OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments made between **1 July** and **30 September 2020**

Office of the Chief Coroner | 2020 (3)

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 34 recommendations and/or comments issued by Coroners between 1 July and 30 September 2020.

Contents

Recommendations and comments **4**

1 July to 30 September 2020 ..... **4**

Aviation 4

Condon and Gray [2020] NZCorC 61 (15 September 2020) 4

Simcox [2020] NZCorC 58 (9 September 2020) 5

Alcohol and Drug Related 7

Smolenski [2020] NZCorC 60 (10 September 2020) 7

Drowning 10

Anderson and De Bruyn [2020] NZCorC 62 (17 September 2020) 10

Fall 11

Ututaonga [2020] NZCorC 64 (18 September 2020) 11

Fire 12

Awanui [2020] NZCorC 46 (30 July 2020) 12

Leisure Activities 13

Baldwin [2020] NZCorC 51 (14 August 2020) 13

Fraser [2020] NZCorC 37 (2 July 2020) 16

Keane [2020] NZCorC 68 (30 September 2020) 17

Worrell [2020] NZCorC 70 (30 September 2020) 18

Medical Care 20

Sutherland [2020] NZCorC 45 (29 July 2020) 20

Waitohi-Hohepa [2020] NZCorC 53 (27 August 2020) 21

Watson [2020] NZCorC 52 (25 August 2020) 22

Motor Vehicle 27

Bano [2020] NZCorC 38 (3 July 2020) 27

Carrick [2020] NZCorC 66 (28 September 2020) 28

Hartigan [2020] NZCorC 42 (16 July 2020) 29

Leef [2020] NZCorC 44 (24 July 2020) 29

Liebl, Shortland J, Shortland S [2020] NZCorC 49 (7 August 2020) 30

MacIntosh [2020] NZCorC 54 (28 August 2020) 31
McMurtrie [2020] NZCorC 50 (11 August 2020) 32
Tapurau [2020] NZCorC 48 (4 August 2020) 33
Truger [2020] NZCorC 69 (30 September 2020) 37
Ware and Webb [2020] NZCorC 41 (15 July 2020) 38
Whiunui [2020] NZCorC 59 (10 September 2020) 41
Wilson [2020] NZCorC 63 (17 September 2020) 42
Police Shooting 43
Marshall [2020] NZCorC 40 (14 July 2020) 43
Product Related 43
Master X [2020] NZCorC 56 (2 September 2020) 43
Self-Inflicted 47
Cook [2020] NZCorC 39 (8 July 2020) 47
Epapara [2020] NZCorC 67 (30 September 2020) 48
Grose [2020] NZCorC 65 (25 September 2020) 49
Harding [2020] NZCorC 43 (20 July 2020) 50
Spankie [2020] NZCorC 47 (30 July 2020) 52
Sudden Unexpected Death in Infancy (SUDI) 54
Sonny [2020] NZCorC 55 (28 August 2020) 54
Workplace 56
Cleugh [2020] NZCorC 57 (7 September 2020) 56

Recommendations and comments

1 July to 30 September 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/

Aviation

Condon and Gray [2020] NZCorC 61 (15 September 2020)

CIRCUMSTANCES

Neale William Gray, aged 54, of Hokitika and Daryl Robert John Condon, aged 51, of South Westland, both died at Fish River near State Highway 6, Haast Pass on 11 April 2014, from blunt impact trauma of torso and extremities with multiple fractures and visceral injuries from a helicopter collision with fixed terrain.

Both Mr Gray and Mr Condon owned and flew helicopters that were serviced by Matthew Bailey, an aircraft maintenance engineer with Performance Aviation in Wanaka. On 11 April 2014 all three men were in Wanaka to collect Mr Gray's Hughes 300 helicopter which had been undergoing maintenance with Mr Bailey's team. Mr Condon was in attendance so he could experience a flight in a Hughes 300, having recently purchased the same model for himself.

Mr Gray and Mr Condon had intended to leave Wanaka by 4:00pm to fly to Haast Pass. However, at 5:08pm Mr Gray and a maintenance engineer took the helicopter on a test flight, after which the helicopter was released back into service. As it was getting late, offers of accommodation were given to the pair. However, Mr Gray and Mr Condon decided to continue on with their plans.

At 5:29pm Mr Gray and Mr Condon began their flight. At around 6:15pm another pilot was flying above Makarora when he saw a Hughes 300 flying about 800-900 feet above him. He attempted to make radio contact with the pilot of the helicopter to inform him of deteriorating local weather conditions, but there was no reply.

At 9:30pm Police were notified that Mr Gray and Mr Condon were overdue. The following morning at 9:00am, Police located Mr Gray's helicopter in water near the Fish River bridge. The bodies of Mr Gray and Mr Condon were submerged in the wreckage and they were confirmed as deceased at the scene.

The Civil Aviation Authority (CAA) carried out an investigation into the crash on 11 April 2014 and opined that the main contributing factor was Mr Gray's "decision to depart on the flight toward deteriorating weather and lowering ambient light conditions". The identified contributing factors were:

- operating a helicopter into meteorological conditions below Visual Flight Rule (VFR) minima;
- operating a helicopter not equipped to fly in instrument meteorological conditions;
- the pilot was insufficiently qualified for the meteorological conditions; and
- the currency of the pilot's skill and experience.

The CAA report concluded that the crash highlighted the dangers of pressing on into deteriorating weather conditions. The CAA noted that weather-related general aviation accidents remain one of the most significant causes for concern in aviation safety, because they are usually avoidable. Furthermore, pilots operating helicopters have the added capabilities, assuming a site is acceptable, of being able to land almost anywhere. The CAA opined that this advantage should be taken well before continuation of the flight becomes too hazardous.

The CAA stated that no new safety recommendations had resulted from the crash. However, pilots operating under VFR need to ensure that weather conditions along the length of the chosen route are appropriate for the flight.

COMMENTS OF CORONER JOHNSON

I. I agree with the position of the Civil Aviation Authority in that there are no new safety recommendations that stem from this accident. Nevertheless, I take the opportunity to endorse the aforementioned safety message made by the CAA, namely that:

- Pilots operating under VFR need to ensure that weather conditions along the length of the chosen route are appropriate for the flight; and
- Helicopter pilots take advantage of their added capabilities and (assuming a site is acceptable) land the helicopter *well before* continuation of the flight becomes too hazardous.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Daryl Robert John Condon and Neale William Gray taken during the investigation into their deaths in the interests of decency and personal privacy.

Simcox [2020] NZCorC 58 (9 September 2020)

CIRCUMSTANCES

Ian John Simcox, aged 65, of Blenheim died at French Pass in the Marlborough Sounds on 13 March 2015. The cause of death was severe head injury caused by a high velocity impact when the helicopter he was flying crashed into the sea.

On the afternoon of 13 March 2015, Mr Simcox departed a holiday home at Waimaru Bay in his Robinson R44 Raven II helicopter. At approximately 5:30pm, the helicopter struck a power distribution line spanning French Pass. The impact caused one or both of the main rotor blades to come into contact with the cockpit, before the helicopter descended sharply

into the sea. Mr Simcox's body was retrieved from the wreckage by the Police National Dive Squad on the morning of 15 March 2015.

An Aircraft Accident report prepared by the Civil Aviation Authority (CAA) found that Mr Simcox had been flying below the minimum 500 feet height required for Visual Flight Rules (VFR) flights before colliding with the wires. There was sloping terrain directly below the wires, rising to the left. Mr Simcox was seated on the right of the helicopter, and the impact occurred on the lower left side. The CAA report notes it is possible that Mr Simcox believed he had sufficient clearance to avoid impact with the wires. The helicopter climbed as it approached the wires, indicating that Mr Simcox was aware of the obstacle. The helicopter struck the power distribution line at approximately 450 feet above mean sea level. Mr Simcox either did not positively identify the upper transmission line to properly judge clearance, or he identified the obstacle and did not correctly judge the clearance.

The CAA noted that the wires spanning French Pass have been in place since 1974. No marking devices were installed on the wires at the time of the incident. CAA rules do not require the span to be marked due to the height of the structures supporting the wires on each side of the span, and the fact that the wires are considered "shielded". A hazard may be considered shielded if it is lower than another obstacle that is already considered a hazard, and that hazard is marked by standard obstacle markings or lighting. The supporting structures on each end of the span are painted white and red for contrast against foliage and sky. An object may be considered shielded if it is located within 600 metres of the shielding object.

The investigators recommended that the CAA consider an assessment of the adequacy of current markings on hazards to navigable airspace, and that the assessment should ensure that the shielding principles did not prevent hazardous wires and other hazards on low-level transit routes, like those in the Marlborough Sounds, from being marked to provide pilots with a visual warning that they are approaching a hazard.

Weather was not considered a contributing factor to the incident. The CAA report also noted there were no known or suspected defects with the helicopter that might have contributed to the crash.

COMMENTS OF CORONER ANDERSON

I. The wire that was hit by Mr Simcox was not marked, and because of the shielding principles in place at the time of the crash was not required to be marked.

II. During the course of the inquiry into Mr Simcox's death Coroner Scott provided several draft recommendations to the CAA and Marlborough Lines Limited for comment, as set out below.

III. In respect of the CAA, Coroner Scott indicated endorsement of the CAA's own safety recommendation, included in the report discussed above. This was that the CAA should consider an assessment of the adequacy of current markings on hazards to navigable airspace through its policy issue assessment process. Following receipt of Coroner Scott's proposed recommendation, the CAA has advised that it has since completed this assessment. The CAA also noted that its focus is on continuing its safety awareness work and ensuring participants are actively managing their operational risks. The CAA stated that it will continue working with the Aviation Community Advisory Group to encourage and develop other warning systems, particularly obstacle databases that use GPS to assist pilots in wire and wire strike protection systems. It was considered that long term this would be a more feasible and effective solution than physically marking wires.

IV. The second draft recommendation considered by Coroner Scott was that Marlborough Lines Limited should mark the power distribution lines spanning French Pass. Marlborough Lines responded to this draft recommendation advising that the marking of the power lines across French Pass had previously been given significant consideration, together with other spans in the Marlborough Sounds. It advised that many factors needed to be taken into account when considering this issue. These included the length of the span, the strength of the supporting structures and the severe wind loadings in the area. Any changes also need to comply with internationally recognised ICAO standards for marking of power lines.

V. Marlborough Lines also outlined previous steps that had been taken to address the issue. These included the use of the ball markers referred to in the CAA report above, which were removed in 1988; strobe lights that were trialled but later removed because they caused a shipping navigation hazard; and painted plywood hoardings erected on the supporting pylons. The latter were found to be ineffective given the scale of the surrounding structures. Reticulation of D'Urville Island and installing a new undersea cable were both economically prohibitive for a number of reasons, including the terrain.

VI. Marlborough Lines noted in its response to Coroner Scott that both the crash involving Mr Simcox, and the 1985 Tory Channel plane crash in which 8 people died, regrettably involved pilots flying well below the normal permissible height and without regard to aerial crossings that were clearly marked on aviation maps.

VII. I have considered the information supplied in response to the draft recommendations proposed by Coroner Scott. It appears that the CAA recommendation has already been completed.

VIII. In relation to the proposed recommendation regarding the marking of the power distribution lines spanning French Pass, it is clear that this issue has been considered by Marlborough Lines and its predecessors. I also note the practical issues that the company has raised in response to the proposed recommendation. While I acknowledge the position of the agency and will not make a formal recommendation regarding the matter, I strongly encourage Marlborough Lines Limited to continue to revisit this issue, in conjunction with relevant stakeholders. It is important that they continue to explore ways to improve air traffic safety in the vicinity of French Pass, particularly as new technology and warning systems become available.

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

Alcohol and Drug Related

Smolenski [2020] NZCorC 60 (10 September 2020)

CIRCUMSTANCES

Jordan Allan Smolenski, aged 17, of Christchurch, died on 27 August 2017 of cardio-respiratory arrest after inhaling butane for recreational purposes. The manner of his death was accidental.

Jordan was of Māori and Pākehā descent. At the time of his death, Jordan was in year 12 at a high school in Christchurch and living with his father Neil, stepmother Michell, and Michell's ten-year-old daughter. Jordan had a long history of mental health difficulties, including impulsive self-harming which had begun about 18 months before his death. He had also attempted suicide earlier in 2017. At the time of his death, Jordan was prescribed the antidepressant drug escitalopram.

