



OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments
made between **1 April** and **30 June 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 23 recommendations and/or comments issued by Coroners between 1 April and 30 June 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 April to 30 June 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/>

Choking

Toka [2020] NZCorC 28 (16 June 2020)

CIRCUMSTANCES

Takai Samasona Toka, 84 years of age, of Cambridge, died at Oakdale Rest Home, Tennyson Street, Cambridge, on 12 August 2019, as a result of choking.

On 12 August 2019, Mr Toka was eating dinner at a dining room table at Oakdale Rest Home's dementia unit when he began to choke. Despite the efforts of nursing home staff and ambulance paramedics, Mr Toka was unable to be revived and passed away.

After consultation with Mr Toka's GP, Dr Khalil, paramedics incorrectly believed that Mr Toka's death did not need to be reported to the Duty Coroner and told Police they did not need to attend the rest home. Due to the use of non-emergency 105 number, Police did not arrive at the rest home for five hours, by which time Mr Toka's body had been moved to his room to avoid upsetting the other residents.

COMMENTS OF CORONER BATES

- I. It appears there was a breakdown in communication to Police following Mr Toka's death and confusion regarding whether his death should be reported to the Duty Coroner. After speaking with Dr Khalil, paramedics were under the impression that the matter did not need to be reported to the Duty Coroner and advised Police to stand-down. Unfortunately, it appears there is no record of the conversation between Dr Khalil and paramedics. There was also a breakdown of communication between Oakdale and the Police, most likely due to use of the 105 non-emergency number, resulting in a delay of about five hours from time of death before Police were dispatched and over six hours until the Duty Coroner was notified.
- II. In the circumstances of Mr Toka's death, I consider it necessary to make the following comments to the Order of St John and to Ultimate Care Group, pursuant to s 57(3) of the Coroners Act 2006:

- a. A death should be reported to a coroner when, as in this case, it appears to have been sudden, unexpected and/or without a known cause. It is vital that the Police attend without delay in order to inform the coroner and collect any evidence and witness information as required.
- b. When corresponding with Police regarding a sudden, unexpected death, particularly if the cause is unknown or unclear, the emergency 111 number should be used, not the non-emergency 105 number.
- c. Moving and cleaning Mr Toka's body should not have occurred without the Duty Coroner's consent, as the Police had not arrived and completed their initial examination of the scene. I accept that all parties were acting in good faith and had sought permission from Mr Toka's wife. However, a more appropriate course may have been to move other residents from the dining area to minimise their distress and to preserve the scene.

St John response to recommendations and comments:

- III. Having received a copy of my provisional findings in this matter, St John sought feedback from their Medical Director and their Head of Patient Safety and Quality. St John reviewed the circumstances regarding their attending personnel notifying Police to stand-down and accept this should not have occurred.
- IV. St John also comment that it is common (and they believe appropriate) for ambulance personnel to move a body from public view following sudden death, unless the scene is thought to be a crime scene. I take absolutely no issue with this comment in general terms. I do not understand St John to have been involved in moving Mr Toka from where he passed away in the dining area at Oakdale to his bedroom, and cleaning and dressing him. Oakdale staff facilitated these things after seeking permission from Mr Toka's family. At that stage neither the Coroner nor the Police were aware of the circumstances of the death and it was a number of hours before Police attendance.

Ultimate Care Group response to the death and to my recommendations and comments:

- V. Following Mr Toka's death, Ultimate Care Group, the administrators of Oakdale Rest Home, reviewed the circumstances and provided me with a report. As a result of their review, they took the following actions:
 - a. Refresher training for staff regarding the signs and symptoms of choking, and how to manage choking; and
 - b. the location of the nearest defibrillators will now be in both nurse's stations at Oakdale; training will be updated every six months or as required.
- VI. Having received a copy of my provisional findings in this matter, Ultimate Care Group have revised their policy on 'Sudden Death' outlining the importance of using the 111 emergency number and not 105.
- VII. Ultimate Care Group have updated their policy to advise staff that any deceased body when found must not be removed without prior consent from the Duty Coroner if no Police are present on site.
- VIII. Ultimate Care Group commented that due to the layout of the Oakdale dementia unit it would have been "almost impossible" to keep dementia patients away from where Mr Toka passed away. As a result, it was considered necessary to move him, in this instance to his bedroom. I accept the difficulty this situation posed. The move was undertaken in good faith and designed to minimise stress to other residents while preserving Mr Toka's dignity. Having said that, the management team intend to review the practicalities and develop a plan to contain dementia patients in another area should a similar situation occur.

RECOMMENDATIONS OF CORONER BATES

- I. I make the following comments and recommendations to the New Zealand Police:
 - a. Due to a breakdown in communication between Oakdale and Police, there was considerable delay in Police attending Mr Toka's death, during which the opportunity to examine the dining room scene and Mr Toka in situ following death was lost. This may partly be attributable to Oakdale's use of the non-emergency 105 number. The 105 number is relatively new, having been introduced on 10 May 2019, and it is understandable that there may be some confusion regarding appropriate use.
 - b. I recommend that Police amend the guidance provided online regarding use of the 105 number.¹ The guidance should specify that calls regarding a death should always use the emergency 111 number.

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

Diving

Tautari [2020] NZCorC 22 (26 May 2020)

CIRCUMSTANCES

Richard Hepi Tautari of Invercargill died on 30 December 2017 at Kawakaputa Bay, Southland as a result of drowning.

Mr Tautari travelled to Kawakaputa Bay to undertake freediving for paua. He had dived there previously and knew the area. He entered the water and began snorkelling for paua. His partner, Ms Brown, watched him from the shoreline. After 20 minutes, Ms Brown noticed Mr Tautari was not moving. She became concerned and asked a member of the public, Mr McMaster, to check on him.

Mr McMaster swam towards Mr Tautari and realised he was floating face down in the water. Mr McMaster returned to shore and called emergency services. Other members of the public assisted in recovering Mr Tautari's body to shore, where he was confirmed deceased by emergency services.

The Police National Dive Squad (PNDS) conducted an inquiry to determine any causative factors present in Mr Tautari's death. PNDS did not consider that the weather conditions, equipment or any pre-existing health conditions contributed to Mr Tautari's death. They concluded that Mr Tautari's decision to dive alone, an unsafe practice, contributed to his death.

RECOMMENDATIONS OF CORONER ROBINSON

- I. The PNDS offered the following advice for free divers in a prior case, advice which I consider bears repeating:

¹ At <https://www.police.govt.nz/105info>.

- a. Always dive with a buddy, and constantly monitor each other. Employ a one-up, one-down system.
- b. Free divers should constantly review and adjust their weight in relation to the diving they are conducting. Ideally, free divers should manage their weight, to maintain a neutral hover point in the water approximately 30-40% of the depth to which they will dive.
- c. Use a quick release belt buckle.
- d. It is not recommended by Police to dive alone. However, if free diving alone, it is recommended that the diver be marked or tethered to a surface float to show approximate position under water. If this is not possible, then at the very least the diver should always have someone on the surface actively watching movement, and able to assist.
- e. Divers should abandon their weights when they start to get into difficulty.
- f. Do not make yourself hyperventilate before free diving.
- g. Know your limitations, and do not take any unnecessary risks.

II. I endorse these recommendations, and direct that these findings be provided to Water Safety New Zealand and to the editors of the Dive New Zealand magazine for dissemination as appropriate.

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

Drowning

Arvindan [2020] NZCorC 21 (22 May 2020)

CIRCUMSTANCES

Kishore Kumar Arvindan of Hamilton died at Omanawa Falls, Omanawa on 22 April 2018 from drowning.

On 22 April 2018, Kishore Arvindan, aged 27, travelled to Omanawa Falls with some friends. The Falls are situated in an area that is fenced off from public access due to being unsafe, as evidenced by previous serious incidents that have occurred at the Falls. Mr Arvindan and his friends nonetheless got close to the Falls to view the waterfall. They saw people standing at the base of the waterfall and decided to walk down too.

Once they arrived at the waterfall one of Mr Arvindan's friends decided to walk closer. Thinking the water was shallow, she attempted to cross a stream. The water was up to her knees, but the current pushed her into the middle of the base of the waterfall, which is a large pool that is deeper. The current was too strong for her and she struggled to keep her head above the water.

Mr Arvindan jumped into the water to assist his friend but had difficulty staying buoyant also. Another tourist, Mr Black, jumped in to assist both of them. All three of them struggled in the water, but Mr Arvindan's friend and Mr Black managed to get out of the water. Mr Arvindan was unable to get out of the water and resurface. His body was found the following day in the middle of the pool.

COMMENTS OF CORONER ROBB

- I. I note the efforts the Council has made to prevent the public from accessing Omanawa Falls. Despite these efforts, people continue to visit the area. The Council is currently making plans to create a safe accessway which will take some time.
- II. In the meantime, I urge the public to follow advice to not visit Omanawa Falls until safe access is established. There are many dangers associated with this area, including drowning.

