the sea off Motunau Beach, North Canterbury. He became separated from his diving companions and resurfaced alone.

The probable cause of Mr Brookes' death was drowning following possible Cerebral Arterial Gas Embolism (CAGE) in out of air ascent while scuba diving complicated by loss of mask and regulator, overweighting by lead and crayfish and separation from diving buddy

² Stuff.co.nz: Running out of air, holding on to weights and catch all factors in diver deaths (8 March 2016)

<https://www.stuff.co.nz/national/77654300/Running-out-of-air-not-ditching-weights-or-catch-all-cited-as-factors-in-diver-deaths>.

Mr Brookes' 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.

Hollnsteiner and Murphy [2020] NZCorC 5 (17 February 2020)

CIRCUMSTANCES

Daniel Thomas Hollnsteiner of Staten Island, United States died on 25 September 2015 at Lake Tekapo from cold water immersion. James Robert Murphy of London, United Kingdom died on 25 September 2015 at Lake Tekapo from cold water immersion and terminal freshwater aspiration.

Daniel and James were students at Monash University in Melbourne, Australia. They were visiting New Zealand with friends for a holiday at the time of their death. On 25 September 2015 they and their friends hired kayaks from a local kayaking company, Aquanorts, which was owned and operated by Ricky Hartnett. This was a 'freedom hire', meaning Daniel, James and their friends were not accompanied by an instructor or a guide. Other than one member of the group, the students had little to no kayaking experience. In particular, Daniel had kayaked only once before, and this was the first time James had ever kayaked. No demonstration of how to use the kayak or any safety training was provided to the group. Mr Hartnett told the group to stay visible to the beach area where his business was located at all times. He also supplied the group with life jackets.

At about 1:50pm the group set out in the lake in the kayaks. The weather at the time was fine, warm and calm. They decided to paddle to Motuariki Island, approximately eight kilometres from the beach where they had entered the lake. Mr Hartnett saw the group at around 2:10pm. At 3:00pm, he realised he could no longer see them and noticed that weather conditions had deteriorated on the lake. MetService reported that between 1:00pm – 2:00pm windspeed on the lake had increased from 7km/h to 17km/h, and by 3:00pm windspeeds had increased to 19km/h with the air temperature dropping to 11.9°C. At 3:05pm a local helicopter pilot flying over the lake noticed the group dispersed some 600-1200 metres south of Motuariki Island.

At around 3:15pm Mr Hartnett began searching for the group using his powered safety boat but was unsuccessful. He returned to shore after deciding the weather conditions made it too dangerous to continue searching on the lake. He returned to shore some time between 3:30 – 3:45pm.

The change in weather caused issues for the group. One student from the group was hit by a wave and capsized. Daniel and another student went over to assist but their kayak capsized also. All three students stayed in the water clinging to a kayak. After about 45 minutes in the water, Daniel was observed by the other students to become unresponsive. Another wave hit the kayak they were clinging to. Daniel lost contact with the kayak and was unable to be retrieved.

At this moment, James and another student were still in their kayaks at the back of the group. The student James was with was hit by a wave and entered the water. James assisted but fell into the water too. They both attempted to swim to the western side of the lake. The student reached the shore but saw James lying unresponsive in the water behind her.

She swam out and dragged him onto the shore and attempted CPR. James could not be revived. By around 4:00pm six of the students had made it to Motuariki Island.

After returning to the shore having attempted to find the group, Mr Hartnett made further attempts to locate them but was unsuccessful, as his powerboat battery had died. He was given the contact number for the local Coastguard volunteer but did not contact him. He then called locals asking them if they had seen the group, which they had not. Mr Hartnett called the Coastguard volunteer at 4:00pm, and his partner contacted emergency services at around 4:31pm. She reported that the lake water temperature was about 7 – 8 °C.

A search and rescue effort was organised and the group were located at around 5:00pm. Daniel and James were confirmed to be deceased.

COMMENTS OF CORONER WINDLEY

- I. The Coroners Act 2006 makes clear that determinations of civil, criminal or disciplinary liability are not within the stated purposes of a coronial inquiry.³ Whether Mr Hartnett's actions or inactions amount to a breach or an offence under the relevant statutes and regulations is strictly for the District Court to determine. That process has been properly concluded in that jurisdiction.
- II. It is however, a proper and indeed important function of a coronial inquiry to ascertain the broader circumstances in which there has been loss of life, and to consider whether death was avoidable, and whether any comments or recommendations could be made for the purposes of reducing the chances of future death in similar circumstances.⁴
- III. Commercial water craft operators are properly required to bear significant responsibilities and discharge duties to ensure the health and safety of their customers. The specific nature of the Aquanorts operation meant that the legislative framework that it was subject to included entry to a prescribed safety system, the Maritime Operator Safety System ("MOSS").
- IV. I am satisfied that the MOSS provides a system for individualised and robust safety assessment of the relevant operation to ensure safety issues are identified and appropriate systems are implemented to eliminate or mitigate the risk where possible, and adequately respond to emergency situations. However, by operating outside of the required MOSS regime the safety of Aquanorts operation was not subject to external scrutiny, and the risk of the critical failures which eventuated and resulted in Daniel's and James' death were not recognised.
- V. It is not clear to me exactly why Mr Hartnett failed to appreciate his legal obligations in terms of MOSS. He asserts his initial due diligence efforts in 2012 did not disclose such a requirement. It would seem that Mr Hartnett made no further effort to ensure he was compliant with regulatory requirements.
- VI. The critical importance of robust due diligence by operators undertaking commercial adventure activities which pose safety risks to customers cannot be overstated. Had Aquanorts entered the

³ See s57(1).