On Thursday, 24 August 2017, Jordan went on an overnight school camping trip and took two butane camping gas cylinders to use with his camp cooker. He appeared to be in good spirits when he returned the following night. At around 1:00pm on Sunday, 27 August 2017, Neil went to Jordan's bedroom to wake him up. He found Jordan on the bed in an odd position, with his head slumped to the side. His body was cold and stiff, and it was clear to Neil that Jordan had died.

A toxicological analysis detected butane in Jordan's blood and in the brain. Citalopram was detected at levels consistent with normal use.

The Coroner considered whether Jordan's death was a suicide, and concluded that the required standard for suicide was not established, and that Jordan's death was accidental. The Coroner also noted that no person in a management or counselling role at Jordan's school was aware of students using butane for recreational purposes, or talking about the same, in 2017. The Coroner was satisfied that if Jordan and his peers had discussed huffing at the camp, this occurred without the knowledge of teaching staff.

COMMENTS OF CORONER CUNNINGHAME

I. Neil told the inquiry that he wanted to get the message out to other parents about the risks involved with inhaling solvents. He wanted parents to understand warning signs that their children could be inhaling butane, and to prevent others going through the same tragedy he had. These sentiments are commendable.

II. As I said above, in this case, there were no warning signs that Jordan was inhaling butane.

III. Sadly, this issue is not a new one for Coroners. Previous comments and recommendations have been made, but VSA [Volatile Substance Abuse] continues to be a source of harm and even death for young people in Aotearoa.

IV. In 2012 the Chief Coroner's Recommendations Recap No. 2 comprised a case study report on deaths in New Zealand which related to VSA, specifically butane, between 2000 and 2012 (the Case Study).[1] The Case Study found that 63 people had died as a result of intentionally inhaling butane in that time period, of which 87% were under 24, and 77% were male. 30 of these 63 people were Māori.

V. Addressing the issues and challenges associated with VSA, the Case Study states:

> Volatile substance abuse (or VSA) is the intentional use of aerosols, solvents and gases for deliberate intoxication. While there are a large variety of products that are abused, this case study is focused only on deaths that result from the abuse of butane-based substances. VSA, including butane inhalation has been an issue in New Zealand for a number of years, particularly among youth. Although there is a lack of New Zealand

[1] Office of the Chief Coroner of New Zealand *Recommendations Recap A summary of coronial recommendations and comments made between 1 January–31 March 2012* (Ministry of Justice, Issue 2, 2012).

data about the prevalence of VSA in New Zealand and whether or not it is an increasing trend, coronial data demonstrates the cost of this dangerous practice.

Death from VSA can be random, meaning users can die from their first, fiftieth or hundredth use. It is impossible to guarantee safe use. Moreover, the risk of sudden death does not vanish immediately on cessation of inhalation, instead it persists for several hours.

Based on calls to the National Poisons Centre (NPC) the most commonly abused products in New Zealand are those containing propane and butane or butane alone. Data obtained from NPC indicates that the peak age of inhalant abuse is about 13–15 years, with the frequency of use declining by 17–19 years. Calls to NPC relating to exposure to inhalants have remained relatively constant since 2003.

The difficulty faced by those seeking to control VSA is that most of the commonly abused substances in New Zealand are everyday household products and therefore simply making these products illegal is not practical. Further, many of the substances that are being abused have been found to be readily available to young people from local retail shops.

VSA is extremely complex in nature due to the substances involved, the availability of the products and the culture surrounding abuse. Due to this complexity, the need for an inter-agency approach has been advocated. Multiple areas of intervention and prevention have been identified including regulation, education, research, support of vulnerable young people, individual and community health and family and socio-economic issues.

Coroners have made a number of recommendations and comments relating to butane-deaths over the past decade. Several coroners have expressed concerns regarding the availability of abused substances from retailers and have commented on the need for regulation and strategies to address this problem. Other recommendations have discussed the need for a national education campaign and increased publicity to improve knowledge about the risks of VSA and to help curb this dangerous practice.

VI. As a young man with Māori whakapapa, Jordan was among those who the Case Study identifies as being most at risk of VSA. He was 17, which places him at the age range where VSA declines.

VII. In 2013, Coroner Johnson made recommendations following three Inquests into the deaths of three young people from Christchurch, who had died as a result of butane inhalation in a relatively short period of time.[2] Coroner Johnson made recommendations to the Interagency Committee on Drugs (IACD), the Department of the Prime Minister and Cabinet, the Minister of Social Development, and the Associate Minister of Health. She also made recommendations to local councils; Safe Communities Foundation NZ; and to the Media Freedom Committee.

VIII. In a finding from 2016, Coroner McDowell referred to earlier recommendations and comments which have sought to highlight the risks associated with butane inhalation.[3] She also referred to the 2013 Child Youth Mortality

[2] *Inquest into the death of* Samuel John Gold, CSU-2010-CCH-000761, Coroner S P Johnson, 05 July 2013; *Inquest into the death of* Darius Logan Claxton, CSU-2012-CCH-000330, Coroner S P Johnson, 10 July 2013; *Inquest into the death of* Poihaere Eru, CSU-2012-CCH-000626, Coroner S P Johnson, 10 July 2013.

[3] *Inquest into the death of* Jordan Reece Tewani Le'Au, CSU-2014-AUK-000415, Coroner M A McDowell, 08 April 2016 (In Chambers).

Review Committee Special Report: *Unintentional deaths from poisoning in young people* and its recommendations.[4] These recommendations included supporting vulnerable young people, a cross-government focus on youth injury prevention, improving education, inter-agency collaboration and communication (both across government and also wider organisations) and reducing access to substances. Coroner McDowell noted that she had been advised that the Ministry of Health has already taken a number of actions in response to the recommendations made in the CYRMC report.[5]

IX. Coroner Johnson's recommendations have been specifically referred to in other cases involving the deaths of young people who "huff" butane, including in other findings from this year.[6]

X. The New Zealand Drug Foundation website has a video about volatile substances which is intended for New Zealand parents, caregivers, whānau and those working with young people to understand basic facts about inhaling substances.[7] This is a useful resource for conversations with young people. The website acknowledges that while no use is safest, the video can be used to explore the facts about VSA before discussing options.

XI. Earlier cases make it clear that the appropriate agencies are aware of the need for risk reduction around VSA. This means that I do not make any additional recommendations. However, as deaths among young people continue to occur as a result of VSA, and in particular butane inhalation, I consider it worthwhile to urge agencies to continue to build on the work that has been commenced as a result of earlier Coronial recommendations.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Jordan entered into evidence, and any of the details about Jordan's medical or mental health history in paragraphs 31-46, in the interests of personal privacy and decency. It may be reported that Jordan had a history of mental health difficulties including impulsive self-harming behaviour and a suicide attempt, and that he was on antidepressant medication at the time of his death.

Drowning

Anderson and De Bruyn [2020] NZCorC 62 (17 September 2020)

CIRCUMSTANCES

Wayne Anthony De Bruyn, late of Otaki, died at Te Horo Beach, Te Horo on 23 January 2017. The cause of death was consistent with drowning. Mr De Bruyn's friend, Jared Evan Anderson, late of New Plymouth, died at Te Horo Beach, Te Horo, on or about 23 January 2017. The cause of death was drowning.

[4] Child and Youth Mortality Review Committee, Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi "*Special Report: Unintentional deaths from poisoning in young people*" (Child and Youth Mortality Review Committee, August 2013).

[5] Tewani Le'Au, above n3, at [16].

[6] *Inquest into the death of* Tairone Joe Nepi Bryan, CSU-2017-AUK-001668, Judge C J Thompson, 07 August 2020 (In Chambers).

[7] NZ Drug Foundation "Did you know Volatile substances" <www.drugfoundation.org.nz>.

On 23 January 2017, Jeffrey Ward observed Mr De Bruyn and Mr Anderson in an orange inflatable raft floating past him towards the Otaki River mouth. Mr Ward was concerned as he knew the danger of being in such a small boat in this part of the river. He decided to return to his ute nearby to get some rope just in case.

When Mr Ward returned from his ute, the raft was about 100 metres further away from him and only 20 metres from the sea. Mr Ward called the Police at about 1:40pm to notify them that the men were in trouble. He saw Mr Anderson jump out of the raft and try to hold it briefly, standing in water up to his chest, before jumping back on with his legs still in the water. The raft was then carried along very quickly and over the first set of waves. The second set of waves tipped the raft over, with both men entering the water. Mr Ward did not see Mr De Bruyn again. He saw Mr Anderson grab onto the overturned raft and try to pull himself up, but after several more waves hit the raft, Mr Anderson fell off and was not seen again.

Mr De Bruyn was found in surf approximately 15 metres from the shore later that afternoon, but despite extensive search efforts Mr Anderson could not be found. Mr Anderson's body was eventually located and recovered from rocks near Paekakariki on 28 January 2017.

Maritime New Zealand (MNZ) conducted a review of the incident, including an inspection of the raft. MNZ noted several factors contributing to the capsizing and deaths of Mr De Bruyn and Mr Anderson:

a Neither party had any previous boating experience.

b Neither party was wearing a life jacket.

c The raft was not suitable for use in the strong winds experienced on the day, which would have made it very difficult to control.

d The raft was not suitable for the tidal flow – it was likely the speed of the water flow exceeded the maximum speed of the raft (1 or 2 knots).

e The maximum wave height of the raft was cited as 300mm. The waves encountered on the day were in excess of 1 metre, capable of flipping and/or swamping the raft.

COMMENTS OF CORONER FITZGIBBON

I. Maritime New Zealand continues to promote the use of life jackets for all recreational boating activities. This is a sad reminder of the tragic consequences of failing to follow this recommendation.

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

Fall

Ututaonga [2020] NZCorC 64 (18 September 2020)

CIRCUMSTANCES

Taison Mark Ututaonga, aged 26, of Whangarei died on 19 December 2017 at Auckland of multiple blunt force injuries.

Mr Ututaonga lived between Whangarei and Auckland. When in Auckland, he stayed with his cousin, Jade Taka, in an apartment on the 10th floor in an apartment block situated in Auckland central. He was diagnosed with schizophrenia in 2012 and became a patient of the Auckland District Health Board (ADHB). He required intramuscular antipsychotic medication. He last received this medication on 1 December 2017.

During the morning of 19 December 2017, Mr Ututaonga repeatedly came out of his room and asked Mr Taka for cigarettes. Mr Ututaonga said he was feeling sick and hearing voices. While Mr Taka was doing some chores, he was told by his partner that Mr Ututaonga was acting strangely. Mr Taka's son indicted that Mr Ututaonga was on the balcony of the apartment. Mr Taka went to the balcony but could not see Mr Ututaonga. He looked over the edge and saw Mr Ututaonga lying on the ground floor of the apartment complex, beneath the balcony. Another resident who lives on the 7th floor told Police that he heard a man yell and then saw out his window Mr Ututaonga falling past the balcony of his apartment at around 10:42am.

Mr Ututaonga was very unwell on the day of his death and was most likely suffering from an intensification of his psychosis. Given this, he was unable to form the intention to jump off the balcony and was not aware of his actions.

COMMENTS OF CORONER BELL

I. After Mr Ututaonga's death, the ADHB Mental Health and Addictions Directorate conducted an incident review into his death. A review is routinely undertaken following a serious incident related to a patient of ADHB. The purpose is to review the care that has been provided and identify any opportunities to improve the service. Four issues were identified one in particular being that cultural support may have made a difference with engagement, however none was offered to Mr Ututaonga. The recommendation was to achieve an outcome where Māori accessing Community Mental Health Services will have available to them a process for accessing culturally appropriate support.

II. The other three issues identified lack of good documentation and a comprehensive plan, community risk training was unavailable and staff orientation was insufficient to ensure full capability with all expected core tasks. Recommendations have been put in place to address these issues.

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

Fire

Awanui [2020] NZCorC 46 (30 July 2020)

CIRCUMSTANCES

Alan Charles Awanui, aged 57, died at his home at 218 Union Street, Milton on 7 May 2016. The cause of death was smoke inhalation as a result of an accidental house fire.

On 7 May 2016, Mr Awanui's home caught fire. After the blaze was extinguished, Mr Awanui was found deceased inside the house. The New Zealand Fire Service did not find any evidence of smoke detectors in Mr Awanui's home.

COMMENTS OF CORONER TUTTON

I. The importance of having working smoke alarms has been the subject of many public safety campaigns. The Fire Service recommends that wherever possible, hard-wired and interconnected smoke alarms are installed. If the alarms cannot be hard-wired, the Fire Service recommends long-life photoelectric smoke alarms that last for 10 years before needing to be replaced.