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

Aziz [2020] NZCorC 19 (21 May 2020)

CIRCUMSTANCES

Imtiaz Aziz of Auckland died on 4 February 2018 at Manukau Harbour between Kauritutahi Island and Brooks Beach of undetermined causes but in the context of getting into difficulties in the sea (likely drowning).

On 4 February 2019, Mr Aziz, aged 40, and two of his children left for Kauritutahi Island to go fishing. The tide was low enough for them to walk out to the island. They were not wearing lifejackets.

Mr Aziz's wife, Ms Pillay, went down to Brooks Beach at about 11am. The tide was coming in with high tide due at 1.46pm. Ms Pillay saw Mr Aziz and the children making their way back to beach from the island. His daughter could swim but his younger son could not. Mr Aziz was carrying his son on his back. Ms Pillay became concerned as it looked like Mr Aziz was being pulled further away from the shore, and she sought the help of others on the beach. Members of the public kayaked out and came across his daughter, who was swimming well. Deciding she was safe, they continued to Mr Aziz and his son who were about 100m further out and who were in a stronger current and deeper waters. They could only see one head above the waves.

The kayakers were able to collect Mr Aziz's son safely. They saw Mr Aziz floating face down. When they reached him, he was unconscious. It took 10 to 15 minutes for them to return to shore with Mr Aziz. When they returned emergency services were called and CPR was commenced. Sadly, Mr Aziz could not be revived and was pronounced dead at the scene.

Auckland Council provides general information on how to be safe in Regional Parks. There is information on water and Park safety available on the Council's webpage and notices on the Park map at the front entrance arrival notice board, and in the brochures for bookable facilities including Awhitu House. At the time of Mr Aziz's death, the information did not include warnings about Kauritutahi Island. However, after Mr Aziz's death, the Council created a natural hazard warning notice to be placed in the Awhitu House information book, and at Park notice boards. Copies of the notice were to be given to the trust that manages the nearby Awhitu Environmental Camp (Awhitu High Wire Trust Lodge) to use within the lodge.

The Council advised that it was also going to update the information that it provides to customers when booking facilities or space for Park events with the following warning "It is not safe to walk out to Kauritutahi Island as the tide comes in quickly and can be around 2 meters deep".

COMMENTS OF CORONER GREIG

- I. Tragically Mr Aziz's death was preventable, had he been wearing a life jacket. This case illustrates the importance of wearing a lifejacket when engaging in water-based activities. Water Safety New Zealand, Auckland Council, Drowning Prevention Auckland and Surf Lifesaving New Zealand (amongst others) recommend wearing a lifejacket at all times when fishing from rocks, as the family had been doing. This is an issue that has been the subject of ongoing and recent water safety publicity. In 2018 Auckland Council and Surf Lifesaving Northern Region and Drowning Prevention Auckland ran a safety awareness campaign on the importance of using lifejackets.
- II. In consideration of the actions taken by Auckland Council and the general information on water safety and use of life jackets, I do not consider it necessary to make recommendations on this matter.

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

Choi [2020] NZCorC 35 (30 June 2020)

CIRCUMSTANCES

Seunghyeon Choi (also known as Tom), aged 16, of South Korea, died on 5 December 2015 at Ngaruroro River mouth, Napier of drowning.

Seunghyeon was studying at the New Horizon College of English at Napier. He resided with his host parents, Mr and Mrs Loveridge, and a 17-year-old German student, Lasse. On 5 December 2015, Seunghyeon went to Ngaruroro River mouth with Mrs Loveridge and Lasse. Mrs Loveridge described herself as a poor swimmer, however, she could reach the other side of the lagoon with her limited ability. She described Lasse as a strong swimmer who could assist anyone if they got into difficulty.

Whilst attempting to swim to the other side of the lagoon, Seunghyeon got into difficulties and disappeared underwater. Lasse tried but was unable to find Seunghyeon, partly because he was not wearing his glasses but mostly because the water was so murky that he could not even see his own waist. A member of the public jumped into the water to assist but was also unable to locate Seunghyeon. Emergency services were called and Seunghyeon's body was recovered the following day, 6 December 2015, by members of the Police National Dive Squad. He was located approximately 10 metres from where he was last seen alive.

It is noted that Coroner C J Devonport was initially responsible for this matter. On 22 November 2016, Coroner Devonport notified Mrs Loveridge pursuant to section 58 of the Coroners Act 2006 in respect of Seunghyeon's death. Under section 58, a Coroner may comment adversely on the conduct of any person in relation to the circumstances of the death concerned, and that person has the right to be heard in relation to the proposed comment. Coroner Devonport received no response regarding the proposed adverse comment.

RECOMMENDATIONS OF CORONER FITZGIBBON

- I. Coroner Devonport had a meeting with staff from New Horizon College and received further information from them during his inquiry. He also obtained some information from Seunghyeon's family about his swimming ability.
- II. Seunghyeon did not receive swimming lessons as a child, and his exposure to a water environment in Korea was limited to a family summer holiday where he would play in a beach environment. Mrs Loveridge describes him as appearing to breaststroke while swimming across the lagoon towards her and Lasse. However, I am satisfied that Seunghyeon had some swimming ability.
- III. Mrs Loveridge invited Seunghyeon to join her and Lasse for swimming. She did not make any enquiries as to his swimming ability. No floatation device (such as a boogie board) was made available for use by Seunghyeon. On arrival at the lagoon Mrs Loveridge entered the water and commenced swimming to the other side of the lagoon, without any discussion with Seunghyeon. Lasse asked Seunghyeon if he was intending to swim and Seunghyeon responded that he was. Seunghyeon asked Lasse if the water was deep and Lasse responded that it was very deep, and that Seunghyeon would not be able to stand on the bottom. Lasse then commenced swimming across the lagoon.
- IV. Seunghyeon also decided to swim across the lagoon. He did not voluntarily communicate to Mrs Loveridge or Lasse that he could not swim, or what swimming ability or experience he had. Even when told by Lasse that the water would be over his head, Seunghyeon has not communicated any concerns about doing this.
- V. New Horizon College of English were notified by Coroner Devonport that a recommendation of this inquiry would be that amendments are made to their 2015 Home Stay student handbook. The amendment would include reference to students assessing their ability before undertaking potentially hazardous activities, such as swimming.
- VI. New Horizon College of English accepted the proposed recommendation and altered the 2016 student handbook to provide a section on outdoor safety including tramping, water safety, rivers, beaches and rip currents. In the section for Underwater Safety - there is highlighted "**Don't go in the water if you can't swim. Don't be embarrassed to tell people you can't swim. It's okay**". In February 2016 New Horizon College of English obtained a set of visual posters about areas of safety which is displayed in the student room. Teachers have used these as discussion topics in their classes. A two-hour safety program has been developed which will be compulsory for new students on the Friday afternoon of their first week at the college which covers all aspects of safety with visual slides in conjunction with the handbook. I am satisfied that the steps taken by New Horizon College of English are adequate and therefore no further recommendation is required.
- VII. The New Horizon College of English Home Stay handbook for host families includes encouraging them to take their students on activities such as bush walks and beach visits. However, many young visitors from overseas may not have been raised in the outdoor-type environment that many young persons in New Zealand are raised, and it is important that home stay hosts be alert for potential dangers and provide guidance to young persons under 18 who are in their care. Notice was given of the intention to recommend that the New Horizon College of English Homestay Booklet for Hosts include such a reminder. New Horizon

College of English has altered the 2016 Homestay Handbook to include appropriate guidance to hosts for their students relating to outdoor activities including tramping and swimming, and with reference to the Mountain Safety Council guidelines and the Water Safety Code. The booklet includes under "swimming"- **"Ask a student if they can swim"**. There is also a swimming questionnaire resource that hosts can go through with students.

- VIII. The questionnaire is a comprehensive enquiry as to a person's swimming ability and experience and includes water safety information such as wearing lifejackets on boats, not swimming alone, swimming between flags at beaches, and not diving into rivers or the sea in circumstances that may result in head injury. The College also organised a homestay evening in which the issues around safety are discussed fully with homestay hosts. I am satisfied that the steps taken by New Horizon College of English are adequate and therefore no further recommendations are required.

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

Welsh [2020] NZCorC 24 (9 June 2020)

CIRCUMSTANCES

Maxine Billie Welsh of Dargaville died on 29 December 2018 at Dargaville Hospital from drowning.

Maxine was 19 months old and the youngest of two siblings. Approximately six months prior to her death, her family was gifted a swimming pool. There was no fencing around it but the family had safety rules including removing the ladder from the pool and putting the cover on when it was not in use.

When the family was at home, the front and back doors were often open but wooden boards were used to prevent the children from going outside. However, Maxine's older sister knew how to remove the boards if they were not properly jammed in.

On the evening of 2 March 2015, a family member came to visit. Maxine's sister alerted her mother that Maxine was outside. The back door was open and Maxine was found face down in the swimming pool. Emergency services were contacted and resuscitation efforts were commenced. Maxine was transported to Dargaville Hospital but sadly died that night.