⁴ See ss 57(3) and 57(A).

MOSS as it was required to do, the combination of risks that eventuated on this occasion would almost certainly have been identified, and whether by elimination or mitigation, would have meant Daniel's and James' tragic deaths could potentially have been avoided.

- VII. I accept there are practical limitations to Maritime NZ's ability to proactively detect non-compliant commercial operators and the industry itself and members of the public can assist in identifying operators of potential concern. A commercial maritime operation that is in MOSS can be readily identified by the fact that the safety certified vessel(s) involved in the operation is/are marked with a six-digit number with a 'MSA' or 'MNZ' prefix. If members of the public or other industry operators have any concerns about a commercial maritime operation, those concerns should be promptly reported to Maritime NZ to investigate.
- VIII. Given the limitations on comments and recommendations made under s 57A, I have not considered whether the differentiating criteria of the use of a powered safety boat meant that the MOSS prescribed safety system provided for a markedly different safety system to that provided for under the adventure activities regulations, had they instead applied. Similarly, I have not considered the adequacy of the broad-based duties and obligations under the Health and Safety at Work Act 2015 in circumstances where the specific characteristics of a commercial kayak rental operation mean it is not captured under either the MOSS or the adventure activities and is therefore not subject to a prescribed safety system. An assessment of the potential number of operations that fall within this category and the safety risks associated with such operations may be an issue for WorkSafe to consider further.
- IX. It must be acknowledged that individuals also bear a level of personal responsibility for ensuring their own safety when undertaking water activities, whether in commercial or recreational settings. When participating in a commercial activity the substantive responsibilities and duties lie with the commercial operator. However, individuals ought to also undertake their own due diligence in relation to their personal safety. In 2018 Maritime NZ published a *Paddle Craft Guide*⁵ with safety guidance for users of both recreational and commercial paddle craft. Other information and resources for recreational kayaking, waka ama, and canoeing activities is also available on its website.⁶
- X. Some simple steps individuals can take to enhance their own safety while engaging in commercial paddle craft activities include:
- *Ask questions* - query the level of experience or skill needed to do the activity safely, or any aspect of the activity, the area, or the conditions which you are unsure about
 - *Stick to your limits* – know how to paddle, manoeuvre, get back into or onto your boat, and limit yourself to areas and conditions relative to your skill and experience
 - *Know the safety plan* – make sure the operator has provided a clear briefing about what risks you may encounter and what to do and what to expect in an emergency

⁵ See <https://www.maritimenz.govt.nz/recreational/documents/paddle-craft-guide.pdf>.

⁶ See <https://www.maritimenz.govt.nz/recreational/kayaks-and-canoes.asp>.

- *Check out reviews* – what do previous customers say about the operator and any issues encountered?
- *Check the conditions* – check or ask the operator for the forecast to see what conditions are expected to be encountered
- *Avoid impairment* – ensure you are well rested and avoid alcohol or any substances that could impair your ability to undertake the activity or respond in an emergency
- *Wear a lifejacket that fits*
- *Dress for visibility and for the water temperature* – to best protect against the risks of cold water immersion, in water less than 10°C, synthetic fibre clothing should be worn; polypropylene long-johns and long sleeved top, waterproof outer jacket, or ‘farmer john’ neoprene wetsuit, wetsuit booties and either a woollen hat or neoprene hood
- *Ensure you have a means of communication* – ideally two waterproof means of communications should be carried
- *If it doesn’t look or feel right, then it probably isn’t* – Be prepared to turn back or give it a miss this time – ‘If in doubt, don’t go out’

XI. In light of my view that the legislative regime that applied to Aquanorts was adequate, and the fact that Aquanorts is no longer operating, I make no formal recommendations.

XII. However, in an effort to promote public awareness and enhance safe practices in commercial kayak and other water craft rental activities I direct this Finding be sent to the following and further disseminated as appropriate:

- a. New Zealand media outlets
- b. the Sea Kayakers Association of New Zealand (KASK)
- c. Water Safety New Zealand
- d. Maritime NZ; and
- e. WorkSafe.

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

Medical

Amundsen [2020] NZCorC 4 (31 January 2020)

CIRCUMSTANCES

Edwin Donald Amundsen of Auckland died on 15 October 2015 at Middlemore Hospital, Auckland of acute bilateral occipital infarction with the antecedent cause atherosclerotic cerebrovascular disease, with hypertension a contributing factor.