II. Given the existing, readily available guidance in relation to the use of smoke alarms, I do not consider it is necessary for me to make recommendations.

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

Leisure Activities

Baldwin [2020] NZCorC 51 (14 August 2020)

CIRCUMSTANCES

Daniel Nils Baldwin, aged 19, died on 17 May 2017 at Wellington Hospital of traumatic subdural haemorrhage sustained during a rugby game.

On 13 May 2017 Daniel was playing rugby in Porirua. In about the 70th minute Daniel tackled a winger from the opposite team. He tackled him front on in the low crouched position at hip height with his right shoulder. As the winger went forward Daniel held on for a couple of metres before releasing. Daniel fell to the ground and when he tried to get up he came back down onto his elbows and shook his head. This was the first indication that Daniel had received a head knock.

When play stopped a few seconds later the referee saw that Daniel was up and walking to join the line out. One of Daniel's teammates noticed that he was unsteady on his feet and told Daniel to get checked and turned him towards the side line. As Daniel walked off, he looked lethargic in his pace and it appeared that something was not quite right. Daniel was dazed and his coach was concerned about concussion. The referee and coach performed a player assessment for concussion. Daniel was quick in his responses but his speech was quite slow and slurry which was not how he usually spoke. He was also chopping and changing his answers saying he did not drive and then he did, and someone needed to drive his car home. The referee recommended that Daniel stay off for the remaining ten minutes.

The referee saw Daniel lose his balance, stumble backwards and end up on the ground. When the referee stopped play to check on Daniel he found that his condition had worsened, his speech was slurred and he started to slip into a lying position. When the game ended Daniel was no longer communicating and his eyes had started to roll back into his head and were flickering. Daniel's level of consciousness had deteriorated rapidly and he had gone limp. The coach tried to

keep Daniel awake by yelling and gently slapping his cheek. An ambulance was attending an incident on another field and players were sent to get it.

Daniel was intubated at the scene and transported to Wellington Hospital with a traumatic subdural haemorrhage. He had surgery for a decompressive hemicraniectomy. Later CT scans showed progressive infarction which meant that he had a further brain bleed. Treatment was withdrawn on 17 May 2017 and Daniel died.

All referees are required to attend a Rugby Smart Course which must be completed annually. It is run by the Regional Development Officer for the areas through Wellington Rugby Football Union. Rugby Smart is primarily about the safety of players and contains aspects of concussion training. The Rugby Smart training covers concussion in detail. Some of the signs of concussion are a witnessed head or neck contact; a player's ability to get up after play; short term memory loss, confusion; feeling nauseous and dizzy; stumbling or being unsteady on their feet, looking lost; the focus in their eyes is not normal and looks lazy; slurred speech; blurred vision or seeing spots; and headaches.

There was a relatively new training initiative available called "Blue Card Initiative" which allows the referees to issue players with a "blue card", if they believe a player is concussed. A player issued with a blue card will be stood down for a period and will require medical clearance before returning to the team. The referee for Daniel's game had not yet completed the Blue Card training at the time of Daniel's death. However, he still had the power (as match referee) to order any player from the field if he suspected concussion.

Daniel's coach had attended the Rugby Smart training. At training the Wednesday before the game there was a discussion and practical session about the technical aspects of tackles so that everyone in the team was fully aware of what makes a good tackle. There were no concerns with Daniel at this training. The team had also recently had training on concussion to ensure they knew what to do and were aware to look out for each other both on and off the field. The players knew they had a responsibility to get a player off the field or indicate to the referee or coach if they thought a teammate had been concussed.

COMMENTS OF CORONER FITZGIBBON

I. Wellington Rugby[8] identified some learnings/recommendations as a result of their report. In their view a safe rugby environment is the paramount consideration in delivering the game at all levels and Wellington Rugby continues to work with NZ Rugby on educating all participants to ensure safety underpins the game's continued existence.

Education

II. Wellington Rugby is conscious that players need to be upskilled on the effects of concussion and is aware of the Rugby Smart players online Module (being trialled at the time):

- Accordingly, Wellington Rugby, through the Coach Development Network (CDO), will ensure a targeted approach to identified groups of players completing the online module this season; with a view to formalising this requirement for all players ahead of the 2018 season.

[8] In their Inquiry Report into Daniel Baldwin Incident.

- Wellington Rugby will also continue to assist clubs in promoting discussion around concussion management. This includes the recent initiative by clubs to workshop the subject with their colt's grade players. A number of clubs have already been engaged in information sharing evenings, which has been supported by WRFU sponsor, Burger King.

Medical

III. Whilst immediate medical attention was provided in this instance it is recognised that such immediate attention is critical to ensuring the best possible care for players when treating serious injury incidents:

- Wellington Rugby has recently clarified Wellington Free Ambulance park access protocols with each of the region's four Council's and communicated this to all member clubs to ensure there is no confusion on what these expectations are.

Reporting/Notification

IV. The reporting of head knocks, and suspected concussion is vital to enable an accurate record on the NZ Rugby player database, which in the long term can assist GP medical records. This includes non-Blue card incidents:

- Wellington Rugby will maintain a register of reported suspected concussions that are not Blue Carded to ensure Graduated Return to Play Protocols are adhered to.
- Wellington Rugby will establish a notification procedure with a definitive timeframe for clubs, schools and WRRA to account for incidents that require the attendance of an ambulance and the hospitalisation of players. This notification will require immediate contact with identified WRFU personnel, for any further escalation as appropriate.
- Wellington Rugby will elevate the initiative with an increased rebate incentive for the balance of the season to drive greater engagement on injury management and reporting to support player welfare.

V. I have considered whether any recommendations or comments should be made for the purposes of reducing the chances of further deaths occurring in circumstances similar to those in which Daniel's death has occurred. From the evidence it is apparent that Daniel sustained an immediate head knock in about the 70th minute of the game. This was seen by his coach, the referee and other players. Within a short period of time, his condition deteriorated significantly, and ambulance staff were alerted. Ambulance staff attended to Daniel within the first few minutes of the head knock and categorised his condition as critical. Regardless of their interventions and transport to hospital, Daniel did not recover.

VI. In my view, there are no recommendations I can make to reduce the chances of further deaths occurring in circumstances similar to those in which Daniel's occurred.

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

Fraser [2020] NZCorC 37 (2 July 2020)

CIRCUMSTANCES

Morgan Ross Fraser of Palmerston North died on 27 June 2017 at Mount Taranaki of multiple traumatic injuries because of a fall from height. He was a soldier with the New Zealand Defence Force holding the rank of Private (PTE).

On 27 June 2017, PTE Fraser set out to climb to the top of Mount Taranaki. He had borrowed crampons, ice picks and a personal locator beacon for the climb. On 28 June 2017 he was reported missing and a search and rescue operation was launched. The search located PTE Fraser at the base of Crater Valley, which is to the west of Ambury's Bluff. He was sadly deceased and was missing his right crampon.

The New Zealand Mountain Safety Council (MSC) prepared a report on the incident to identify any contributing factors and suggest recommendations which may prevent similar incidents of this nature occurring in the future. The MSC considered that PTE Fraser was not suitably experienced for a solo winter climb and that his crampons were not compatible with the boots he was wearing.

COMMENTS OF CORONER FITZGIBBON

I. Given the MSC's clear focus on preventing further outdoor recreation fatalities, they will often make recommendations aimed at preventing accidents like this from occurring again. MSC note that mountaineering is an inherently risky recreational pursuit, and it is often this balance between risk and reward that attracts and motivates climbers, or if not, climbers are at least aware of this fine balance. It is impossible to remove all the risks from mountaineering. The MSC encourages those with the relevant skills, experience and knowledge to undertake outdoor recreation activities, including mountaineering, and in no way suggests people should not get involved in the pursuit.

II. Unfortunately, MSC state that on occasion things do go wrong, and despite the best intentions and actions, serious accidents do occur. Through reviewing all the evidence available and considering at length how this accident can be used as a learning point for others, the MSC encourages all mountaineers to consider the following points:

a. New and aspiring climbers should learn from suitably experienced and ideally qualified alpine instructors. There are a number of suitable courses available around the country;

b. There are multiple different crampon styles available on the market. Each crampon style is designed to suit different types of boots. When planning a trip which will include travelling on snow or ice, carrying crampons which are compatible with your boots is critical. Crampons and boots should be checked for compatibility before every trip, this is essential for anyone hiring or borrowing crampons and boots;

c. Ensure that your climbing objective is compatible with your situation. Always remain vigilant to changes in your environment and when things are not quite going to plan, always be prepared to make the decision to turn around.

III. The recommendations made by the MSC are consistent with current proactive prevention focused messaging delivered by the MSC and its partners and I make no formal recommendations.

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

Keane [2020] NZCorC 68 (30 September 2020)

CIRCUMSTANCES

James William Keane, aged 43, of Wanaka died on 14 October 2018 at Mt Isthmus near Wanaka due to massive subarachnoid haemorrhage.

On the morning of 14 October 2018, Mr Keane and a friend, Dylan Lamoureux, were preparing to fly down Mt Isthmus by speed wing flight. Mr Keane was first to launch. Mr Lamoureux watched as Mr Keane's 'wing' dived forward, slightly to the left. Mr Keane then pulled hard to the right as if he was trying to correct it. As Mr Keane was just getting off the ground he disappeared over the brow of the hill. Mr Lamoureux heard Mr Keane's wing scuffle down the hill and could tell that Mr Keane had landed on the ground with impact. He called out to him but received no response.

Mr Lamoureux found Mr Keane about 150 metres down the hill from the launch site and saw that he was wrapped in his wing. Mr Keane was unconscious and in a serious condition. Mr Lamoureux commenced CPR. A paramedic arrived via helicopter approximately an hour after.

Mr Keane was transported via helicopter to Dunedin Transport but sadly died there the same day.

COMMENTS OF CORONER ELLIOTT

I. The CAA said that speed wing flying comes under *Civil Aviation Rule- Part 106 Hang Gliders-Operating Rules*. This states:[9]

106.5 - Pilot requirements

a. A pilot of a hang glider must—

i. be a bona fide member of a hang-gliding organisation; and

ii. hold an appropriate hang glider pilot certificate; and

iii. comply with the privileges and limitations of his or her pilot certificate and any applicable ratings; and

iv. comply with the operational standards and procedures of the hang-gliding organisation.

b. Despite paragraph (a)(ii), a person who does not hold an appropriate hang glider pilot certificate may operate a hang glider under the direct supervision of the holder of a hang glider instructor certificate issued by a hang-gliding organisation referred to in paragraph (a)(i).

II. The CAA said that training requirements for speed wing flying are established by the New Zealand Hang Gliding and Paragliding Association (NZHGPA).

[9] Civil Aviation Authority of New Zealand: Part 106, CAA Consolidation: Hang Gliders – Operating Rules. https://www.aviation.govt.nz/assets/rules/consolidations/Part_106_Consolidation.pdf

III. The CAA concluded that the current NZHPGA requirements for speed wing flying are ‘suitable for the activity.’ It considered that a further in-depth investigation by CAA was not warranted in this case.

IV. The CAA also noted that speed wing flying ‘comes with elevated levels of risk compared with normal paragliding due to the higher speeds involved and being in very close proximity to the ground.’ The fact that Mr Keane tripped or lost his footing while running during the launch may illustrate this elevated level of inherent risk.

V. In these circumstances, I make no comments or recommendations pursuant to s 57A of the Coroners Act 2006.

VI. A copy of these findings will be sent to the CAA and the NZHGPA for their information.

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.

Worrell [2020] NZCorC 70 (30 September 2020)

CIRCUMSTANCES

Lauren Kimiyo Worrell (Kimi), aged 28, a United States citizen living in New Zealand, died at Castle Rock, Waiau in the Coromandel, on 19 August 2018, from multiple rib and skeletal fractures, crush injuries to lungs, lacerations of liver and spleen, multiple soft tissue injuries, head injuries and blood loss following a fall.

At 9:50am on 19 August 2018 Kimi was rock climbing with her boyfriend Richard Graham at Castle Rock. Kimi had approximately three years of climbing experience in both the United States and New Zealand. She had climbed Castle Rock before.

Kimi and Richard planned to climb the Archibald Baxter route, by first descending the Quiet Earth route. At the top of the Quiet Earth route, two bolts were drilled into the rock face. Hooked onto the bolts was a nylon rope that ran from the top bolt and down the five-metre ledge to the first rappelling station. As Richard was preparing his equipment at the top of the pinnacle he saw Kimi four to five metres below him on the ledge about to go over the steepest part towards the rappelling station. She then appeared to slip, falling over the edge of the ledge and out of his view.