RECOMMENDATIONS OF CORONER MILLS

- I. In New Zealand, swimming pools remain the most common location for children aged ten and under to drown. The most common factors in these deaths were a lack of supervision (even momentarily), a faulty or non-compliant gate or fence, and an underestimation of the wandering ability of small children.
- II. The Building Act 2004 and the Building Regulations 1992 currently regulate pool fencing. These apply to pools with a maximum depth of 40cm or more and require:

- a. Every residential pool filled or partly filled with water must have physical barriers that restrict access to the pool by unsupervised children under 5 years of age.
 - b. The barriers must either surround the pool or, for small heated pools, cover the pool.
 - c. Barriers must not have permanent obstructions or projections on the outside that could assist children in negotiating the barrier.
 - d. Pool gates must open away from the pool, not be readily opened by children, and automatically close after use.
- III. The full legal requirements and duties can be found in ss 162A-E of the Building Act 2004 cl F9 of the Building Regulations 1992.
- IV. Pursuant to s 57(3) of the Coroners Act 2006, I reiterate key safety messages that have been publicised by Water Safety New Zealand to keep babies and toddlers water safe:
- a. Constant active adult supervision is required at all times - always keep babies and toddlers within arms' reach around water. It takes less than a minute for a child to drown.
 - b. If you're in a group, have an active adult supervision roster - don't rely on older children to supervise younger ones in, on or around water. Constant active adult supervision is required at all times.
 - c. Identify water hazards in and around the home - ensure your pool is properly fenced and complies with the safety requirements under the new pool safety legislation. Ensure your pool has properly working safety latches. Empty water from unused paddling pools, buckets and containers after use and ensure you have a safely fenced play area. Also when on holiday check for water hazards and ensure pool gates are secure and locked at all times.
 - d. Avoid distraction - put your phone away when supervising children around water. Their lives are in your hands and their safety requires your full attention. A child can drown in the time it takes to read a text message.
 - e. Teach your children water safety behaviour - as soon as they are old enough to understand, teach your children things like: 'Never go near the water unless you're with a grown up'. It is important our children are taught that while water is to be enjoyed, it must also be respected. It is imperative they are taught about the risks and dangers associated with water-based activities.

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

Fall

Phillips [2020] NZCorC 18 (7 May 2020)

CIRCUMSTANCES

Kenneth Allan William Phillips, of Hamilton, died on 7 August 2019 at Waikato Hospital from non-survivable injuries to the skull and brain, due to an accidental fall.

On 7 August 2019, Mr Phillips, aged 88, climbed a ladder to clean the chimney at his house. His son, who was visiting at the time, heard a loud bang outside and went to investigate. He found his father lying injured on the ground. It appeared Mr Phillips had fallen from the ladder, which had a height of three metres. Mr Phillips was transported to Waikato Hospital.

He arrived at the hospital and was assessed as being comatose, with fixed and dilated pupils indicating a severe and immediately life-threatening brain injury. A CT scan revealed a haemorrhage that compressed his brain and put pressure on his brain stem, which was invariably terminal. Medical staff and Mr Phillips' family decided to take Mr Phillips off life support, and he died at 10.25pm the same day.

RECOMMENDATIONS OF CORONER BATES

- I. The risks of climbing ladders are well known. ACC has online and televised campaigns about these risks and advises that most injuries at home are caused by falls and many of those are caused on or around ladders. ACC recommends considering the following before using a ladder:
 - a. Should I use a ladder for this job? Should I consider hiring a professional?
 - b. Is the ladder safe to use?
 - c. Is the ladder set up correctly?
 - d. Consider tying the ladder to something stable to prevent movement.
 - e. Never overreach sideways.
 - f. Keep three points of contact on the ladder at all times (for example, two hands and one foot).
 - g. Never climb higher than the third step from the top of a straight ladder.

- II. I endorse the above comments and add the following:
 - (h) Should I have someone assist and supervise me by stabilising the ladder while I am on it, and by having them remind me if I do not appear to have considered or be adhering to points (a) to (g).

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

Hyperthermia

Edwards [2020] NZCorC 29 (19 June 2020)

CIRCUMSTANCES

Waiata Edwards, aged four months, of Otatau died on 20 December 2016 at 45 Factory Road, Otatau, Waikato District of hyperthermia due to environmental conditions (sleeping in a hot car).

On 19 December 2016, Waiata was sleeping in a bassinet in her mother's Toyota Estima van while her mother and mother's partner completed renovations on their house. The back seats of the Toyota were folded flat, with Waiata's bassinet positioned on the floor behind the front passenger's seat. Waiata was dressed in a onesie (no legs) and was in the bassinet

with a baby blanket as well as a feather blanket. Both her mother and her mother's partner regularly went to check on Waiata during the night.

Waiata's mother slept in the van on the morning of 20 December 2016. She was cold at this time and lowered the driver's window by less than an inch. She fed Waiata a bottle at some stage and was awoken around 2:30pm by her partner knocking on the van's window. They checked Waiata and noticed that she was unresponsive in the van. Emergency services attended but were unable to resuscitate Waiata.

Thermal testing of the van was completed the following day around the time Waiata was found. When the gauge was checked at 3:07pm it recorded a temperature of 42.9°C. Weather data from the New Zealand Meteorological Service recorded the temperature on 20 December with a high of 21°C and a low of 30°C. It is believed that conditions were similar the following day when the testing was completed.

COMMENTS OF CORONER MCDOWELL

- I. Babies and young children are less able to regulate their body temperature which makes them susceptible to hyperthermia in a short period of time. That is, babies and children left in hot cars are at risk of heatstroke, dehydration and death. Additionally, as occurred in this case and as an American study showed, even at relatively cool ambient temperatures the temperature rise in vehicles is significant on clear sunny days and puts infants at risk for hyperthermia. Vehicles heat up rapidly, with the majority of the temperature rise occurring within the first 15 – 30 minutes. Leaving the windows opened slightly does not significantly slow the heating process or decrease the maximum temperature attained. Public education efforts would seem necessary to decrease fatalities in this situation.
- II. Accordingly, I propose to send a copy of this finding to Safekids Aotearoa, a service of Starship Children's health, whose mission is to reduce the incidence and severity of unintentional injuries to children aged 0 – 14 years. As recognised experts in unintentional child injury prevention Safekids is well placed to give consideration to raising awareness of this issue and how best to promote safety messaging.

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

Teepa [2020] NZCorC 15 (6 May 2020)

CIRCUMSTANCES

Nathan Pohikura Apanui Teepa, aged 2 years and 9 months, of Rotorua, died on 13 February 2019 at 16A Scott Avenue, Rotorua of hyperthermia.

Nathan's grandfather and other whānau members lived in a house at the front of the property. The children at each house would often play together and travelled between the two houses. Nathan would sometimes walk to his grandfather's house himself. He occasionally played in his parents' cars although he was not allowed in them by himself. Nathan could use the keys to unlock the car doors but his mother's car was often unlocked.

On the morning of 13 February 2019 Nathan and his mother, Mary, got a ride with Mary's co-worker as Mary's car would not start. It was very hot that day, with Rotorua reaching a temperature of 32.2 degrees. Nathan and Mary returned home around 5:00pm and went between their house and the front house several times. When they returned to their house Nathan's sister was asked to watch him while Mary showered. Once out of the shower, Mary sent an older child to the front house to find Nathan. This child did not thoroughly check the front house and returned home to report that Nathan was there, although this was not in fact the case.

Later, Mary sent Nathan's sister to fetch him from the front house but was advised that he had not been there. The whānau looked for Nathan around the property before expanding their search. Nathan had not been seen for 60 to 90 minutes before he was found in Mary's car.

RECOMMENDATIONS OF CORONER BATES

- I. The following comments are in no way intended as criticism of Nathan's whanau, who clearly took very good care of him. I make the following comments pursuant to s57(3) of the Coroners Act 2006:
 - a. Nathan's death is a tragic reminder of the need for toddlers and young children to have constant adult supervision.
 - b. Nathan's death is also a reminder that adults should ensure vehicles are kept locked and keys are stored securely. Although on this particular occasion it is not clear that Nathan accessed the keys, and the car was likely unlocked, he was an intelligent, mobile and curious individual known to be able to use keys to unlock the vehicle. No doubt other toddlers and young children fit a similar profile.
 - c. Finally, I express a view that toddlers and young children should not be permitted to use motor vehicles as play areas, even occasionally and with adult supervision. If vehicles are identified as a play area by a child, given their naturally inquisitive minds and tendency to wander, this may lead to further exploration of them in the absence of any supervision. There are obviously a multitude of risks a child may be exposed to in a motor vehicle, particularly if unsupervised.

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

Medical Care

Karst [2020] NZCorC 31 (29 June 2020)

CIRCUMSTANCES

Timothy Philip Karst, aged 59, of Christchurch, died on 20 April 2018 at 54 Roker Street, Somerfield, Christchurch of ischemic heart disease secondary to blood loss into the right chest cavity, a complication of a recent lung biopsy.