Mr Amundsen, aged 57 years, lived in Auckland with his wife and three children. On Monday, 12 October 2015 he experienced a visual disturbance while reading the newspaper and he developed a constant headache. The following morning, he went to his GP who organised for him to be taken to Middlemore Hospital.

He was seen by medical staff and reported that his headache had increased in severity but that he had no other issues. He was assessed as having a severe atypical migraine by medical staff, who investigated his condition further. He underwent blood tests, electrocardiogram and a CT scan, which reported as normal. He also attended an appointment at a local eye clinic, the results of which were reported as being normal. Mr Amundsen was discharged from hospital on 14 October 2015.

On 15 October 2015 medical staff from Middlemore Hospital called Mr Amundsen and he told them that his headache was ongoing, and his vision had worsened. He was advised to immediately return to the hospital. While on the way, Mr Amundsen began vomiting and became unresponsive. He was then transferred to Middlemore Hospital by ambulance. He was assessed in the Emergency Department and referred to the stroke team. Another CT scan showed that Mr Amundsen had suffered a stroke. Mr Amundsen's condition deteriorated, and he died in the evening of 15 October 2015.

The adequacy of Mr Amundsen's assessment and treatment were considered by the Coroner. Dr Annemarei Ranta, an associate professor and consultant neurologist, reviewed the care given and provided a report. She noted that many aspects of Mr Amundsen's care were highly appropriate even though he was not seen by a neurologist.

However Dr Ranta also had a number of concerns. She reported that she would have expected a more detailed documented neurological and vision history and examination of Mr Amundsen given his symptoms. In addition, the initial CT scan showed early ischaemic changes indicative of stroke that were missed. Finally, Dr Ranta queried the decision to refer Mr Amundsen to an ophthalmologist rather than a neurologist, as well as the fact that the significant extent of his visual impairment – which suggested a brain origin - was not reported to his doctor at Middlemore Hospital before his death. Dr Ranta considered Mr Amundsen's initial diagnosis as tenuous in the circumstances and explained that she would have pursued further imaging in this situation. She concluded that a neurologist should have been consulted earlier, but also noted that there was no onsite neurologist at Middlemore Hospital on the day of Mr Amundsen's admission.

Dr Ranta's diagnosis was that Mr Amundsen was very likely suffering from stroke already on 13/14 October, and this was probably missed by medical staff who treated him. She also considered that discharging him was appropriate given his provisional diagnosis of an "atypical migraine", but that other diagnoses ought to have been explored. Ultimately, she

concluded that had Mr Amundsen been properly diagnosed and treated when he first presented at Middlemore Hospital, it is possible he would have survived.

COMMENTS AND RECOMMENDATIONS OF CORONER GREIG

- I. At the heart of this case is that Mr Amundsen was not referred for a specialist review by a neurologist on his first admission.
- II. Middlemore Hospital is a large tertiary hospital that does not have an on-site neurology service. Accordingly, all patients admitted to hospital with symptomology that may indicate brain pathology are admitted under a general medical team and assessed initially by doctors who are not neurologists. They do not have the neurology knowledge and expertise of a vocationally registered neurologist. In this system, it is essential that there is a robust process for ensuring that cases are appropriately identified for specialist inpatient neurologist review and that daily specialist inpatient neurologist review is available.
- III. There is evidence before me that visiting neurologists from Auckland City Hospital now attend Middlemore Hospital daily on week days. This is an increase from when Mr Amundsen was in hospital and a positive development.
- IV. There is no evidence before me as to what protocols are in place for referring inpatients at Middlemore Hospital for specialist neurology review – particularly in cases where patients present with symptoms that do not seem immediately life threatening but may result from brain pathology.
- V. On the basis of the lessons learned from this case, including the issue of the lack of reliability of radiologist interpretation on subtle signs of infarction on early CT scans, but acknowledging that time has moved on, I encourage Counties Manukau DHB to review its protocols for referral for specialist neurology review and satisfy itself:
 - a. that cases like Mr Amundsen's will now be referred for such review; and
 - b. that it has sufficient specialist neurology capability to conduct prompt reviews of such cases.

RESPONSE TO RECOMMENDATIONS

- I. Dr Peter Watson, Chief Medical Officer has advised that Counties Manukau DHB (the DHB) accepts my provisional findings and recommendations. He advised that:
 - a. The Division of Medicine has reviewed its model of care for acute neurology services;
 - b. Middlemore Hospital is now served five days a week by a visiting neurologist from Auckland DHB;
 - c. Whilst presentations in the weekend remain as a potential gap in service it is unlikely that the DHB will be able to provide routine daily weekend review by a specialist neurologist due to resource constraints and competing clinical demands. The DHB will continue to monitor its

service and consult with Auckland DHB to see what, if any, further improvements can be made;

- d. The DHB has also reviewed its processes for referral to neurology services and satisfied itself that the referral processes are well understood by general medical staff and that there are good lines of communication within the DHB and also between Counties Manukau DHB and Auckland DHB neurology service;
- e. The DHB does not have specific written protocols to guide referral to neurology services because the question of whether to refer cases with some degree of diagnostic uncertainty is an individualised clinical decision inherent in general medical care. Accordingly, the DHB does not consider written protocols would be helpful as they are insufficiently nuanced to guide management in clinical scenarios where a patient's presenting symptoms are subtle and possibly attributable to a variety of causes;
- f. However, as a result of the improvements made to the DHB's acute neurology model of care the DHB is confident that cases like Mr Amundsen's are now significantly more likely to be referred for specialist neurology review.