Two other climbers in the area reported hearing a noise above them which sounded like a rock tumbling from the top of the cliff, then hearing a “snap” or “pop”. On looking up, they saw Kimi falling through the air with a full length of rope which appeared to be coiled around her body. They made their way to Kimi finding that she had suffered significant injuries. She was unconscious, but breathing. Some 10 minutes later her breathing stopped and CPR was attempted. However, this was unsuccessful and she died at the scene.

Police examined the scene where Kimi fell and recovered a purple coloured nylon rope and two anchor points. It was noted that the rope appeared to be weathered and fatigued. The lower end of the rope was frayed, indicating the possibility that it had snapped and a further piece was missing. Evidence suggested that Kimi did not anchor herself to a secondary point using her own ropes at the summit of Castle Rock, but instead relied solely on the nylon rope attached to the rock face, which was severely structurally compromised from elemental exposure. As she descended the ledge, she slipped, causing her to fall downwards. While the loop attached to her harness should have prevented her from falling, due to the deteriorated state of the nylon rope, it snapped causing her to fall some 120 metres to her death.

The investigation noted that using a fixed point nylon rope alone was not good climbing practice. Best practice is for climbers to use their own ropes to avoid the potential for single points of failure.

RECOMMENDATIONS OF CORONER ROBB

I. Kimi's death would have likely been prevented had she not used the purple nylon rope to descend the rock ledge.

II. The risks associated with rock climbing are well known. The New Zealand Alpine Club's (NZAC) Rock Climbing Access Framework (2017) states that:[10]

> Recreational rock climbing is not regulated. It is a fundamental climbing tenet that every Climber is responsible for their own actions and safety at all times. NZAC encourages all Climbers to:
>
> - Comply with all access rules and the NZAC Crag Code of Conduct
> - Acquire the necessary skills and knowledge to climb safely
> - Encourage other Climbers to do likewise

III. Furthermore, the NZAC's Climbing Access Framework states that there are no regulations governing the development of rock climb routes. Route developers who attach fixed anchor bolts into rock faces are described as individuals acting privately or as part of a climbing club, "who seek to establish and/or maintain rock climbs". These fixed anchors are described as a "form of fall protection" that allows many types of rock to be climbed and should be installed in accordance with the NZAC's Bolting Philosophy & Standards.

IV. With regard to the Anchor inspection/maintenance of bolting (fixed anchor) practices and hardware, the NZAC Bolting Philosophy and Standards (2017) states:[11]

> Climbers are responsible for checking the safety of bolts that they intend to use. If an issue is identified (such as corrosion, cracking, dangerous placement etc) speak to NZAC or local climbing group.

V. The NZAC Code of Conduct for Rock Climbers (2017) advises that climbers are responsible for managing their own risk:[12]

> Risk is inherent in climbing.
>
> It is the responsibility of each climber to exercise his or her own judgement and discretion at all times when climbing. Each climber must assume total responsibility for his/her climbing safety. That includes assessing the adequacy of any fall protection, whether fixed or temporary (e.g. bolts or trad gear).
>
> Adopt safe climbing practices at all times. Beware of hazards to other users, especially at busy crags and/or crags with loose rock.

[10] https://alpineclub.org.nz/parkside/wp-content/uploads/2018/01/NZAC-1.-Access-Framework_Dec-2017.pdf

[11] https://alpineclub.org.nz/parkside/wp-content/uploads/2016/07/NZAC-3.-Bolting-Standards_Dec-2017.pdf

[12] https://alpineclub.org.nz/parkside/wp-content/uploads/2016/07/NZAC-4.-Code-of-Conduct-for-Rock-Climbers-Dec-2017.pdf

VI. I endorse the above and recommend that all climbers use their own rope systems and do not rely on ropes affixed to rock faces as a single point of safety.

VII. Interested parties, as defined under the Coroners Act 2006, were provided with a draft copy of this finding, comments. The response from NZAC included their suggestion that having climbing organisations take responsibility for ropes and fixings on climb routes would be problematic. Identifying which entities fall within the descriptor 'climbing organisation' is difficult to definitively determine. As climbing is an unregulated individual pursuit, having clubs or other organisations taking responsibility for ropes and fixings would not be a pragmatic way of managing risk. There is no national entity in a position to identify every climbing route in New Zealand and monitor and maintain the ropes and fixings that any individual may have placed on any given route.

VIII. The NZAC proposed the following recommendations:

i. Amend the NZAC's Rock Climbing Access Framework to discourage the installation and use of fixed ropes, slings and other soft equipment, to prevent climbers from being placed in a situation where reliance on weathered soft equipment is an option; and

ii. Consider, if practicable, additional functionality to ClimbNZ (the online database of climbs hosted by the NZAC) to allow climbers to self-report on safety issues associated with climbs.

IX. I am grateful for the pragmatic recommendations put forward by the NZAC. I consider those measures may reduce the risk of death occurring in similar circumstances in the future, and formally adopt the above two recommendations accordingly.

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

Medical Care

Sutherland [2020] NZCorC 45 (29 July 2020)

CIRCUMSTANCES

Murray John Sutherland, aged 58, of Christchurch died on 16 June 2017 at St George's Hospital, 249 Papanui Road, Christchurch from blood loss, left haemothorax and cardiac tamponade secondary to a leaking and thrombotic anastomosis following coronary bypass grafting surgery.

In February 2017, Mr Sutherland was diagnosed with ischemic heart disease affecting two coronary arteries. A later echocardiogram identified a prior myocardial infarction and a left ventricular ejection fraction of 45%, indicating a degree of reduced cardiac output. He was referred for cardiac surgery (coronary artery bypass grafting).

In advance of surgery, Mr Sutherland attended an outpatient appointment where usual pre-operative assessment and investigations occurred, and the surgery was performed at St George's Hospital, on 14 June 2017. The surgery itself was unremarkable and he was transferred to the Intensive Care Unit (ICU) for recovery.

On 15 June 2017 Mr Sutherland's kidney function deteriorated. His doctor considered that the deterioration was due to the surgery and Mr Sutherland's poor diabetic control. A patient with renal failure can have sudden changes in the salt level in the blood, particularly potassium, which in turn can cause cardiac dysrhythmias and in severe cases, cardiac arrest. Accordingly, he was kept in the ICU for an additional day to ensure that no complications arose. Two anti-platelet medications were administered, aspirin 100mg and clopidogrel 75mg (both daily) commencing at 10:00am.

On the evening of 16 June 2017 Mr Sutherland went into cardiac arrest from which he could not be revived, despite immediate CPR, intubation, and the reopening of his chest.

A post mortem examination noted that when Mr Sutherland's chest was re-opened following his collapse, approximately one litre of blood was found in the left lung cavity comprising a mixture of blood and blood clot. That accumulation of blood would have caused his cardiac arrest by preventing his heart from beating adequately.

The Coroner sought an expert opinion from Mr Peter Alison, an Auckland based cardiothoracic surgeon, on the level of care received by Mr Sutherland. Mr Alison queried the use of aspirin on day one post-surgery, as Mr Sutherland had a rising creatinine level, and preoperative renal impairment. Mr Alison also noted that clopidogrel was administered on day two post-surgery. The rationale for its use was to achieve an improvement in graft patency, although it can increase the rate of bleeding post-surgery.

Mr Alison opined that combining aspirin therapy with clopidogrel leads to potent synergistic antithrombotic effects, that increases the risk of major bleeding after surgery. This risk must be weighed against the benefits the medications may provide in maintaining the patency of the grafts.

The Coroner held that it seemed unlikely that Mr Sutherland's death could have been prevented and there was no suggestion of surgical error, or failings on the part of the clinicians involved. However, the Coroner noted that much had been written on the use of clopidogrel in conjunction with aspirin in the perioperative period, but there does not appear to be a consensus in the literature as to the benefits of its use.

RECOMMENDATIONS OF CORONER ROBINSON

I. I recommend that the Canterbury District Health Board and St George's Hospital review their protocols as to the administration of clopidogrel post coronary artery bypass grafting surgery, including by reference to the literature cited herein.

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

Waitohi-Hohepa [2020] NZCorC 53 (27 August 2020)

CIRCUMSTANCES

Henare Parata Waitohi-Hohepa, aged four months, died on 17 June 2016 at 122 Chichester Drive, Rosehill, Papakura, Auckland as a result of sepsis caused by underlying MRSA (methicillin-resistant staphylococcus aureus) and S pyogenes bacteraemia.

On 13 May 2016 Henare's mother took him to his GP as he had a few blisters on his trunk and one on his right arm but was otherwise well. He was given a trial of an antibiotic cream used for skin infections. Henare was taken back to the GP on 19 May 2016 as he had had sores on his head for two days. The sores on Henare's hand and trunk had improved but the GP noted that the sores on his head were moist and weepy with a yellowy discharge. He was eating and drinking well and did not have a temperature. The GP's impression was that Henare had infected dermatitis or a wound infection and prescribed a seven day course of antibiotics.

Henare and his mother returned to the GP on 15 June 2016 about the sores on his head. She reported that the sores had been getting better with the medications, but they had run out. The GP noted that Henare had a moist weepy discharge and their impression was that he had recurrent seborrheic dermatitis. The GP prescribed a seven day course of the same antibiotics and planned to review Henare and do a full baby check the following week.

At approximately 9:00am on 16 June 2016, after being fed and winded, Henare was placed to sleep on his back on a mattress on the bedroom floor. He remained there whilst his mother helped her other children. Henare was found unresponsive by his mother at approximately 9:20am and was unable to be resuscitated.

The pathologist advised that Henare had an external weeping rash on his head and neck that were probably the source of the blood borne infection, MRSA, which is a type of bacteria that is resistant to several antibiotics.

The Coroner noted that Henare's mother was an experienced mother. She was conscious of monitoring Henare's health and was prepared to seek medical help if concerned. She took Henare to the doctor three times in the five weeks before he died so that his skin could be assessed, and treatment prescribed. She had no reason to think that Henare would develop a life threatening infection as a result of the skin infection and she noticed no particular signs or symptoms that made her concerned that Henare was acutely unwell in the hours before his death.

COMMENTS OF CORONER GREIG

I. This is not a matter on which I consider recommendations to be appropriate. However, I highlight to the Child and Youth Mortality Review Committee to whom this finding will be sent, that this is the third matter which I have considered recently in which a baby has died suddenly at home from what has subsequently been found to be an infection, without the parents noticing symptoms of illness or deterioration in the baby in the immediate period before the death.

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

Watson [2020] NZCorC 52 (25 August 2020)

CIRCUMSTANCES

Violet Florence Watson, aged 78, died on 29 April 2019 at Auckland Hospital of pneumonia and respiratory failure, complications that followed injuries Mrs Watson sustained as a result of a falling accident on 18 April 2019.

On 18 April 2019 Mrs Watson travelled to Waiheke Island with two friends. The group intended to spend several days at a holiday home. That evening, they were socialising in the loungeroom of the holiday home. The lounge had sliding

doors onto a deck area at the front of the property. Around 11:00pm Mrs Watson went outside onto the deck, through the sliding doors, to smoke a cigarette. Shortly afterwards her friends in the lounge heard a sound from the deck. They went to see what had happened and located Mrs Watson lying on the ground below the deck. She was lying on her right-hand side, facing away from the deck, around two metres from the deck edge on the other side of a timber retaining wall.

An ambulance was called and Mrs Watson was taken by helicopter to Auckland City Hospital where she was diagnosed with multiple injuries. Her condition continued to deteriorate with pneumonia and respiratory failure until she died on 29 April 2019.

Auckland City Council reported that the owners of the holiday home applied to the Council in 2003 for consent to make alterations to the living room of their existing dwelling and to construct a new deck. The application included architectural designs for the deck, which recorded: “Deck under 1.0m” and “Deck (new) not to exceed 1.000 in height above the ground.” The design made no provision for barriers or railings on the deck. Consent was granted on 26 June 2003 and recorded that there were to be four proposed inspections of the dwelling alterations. Two of these were related to the deck: inspection of the foundations and the final inspection.

Records indicate that, in this case, a single inspection was conducted in early 2004 and did not include the construction of the deck (which had not then begun). There is no record of any subsequent inspections. The building owners did not request that the Council subsequently inspect the deck. They also did not apply for a Code Compliance Certificate.