Mr Karst had biopsies performed under general anaesthetic on 9 April 2018 for the investigation of a non-specific interstitial lung disease. On 17 April 2018, he visited his doctor complaining of pain in his chest and left arm, which was diagnosed

as shingles. On the date of his death, he called an ambulance experiencing chest pain. He collapsed upon the arrival of ambulance staff and could not be revived.

A full post-mortem examination was undertaken, which indicated Mr Karst had suffered a significant haemorrhage. The pathologist concluded that after the lung biopsy, Mr Karst had bled slowly into his right chest cavity, with the most probable source of bleeding being the thoracotomy incision on the right lateral aspect of the chest wall at the sixth intercostal space.

In order to fully assess the circumstances of Mr Karst's passing and to explore whether his death could have been prevented, the Coroner sought advice from Cardiothoracic Surgeon, Mr Peter Alison.

Mr Alison interpreted the autopsy findings as suggesting the bleeding was more likely to have come from one of the sites through the telescopic instruments which were introduced to the chest. He noted that bleeding from the edge of the lung, stapled closed by the instrument used to cut and staple the wall and lung simultaneously, was most likely to happen around the time of the operation. Mr Alison regarded two litres of blood loss as "a lot" and for it to have occurred relatively late after the operation was unusual. However, bleeding is always a potential complication of surgery, and while a blood clot may stop bleeding at the time of the procedure, it may later become dislodged with resultant blood loss. Mr Alison was satisfied that there were no issues as to the manner in which the procedure was performed.

Mr Alison's opinion was that the complications Mr Karst suffered were infrequently encountered and to have occurred in sequence sufficient to cause death was very unusual. It did not reflect on the standard of care received by Mr Karst at the time of his operation or post-operatively.

Dr Lynette Murdoch was also instructed by the Coroner to review the general practitioner's evidence and found no fault with the assessment. She agreed that it was likely Mr Karst's chest pain on 17 April 2018 was due to shingles and different from the chest pain he experienced immediately before his death, which was likely to have been cardiac pain.

While the Coroner appreciated the concerns raised by Mr Karst's wife, he was satisfied by the evidence of the two independent reviewers that Mr Karst's death resulted from rare complications of the biopsy surgery and that there was no want of care involved.

RECOMMENDATIONS OF CORONER ROBINSON

- I. I recommend that the Canterbury District Health Board develop a resource for patients (and their families) and general practitioners:
 - a. identifying the potential complications that can arise from lung biopsy surgery;
 - b. signs and symptoms of the same;
 - c. a pathway detailing recommended:
 - i. assessment of patients presenting with such signs or symptoms;
 - ii. differential diagnosis;
 - iii. investigations;
 - iv. treatment; and

v. threshold for escalation/referral.

II. Following development of the same, it would be appropriate for the resultant work to be shared across cardiothoracic departments in New Zealand.

III. Pursuant to section 57B Coroners Act 2006 my draft recommendation was provided to the Canterbury District Health Board for comment. Mr Brogden, corporate counsel for the District Health Board replied:

I have discussed the provisional findings with Mr Graham McCrystal, Clinical Director Cardiothoracic Surgery, Canterbury District Health Board. He acknowledges the recommendation, and noted that relevant material could be placed on Community Health Pathways, which GP's in most regions of NZ have access to. Separate material for patients/whanau can also be prepared (in addition to existing material).

Mr McCrystal believed it will take around six months to prepare and implement the above.

IV. I thank him for the response, and confirm my recommendations.

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

Motor Vehicle

Bullock [2020] NZCorC 34 (30 June 2020)

CIRCUMSTANCES

Shane Bullock of Wanganui, aged 50, died on 26 March 2018 at Wellington Regional Hospital as a result of injuries sustained in a collision while riding his Harley Davidson motorcycle.

At around 6.30am on 23 March 2018, Mr Bullock failed to stop for a red light at the intersection of State Highway 1 and Whitford Brown Avenue in Porirua (the intersection), colliding with another motor vehicle. Mr Bullock was admitted to Wellington Hospital with numerous fractures, bleeding from the left lung, and a possible aortic injury.

Mr Bullock had a number of chronic medical problems which affected his treatment. Despite medical efforts, his condition continued to deteriorate and he died on 26 March 2018.

A Crash Investigation Report prepared by Senior Sergeant Glenn Marshall of the Police Serious Crash Unit found that the road was in good condition, free of contaminants and well-lit at the time of the crash. It also noted that the traffic signals were visible from 500m prior to the intersection.

Toxicology tests confirmed drugs including tramadol and methamphetamine in Mr Bullock's blood. These can have significant effects on driving ability and complex decision making. However, it was not possible to determine if Mr Bullock's reactions had been impaired by these drugs.

Since 2000, there have been a significant number of crashes at the intersection, with two fatalities resulting from motorists failing to stop for red traffic signals. Senior Sergeant Marshall noted that if the intersection was grade-separated, like other such intersections in the region, it would prevent further collisions from occurring.

RECOMMENDATIONS OF CORONER RYAN

- I. Considering the crash history of the intersection of State Highway 1 and Whitford Brown Avenue, as well as the recommendation made by the Senior Sergeant Marshall, I make the following recommendation pursuant to section 57(3) of the Coroners Act 2006:
 - a. That Porirua District Council and New Zealand Transport Agency inspect the design and/or layout of the intersection of State Highway 1 and Whitford Brown Avenue and consider whether changes should be made to reduce the likelihood of similar crashes occurring in the future. This recommendation is directed to the Chief Executives of the Porirua District Council and of NZTA.²

Carey [2020] NZCorC 26 (11 June 2020)

CIRCUMSTANCES

William Grant Carey of Piarere, South Waikato, died on 21 April 2018 on Eldonwood Drive, Matamata, from severe head injuries and associated injuries caused in a motor vehicle collision.

Mr Carey was 22 years of age. He was socialising with friends during the night of 20 April 2018 and they were consuming alcohol. They asked another friend to drive them to a bar in the Matamata township. Despite not having a licence, this friend was frequently their sober driver as he was under the legal age to drink alcohol at a public venue. The vehicle they utilised, a Toyota Corolla, belonged to Mr Carey's friend and all occupants were aware that it was unwarranted and not roadworthy.

After dropping Mr Carey and his friends off, the driver was stopped by Police due to a rear light fault. The officer determined that the driver and his passenger were unlicensed but he passed an alcohol breath test. The driver was given a warning, allowed to drive the vehicle home then forbidden from driving anywhere else until he was licenced. No steps were taken to 'green sticker' the vehicle (placing a green sticker on the vehicle drawing attention to the fact that it was not to be driven) despite it being unwarranted at the time.

Around 1:15am on 21 April 2018, the driver returned to pick up Mr Carey and his friends upon their request. They arranged to meet at a side street to reduce the chances of the vehicle being observed by the Police. Mr Carey sat in the

² NZTA informs after receiving a copy of the recommendation that it is in the process of reviewing this intersection. Notwithstanding this, the recommendation remains to record the necessity for such a review.

driver's seat and although he was noticeably intoxicated and unfit to drive, the group allowed him to do so. During the journey, he was driving at excess speeds of up to 120km/h. One of the passengers told him to slow down and he did.

Mr Carey continued to drink alcohol when they returned to a friend's address. Around 4:00am, Mr Carey asked for the keys to the Toyota, but he was refused. Mr Carey told another friend that he needed to get away from the address following an argument with someone. He said that he wanted to drive slightly up the road but would stay within sight. He was given the keys.

Mr Carey drove to an intersection and returned after approximately five minutes. Shortly after, around 4:30am, he drove off again at speed. One of his friends contacted *555 to report his manner of driving.

Mr Carey drove the Toyota Corolla on Smit Street, Matamata. He failed to stop at the intersection with Station Road and crossed into the entranceway to Eldonwood Drive. His vehicle collided with a concrete and stone pillar. Police responding to the *555 call came across the collision around 4:40am and found Mr Carey deceased in the vehicle.

COMMENTS OF CORONER ROBB

Police

- I. It is unfortunate that the Police did not take more formal steps to prevent the Toyota from being driven on this night when they found it: being driven at 12:40 a.m.; by a 17-year-old; who was unlicensed; when the vehicle had no Warrant of Fitness; when the vehicle was unroadworthy. However, I acknowledge that this in itself may not have prevented this particular group ignoring a green sticker and to continue to drive on the vehicle illegally.

William and his friends and associates

- II. Presently there are considerable efforts to educate the public to the risks of drink-driving and driving while under the influence of drugs. As part of those education campaigns there has been an emphasis on ensuring that friends and associates do their part in preventing others from driving when they are in a state that makes it unsafe for them to drive. In this respect an effort is made to ensure a level of community responsibility and to develop a proactive approach whereby friends and associates look after each other when it comes to safe driving practices.
- III. For each of the young people involved on this night there is a demonstrable willingness to:
 - (a) drive a vehicle as an unlicensed driver,
 - (b) or, be driven by unlicensed drivers,
 - (c) to drive and be driven around in an unwarranted and demonstrably unroadworthy vehicle,
 - (d) to be driven by a friend who is heavily intoxicated and/or under the influence of drugs,
 - (e) to allow a friend to drive a vehicle while heavily intoxicated.
- IV. This was an entirely avoidable death.