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

Murray [2020] NZCorC 3 (24 January 2020)

CIRCUMSTANCES

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

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

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

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

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

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

The Coroner found that Mr Murray's death arose from a known and significant side effect of clozapine. His treating team was alert to the effects of clozapine and monitored him for any issues regularly. When issues arose for Mr Murray, advice was dispensed and when the issues deteriorated in following months it was managed appropriately.

COMMENTS OF CORONER GREIG

- I. Auckland District Health Board has in place evidence-based guidelines for staff entitled Clozapine Use and Management of Side Effects. This document includes information on monitoring for and managing constipation.
- II. The evidence before me is that the ADHB clinical staff caring for Mr Murray were aware of constipation as a side effect of clozapine and monitored for it routinely as stipulated by the guidelines.
- III. These matters are to be commended.

RECOMMENDATIONS OF CORONER GREIG

- I. Given that fatal constipation/bowel obstruction is the leading cause of death related to clozapine in New Zealand and that the complication can arise even when a person has been taking the medication uneventfully for many years (which was the case with Mr Murray) I recommend that Auckland District Health Board gives consideration to:
 - a. strengthening the warnings about the dangers of constipation in those taking clozapine in the guidelines for Clozapine Use and Management of Side Effects; and
 - b. including stronger messages in the guidelines about proactive follow up and assertive education and management of patients who raise constipation as an issue or potential issue.
- II. A copy of these findings will be sent to the Centre for Adverse Reactions Monitoring (CARM) in Dunedin and to Medsafe.

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

Thorpe [2020] NZCorC 6 (18 February 2020)

CIRCUMSTANCES

Amy Louise Thorpe died on 4 December 2018 at 35 Lyon street, Invercargill of an epileptic seizure.

Ms Thorpe was 34 years old and had a history of epilepsy and other conditions. She consumed about two litres of Coca-Cola and between 500mls to one litre of energy drinks a day. At the time of her death Ms Thorpe was 15 weeks pregnant. Since becoming pregnant her seizures had increased in frequency to about once a week.

Ms Thorpe was referred to a consultant obstetrician and gynaecologist who noted poorly controlled seizure disorder and recorded that Ms Thorpe had frequent grand mal seizures with random triggers. Despite previous poor compliance with attendance at neurology appointments, a referral was made to a neurologist.

In November 2018 Ms Thorpe was seen by a neurologist, Dr Hammond-Tooke, who reported that the epilepsy diagnosis was uncertain but treated Ms Thorpe on the basis of that diagnosis. He advised Ms Thorpe that she either needed to try another antiepileptic medication or she needed to be admitted to hospital for EEG monitoring. Ms Thorpe was reluctant to undergo further video EEG or change her medication.

On 4 December 2018 Ms Thorpe was found face down on her bed with the lower half of her body on the bed and her torso leaning over the bedside cabinet. Attempts to revive her were unsuccessful.

Looking at whether Ms Thorpe's death could have been prevented, Coroner Robinson sought medical advice from Dr Hammond-Tooke as to the potential significance of excess caffeine consumption in this case. Dr Hammond-Tooke reported that pre-clinical studies suggest that caffeine increases seizure susceptibility while in some cases, chronic use of caffeine may protect against seizures. Caffeine also lowers the efficacy of several drugs, especially topiramate. Dr Hammond-Tooke considered that until clinical studies suggest otherwise, caffeine intake should be considered as a factor in achieving and maintaining seizure control in epilepsy. He also concluded that large amounts of caffeine probably can cause seizures, but it is unclear if modest amounts are a significant concern in clinical practice. In the case of Ms Thorpe, Dr Hammond-Tooke noted it is possible that excessive caffeine contributed to poor seizure control.

Coroner Robinson considered that there is value in giving some publicity to Ms Thorpe's case in order that the general public is aware of the potential consequences of excessive use of caffeine contained in products in patients suffering epilepsy. He also thought it may be appropriate for patients with epilepsy to be cautioned as to the potential consequences of excessive caffeine use.

RECOMMENDATIONS OF CORONER ROBINSON

- I. I direct that a copy of this finding be made available to the Royal New Zealand College of General Practitioners and Epilepsy New Zealand for dissemination amongst their members as those entities consider appropriate.
- II. To the extent that there is an association between excess consumption of caffeinated drinks and poor seizure control, advice to patients of such potential effects may mitigate the risk of deaths in similar circumstances.