The relevant and mandatory structural requirements to prevent falling accidents were contained in clause F4, Schedule 1 of the Building Regulations 1992 (known as the Building Code, under Part VI of the Building Act). It stipulates:

> **Clause F4 – Safety from falling**
>
> **Objective**
>
> F4.1 The objective of this provision is to safeguard people from injury caused by falling.
>
> **Functional requirement**
>
> F4.2 Buildings shall be constructed to reduce the likelihood of accidental fall.
>
> **Performance**
>
> F4.3.1 Where people could fall 1 metre or more from an opening in the external envelope or floor of a *building*… a barrier shall be provided.

The Building Code gave no direction as to how this measurement should be made. According to the Council, at the time this deck was constructed there was no uniformly-held view amongst building practitioners as to how minimal or maximal distances should be measured. While measurements are readily determined between hard surfaces, difficulties can arise when one surface is not solid, such as soil.

The Building Act 2004 overhauled the regulatory environment applying to building construction. Under the 2004 Act, regulations may be made specifying that there is only one means of complying with a provision of the Building Code.

Where regulations are made, compliance with them is mandatory. Where regulations are not made, a person can comply with the Building Code "by any means", including by complying with an acceptable solution.[13]

When inspected by Council officials subsequent to Mrs Watson's death, the deck was found to be structurally sound, well-braced and to in some respects exceed the Code requirements (for example, it rested on more piles than was required). The deck had barriers at each side. On the right side (when viewed from the lawn) was a slatted visual screen. On the left was a barrier seemingly constructed to prevent falling and built to the F4 standard. The latter barrier extended around the front of the deck, but by less than one metre in length. The rest of the front of the deck had no barrier. When measured by Council officials the deck's height was slightly over one metre. On the left side (when viewed from the front lawn) the deck's height was 1105mm, and on the right was 1035mm.

The Council acknowledged that the amount by which the deck exceeded the one metre specification "would be considered minor", but that if vertically measured at the time of construction the deck would have failed the inspection. The characteristics of the 'fall area' below the deck were of greater concern. These included a sloping lawn down to the timber retaining wall, and then a further slope in the lower section of lawn below the wall and further from the deck. The timber retaining wall was located about 900mm from the deck edge and was around 300mm in height. Because the lawn below the deck sloped downhill to the retaining wall, the wall sat above the upper lawn by around 110mm, as a timber ridge running the width of the lawn. The lower lawn below the wall was a further 300mm drop. The Council described this wall as "in a position and distance where it would create a significant hazard to any person falling on to it from the deck."

The Council explained that, at the time of the deck's construction, territorial authorities generally applied principles of 'total fall', rather than measuring the simple vertical height of a surface. Subsequent to the construction of the deck, the Department of Building and Housing issued Determination 2008/081[14] to reflect and require the 'total fall' approach. Because a falling person would normally pitch forward, on sloping ground the measurement would not be taken at the point of initial impact but at the point where the fall would be arrested. The status of this Determination is that it was legally binding as between the parties to the determination (the property-owners and the Department) but it is to be treated merely as guidance in other similar cases.

Applying that approach, the Council noted that a fall from this deck of around 1.5 metres was possible due to the slope of the lawn and the step down from the retaining wall. It was noted that "regardless…of which method is used to measure the height, it would not comply presuming the ground level is unchanged since the deck was built." There was no evidence of shifts in the ground level over the time since the deck was constructed.

The evidence established that the deck was structurally sound but omitted safety barriers along the full frontage of the deck sufficient to prevent falls. It is apparent that a fall of more than one metre was possible from the surface of this deck. The slope of the lawn made it likely that a person falling from the deck would not be arrested at the point of impact but could continue to fall for some distance.

[13] Section 21(2) Building Act 2004.

[14] Determination 2008/081 "Safety Barrier to a deck located adjacent to a retaining wall at Oraka Beach Road, Mahia" Department of Building and Housing 28 August 2008 available at https://www.building.govt.nz/assets/Uploads/resolving-problems/determinations/2008/2008-81.pdf.

Consistently with those identified risks, following her fall, Mrs Watson was found approximately two metres from the deck edge and on the other side of the retaining wall. The retaining wall represented a significant additional hazard to any person falling. It projected above the upper lawn surface by 110mm and had a sharp upper edge.

The Coroner considered that the weight of evidence compelled a finding that the causes of the injuries Mrs Watson sustained when falling were:

a the lack of any safety barrier or railing across most of the frontage of the deck;

b the slope of the lawn beneath the deck, which would not have immediately arrested Mrs Watson's fall; and

c the retaining wall edge which projected upwards from the lawn surface.

RECOMMENDATIONS OF CORONER BORROWDALE

I. Having given due consideration to all of the circumstances of this death, I consider that there are comments and recommendations that can usefully be made pursuant to section 57(3) of the Coroners Act 2006. These comments and recommendations are made for the purpose of reducing the chances of further deaths arising in similar circumstances.

II. I make these comments and recommendations having first consulted with the Council and MBIE pursuant to section 57B of the Act.

III. I make the following comments pursuant to section 57(3) of the Act:

a. I consider it likely that a contributing cause in Mrs Watson's death was the lack of prescription as to how the falling distance from this deck should have been measured by those involved in its construction. It seems to me likely that the builder measured the distance between the deck and the soil beneath the deck, and that this was 'near enough' to 1 metre – or may have been in fact 1 metre, if allowance is made for possible soil movement over time – that the deck was considered to comply with the building consent, and therefore to not require a barrier to be installed across it.

b. It is apparent that the builder cannot have applied a 'total fall' approach to measuring the deck, or it would have been obvious that the fall distance substantially exceeded 1 metre.

c. In my view a preferable approach is that reflected in Determination 2008/081. This Determination adopts, and prescribes in that instance and for that subject property, a 'total fall' measurement approach. Under that approach, it was determined that "the fall height cannot be calculated just in terms of the vertical height above the surface immediately below it." Rather, the fall height must be measured to take account of the steep slope in front of the deck, down which a person could tumble if they fell.

d. However, the utility of that Determination is limited. It binds only the Department of Building and Housing and the property owners who sought the determination.

e. As the Determination indicates, the potential for such measurements to matter is not limited to the property at which Mrs Watson was injured. There is a wider public interest in the safety of decks and other structures from which persons might fall, and it is not in my view satisfactory for the measurements on which safety barriers depend to be subject to discretionary decision-making by owners or their builders.

f. The Council stated in response to my consultation that it supported the Chief Executive of MBIE giving active consideration to clarifying and requiring a 'total fall' measurement approach to structures to which the F4 standard applies. Council considered that "clarity on how to measure 'fall' in Clause F4 of the Building Code would be useful."

g. MBIE responded by way of stating as follows:[15]

> At this time MBIE is of the view that the regulations set an appropriate level of performance.
>
> MBIE acknowledge that there may be circumstances where the risk to people could increase due to ground features in the immediate fall area. MBIE currently provides additional fall measurement guidance on its website – refer https://www.building.govt.nz/building-code-compliance/f-safety-of-users/f4-safety-from-falling/barriers-and-handrails/. This guidance is to assist people to comply with the requirements of Building Code clause F4 – Safety from falling. Included in this guidance is consideration of the ground features such as sloping ground beyond the fall area.
>
> MBIE is considering a number of technical improvements to the safety from falling provisions within the F4 Acceptable Solution and will include your recommendation as part of the content to review.

IV. I am grateful to MBIE for directing my attention to this website resource, which does provide helpful guidance on how to measure the fall from a deck where there is a sloping surface beneath. My recommendation below accordingly reflects the commitment that MBIE has given that it will consider providing further guidance within the standard.

V. I therefore make the following recommendation pursuant to section 57(3) of the Act:

a. That when considering making technical improvements to the safety from falling provisions within the F4 standard, the Chief Executive of the Ministry of Business, Innovation and Employment should give active consideration as to whether a 'total fall' measurement approach to structures should be expressly prescribed in the standard.

Rationale

VI. The purposes of this recommendation are to:

a. encourage the making of further prescriptive regulation to ensure that Clause F4 "Safety from Falling" of the Building Code is given greatest efficacy; and

[15] 3 July 2020 letter from John Sneyd, General Manager, Building System Performance, MBIE.

b. to prevent injuries or fatalities from falls from buildings, in circumstances where a barrier on the building was properly required.

VII. This death may have been prevented if the deck at the property had been apprehended by the builder as having a fall distance of greater than 1 metre.

VIII. The intention of drawing public attention to this recommendation is that those who regulate the safe construction of buildings have powers available to them to enhance the mandatory prescriptions that protect against falling injuries or fatalities.

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

Motor Vehicle

Bano [2020] NZCorC 38 (3 July 2020)

CIRCUMSTANCES

Tahiran Bano of Miramar died on 19 March 2016 at Wellington Hospital from a severe head injury she received as a result of being struck by a motor vehicle on 11 March 2016 on Cobham Drive in Wellington.

Cobham Drive is part of State Highway 1. The road has a posted speed limit of 70 km/h and consists of four lanes, two in each direction. These are separated by a median strip which is covered in established bushes that in some sections have grown to the road edge.

Mrs Bano was attempting to cross the east bound lanes of Cobham Drive while on her way to visit her son and then meet her husband, Mohammed Shafi. The location where Mrs Bano chose to cross Cobham Drive was partly round a sweeping right-hand bend with high bushes on the median strip. This location did not offer her a good view of the traffic approaching from the east. The drivers travelling towards her from the east had an equally poor view of her.

COMMENTS OF CORONER FITZGIBBON

I. At the time of this crash there were no pedestrian crossings, bridges or underpasses along the section of road where pedestrians can cross the road safely. The only crossing available was at the intersection of Cobham Drive and Evans Bay Parade and this crossing is 1.1 km west of the crash location. Constable Lisa Toseland comments in her report that considering the ASB Sports Centre is used by a wide demographic of people, and the Kilbirnie shopping centre is a large shopping precinct, there are limited means for those walking, especially from the eastern suburbs to follow the most direct yet safest route to their intended locations.

II. Mr Shafi has raised concerns about pedestrian safety on Cobham Drive after the death of his wife and wants to ensure that another family does not have to go through a similar situation in the future. At the time of completing these Findings the Wellington City Council through the Let's Get Wellington Moving Program, plans to make it safer for people to cross some of the busier roads including Cobham Drive. Consultation on options for helping people on

foot and on bikes to safely cross Cobham Drive is likely to happen in mid-2020. A safe crossing would connect with new paths under construction on the seaward side of Cobham Drive, around Evans Bay, and new paths in and around Kilbirnie.

III. Due to this I will not be making any formal recommendations however a copy of this finding is to be sent to the Wellington City Council for their consideration during the consultation process for safe crossing options on Cobham Drive.

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

Carrick [2020] NZCorC 66 (28 September 2020)

CIRCUMSTANCES

Zackery Levi Henry Carrick, aged 20, died on 21 August 2018 at Aldwins Road, Christchurch of multiple injuries.

At approximately 6:15pm on 21 August 2018, Mr Carrick was riding his Yamaha motorcycle in a north-easterly direction on Aldwins Road. At that time, Lorraine Michell and her husband were driving in a Nissan Leaf vehicle. Ms Michell was driving south-west on Aldwins Road, with the intention of doing a U-turn at the right turning bay near the intersection of Edmonds Street. She entered the turning bay, awaiting a break in the traffic to complete the U-turn.

Mr Carrick's motorcycle approached from the south-west. He was overtaking other vehicles and was travelling at between 108.5 and 127.5 km/h. The speed limit in the area was 60 km/h. As Ms Michell turned to the right to perform the U-turn, the headlight of Mr Carrick's motorcycle was behind or beside an oncoming car. Mr Carrick braked but collided with the passenger door of the Nissan. He was thrown from the motorcycle and died as a result of the multiple injuries he sustained. Mr Carrick's excessive speed contributed to the collision.

COMMENTS OF CORONER ELLIOTT

I. Waka Kotahi/NZ Transport Agency states on its website:

> The single biggest road safety issue in New Zealand today is speed – drivers travelling too fast for the conditions.
>
> Speed affects all crashes. It can be a factor in causing them and it has a direct effect on the damage done in a crash. It is clear from the crash statistics that many people underestimate how changing conditions, such as wet weather, can increase road risk.
>
> In 2019, speeding was a contributing factor in 73 fatal crashes, 408 serious injury crashes and 1,457 minor injury crashes.
>
> …
>
> The speed limit is the maximum legal speed that you can travel at on a road in perfect conditions.
>
> …
>
> The faster you drive, the more likely you are to crash. As your speed increases:

- the distance you need in order to stop increases
- there is a greater probability that you will be going too fast if you meet an unexpected change in road conditions
- there is a greater chance that other road users will misjudge how fast you are travelling.