- V. The death was principally brought about by William's own actions and decisions. However, his decisions fell out of a context of socialising with others, where there were opportunities to prevent him from having access to a motor vehicle. Had he been prevented from having access to the Toyota on this night he would not have driven to his death.
- VI. It is perhaps fortunate that he had not crashed the vehicle when it was not full of his friends as he drove them from the bar to the residential address. Had that occurred the circumstances of William's death in this collision would have been even more tragic. However, the fact that he did not crash while driving on that occasion was in my view a matter of good fortune rather than any good management on the part of him or anyone else who chose to get into the vehicle with him in the early hours of 21 April 2018.

RECOMMENDATIONS OF CORONER ROBB

- I. Having regard to the circumstances of this death I reiterate the comments and recommendations of many coroners, and the education messages presently in circulation. I reinforce the importance of:
- (a) not driving while under the influence of alcohol and/or drugs,
 - (b) only driving vehicles that are roadworthy and have a current Warrant of Fitness,
 - (c) always wearing a seatbelt in a motor vehicle,
 - (d) ensuring that friends and associates do not drive when under the influence of alcohol and/or drugs,
 - (e) ensuring that you never get into an unwarranted vehicle that is not roadworthy and is being driven by somebody under the influence of alcohol and/or drugs.

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

Ene & Sione [2020] NZCorC 14 (14 April 2020)

CIRCUMSTANCES

Tauvale Ene and Faraimo Sione of Christchurch died on 7 May 2017 at State Highway 1 near Woodend of traumatic injuries sustained in a motor vehicle collision.

Messrs Ene and Sione travelled from Christchurch to Culverden, North Canterbury six days a week to do carpentry work. Because of the distance and travelling times involved, they left Christchurch at approximately 4:30am and got home between 6:30 and 8:00pm. Mr Ene drove while Mr Sione talked to him to keep him awake.

Messrs Ene and Sione did not usually work on Sundays, but on 7 May 2017, the pair drove to Culverden to work, leaving around 2:30pm to travel back to Christchurch.

At approximately 3:45pm, as they were driving south from Woodend, their vehicle crossed from the southbound lane into the northbound lane, colliding head-on with an oncoming vehicle. There were no indications that Mr Ene braked or swerved to avoid the collision.

COMMENTS OF CORONER TUTTON

- I. The dangers of driving while suffering from fatigue are well known. Advice on dealing with fatigue is available on the New Zealand Transport Agency website at: <https://www.nzta.govt.nz/safety/driving-safely/fatigue/>

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

Root [2020] NZCorC 23 (28 May 2020)

CIRCUMSTANCES

Gareth John Root of Blenheim, died on 29 December 2018 at Blenheim Top 10 Holiday Park, 78 Grove Road, Blenheim, from drowning.

Mr Root was consuming alcohol with another resident at the Holiday Park on the night of 28 December 2018. He was noticeably intoxicated and the other resident assisted Mr Root into bed around 10:30pm.

Around 1:00am on 29 December 2018, Police received a notification of a priority traffic complaint at the Holiday Park. It was reported that a black Toyota Hilux utility was being driven erratically. Witnesses reported hearing loud crashing sounds as the Toyota collided with trees and other vehicles at the Holiday Park. The vehicle had also struck a tent, narrowly missing its occupants.

A witness driving near the Holiday Park noticed the outline of a utility vehicle with its headlights on in a precarious position on a river bank. It appeared to be stuck on something. The witness parked their vehicle and returned to the Holiday Park. He saw the utility submerged upside down in the river. There was no way they could open any doors due to the depth of the water. When emergency services retrieved the vehicle, Mr Root was located deceased inside.

Based on evidence at the scene, the Serious Crash Unit determined that Mr Root's vehicle failed to negotiate a bend and left the road. He made numerous attempts to return to the road but his vehicle slid down the river bank. Prior to the vehicle rolling into the river, Mr Root had at least five opportunities to seek assistance rather than continuing to drive.

Toxicology testing confirmed that Mr Root was more than three times over the legal blood alcohol limit for New Zealand drivers. Cannabis and tetrahydrocannabinol (THC) were confirmed in the blood.

COMMENTS OF CORONER ROBINSON

- I. Police identified the absence of signs, barriers, or reflectorised marker posts to highlight the sharp bend in the road.
- II. While ultimately Mr Root's death was due to the manner of his driving, there may be some merit in the camping ground considering the installation of some signage to highlight the corner.

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

Stewart [2020] NZCorC 20 (20 May 2020)

CIRCUMSTANCES

Jaime Dean Stewart of Whangarei died on 1 October 2016 at Kokopu Road, Whangarei as a result of a severe penetrating injury to his forehead sustained in a single vehicle car crash into a wooden barrier.

On 30 September 2016, Jaime, aged 18, drove to his father's house to spend some time with him. His father noticed that he had been drinking alcohol. They talked for an hour and Jaime had two drinks over this period. His father told him to go home and get some sleep before work, and Jaime left.

In the early hours of 1 October 2016, a member of the public came across Jaime's vehicle which was in a ditch and saw that Jaime had sustained serious injuries and appeared to be deceased. Jaime was confirmed dead at the scene.

Northland Police Serious Crash Unit investigated the crash and prepared a Crash Analysis Report. It found that Jaime's vehicle had left the road and drifted 17.6 metres before hitting a wooden barrier (a sight rail) guarding a cattle underpass. The fragmented railings penetrated the windscreen to enter the driver's cabin, and in doing so, struck Jaime. It was considered likely that Jaime had fallen asleep and this caused him to veer off the road. It was noted he was not wearing a seatbelt, was above the driving legal alcohol limit and had methamphetamine and cannabis in his system at the time of the crash. The Crash Analysis Report stated that if the railing had been a steel Armco barrier, Jaime's chances of survival may have increased. Subsequent investigations by the Whangarei District Council found that the sight rail was a roadside hazard.

COMMENTS OF CORONER GREIG

- I. The sight rail that Jaime crashed into has been identified as a significant hazard.
- II. As a result of a review of the circumstances of the crash commissioned by Whangarei District Council, Traffic Engineer Mr Spoonley recommended to the Council that a systematic review be undertaken of all sight rails in the network to:
 - (a) Ascertain whether the sight rail is required and whether it could be replaced by a safer system compliant form of delineation such as edge marker posts;
 - (b) If the sight rail is still the appropriate form of delineation rebuild/modify the sight rail to be compliant with the RTS 5 (Guidelines for rural road marking and delineation);
 - (c) Whether the timber sight rail can be replaced with a compliant guardrail system; and
 - (d) Ensure that the appropriate hazard markers are provided.
- III. Mr Nick Marshall, Team Leader - Road Safety and Traffic Engineering Northland Transport Alliance, Whangarei District Council advised that Council agrees with the findings and recommendations outlined in Mr Spoonley's report. Mr Marshall advised that the Council planned to immediately remove the existing sight rails at the site of Jaime's crash, and will collate a list of all sight rails in the Council's networks (Whangarei, Kaipara and Far North) and review their need for either removal, modification or replacement. It will prioritise

treatment based on risk and target the highest risk sites in the 2020-21 budget, with remaining sites being addressed in the three years thereafter.

- IV. The Serious Crash Unit also made recommendations in its Crash Analysis Report. One recommendation was aimed at dealing with the safety issue of the sight rail hazard. This concern is addressed by the Council's plans to undertake work on all sight rails in the Councils networks as outlined above.
- V. The Crash Analysis Report also recommended that either a raised barrier be installed at the centreline in the area where the crash occurred to prevent cross centreline crashes, or alternatively, Audio Tactile Profile (ATP) be installed at the centreline. Mr Marshall advised that the Council agreed with the recommendation to provide ATP, and that this would form part of its Standard Safety Interventions business case to NZTA, seeking funding for this route and other High Risk Rural Roads.
- VI. In view of the measures that Whangarei District Council has advised that it is taking to address the safety issues identified following Jaime's crash, I do not consider that there is a need for me to make recommendations. The Council's actions in relation to assessing the specific risk parameters of all sight rails in its district and, based on the assessment of risk, either removing, replacing or modifying them is a very positive safety step for the region.

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

Tobin and Kronfeld-Tobin [2020] NZCorC 32 (29 June 2020)

CIRCUMSTANCES

Christopher Francis Tobin, aged 51 years, of Auckland, died at the intersection of Mount Eden and Bellevue Road, Mount Eden, Auckland on 11 July 2017 of chest injuries sustained in a motor vehicle crash. Mr Tobin's son, Jack Gregory Kronfeld-Tobin, aged 16 months, of Auckland died at Starship Children's Hospital on 14 July 2017 of cervical spinal cord injury sustained in a motor vehicle crash that occurred on 11 July 2017.

Mr Tobin was driving with Jack, his daughter Elle and the family's Huntaway dog on their way home from the central city. At approximately 3.20pm, Mr Tobin failed to negotiate a left-hand bend, crossed the painted flush median and crashed into an oncoming double decker bus. Mr Tobin was pronounced dead at the scene. Jack was taken to Starship Children's Hospital in a critical condition, where he passed away on 14 July 2017.