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

Motor Vehicle

Kaiwai [2020] NZCorC 11 (3 March 2020)

CIRCUMSTANCES

Hori Papa Ngaro Kaiwai of Rotorua died on 12 March 2018 at State Highway 5, Mamaku of a massive head and upper cervical spinal injury sustained in a motor vehicle collision.

Mr Kaiwai and his wife had been in Adelaide, South Australia for a conference. They travelled back to New Zealand overnight on 11 March 2018, leaving Adelaide at 9:00pm and arriving in Auckland at 5:00am due to travelling through Melbourne.

Mr Kaiwai drove them back to Rotorua the next day. Prior to entering the Mamaku Ranges, Mr Kaiwai stopped the vehicle in a lay-by area to sleep for approximately 15 minutes before continuing the journey. Shortly after, his vehicle drifted from the southbound lane across the centreline and into the northbound lane and collided with a campervan. Mr Kaiwai died from injuries he sustained.

RECOMMENDATIONS ENDORSED BY CORONER ROBB

- I. The dangers of driving while fatigued, particularly following overnight travel, are evidenced by this death. The New Zealand Transport Agency (NZTA) identified the following warning signs of fatigue:
 - a. Restlessness
 - b. Blinking frequently
 - c. Yawning
 - d. Excessive speed changes
 - e. Braking too late
 - f. Forgetting the last kilometres
 - g. Drowsiness
 - h. Centreline drift
- II. NZTA notes that it is a common myth that coffee, fresh air or music help combat fatigue. These measures only help in the short-term and NZTA advises that stopping and getting a good night's sleep is the only cure for fatigue.

Where stopping overnight is not a practical possibility, frequent breaks, and as necessary frequent breaks including a period of sleep, should be incorporated into the journey.

- III. Pursuant to s 57(3) of the Coroners Act 2006, I endorse NZTA's message to stop and have a proper sleep prior to driving. I encourage drivers to only continue their journey when they feel fully refreshed.

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

Pene [2020] NZCorC 13 (17 March 2020)

CIRCUMSTANCES

On 5 October 2018, Barrett Pene, aged 82, was driving his Toyota vehicle in a westerly direction on Saddle Road from Woodville toward Palmerston North. Mr Pene failed to negotiate a left-hand bend and travelled across the centre line. His vehicle collided with a Mazda vehicle travelling in the opposite direction. The driver of the Mazda had no opportunity to avoid the collision and Mr Pene suffered fatal injuries as a result of the crash. He died at the scene.

Prior to his death, Mr Pene did not enjoy the best of health. He had gone through two sessions of chemotherapy, for cancer. The post mortem report noted that Mr Pene was susceptible to cardiac arrhythmia due to the patchy myocardial fibrosis. As a result, the pathologist was unable to exclude the possibility of an arrhythmia occurring at the critical moment before the collision. The pathologist also noted that based on the blood loss Mr Pene suffered, he was alive at the time the crash occurred.

The Police crash analyst examined the scene and found that, as Mr Pene approached the bend where the crash occurred, there was a 45 km/h speed advisory sign located in a dip in the road, followed by an area used for parking road maintenance machinery. At the time of the crash, yellow and orange-coloured machinery was parked there. In addition, there were trees and shrubs surrounding the approach to the scene, including a broom with yellow flowers. The analyst considered that the speed advisory sign located off the road, in conjunction with the yellow, orange, black, and varying shades of green on the approach to the bend appeared to reduce the effect of the single speed advisory sign, and the warning of the severity of the approaching bend.

The Coroner concluded that there were two possible scenarios in Mr Pene's death. The first was that Mr Pene was travelling too fast and may not have appreciated the severity of the approaching bend because the speed advisory sign was not so obvious. The second was that Mr Pene suffered a medical event at the critical moment while approaching the bend. Given the pathologist's conclusion, it was possible that, although alive in the lead-up to the crash, Mr Pene was affected by a cardiac arrhythmia. However, there was no evidence to either support or discount this possibility.

COMMENTS OF CORONER RYAN

- I. With regard to comments that could usefully be made pursuant to section 57(3) of the Coroners Act 2006, I note the issue raised by the crash analyst with regard to the location of the speed advisory sign on the eastern approach to the bend where the crash occurred. Although it cannot be stated with certainty that this was a factor in the cause of the crash, I draw this to the attention of the roading authority responsible for maintaining this

section of the road with the expectation that consideration will be given to whether this signage needs to be improved.

- II. After receiving a draft of this finding, New Zealand Transport Agency advises that the signage leading up to this bend has now been improved with regard to its location, and two combined speed advisory/chevron signs have been installed. In addition, consideration is being given to whether audio tactile pavement markers (rumble strips) should be installed for the entire Saddle Road route.
- III. I am satisfied that the changes made by NZTA as recorded above are a significant improvement to this bend, and commend NZTA for taking such remedial action.