The severity of injuries resulting from a crash is directly related to the impact speed of the vehicle – whether or not speeding was a factor in the crash.

II. Waka Kotahi has been conducting a speed road safety advertising campaign.

III. In order to reinforce this message, I make the following comments pursuant to s 57A of the Coroners Act 2006:

On 21 August 2018, Zackery Levi Henry Carrick was riding a motorcycle on Aldwins Road Christchurch when he collided with a vehicle which was in the process of making a U-turn. Mr Carrick was travelling at between 108.5 and 127.5 km/h. The speed limit in the area was 60 km/h. Mr Carrick's excessive speed contributed to the collision. His death illustrates the danger of driving at excessive speeds.

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

Hartigan [2020] NZCorC 42 (16 July 2020)

CIRCUMSTANCES

Chloe Hope Hartigan, aged 17, of Karikari Peninsula died on 1 January 2017 at Oruru Road, Taipa of massive chest injuries.

At 2:10am on 1 January 2017, Ms Hartigan was walking south on Oruru Road, Taipa. The roadside was uneven and the area was unlit. Ms Hartigan stumbled into the southbound lane and was struck by a Toyota Hiace van travelling in the same direction. Ms Hartigan died at the scene.

The Serious Crash Unit report noted that it would be prudent for a pedestrian walking in this area to walk on the opposite side of the road, so they are facing the traffic approaching them.

COMMENTS OF CORONER BELL

I. I endorse the comment made by the SCU that it would be prudent to walk on the opposite side of the road, facing the oncoming traffic.

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

Leef [2020] NZCorC 44 (24 July 2020)

CIRCUMSTANCES

Wayne Damian Leef, aged 49, died between 12 July and 13 July 2017 at Mitimiti beach, Northland, from asphyxia (sea water and sand) as a result of a motorcycle crash on the beach.

On the evening of 12 July 2017 Mr Leef was riding his Suzuki motorcycle on Mitimiti beach, when he crashed and came off the motorcycle. Although it is not known why Mr Leef crashed, he was not wearing a helmet, the motorcycle's front light was not working, and it was dark and raining at the time. Toxicology testing also showed that the level of alcohol in Mr Leef's blood exceeded the legal blood alcohol limit for a New Zealand driver.

COMMENTS OF CORONER MCDOWELL

I. Mr Leef's death is a tragic reminder of the need to wear a helmet when riding a motorcycle. This is applicable to both on and off-road motorcycles. Whist it cannot be said that a helmet would have prevented Mr Leef's death, helmets do reduce the likelihood of head injury in the event of a crash.

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

Liebl, Shortland J, Shortland S [2020] NZCorC 49 (7 August 2020)

CIRCUMSTANCES

Marina Liebl, Jesse Phillip Ariki Douglas Shortland, and Samantha Jade Shortland died on 8 October 2017 at Dipton from multiple traumatic injuries sustained in a motor vehicle crash.

Ms Liebl was a tourist from Germany. On the morning of 8 October 2017, she hired a car from a rental car company in Queenstown. To be eligible to hire the car, the rental company required, and Ms Liebl completed, a "Safe Drive" form. The form, prepared by the rental company, was a self-assessment tool intended to evidence that Ms Liebl (as a foreign driver) was familiar with the New Zealand road rules; had driven regularly in her home country; felt well prepared to drive in New Zealand; and had driven a similar vehicle in the past.

On the evening of 8 October 2017, while traveling on the Dipton-Winton Highway (in an area known as Benmore) Ms Liebl's vehicle departed from the correct lane into the path of the vehicle occupied by Mr and Mrs Shortland, following which the vehicles collided. Analysis of the crash revealed that both vehicles were travelling at excess speed and fatigue likely contributed to Ms Liebl moving into the oncoming lane. Examination of her vehicle showed that it appeared to have hit at approximately a 30-degree angle which was not consistent with a traditional head-on collision. It could not be determined if Ms Liebl departed her lane because she was not accustomed to driving on the left-hand side of the road.

The Coroner determined that the Safe Drive Form was inadequate as it provided no effective evaluation of the person's ability to drive in New Zealand, nor of their knowledge of the road rules. He considered studies by University of Otago researchers, Neil Carr and Ismail Shaheer, who identified that only a limited proportion of respondent overseas drivers were able to satisfactorily complete a questionnaire based on the theory test that is a prerequisite to the obtaining of a New Zealand drivers' licence.

The study identified that there appeared to be a serious gap in the knowledge of self-drive international visitors to New Zealand regarding the driving rules in the country. As such, it lends weight to concerns about the preparedness of international visitors to take to the roads of New Zealand without putting themselves and/or other road users at risk. The Coroner noted that further research was needed but did observe that the number of self-drive international visitors to New Zealand was only likely to increase in the future. Accordingly, the development of a cohesive plan to increase self-drive international visitor knowledge of the rules and safety practices related to driving in New Zealand was needed. The Coroner noted that this plan needs to include the provision for the development of effective tools to aid international visitors. Such a route is important for the continued health of the national tourism industry and the welfare of all road users. Putative measures that seek to ban international visitors from New Zealand roads are not a solution that will benefit the country.

RECOMMENDATIONS OF CORONER ROBINSON

I. While I cannot make a sufficient link between the "Safe Drive" form process, the apparent lack of knowledge of overseas drivers of New Zealand road rules and the circumstances of this crash in order to make formal recommendations or comments, I would certainly encourage rental car companies to reflect on the research cited and my remarks above and consider introducing some qualitative assessment into the process for determining whether to rent a vehicle to an overseas driver.

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

MacIntosh [2020] NZCorC 54 (28 August 2020)

CIRCUMSTANCES

Eric Robert MacIntosh, aged 79, of Wellington, died on 6 May 2017 from multiple injuries received in a motor vehicle collision.

On 4 May 2017 at around 2:40pm Mr MacIntosh was driving his Kia Rio car on State Highway 2 at Clareville Straights, between Carterton and Masterton in the Wairarapa, when witnesses observed his car to swerve within its own lane, in big "lazy" swerve movements. Mr MacIntosh's head was seen to be "bobbing up and down", before his car swerved more widely, crossing the centre line and colliding head-on with another vehicle.

Emergency services attended the scene and noted that Mr MacIntosh was diabetic, from his Medic Alert bracelet. Police speculated from Mr MacIntosh's blood glucose levels taken by paramedics, that he had a diabetic hypoglycaemic event while driving. Mr MacIntosh was airlifted to Wellington Hospital, however was unable to recover from his extensive injuries and died on 6 May 2017.

A Serious Crash Unit investigation was conducted which identified that a causative factor was the "high likelihood" that Mr MacIntosh had experienced a hypoglycaemic low prior to crashing. A contributing, but not causative, factor was that Mr MacIntosh's vehicle had an imbalance in the rear tyre pressure, which could cause instability when cornering. Lastly, the Unit recorded for 'special notice' (but not as a contributory or causative factor) that the road markings in this area did not have a tactile profile. Had these been present, Mr MacIntosh would have been provided with an early indication he was leaving his own lane.

COMMENTS OF CORONER BORROWDALE

I. In its report the Serious Crash Unit identified a roading improvement that could be made: that an Audio Tactile Paint strip (ATP – rumble strip) could be installed along the centre line, to provide audible and sensory feedback to both driver and occupants should their vehicle stray from its designated lane.

II. I notified this suggested roading improvement to the New Zealand Transport Agency (NZTA, the agency responsible for this section of road) for its comments.

III. The NZTA responded to this suggestion with its confirmation that ATP markings on road edges and centrelines have significant safety benefits, in reducing the occurrence of run-off-road crashes and centre-line crashes. NZTA has published guidelines on its use of ATP markings.[16]

IV. NZTA advises that in September 2017 this section of the Clareville Straights on SH2 underwent reinstatement of an ATP strip, in accordance with the best practice standards specified in these Guidelines.

V. Having given due consideration to all of the circumstances of this death, and given NZTA's confirmation that ATP markings are now present at the site of this crash, I do not consider there are any other comments or recommendations that could usefully be made pursuant to section 57(3) of the Coroners Act 2006.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Eric Robert MacIntosh during this inquiry following his death in the interests of decency.

McMurtrie [2020] NZCorC 50 (11 August 2020)

CIRCUMSTANCES

Robin Laurence McMurtrie, aged 83, of Hokitika died on 25 January 2016 at Grey Base Hospital, Greymouth of acute heart failure, as a result of several heart conditions and the trauma of the vehicle accident (including a fracture dislocation of the right pelvis.

Following a stroke in August 2015, Mr McMurtrie used a mobility scooter. His vision had also been worsening and he was incapable of judging depth. At approximately 4:20pm on 25 January 2016 Mr McMurtrie was riding his mobility scooter westwards on Hampden Street in Hokitika. He came to a stop at the intersection of Hampden and Fitzherbert Streets. After waiting a while, Mr McMurtrie rode into the junction. At the same time, a Holden SUV was driving southbound on Fitzherbert Street. The driver saw the mobility scooter pull out and braked suddenly but was unable to avoid colliding with it. The mobility scooter was pushed onto its side and Mr McMurtrie was thrown from it. He was taken to Grey Base Hospital where he later died.

RECOMMENDATIONS OF CORONER KAY

[16] 2010 NZTA New Zealand Guidelines for Using Audio Tactile Profiled (ATP) Roadmarkings https://www.nzta.govt.nz/assets/resources/audio-tactile-profiled-roadmarkings-guidelines/docs/atp-guidelines.pdf . These Guidelines confirm the safety benefits of ATP markings, and state that research establishes that they reduce centreline crashes by 30% on average.

I. There is no evidence that Mr McMurtrie did not know how to properly operate the controls of his scooter, or that he was physically unable to properly operate them.

II. The current legal framework does not allow anyone to insist that a mobility scooter user has a medical assessment before being allowed to use, or continue to use, such a device. However, the current legal framework does allow Police officers to discourage users of mobility scooters operating on the road - according to rule11.1(2) of the Land Transport (Road User) Rule 2004, a driver must not drive a mobility device (of which a scooter is a type) on any portion of a roadway if it is practicable to drive on a footpath. Whilst cognisant of the many demands placed upon Police officers, pursuant to section 57(3) of the Coroners Act 2006 I recommend that when Police officers see a mobility scooter being used on the roadway, they speak to the user about the safety risks they face by doing so, and educate the user regarding the legal framework.

III. Taking into account that this is not the first time in New Zealand that a user of a mobility scooter has died as a result of using a mobility scooter on the roadway, pursuant to section 57(3) of the Coroners Act 2006 I recommend that the Ministry of Transport:

a. consider issues of education of the users of mobility scooters and their safe operation, particularly when crossing roadways; and

b. consider any means of ensuring that the health of users of mobility scooters is of the standard required to safely operate them in public environments.

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

Tapurau [2020] NZCorC 48 (4 August 2020)

CIRCUMSTANCES

Pai Tairuia Tapurau of Putaruru, aged 55, died on 24 May 2018 on State Highway 28, Tapapa, of severe head injuries and multiple rib fractures as a result of a motorcycle accident.

On the afternoon of 24 May 2018, Pai was riding his motorcycle on State Highway 28. As he approached a right-hand bend, an associate travelling behind him observed a large smooth section of road towards the right-hand side of the lane, with potholes and tar seal breaking on the left side of the lane. Pai remained on the right side of the lane and rode over the smooth patch of tar seal. The back wheel of his motorcycle slid as he was negotiating the bend and he was thrown from his motorcycle.

The Serious Crash Unit (SCU) investigated the crash. The road was examined and found to be in poor condition leading up to, and at, the accident site. The left side of the southbound lane was very different to the right side. The right side, where Pai was riding, showed signs of polishing and flushing where the tar and binder material was at the top of the surface and there was very little chip seal exposed. The left side, where Pai's associate was riding, showed signs of cracking, broken patches and potholes (some of which had been unsuccessfully repaired with asphalt seal). The centre of the lane was raised, forming a ridge line.