The Police crash investigation noted evidence that Mr Tobin appeared to have been driving in a normal manner immediately before the crash, but was observed to drive straight through the bend and onto the other side of the road without accelerating, slowing down or braking. The investigating officer concluded that distraction, from the unrestrained dog in the car or another factor, was a possible contributor to the crash.

Post-mortem toxicology results identified the drugs methamphetamine and amphetamine in Mr Tobin's blood, as well as GHB (a powerful central nervous depressant). While it could not be known whether he stopped concentrating, was falling asleep or was otherwise impaired, taking into account all the evidence the Coroner was satisfied that drugs played a direct role in the crash.

Jack was in a forward facing Safe-n-Sound Meridian AHR child restraint, an approved restraint under New Zealand standards as it met the Australia “5Tick Standard”. However, the investigating officer noted that there were aspects of the restraint’s use which could have been improved and increased Jack’s safety in the crash. The restraint was secured by a seat belt but the tether (anchorage) straps were not attached to the car. It was also suggested that a rear facing restraint would have been safer, per Plunket’s advice that babies be kept in a rear facing restraint until at least two years of age.

Auckland Transport also identified the rear facing child restraint and how it was secured as issues, and recommended that child restraint clinics and roadside checks be facilitated to improve child restraint education.

COMMENTS AND RECOMMENDATIONS OF CORONER GREIG

Drug driving

- I. The dangers of drug driving are increasingly being recognised. In 2019 NZTA launched a campaign on television, Facebook and Instagram to raise awareness amongst New Zealanders of the prevalence and harm of drug driving. In view of the increasing awareness of this issue and the work being done in this arena, I do not consider that recommendations by me are necessary.
- II. A copy of these findings will be sent to the Chief Executives of NZTA and the New Zealand Drug Foundation to highlight the circumstances of these deaths.

Child restraints

- III. The issue of a mandatory requirement for rear facing child restraints for children under two years, and compulsory use of tether straps, are not matters that it is appropriate for me to make recommendations on in this case. However, the issues related to child restraints raised in the course of this inquiry are concerning and important in relation to saving children's lives and it appears that there is varying and conflicting information available to New Zealand parents on these issues. Clear information for parents and caregivers on what is safest for their children and consideration of strengthening of the regulatory framework may prevent deaths in situations similar to the crash which led to Jack’s death.
- IV. Accordingly, a copy of these findings will be sent to the Chief Executives of the Ministry of Transport; the New Zealand Transport Agency; Plunket, Safekids Aotearoa and Auckland Transport to highlight the circumstances of Jack’s death. The findings may assist with consideration of what action, regulatory or other, may help to prevent deaths in similar circumstances.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Jack Gregory Kronfeld-Tobin and/or Christopher Tobin entered into evidence in this inquiry upon the grounds of personal privacy and decency.

Wilkinson [2020] NZCorC 25 (9 June 2020)

CIRCUMSTANCES

Caleb Lawrence Wilkinson, aged 24, of Christchurch died on 7 January 2018 on State Highway 75 near Duvauchelle, Banks Peninsula of multiple injuries as a result of a motor vehicle collision.

Mr Wilkinson was travelling east on his Kawasaki Ninja motorcycle on State Highway 75 towards Akaroa on 7 July 2018. As he approached a left-hand bend, he overtook a line of slower moving vehicles and crossed into the oncoming lane. He collided with an oncoming Nissan X Trail 4 Wheel Drive vehicle and died at the scene.

Analysis by the Serious Crash Unit concluded that Mr Wilkinson had made the decision to overtake when some of his forward vision was likely to have been blocked by a campervan in front of him, with the oncoming vehicle hidden from his view.

COMMENTS OF CORONER ELLIOTT

- I. The Waka Kotahi NZ Transport Agency (NZTA) Road Code advice about overtaking:

Passing on the right

Passing on the right can be dangerous, especially if you have to:

- change your path of travel
- enter a lane or part of the road used by oncoming vehicles.

Before passing, always ask yourself 'is it really necessary to pass?' Don't pass just because you are feeling impatient with the car in front - that's often when crashes happen.

If you do decide to pass, follow the rules shown below.

Before you pass:

- make sure you will be able to see at least 100 metres of clear road ahead of you **once you have finished passing** - if not, don't pass
- look well ahead to make sure there are no vehicles coming towards you
- look behind to make sure there are no vehicles passing you
- signal right for at least three seconds before moving out to pass.

Before pulling in front of a vehicle you have passed:

- make sure you can see the vehicle in your rear view mirror

- signal left for at least three seconds.³

II. Given this advice is incorporated into the Road Code, it is not necessary to make any comments or recommendations.

Issues raised by Mrs Wilkinson

III. Mr Wilkinson's mother, Colleen Wilkinson, said that her son loved motorcycle riding but was very safety conscious. He had done a defensive motor cycle driving course and invested in good quality protective clothing. He also did track racing to gain more skills.

IV. Mrs Wilkinson raised some issues. I referred these to Senior Constable Isitt for consideration. These were:

Vehicle colour

V. Mrs Wilkinson raised the possibility that her son had not seen the approaching vehicle because it was red and in shadow.

VI. Senior Constable Isitt noted that some research has identified a relationship between vehicle colour and crash risk. He said:

The association between vehicle colour and crash risk was strongest during daylight hours where relative crash risks were highest for [black, blue, grey, red and silver] compared to white by up to around 10%.

VII. Senior Constable Isitt said that he initially thought that this had contributed to the crash. However, after carrying out some calculations to identify the respective positions of the vehicles, he discounted this as a contributing factor to this collision.

VIII. Mrs Wilkinson also asked whether vehicles (especially red ones) should travel on country roads with their lights on. Senior Constable Isitt replied that, based on the research he cited, all cars not coloured white would need to drive with their headlights on.

Double yellow lines

IX. Mrs Wilkinson asked whether, if this is an unsafe section of road, there should be double yellow lines.

X. Senior Constable Isitt replied:

I think it was an area where a skilled rider could overtake a vehicle, one vehicle.

XI. It therefore appears that Senior Constable Isitt does not consider double yellow lines to be necessary in this stretch of road.

Passing lanes

³ NZTA Road Code – Key Driving Skills: Passing – <https://www.nzta.govt.nz/resources/roadcode/about-driving/passing/>

- XII. Mrs Wilkinson asked whether more passing lanes would make the road safer. Senior Constable Isitt replied that passing lanes would always make roads safer for overtaking.

Discussion

- XIII. Section 57A of the Coroners Act 2006 states that coronial recommendations or comments must be clearly linked to the factors that contributed to the death to which the inquiry relates.
- XIV. Senior Constable Isitt concluded that the colour of the oncoming vehicle did not contribute to the collision. He also concluded that the oncoming vehicle was obscured from Mr Wilkinson's view by a campervan, which means that the use of headlights by the oncoming vehicle was not relevant to the collision. I therefore have no power to make any comments or recommendations in relation to these issues.
- XV. Mrs Wilkinson invited me to recommend that more passing lanes are installed on winding, country roads. The decision about whether to build overtaking lanes on any given roadway is, according to information on the NZTA website,⁴ technical and complex. It appears that, as with many safety initiatives, considerations of cost and practicality must be weighed against the risks relating to a particular section of road.
- XVI. For these reasons, a broad recommendation about passing lanes generally is unlikely to result in any change. However, a copy of these Findings will be sent to NZTA so that they are aware of the circumstances of this collision. I invite them to consider whether the circumstances of Mr Wilkinson's death warrant consideration of any additional safety features, either in relation to that stretch of road or generally, and including Mrs Wilkinson's comments as described above. I would appreciate a response to this invitation, so that Mr Wilkinson's family may be informed of NZTA's position.

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

Brew [2020] NZCorC 33 (30 June 2020)

CIRCUMSTANCES

Jamie Wayne Brew of Beachlands, Auckland died on 10 January 2017 at 33 Constellation Avenue, Beachlands in circumstances amounting to suicide.

Mr Brew was a volunteer firefighter and was exposed to numerous traumatic events through his service, including attending suicides. Mr Brew also had a history of depression for which he was receiving treatment. Concerns were raised by Mr Brew's partner about the support provided by Mr Brew's employer to firefighters following traumatic events. Mr Brew was

⁴ <https://www.nzta.govt.nz/roads-and-rail/road-engineering/passing-and-overtaking/technical-information/>

employed by the New Zealand Fire Service but Fire and Emergency New Zealand (FENZ) assumed all its functions in July 2017.

Coroner Mills received a report from FENZ about the trauma policies at the time of Mr Brew's death and changes that have subsequently been made. New initiatives include:

- a. A dedicated full-time Welfare Officer in the Auckland/Northland region;
- b. New policies including a high-level Safety, Health and Wellbeing Commitment;
- c. An expanded peer support team;
- d. Safe@Work (a system for Health and Safety reporting);
- e. Psychological Wellbeing workshops; and
- f. A Positive Workplace Culture team.