Tavinor [2020] NZCorC 7 (21 February 2020)

CIRCUMSTANCES

John Edward Tavinor of 293 Gun Club Road, Pukekohe, aged 32 years, died instantly on 20 November 2000 on State Highway 1 at Penrose, Auckland (Southern Motorway), as a result of head and neck injuries he received when he was struck by a part of a truck driveshaft.

At about 10:25 am on 20 November 2000, Mr Tavinor was travelling north in a utility vehicle on the Southern Motorway, State Highway 1, at Penrose, Auckland, in the lane closest to the median barrier. At the same time, a Mitsubishi truck ("the truck"), was travelling south in the lane closest to the median barrier, carrying two containers.

The driveshaft of the truck detached, and the front or yoke slip portion of the driveshaft's front universal joint was projected from the bowels of the truck, over the median barrier and through the windscreen of Mr Tavinor's vehicle. The driveshaft component struck Mr Tavinor in the head and neck area killing him instantly.

An inquest into Mr Tavinor's death took place before Coroner Dr Murray Jamieson on 2-6 December 2002. On 22 July 2003, Coroner Jamieson issued his Reserved Findings, concluding that the truck's driveshaft "had disintegrated when one of its bearings failed".

In November 2013, a Consulting Engineer Mr Peter Morgan, petitioned the Crown Law Office to open a fresh Coronial inquiry into Mr Tavinor's death. In the application for a new inquiry into Mr Tavinor's death, Mr Morgan noted that two servicing mechanics carried out an unrecorded, makeshift and inadequate repair to the truck on 9 November 2000. They used "heli-coil" inserts to replace loose bolts fastening the gearbox bellhousing. According to Mr Morgan, the primary cause of the driveshaft failure was the ripping out of these heli-coil inserts, with a secondary cause being the lack of any rear support mounts for the gearbox, cantilevered off the engine bellhousing;

On 10 April 2014, the Deputy Solicitor General, acting pursuant to s 97 of the Coroners Act 2006, ordered another inquiry into Mr Tavinor's death, on the grounds that the discovery of new facts as to the proximate cause of the failure of the driveshaft of the southbound truck made it desirable to open another inquiry.

After some delays, the second inquest into Mr Tavinor's death commenced on 27 November 2017. On the second day of the hearing, Eaton Corporation, a company based in USA and the manufacturer of the truck's gearbox, sought an

adjournment on the grounds that it had not received notice of the inquest. The adjournment was granted on 29 November 2017 and the second inquest resumed on 6 August 2018.

The primary issue to determine at the second inquest was what caused the truck's driveshaft to disintegrate. A number of experts gave evidence on that issue, including Mr Paul White. NZTA were represented by Mr R Wilkin.

Coroner Matenga found that the weight of evidence overwhelmingly supported the view that the disintegration of the truck's driveshaft resulted from bearing failure. He was unable to determine what initiated the bearing failure, or what the precise sequence of events was that led to the disintegration of the driveshaft. However, he found that wear and tear, and lack of proper and compliant maintenance, including that carried out on 9 November 2000, were the probable contributing causes of the bearing failure. He also concluded that the available evidence did not support a conclusion that there was anything inherently defective about the design of the truck, including its gearbox.

COMMENTS OF CORONER MATENGA

- I. I am conscious that over 19 years have now passed since Mr Tavinor's death, and that many of the recommendations made by Coroner Jamieson in his reserved findings had already been put into effect as at 22 July 2003. The reality is that in the years since Coroner Jamieson issued his reserved findings, matters have moved on in the trucking and heavy motor vehicle servicing industry. As such, there may well be limited utility in further recommendations being made on the basis of findings made in relation to an incident that occurred nearly two decades ago.
- II. Coroner Jamieson expressed the view that the caging of driveshafts should be further considered. In this respect, I asked NZTA to provide submissions addressing the legislative history and current NZTA policy considerations as to protective structures for driveshafts. I am grateful for the information which Mr Wilkin duly provided.
- III. It is apparent that, historically, the legislative and regulatory requirements in New Zealand with respect to such protective structures were only applicable to passenger service vehicles such as buses.
- IV. The Land Transport Rule: Heavy Vehicles 2004 came into force following the death of Mr Tavinor. Taking specific cognisance of the Tavinor incident, clause 3.4(3) provides that:

A device fitted to a vehicle to restrict the field of swing of a driveshaft in the event of driveshaft failure must be maintained to within safe tolerance of its original condition.