The Coroner considered numerous possible contributing factors to Pai's death including:

- It would have been especially difficult for a motorcycle to navigate the undulating nature of the road surface with limited friction available on the section that Pai rode, particularly around a curve when the road was wet. There was a separate recent incident with a motorcycle at or near the same location, with a less serious outcome. The complaint on that occasion being that the rider had crashed due to encountering a flushed patch of road.
- The helmet that Pai wore was unsuitable for its purpose and wearing a more suitable helmet may potentially have reduced the level of his head injury and consequently reduced the risk of his death in this accident. There is no direct medical evidence that this would have prevented his death, the impact was clearly significant with Pai suffering fractured ribs as well as the head injuries. However, the Coroner acknowledged the SCU advice that the helmet was of poor quality so there remains a possibility that this was a factor in his death.
- Pai had consumed cannabis some time in advance of his death. Cannabis remains detectable for 21 days or more, but the psychoactive effect lasts only hours. Precisely when and in what quantity he consumed cannabis is unknown and in theory this could have been a contributing factor. However, the witness and physical scene evidence establishes that Pai was riding at a moderate speed, well below the speed limit, and his riding behaviour showed no indication of risk-taking, recklessness, or inattention. There was nothing in the evidence to indicate that he was intoxicated at the time that he slid on the smooth road surface. There is no evidence to indicate that his consumption of cannabis at an unknown time or date left him intoxicated at the time of the accident.
- It is possible that Pai was less familiar with the motorcycle that he rode on this day, there is potential that this may have negatively impacted on his ability to control the motorcycle on a difficult road surface.

The Coroner found that the condition of the road was the most significant contributing factor leading to the accident, and as a result to Pai's death. The New Zealand Transport Agency is responsible for maintaining state highways in New Zealand. State Highway 28 is classified as a regional distributor highway (RDH), the lowest classification of state highway under the One Network Road Classification system. Downer is contracted to carry out maintenance and repair State Highway 28.

A matrix system is used to classify priority of maintenance works in each monthly programme. Depending on the classification, work may not be completed in that month as other priorities arise. The uncompleted work is then rolled over into the next month's programme. Downer is then required to reinspect the network monthly to review work needs which includes reprioritising of any defects already recorded in the system that have not yet been completed. Maintenance can be subject to a Principal Intervention Period (PIP).

For the purposes of this inquiry NZTA explained a PIP:

> *The correct interpretation of the contractual Principal Intervention Period (PIP) is as follows:*

Given its status as a Regional Distribution Highway (RDH), any work on State Highway 28 would warrant a high priority when either a third party, The Transport Agency or the Contractor's own routine inspections determine that a defect constitutes a potential safety hazard.

PIP means the period in which the contractor must rectify any particular instance of a defect that is identified by a third party, the Principal or the Contractor, and constitutes a potential safety hazard, may adversely reflect on the Principle or is considered offensive, regardless of whether or not compliance with the contract standard is being achieved. Events deemed to be an immediate safety hazard will be managed as an incident response.

NZTA advised that crash history of the curve where Pai's accident occurred indicated a high number of crashes at or near this location. The site was scheduled for a reseal in the 2018/19 summer construction season. It was under temporary traffic management and a 70 km/h speed restriction. The works did not occur prior to Pai's death due to other priorities and poor weather conditions.

COMMENTS OF CORONER ROBB

I. Pursuant to section 58 of the Coroners Act 2006, the NZTA, Police, and Downer were provided with a draft of the Finding in order to allow them an opportunity to respond.

II. On receipt of the draft Finding senior members of Downer and its Central Waikato Network Outcomes Contract (NOC) team met with the NZTA to discuss the circumstances that led to this accident and ultimately Mr Tapurau's death. The responses that I received from both NZTA and Downer were thorough and detailed, and it was clear to me that they had given Pai's death a great deal of consideration. I do not include the entirety of the responses that I received from NZTA and Downer but have modified aspects of my Finding on the basis of information they provided in addition to repeating aspects of the information they provided to me as set out below.

III. Both Downer and NZTA asked that I again convey their condolences for Pai's death:

> Again, I would like to express our condolences to Pai's family and friends for their loss. Pai's death was also a big loss for our team - as an organisation involved in the maintenance of New Zealand's roading networks we take our obligations to the NZTA and the public very seriously. We… will be taking on board any relevant recommendations and comments included in the finalised inquiry." (Executive General Manager, Transport Service, Downer New Zealand)

> Following this crash a lessons learned debrief was instigated by Waka Kotahi with all Downer staff involved. In attendance, were Waka Kotahi's National Manager Traffic and Safety and National Traffic and Safety Engineer who also provided a focus on motorcycle related safety. This debrief provided the opportunity to thoroughly examine events leading up to this crash and to reinforce with all staff the contract requirements in relation to responding to road pavement defects that can become safety issues.
>
> Waka Kotahi would like to take this opportunity to extend our condolences to Mr Tapurau's family and friends. This event has had a significant impact on our staff involved in the management of this area of the State Highway network, whom are very focused and passionate about maintaining and improving the safety of the State Highway network. (Senior Manager, System Management, Waka Kotahi NZTA)

IV. Downer and NZTA confirm that works at the site of Pai's accident were completed on 31 May 2018 and that the road was subsequently resurfaced during 2018.

V. Downer had suggested that State Highway 28 has been subject to changes in type and frequency of traffic in the years since it had first been classified as a Regional Distributor Highway and that consideration be given to classification. NZTA advised that it had not considered a formal proposal to review the classification of State Highway 28 however a review of all classification change needs across the whole network was presently underway.

VI. NZTA further advised that whilst a change in classification would affect the priority assigned initially to routine management work, it would not affect the outcome relating to any defects that might cause harm to the travelling public. Regardless of its classification, as a Regional Distributor Highway any work on State Highway 28 would warrant a high priority when either at a third party, Waka Kotahi, or the contractor's own routine inspections determined that a defect constitutes a potential safety hazard.

VII. While steps were taken to schedule repairs to the road where Pai ultimately lost his life, this scheduling was not put in place until 18 May 2018. Skid resistance issues had been identified at this location from at least February 2018. I consider greater urgency should have been given to repairs needed at that location. As I understand it a PIP could be generated by the NZTA, but also could have been initiated by Downer inspecting and identifying the issues associated with that location between February and May 2018. It is unfortunate that two accidents occurred at or near that location before the need for road repair was prioritised, and tragically one of those accidents resulted in the loss of life.

VIII. In answering my concern about why the work scheduled to be undertaken at the accident location in February/March 2018 was not completed at that time, Downer further advised:

> Downer had at the time re-prioritised the SH 28 fold as severity 4 (high) and our job management system and work program.
>
> Downer had re-scheduled the physical works after February/March 2018 and was taking proactive steps to remedy the defects, including prior to attending the meeting on 3 May 2018 and being notified of the customer complaint on 15 May 2018. At that stage in the contract period there were significant amounts of defects on the network that required different interventions.

IX. Downer went on to explain that it was working with a subcontractor during the period 4 April 2018 and 10 May 2018 to ensure the works could be performed and completed. They had requested a start date on 16 April 2018 but through a combination of adverse weather and temporary unavailability of specialist equipment, the scheduled works had to be changed to an alternative treatment selection due to the on-set of winter.

X. Downer had reflected on the lessons learnt meeting with NZTA and explained this had resulted in proposed updating of its internal maintenance procedures, with the outcome that the identified works would now be classified as "high priority task". This would remove the possibility of reprioritising of other works and ensure that it was completed within a month of the need being identified. In concluding their response Downer recorded the following:

> Again, we would like to express our sincere condolences to Pai's family and friends for their loss. Since the crash Downer has reviewed and developed its internal systems and processes to improve its responses to safety defects identified in the network and the prioritisation of repairs. How our team records contract communications and information to improve response times also continues to remain a key focus for Downer.

XI. A review of the evidence and the multiple responses from NZTA and Downer leave me assured that the need to identify and undertake road repairs where public safety is an issue is well recognised by those who are responsible

for this work. The consequences of not undertaking that work before a fatality occurs has been candidly acknowledged and appropriately responded to. I trust that this serves as the best way to ensure that deaths do not occur in similar circumstances in the future. Having regard to the considered responses provided by NZTA and Downer I make no additional recommendation or comment on those issues.

Motorcycle Helmet

XII. I acknowledge and adopt the recommendation from the SCU report highlighting the importance of motorcycle riders wearing safety helmets that are appropriate for use and provide the greatest protection from head injury. Anything that can potentially reduce the risk of a head injury being fatal is important to highlight to motorcycle riders.

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

Truger [2020] NZCorC 69 (30 September 2020)

CIRCUMSTANCES

Scott Robert Truger, aged 43, of Otaki died on 23 September 2016 on State Highway 1 from multiple injuries sustain from a motor vehicle accident.

Scott was employed in Wellington and drove between Otaki and Wellington for work. On 23 September 2016, Scott finished his work shift at 4:00am (he was required to work overnight). He was driving to Otaki along State Highway 1.

Scott was seen by other road-users to be driving in an erratic manner, and was drifting from side to side. He then attempted to overtake a vehicle in front of him, which caused a van travelling in the opposing lane of traffic to swerve to avoid a collision. Behind this van was a large truck. The driver of the truck saw Scott return to his lane of traffic. However, he once again turned into the opposing lane of traffic about 50 metres in front of the truck which resulted in a collision between his vehicle and the truck. Scott died as a result of the collision.

Subsequent toxicological analysis revealed that Scott's blood contained methamphetamine, cannabis and alcohol.

The Serious Crash Unit (SCU) investigated the crash and found that fatigue, distraction and a combination of alcohol, cannabis and methamphetamine were causative of the crash. The SCU recommended that a raised tactile marking be installed in the centre of the road in order to reduce risks to road-users on this particular section of State Highway 1.

RECOMMENDATIONS OF CORONER DUNN

I. I have received a recommendation from the Serious Crash Unit expert. The recommendation suggests the installation of the raised tactile markings in the centre of the road. Such markings provide audible and physical stimulation to the driver should they come close to or drive over them. The desired effect is to increase the likelihood that drivers realise they are moving out of their lane and obtain an opportunity to self-correct.

II. It is accepted that no one definitive explanation can be given as to why Scott crossed into the wrong lane. It is reasonable that it was a combination of fatigue, distraction, effect of drugs and possibly falling asleep.

III. Nonetheless I am of the view that the recommendation made by the Serious Crash unit expert is helpful and could in the future reduce the chances of further deaths occurring in similar circumstances. Accordingly, I recommend the installation of raised tactile markings on the two-lane road in question.

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

Ware and Webb [2020] NZCorC 41 (15 July 2020)

CIRCUMSTANCES

Charlotte-Rose Mary Eliza Ware, aged 17, and Sandra Edith Webb, aged 66, died on State Highway 3 near Otorohanga on 8 May 2019, from multiple injuries sustained in a motor vehicle accident.

Ms Webb had travelled from Australia to New Zealand, arriving at around 1:00am on 8 May 2019 at Auckland Airport. She hired a car and began to travel to Hawera to visit family. At around 7:45am, Ms Webb was driving west on State Highway 3 near Otorohanga when her vehicle crossed the centre line and collided head-on with Ms Ware's eastbound vehicle. As a result of the collision, Ms Webb and Ms Ware suffered fatal injuries and passed away. The analysis of Ms Webb's blood detected levels of tramadol, codeine, and paracetamol, all consistent with normal use.

The Serious Crash Unit investigated the incident and found that the combination of a very long journey, limited rest and sleep, and the sedating effects of the medications detected in Ms Webb's system, indicated that Ms Webb was likely fatigued prior to the collision.

COMMENTS OF CORONER BATES

I. I wish to acknowledge a letter I have received from Charlotte-Rose's mother Ms Clark-Ware raising the issue of fatigued drivers and the danger they may present on our roads, in particular those who are fatigued following a long journey to New Zealand. Her concerns are valid, and the risks associated with fatigued drivers are real. I have taken her views into account when making comments and recommendations.

II. Medications carrying warnings against the operation of a motor vehicle following their use do so for a very good reason. The sedative effects of these medications are real. Sedation may be increased through use of a combination of these medications, even when each is used at or below recommended doses. The consumption of sedative medication, particularly several types in combination, combined with control of a motor vehicle increases the risk of disastrous consequences.

III. When driver fatigue is combined with the consumption of sedating medications the risk of disastrous consequences is amplified, as tragically demonstrated in the present case.

IV. The dangers of driving while fatigued, particularly following overnight travel, are evidenced by both of these deaths. Waka Kotahi, the New Zealand Transport Agency (Waka Kotahi) has identified the following warning signs of fatigue and I urge all motorists to be mindful of them:

a. Restlessness

b. Blinking frequently

c. Yawning

d. Excessive speed changes

e. Braking too late

f. Forgetting the last kilometres travelled

g. Drowsiness

h. Centreline drift

V. Waka Kotahi notes it is a common myth that coffee, fresh air or music help combat fatigue. These measures only help in the short-term. Waka Kotahi advise that stopping and getting a good night's sleep is the only cure for fatigue. Where stopping overnight is not a practical possibility, frequent breaks, and if necessary frequent breaks including a period of sleep, should be incorporated into the journey.