COMMENTS OF CORONER MILLS

- I. There is no doubt that firefighting is a stressful occupation. Firefighters are exposed to traumatic and disturbing incidents on a regular basis. It is apparent both from Mr Brew's partner's statements and from Mr Brew's medical notes, that his workplace trauma contributed to Mr Brew's depression and probably his use of alcohol.
- II. FENZ has an obligation to ensure that firefighters are kept safe, including psychologically safe, at work. The increased focus on wellbeing and improving the culture is to be commended and encouraged. Given the changes and improvements made by FENZ, I do not propose to make a formal recommendation, but it is hoped that the FENZ will continue to focus on and improve services for staff and to ensure a culture which enhances the wellbeing of all staff is fostered.

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

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

Gower-James [2020] NZCorC 36 (30 June 2020)

CIRCUMSTANCES

Mark Gower-James, late of Whanganui, died at 734 Rapanui Road, Whanganui on 6 May 2015. His death was self-inflicted.

Mr Gower-James was known to the Community Mental Health Team and had several interactions with them over the years. Due to Mr Gower-James' death a Serious Incident Analysis Report was completed by the Whanganui District Health Board. The report records what happened and what has been learned that may help decrease community suicide in the future.

COMMENTS OF CORONER FITZGIBBON

- I. As a result of the Serious Incident Analysis Report completed by the Whanganui District Health Board the report held that the care delivered to Mr Gower-James was responsive and met the appropriate standard of care. Four key findings were identified in relation to the care Mr Gower-James received and recommendations have been developed which will support existing suicide prevention strategies within the service and community.

Four key findings:

1. Shared documentation and explicit operational processes can be developed further;
2. Electronic compatibility between GP and MHL records;
3. No documented evidence of formal assessment of risk in the MHL notes or since 2013 in GP notes; and
4. Clinically relevant verbal interactions between psychiatrist and the MHL nurse had not been documented.

Recommendations:

1. Continue work in Whanganui rising to the challenge to create a pathway from general practice for a range of mental health wellbeing services including MHL. Review model structure and balance between integration between primary and secondary services to promote a seamless experience for people and their families and meet operational standards of both primary and secondary care;
 2. Identify and implement a process that will accurately reflect MedTech (GP patient record) MHL notes in Jade (Mental Health Patient Record) documentation. Develop a process for electronically uploading clinically relevant paper notes;
 3. Identify and establish a risk assessment framework suitable for primary MHL services that is reflected in the Jade notes;
 4. Strengthen process for caseload review for primary care MHL caseloads and utilise multidisciplinary forum for complex case review.
- II. In light of the recommendations made by Whanganui District Health Board I will not be making any further recommendations or comments.

Note: Pursuant to section 71 of the Coroners Act 2006, no person may, without a coroner's authority or permission, make public a particular of the death other than the name, address and occupation of the person concerned, and the fact that a coroner has found the death to be self-inflicted.

An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Gower-James taken by Police in the interests of decency or personal privacy.

McIntosh [2020] NZCorC 17 (7 May 2020)

CIRCUMSTANCES

Levi Jacob McIntosh, aged 21 of Katikati, died on 16 May 2019 at Katikati College, Katikati in circumstances amounting to suicide.

Mr McIntosh consumed alcohol with friends throughout the day of 16 May 2019. His mood deteriorated as the day went on and he became intoxicated. At around 5:00pm Mr McIntosh and his friend got into a physical fight on the street. Following this, Mr McIntosh ran into the road before collapsing on a median strip. He was breathing but did not verbally respond to those trying to help him. When he woke up suddenly, Mr McIntosh immediately became aggressive. He ran towards and jumped into the Uretara stream. Passers-by followed him and, when he climbed out of the stream, persuaded him to sit down. While there Mr McIntosh talked about killing himself in a different way. He repeatedly said that no one loved him or cared about him. Mr McIntosh was taken back to the ambulance and appeared to have calmed down. No one informed the attending Police or paramedics about Mr McIntosh feeling suicidal.

While being assessed by paramedics, Mr McIntosh stated that he could not wait to die but refused to elaborate. Paramedics informed Police of this and advised that Mr McIntosh was being difficult and not answering questions. When Police drove Mr McIntosh to his campervan, he gave no indication that he was having suicidal thoughts.

At around 7:31pm CCTV footage showed Mr McIntosh entering Katikati College grounds carrying several items. Mr McIntosh was found deceased on the College grounds the following morning.

COMMENTS OF CORONER BATES

- I. The following paragraph is not intended as criticism of any person involved with assisting Mr McIntosh. I commend members of the public for coming forward and offering what assistance they could, just as I commend emergency services for their work. Each individual assisting was acting with limited, differing or no information in terms of Mr McIntosh's suicide risk.
- II. Mr McIntosh's death is a sad reminder of the importance of informing emergency services; be they Police, ambulance or fire, when someone may be at risk of suicide. Even when emergency services are not involved, people should be encouraged to inform a responsible trusted person.
- III. Suicide risk may be evidenced through historic or recent actions or words, even when those actions or words appear to be flippant or the product of intoxication. The need to speak up may be more acute where a person's judgement is affected by some form of intoxication, increasing the possibility of them acting impulsively. Information sharing is crucial and may prevent loss of life. I make no further comment or recommendation pursuant to s 57(3) of the Coroners Act 2006.

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

An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr McIntosh taken during the investigation into his death 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.

Green [2020] NZCorC 27 (12 June 2020)

CIRCUMSTANCES

Caden Albon William Green, aged two months, died on 17 January 2017 at 58 Zelda Avenue, Clover Park, Auckland of sudden unexplained death in infancy associated with an unsafe sleep environment (bed sharing with adults).

The safe sleep message given by health professionals to reduce the risk of sudden infant deaths is that the safest place for a baby to sleep in the first year of their life is in their own space, face up, face clear and smoke free. Caden's parents were aware of this message and had been following the advice about Caden having his own space and sleeping on his back carefully. Tragically, on the night Caden died Ms Green was overwhelmed with tiredness and fell asleep inadvertently having brought Caden into bed with her in the middle of the night to breastfeed him. This highlights a risk when tired mothers bring their babies into bed to feed them.

The evidence is that Caden was a well-nourished and well cared for and dearly loved baby. His death in such very sad circumstances highlights the vigilance that must be maintained to ensure that every sleep for a baby is a safe sleep and the importance of heeding the public health messages that help to keep new-born babies safe from sudden unexplained death in infancy.

Bedsharing with adults creates an unsafe sleeping environment for babies due to the difference in body sizes and the lack of protective reflexes available to the infant. Adults can move while asleep and may not notice accidentally overlaying an infant, particularly if tired, as was the case here.

COMMENTS OF CORONER GREIG

- 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 sleep message was given to Caden's family and understood and that usually this advice was carefully followed. In these circumstances I do not consider recommendations are necessary.
- II. I note that the Ministry of Health launched a SUDI prevention programme in August 2017 directed at significantly reducing the deaths of babies. A key focus of the programme is to target the two key modifiable risks of SUDI: exposure to tobacco smoke during pregnancy and unsafe bed sharing.
- III. Such measures are clearly desirable to prevent the deaths of future infants.
- IV. A copy of these findings will be sent to the Ministry of Health and Change for our Children for their records.

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

Synthetic Cannabis

Mihinui [2020] NZCorC 30 (24 June 2020)

CIRCUMSTANCES

David Wayne Phillip Kerewaro Mihinui of Manurewa, aged 29, died at Maurice Street, Papakura on 14 November 2017 of the effects of synthetic cannabis.

At the time of his death, Mr Mihinui was subject to an order under section 29 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. He had been diagnosed with schizophrenia at the age of 18 and was living independently but under the care of Mahitahi Trust. Mr Mihinui was a known drug user with cannabis being his preference.

Mr Mihinui was at an address on Maurice Street, Papakura on 14 November 2017 with numerous people. Someone noticed that Mr Mihinui appeared to be asleep and unsuccessfully tried to wake him to take him home. His face was blue and blood was observed coming out of his nose and mouth so emergency services were contacted. It was confirmed that Mr Mihinui had died.

There was conflicting evidence from witnesses who were with Mr Mihinui or at the property on 14 November 2017, as to whether he drank alcohol, smoked cannabis or synthetic cannabis that day. However, toxicology testing confirmed the presence of both cannabis and synthetic cannabis in Mr Mihinui's blood, with only a trace of alcohol. The results also indicated Mr Mihinui was taking anti-psychotic medications.

RECOMMENDATIONS OF CORONER BELL

- I. Unfortunately, Mr Mihinui's consumption of synthetic cannabis has resulted in his death.
- II. The dangers of consuming synthetic drugs include:
 - It is promoted or sold as a form of synthetic cannabis, but that there is no cannabis in the product.
 - The synthetic drug can be made to look like cannabis by using dried plant or other material, but it is saturated in a synthetic drug not THC (tetrahydrocannabinol) the active ingredient in cannabis.
 - The pharmaceutical agents from which synthetic cannabis was developed were attempts to create new medications to treat spasms and epilepsy but were found to be unsuitable and were discarded. The nature of the synthetic drug is unknown to the purchaser and unknown or poorly understood by the manufacturers/distributors in New Zealand.