- V. Mr Wilkin submitted that clause 3.4(3) was intended to take into account the fact, as a result of the incident that is the focus of this inquest, Mitsubishi Fuso NZ began to voluntarily fit driveshaft loops to their vehicles upon entry into New Zealand. I record that the NZTA is only aware of Mitsubishi Fuso fitting driveshaft loops as original equipment, and is not aware of any after-market loops being fitted to any trucks.
- VI. I note Mr White's views, with some concern, that the driveshaft loops voluntarily fitted by Mitsubishi Fuso would not prevent the incident that occurred in the present case from occurring again. Mr White commented that:
 - a. The size of the loop is smaller than that required by the Low Volume Technical Association for a light vehicle safety loop;

- b. The mass of a car driveshaft is significantly less than that of a truck. The loop fitted to a current Fuso would probably be torn off;
 - c. A meaningful safety loop would be quite a significant structure and require anchoring to the chassis rails or a substantial crossmember which may or may not be practical.
- VII. Mr Wilkin submitted that the benefit to cost ratio of retrofitting driveshaft containment devices to the approximately 120,000 trucks and buses in the country fleet is one-tenth of that required to be supported by the NZTA in terms of value on investment. The NZTA has also pointed to the historic infrequency of fatalities and serious injury crashes attributable to driveshaft failure, and the lack of any regulatory requirements for driveshaft containment devices for trucks in overseas jurisdictions.
- VIII. Reasoning of this nature will provide little comfort to those personally affected by Mr Tavinor's death. There would, however, appear to be a significant degree of futility in any recommendation that the issue of driveshaft containment devices should be revisited by the NZTA.
- IX. I note that post Mr Tavinor's death in 2000, the NZTA:
- a. Invested in educating industry, especially the service and repair industry, about driveshaft failure prevention, by publishing information on its website and giving face-to-face presentations to industry about driveshaft failure and prevention; and
 - b. Added specific driveshaft checking requirements to the 6-monthly Certificate of Fitness inspection carried out on heavy vehicles.
- X. I accept the NZTA's submission that the best approach is to continue its focus on prevention of driveshaft failure, managing the risk by making sure those involved in the servicing and repair of heavy vehicles have better understanding of how driveshafts need to be inspected and serviced, and the importance of adherence to manufacturers' instructions.
- XI. I agree with Mr Wilkin that there must be further acknowledgement by the heavy vehicle servicing and repair industry as to the need to continue to take steps to maintain and increase its awareness and knowledge about this issue, with the aim of minimising the likelihood of further tragic events such as Mr Tavinor's death.
- XII. Without issuing a recommendation, I encourage the NZTA to take all available steps to raise awareness in the heavy vehicle servicing and repair industry as to:
- a. The potential consequences of "wear and tear" that is not identified and addressed in servicing; and
 - b. The critical importance of competent and compliant servicing and repair work.
- XIII. No recommendations will be made. However, I will distribute this finding widely so that those involved in the heavy vehicle industry will be reminded of the circumstances which lead to Mr Tavinor's death and work to ensure that lessons have been learned.

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

Chan [2020] NZCorC 8 (26 February 2020)

CIRCUMSTANCES

On 2 November 2017, Mr Chan was found by his mother unresponsive. The Coroner was satisfied to the requisite standard that Mr Chan's death was a suicide.

COMMENTS OF CORONER BELL

- I. In the interests of public awareness, I make the following comments pursuant to section 57(3) of the Coroners Act 2006:
 - (a). The Ministry of Health publishes information about suicide prevention, the signs to watch for, and ways of supporting someone who is suicidal. That information can be found at: <https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide>
 - (b). The Ministry of Health suicide prevention online resources also include contact details of a number of organisations that offer assistance and support: <https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/supporting-someone-who-suicidal>

Note: Pursuant to section 71 of the Coroners Act 2006, no person may, unless granted an exemption under section 71A of that Act, make public the method or suspected method of a death, or any details that suggest the method or suspected method of the death.

Pursuant to section 74 of the Coroners Act 2006, it is in the interests of decency and personal privacy to prohibit the making public of photographs of the deceased taken by the police.

Holder [2020] NZCorC 9 (26 February 2020)

CIRCUMSTANCES

Kingsley Lawrence Holder, aged 15, died on 2 June 2016 at Green Island, Dunedin. His death was self-inflicted.

COMMENTS OF CORONER TUTTON

- I. Kingsley was 15 when he died, and his friends were of similar ages.
- II. It is clear that it was difficult for Kingsley's friends to deal with the issues they faced, and they were upset by his death. It is important that all of Kingsley's friends know that none of them are responsible for the decision he made – they are not to blame for his death.
- III. Help is available to anyone who is struggling and thinking of harming themselves. Help is also available to anyone who is concerned or aware that a friend, family member or anyone else is feeling that way.

IV. Information about the ways you can support someone who is thinking about harming themselves is available at:

<https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal#urgenthelp>

V. The website contains information about what to do if you think someone needs urgent help:

If someone has attempted suicide or you're worried about their immediate safety, do the following.

- **Call your local [mental health crisis assessment team](#) or go with them to the emergency department (ED) at your nearest hospital.**
- If they are an immediate physical danger to themselves or others, call **111**.
- Remain with them and help them to stay safe until support arrives.
- Try to stay calm and let them know you care.
- Keep them talking: listen and ask questions without judging.

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

Services that offer more information and support

Below is a list of some of the telephone helplines or services available which offer support, information and help. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated.

For counselling and support

- Need to talk? Free call or text **1737** any time
- [Lifeline](#) – **0800 543 354**
- [Samaritans](#) – **0800 726 666**

For children and young people

- [Youthline](#) – **0800 376 633**, free text **234** or email talk@youthline.co.nz (for young people, and their parents, whānau and friends)
- [What's Up](#) – **0800 942 8787** (for 5–18 year olds; 1 pm to 11 pm)
- [The Lowdown](#) – visit the website, email team@thelowdown.co.nz or free text 5626 (emails and text messages will be responded to between 12 noon and 12 midnight)
- [SPARX](#) – an online self-help tool that teaches young people the key skills needed to help combat depression and anxiety

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

An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Kingsley taken during the investigation in the interests of decency and personal privacy.

Lemalie [2020] NZCorC 1 (7 January 2020)

CIRCUMSTANCES

Montel Zyon Te Herenga Waka Mihaere Lemalie, aged 14, died on 15 December 2016 at 292 Barrow Street, Bluff in circumstances amounting to suicide.

In the months leading up to his death, Montel's friends noticed a change in his demeanour. In October 2016 Montel started telling people that he was having suicidal thoughts. Montel expressed his thoughts in the form of poems or raps in his *Thoughts Book*, the contents of which suggest that he was experiencing some significant psychological distress, but also recognised his future and family as protective factors. On 14 December 2016 he told his friend he was not in a good space.

COMMENTS OF CORONER TUTTON

- I. From the evidence gathered in the inquiry it is apparent that Montel had voiced suicidal ideation on several occasions to his friends. He had told friends that he was thinking about suicide.
- II. It is likely that Montel's friends did not think he would end his life, and that they were also unsure about how to help him when he talked about issues relating to his mental health. It appears that, at times, Montel thought that he was not well liked at school, but the evidence before me reveals that he had friends who were supportive and tried to help him.
- III. Montel was 14 when he died, and his friends were of similar ages. The evidence shows that Montel had been struggling with his feelings and mental health for some time, and elected to talk to his friends, who did their best to help him. One friend said she wished she had told someone. Another said he thought Montel's parents knew of his suicidal thoughts.
- IV. It is clear that it was extremely difficult for Montel's friends to deal with the issues they faced, and they were upset by his death. It is important that all of Montel's friends know that none of them are responsible for the decision he made – they are not to blame for his death.
- V. Help is available to anyone who is struggling and thinking of harming themselves. Help is also available to anyone who is concerned or aware that a friend, family member or anyone else is feeling that way.
- VI. Information about the ways you can support someone who is thinking about harming themselves is available at:
<https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal#urgenthelp>
- VII. The website contains information about what to do if you think someone needs urgent help:

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- [SPARX](#) – an online self-help tool that teaches young people the key skills needed to help combat depression and anxiety

Note: Pursuant to section 71 of the Coroners Act 2006, 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.

An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Montel's body taken after his death and of the contents of his "thoughts book" in the interests of decency and personal privacy.

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.

Ngatuakana [2020] NZCorC 10 (27 February 2020)

CIRCUMSTANCES

Laraya-Amelia Bluezayous Ngatuakana died on 19 August 2017 at 179 Panama Road, Mt Wellington, Auckland from Sudden Unexpected Death in Infancy in the setting of an unsafe sleeping environment (bedsharing with adults/adult bed/pillows).

Laraya-Amelia was put to bed on 18 August 2017 with her parents and older sibling, and was sleeping between her parents. In addition to bed sharing between two sleeping adults, she was resting on an adult pillow. Such practice is hazardous for an infant of this age, in that there is a risk that the sleeping adult, unaware of their movements during sleep, could compromise the airways of the infant.

Laraya-Amelia's parents were advised on several occasions both orally and in writing about the safe sleeping message, namely that the baby should have her own sleeping space, face up, face clear and smoke free. The message was (and is) to keep the sleeping space free of pillows and soft toys.

COMMENTS OF CORONER MCDOWELL

- I. In the past, coroners have made multiple 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. As has been outlined, I am satisfied that the safe sleeping message was advised to Laraya- Amelia's parents. In these circumstances therefore, I do not propose to make any recommendations.
- II. It is worth noting that in August 2017 the Ministry of Health launched its SUDI prevention programme directed at significantly reducing the deaths of babies. A key focus of the programme (and community health services) is to target the two key modifiable risks for SUDI: exposure to tobacco smoke during pregnancy and unsafe bed sharing. The programme intends to consider other facts including breastfeeding, position of baby when sleeping, and alcohol and drug use. In 2019 the Ministry of Health also released its Needs Assessment and Care Planning Guide to provide health professionals with strategies to assess the care, support and health needs of families and whanau in relation to SUDI prevention. District Health Boards across New Zealand have dedicated safe sleep coordinators who can advise on safe sleep programmes and on procuring, distributing and accessing safe sleep devices.
- III. Such measures are clearly desirable to prevent the deaths of future infants.

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.



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