- The synthetic drugs, AMB-FUBINACA and 5F-ADB, have been the cause or contributing factor in a number of deaths in New Zealand, and overseas.⁵
- The quantity and strength of AMB-FUBINACA and 5F-ADB is an unknown gamble which can have fatal consequences.
- Individuals who fall unconscious after consumption of synthetic drugs can die if they do not receive timely and appropriate medical assistance; dying from cardiac event induced by consumption of the drug, or as a result of being comatose and asphyxiating on their own vomit, or they may suffer an hypoxic brain injury.

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

- In order to prevent future deaths from synthetic cannabinoids, Dr Quigley suggested that an all-encompassing harm reduction approach which reduces demand, supply and easy access to treatment for those seeking assistance should be developed. He cautioned that any recommendations on increasing enforcement, targets manufacture, trafficking and supply, while not overly penalising users as this can create a barrier to those seeking medical attention, even in cases of emergency.*
- I agree with Dr Quigley, however I am unable to make any recommendations in this regard, as I have not heard any evidence. I am aware however, that Coroner McDowell is conducting a joint inquiry into deaths from synthetic cannabis which occurred in Auckland. I will refer this suggestion to Coroner McDowell to consider in the course of her joint inquiry. No recommendations will be made by me.*
- Dr Quigley submitted that efforts should be made to inform users of synthetic cannabis, their families and associates, of the dangers of synthetic cannabinoids and the need to get help immediately if someone collapses. I agree.*
- Dr Quigley's advice for the families or associates of synthetic cannabis users was that if a person who has used synthetic cannabis collapses, that person should be immediately shaken to attempt to rouse that person. If the person rouses, that person should then be placed in the recovery position and a call for help should be made. If the person does not rouse, then call for help and commence chest compressions. The call taker who answers the emergency call for help will provide assistance. Do not delay.*

⁵ Adams AJ, Banister SD, Irizarry L, Trecki J, Schwartz M and Gerona R. "Zombie" Outbreak Caused by the Synthetic Cannabinoid AMB-FUBINACA in New York" *New England Medical Journal* 376 (2017) 235-242. Hasegawa K, Wurita A, Minakata K, Gonmori K, Yamagishi I, Nozawa H, Watanabe K and Suzuki O. "Identification and quantitation of 5-fluoro-ADB, one of the most dangerous synthetic cannabinoids, in stomach contents and solid tissues of a human cadaver and in some herbal products" *Forensic Toxicology* 33 (2015) 112-121.

- IV. Dr Quigley is a vocational specialist in Emergency Medicine, he has completed additional studies in clinical toxicology and conducted research in forensic toxicology. He is a recognised expert in emergency management and treatment of drug and alcohol presentations.
- V. I endorse Dr Quigley's advice.
- VI. These findings will be distributed to the media for publication.

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

Tramping

Halehally-Chikkanna [2020] NZCorC 16 (7 May 2020)

CIRCUMSTANCES

Sateesh Babu Halehally-Chikkanna of India died on or about 1 October 2018 at Red Crater Lake, Mount Tongariro, Tongariro National Park, New Zealand of hypothermia due to environmental exposure.

Mr Halehally-Chikkanna and his travelling companions arrived in Turangi on 30 September 2018. Mr Halehally-Chikkanna's son had done a lot of research about the Tongariro Crossing but was not able to travel to New Zealand. Mr Halehally-Chikkanna talked with him on the phone about the crossing that evening. The group briefly looked at the crossing information and noted the need to take thermal clothing and enough food and water for the day.

On 1 October 2018 the group checked the weather forecast noting there was a 40-50% chance of rain. They did not consider the wind or the possibility of snow.

At about 8:00am Mr Halehally-Chikkanna and three male family members set out from the Ketetahi car park with the intention of walking the Tongariro Alpine Crossing and meeting other family members at the Mangatepopo carpark later that day. None of the group were wearing thermal tops and only one had a rainproof jacket. The first part was quite steep and, after two hours, Mr Halehally-Chikkanna was tired. The others told Mr Halehally-Chikkanna to walk as much as he could but if he got too tired to turn around to go back and call to arrange to be picked up. Mr Halehally-Chikkanna continued on but was slowly left behind by the rest of the group. After about 10-20 minutes, the others could no longer see Mr Halehally-Chikkanna walking behind them.

The group of three stopped and had some food at Ketetahi Hut. Mr Halehally-Chikkanna did not arrive at the hut. After leaving the hut the group came across snow and were surprised at how long they had to walk in it for. It started to drizzle and eventually worsened. The group saw a signpost that said Mangatepopo Road was about 7 kms away and the Oturere Hut was one and a half hours away, but in a different direction. As they had arranged to be picked up at the end of Mangatepopo Road, they followed the track in that direction. The weather continued to worsen and, wet and cold, the group decided to turn around and seek shelter in the Oturere Hut. There was no cell phone signal while they were on the track but there was signal at the Oturere Hut and they contacted emergency services to advise they needed help to get out. They were advised that, due to the weather conditions, a helicopter was unable to fly and a rescue team would be

five hours away. The group also contacted Mr Halehally-Chikkanna's wife to advise her that he must have returned to the drop-off point. They requested that she pick them up from Desert Road. The group started walking towards the next hut and came across Search and Rescue personnel before reaching the hut. They were taken to the hut where they received warm clothing and a drink. They called Mrs Halehally-Chikkanna as they walked down towards Desert Road. She reported that Mr Halehally-Chikkanna was not in the carpark and he had not been picked up. The group met their travelling companions and Search and Rescue personnel in the Ketetahi Road carpark and learned that Mr Halehally-Chikkanna was not there.

On 2 October 2018 a member of the Ruapehu Alpine Rescue Organisation was ascending the Red Crater Ridge when he observed Mr Halehally-Chikkanna lying on the ground beside the track. He was wearing a light weight hooded sweatshirt, tracksuit pants and sneakers. He did not have any waterproof gear. There was a pair of gloves, a woollen beanie and some food items on the ground nearby. There were a couple of large rocks between Mr Halehally-Chikkanna and the track which may have provided some shelter from the north westerly wind.

COMMENTS OF CORONER FITZGIBBON

- I. Following this incident, the New Zealand Mountain Safety Council (MSC) report that several projects were initiated to try and avoid a similar event occurring again:
 1. Install signs at the Ketetahi end of the track in an effort to reduce similar groups from starting from the Ketetahi end. This involves:
 - a. A profile map showing a direction of travel arrow from Mangatepopo to Ketetahi and a written description *"The Tongariro Alpine Crossing is best started at Mangatepopo Road end. Hiking the Crossing from here [Ketetahi] adds 350m climb to your trip, making it longer and more difficult"*. The words *"Start"*, and *"Finish"* label the Mangatepopo and Ketetahi ends respectively;
 - b. A WARNING sign describing likely winter conditions, skills, equipment needed, and advice that *"the weather can turn bad FAST"*;
 - c. A large avalanche billboard with QR barcodes for the MetService Tongariro National Park weather forecast and one for the New Zealand avalanche advisory forecast.
 2. Another project has been to change the signage across the entire crossing. The MSC has worked directly with DOC to review the existing signage and to make changes to make these signs engaging and understandable by those with low levels of English. They use pictures and icons and also give the reader their position on the track, so they know how far along they have progressed.
 3. The MSC is currently running an Issue Specific Advisory Group focused on reducing and preventing further safety issues on the Tongariro Alpine Crossing. This process has included facilitating an independent expert group who have suggested a number of potential prevention solutions. The MSC is

currently engaging with relevant stakeholders to identify which of these solutions should be implemented and then they will begin to make an implementation plan which includes funding of these projects.⁶

II. The MSC have a clear focus on preventing further outdoor recreation fatalities and have suggested recommendations which may prevent similar accidents occurring again:

1. Always thoroughly plan your trip, seek help from others if the location or trip is new to you;
2. Check the official MetService weather forecast;
3. Consider what effects the weather will have on the track and how you should mitigate this;
4. Always be prepared to turn back or alter your plans, have a plan B organised;
5. Always take sufficient and appropriate clothing and equipment. Most importantly, always take warm and waterproof clothing layers and don't wear cotton;
6. Emergency shelters should be carried even on day walks with a forecast of fine weather; and
7. When setting off to walk as a group, travel together for the entire journey. Decisions to separate should only be made in an emergency situation., and even then, the risks should be evaluated and mitigated. The most vulnerable people in the group should never be left alone.

III. MSC advise that these recommendations are consistent with current proactive prevention focused messaging delivered by MSC and its partners. Due to the ongoing proposals underway by the MSC, I am satisfied no further recommendations or comments are required.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Halehally-Chikkanna taken by Police in the interests of decency or personal privacy.

⁶ This report has now been completed – more information can be found on the MSC website – www.mountainsafety.org.nz/insights. Some of the proposed solutions would address the causal factors identified by the MSC in their report relating to Mr Halehally-Chikkanna's death.



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