VI. Waka Kotahi actively promote campaigns designed to educate the public regarding the dangers of fatigued and drug-impaired driving. Despite this it appears that medication-related substance impairment remains an under-recognised road safety issue. Waka Kotahi are conducting annual surveys to assess the response and behaviour-change in relation to their current education campaigns. Some of their initiatives include:

Drug driving

a. On-going campaigns addressing the impairing effects of medication, not just illicit drugs, and the fact that it is illegal to drive when impaired by medication, whether prescribed or purchased over the counter. Their campaigns include focus on analgesia (pain relief), as this is a class of medication that is likely to cause impairment and a feeling of drowsiness or sedative effects.

b. Waka Kotahi are redeveloping their senior driver advisory resources. These will include increased focus around the impairing effects of medication. They have recently released an impairment education programme targeting heavy transport drivers and are about to release a programme targeting passenger service drivers. I am informed there is also a learning module available to NCEA secondary school students.

c. Waka Kotahi are developing professional development modules for clinicians such as general practitioners and pharmacists, to ensure consumers are advised correctly regarding the impairing effects of prescribed medication.

Driver fatigue

d. Waka Kotahi regularly feature fatigued and drowsy driving public messaging in social media campaigns. Their education includes a general information web-page on driver fatigue. Online education resources are available to the public through the Waka Kotahi website.

e. Waka Kotahi are currently trialling a programme targeting employers and employees in relation to the impact of fatigue on shift-workers. Waka Kotahi advise that research has shown shift-workers are six times more likely to die in a motor vehicle accident due to fatigue than the rest of the population. Development of this programme is on-going, and it will be rolled-out when complete.

Visiting drivers

f. In 2016 Waka Kotahi produced a report following analysis of the involvement of overseas drivers in crashes. The report showed that very few short-term visitors who crash on New Zealand roads do so within the first few days of arrival. Fatigue as a contributing factor in crashes was shown to be at similar levels between overseas licence holders and New Zealand drivers.

g. The Visiting Drivers Partnership, involving a range of organisations including central and local government and the tourism and rental sectors, continues to deliver initiatives focused on road safety at each stage of a visitor's holiday – planning, booking, in-flight, arriving in New Zealand, and when on our roads.

h. The Rental Vehicle Operators Code of Practice recommends that rental vehicle companies provide links to information such as the Drive Safe website and Waka Kotahi's Driving in New Zealand leaflet. Both of these have information about driver fatigue. Rental operators must also encourage visitors arriving on long-haul flights to stay overnight in the arrival destination. Waka Kotahi's leaflet is also promoted through a number of tourism and accommodation companies.

VII. It is clear to me that Waka Kotahi continue to clearly identify and promote education for the public in relation to drug-impaired and fatigued driving. Unfortunately, despite the extensive and on-going public education initiatives that Waka Kotahi have referred me to, and what I have mentioned in these findings is not an exhaustive list of those, it is not always the case that the general public are aware of or turn their minds to these risks.

VIII. Given the widespread use of and ease with which many over the counter sedating analgesics are obtained and consumed, it is highly unlikely that warnings on packaging are always considered prior to consumption, particularly given how mainstream and familiar some of these medications have become. There is no practical means of ensuring consumers are referred to these warnings at point of purchase, or each time they consume the medication. Public and widespread continuing education appears to be the only answer when it comes to over the counter medication. For this reason, I wholeheartedly endorse the continuing campaigns referred to by Waka Kotahi.

IX. The situation is different with respect to prescribed medication with sedating properties. I am reassured by advice received that Waka Kotahi are developing professional development modules for clinicians to ensure consumers are advised correctly.

X. I note advice from Waka Kotahi that in the Rental Vehicle Operators Code of Practice it is recommended that rental vehicle companies provide links to information such as the Drive Safe website and Waka Kotahi's Driving in New Zealand leaflet. It appears to me that making it a requirement to do so may further promote road safety awareness, for both visiting and New Zealand drivers. Additionally, instead of providing links to information, the information itself could be provided, with an opportunity for discussion. Waka Kotahi may wish to consider whether

this could be implemented, together with rental vehicle company staff training requirements to assist with advising customers.

XI. I am mindful that Parliament is currently considering changes to the drugged driver regime, which would include roadside drug testing. Such tests may capture driving while under the influence of illicit drugs, as well as prescribed medicines, including over the counter medications with sedating effects.

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

Whiunui [2020] NZCorC 59 (10 September 2020)

CIRCUMSTANCES

Brendan Hokena Whiunui, aged 40, died at State Highway 1, Far North on 30 December 2017 as a result of multiple blunt force injuries.

On 30 December 2017, at around 8:00am, Mr Whiunui was driving a Nissan semi- truck and two semi-trailers south on State Highway 1, near Waiharara, Far North District. As Mr Whiunui drove around a right-hand bend, one of the trailers rolled, causing the truck to flip onto its left side. Mr Whiunui suffered fatal injuries and was pronounced dead at the scene.

The corner had a chevron board with a 65 km/h advisory speed. This was incorrect, and the board should have had a 55 km/h advisory speed. A report by Opus International Consultants Ltd recorded that the width of the carriageway was less than specified in the NZTA State Highway Control Manual, and that there is no additional shoulder widening around the curve.

COMMENTS OF CORONER GREIG

I. Since Mr Whiunui's death, the advisory sign has been corrected and a guard rail has been placed along the roadside where the truck rolled.

II. As set out above, the Opus International Consultants Ltd report recorded that the width of the carriageway is less than specified in the NZTA State Highway Control Manual, and that there is no additional shoulder widening around the curve. Although these matters are not directly implicated in Mr Whiunui's crash, these are road safety issues and a copy of these findings and the Opus report will be provided to NZTA with the Opus recommendation highlighted.

III. I have concluded that it is not possible for me to determine on the evidence available to this inquiry that the truck was incorrectly loaded in a manner that caused or contributed to the crash. However, in view of Senior Constable Cramp's theory that the load of watermelons may have shifted to the left of the vehicle and been implicated in the rollover, a copy of these findings will be sent to NZ Watermelons so that it can take the issue raised by the Serious Crash Investigator into consideration when ensuring that its trucks are correctly and safely loaded in accordance with industry standards and guidelines.

IV. In light of the actions outlined above recommendations are not necessary.

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

Wilson [2020] NZCorC 63 (17 September 2020)

CIRCUMSTANCES

Demitrus Darnell Denzel Wilson, aged 8, of Kihikihi died on 31 January 2018 at Kihikihi of traumatic head injuries.

In the early evening of 31 January 2018, Kevin Brown, a friend of Demitrus' father, was milking cows with Demitrus and two of his siblings. Sometime between 7:00pm and 8:00pm, Mr Brown instructed Demitrus to go up to a farm paddock to bring some cows back for milking. Demitrus left on his father's Honda quad bike.

After approximately 20 minutes, Demitrus had not returned. Mr Brown asked Demitrus' brother to go and see where Demitrus was. Demitrus' brother returned about 15 minutes later and told Mr Brown to ring an ambulance as Demitrus had rolled the quad bike.

Family members found Demitrus lying in the paddock with the quad bike nearby and upright. They commenced CPR on Demitrus. Police and ambulance staff eventually arrived, and continued CPR efforts. Sadly, Demitrus could not be revived and was declared deceased by attending paramedics.

COMMENTS OF CORONER DUNN

I. The risks of operating quad bikes in the farming sector have been the subject of previous coronial inquires and ongoing work by Health and Safety regulators for many years.

II. In May 2014 Worksafe New Zealand released an updated Best Practice Guidelines in the Safe Use of Quad Bikes. It notes at 3.1 and 3.4 The Hazards: Under Age Riders

> The hazard is the quad bike being ridden by someone without the skill, weight, and mental development (e.g. perception, cognitive and reaction time capabilities) necessary to safely control it. All manufacturers of quad bikes sold in New Zealand state that children younger than 16 may not ride an adult-sized quad bike for this reason.
>
> The hazard is the activity of riding the quad bike. Operating them can be dangerous if you don't know what you're doing; they may not look it – but quad bikes are powerful and complex pieces of machinery. The rider needs to shift and use their body weight to control the bike. This is called active riding.

III. All manufacturers of quad bikes sold in New Zealand have warning labels that state children under the age of 16 should not ride quad bikes. Such a label would have been on the quad bike used by Demitrus.

IV. It is unfortunate that those warnings were not complied with here. Demitrus weighed 31.5kg and was 8 years of age. His size, weight and skill were not equipped to ride a quad bike in any circumstance let alone on farm land with a moderate gradient.

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

Police Shooting

Marshall [2020] NZCorC 40 (14 July 2020)

CIRCUMSTANCES

Nicholas Nelson Marshall died on 12 July 2016 at Hamilton from multiple gunshot injuries to his chest and abdomen.

On 12 July 2016, the Police Armed Offenders Squad (AOS) carried out a search warrant at a commercial unit occupied by Mr Marshall. The decision by the Police to execute the search warrant using the AOS was made on intelligence available to the Police, and the Independent Police Conduct Authority confirmed that this decision was justified.

Upon entering the commercial unit, the AOS were confronted by Mr Marshall who proceeded to present a firearm at one of the AOS officers, in the presence of another AOS officer. In response to the perceived threat, the officers fired their weapons at Mr Marshall striking him in the chest and abdomen.

The Police and members of Mr Marshall's family met in January 2020 to discuss the events of July 2016.

COMMENTS OF CORONER RYAN

I. At the meeting held in January 2020, and in written submissions made after that meeting, family strongly believe that Police executing search warrants in the circumstances that existed in this case should be wearing body cameras. They suggest that the presence of cameras modifies the behaviour of both sides in such an operation. In addition, footage from the cameras would provide better evidence as to what actually happened.

II. The issue of AOS members wearing body cameras is not a circumstance of the death in this case. However, it is arguable that if the presence of body cameras is likely to modify the behaviour of all parties involved then this may reduce the chances of further deaths occurring in similar circumstances. Because I have no evidence before me on this issue, it is not appropriate for me to make a recommendation that AOS members should wear body cameras during forced entry situations.

III. Nevertheless, I consider that this suggestion has some merit. I have recorded the family's suggestion and my view on it in case Police are looking at the merits of AOS officers wearing body cameras during forced-entry situations.

IV. Having given due consideration to all of the circumstances of this death, I do not consider there are recommendations that could usefully be made pursuant to section 57(3) of the Coroners Act 2006.

Product Related

Master X [2020] NZCorC 56 (2 September 2020)

CIRCUMSTANCES

Master X, aged 15 months, died on 30 September 2016 at Starship Children's Hospital of Haemophilus Influenzae and Streptococcus Pneumoniae meningitis with the antecedent cause orbital and roof fractures sustained in an accidental fall down stairs.

Master X was riding a plastic Milazo tricycle that was pushed by his mother, Mrs X. Mrs X described the tricycle as follows:

> The tricycle has an adjustable handle which extends out the back of the bike. The handle clicks into place when you extend it. The handle is used by adults to push the tricycle. The tricycle has a plastic seat which Master X sits on and there is a plastic railing that is attached at the back of the tricycle which runs around the tricycle for Master X to hold onto whilst on the bike. Above this railing are handle bars that are on top of a tube which attaches to the front wheel.

Mrs X pushed Master X down the hallway and out the front door (over a lip) onto a concrete veranda at the front of their house. To get from the veranda to the driveway of the house there are seven concrete steps. Mrs X said she pushed Master X towards the steps and as she got closer she pulled the extendable handle at the back of the tricycle back so that the tricycle tilted backwards, and the front wheel lifted off the ground. She said that she normally did this.

As Mrs X leant the tricycle back and went to bump the back wheels down onto the first step, the handle at the back of the bike came out of the shaft attached to the bike. Master X tumbled down the stairs on the bike and landed upside down on the driveway still on the tricycle. When Mrs X got to him she saw his face was covered in blood and he was hysterical and crying. There was a lump on his forehead.

Mrs X took Master X to a local Accident and Emergency Centre where he was assessed and then transferred to Starship Hospital by ambulance. A CT scan revealed a fracture of the left orbit with some buckling/overlapping of fragments but no acute intracranial bleed or other abnormality. He was admitted for observation under the neurosurgical team in light of the orbital skull fracture, his young age, and symptoms of drowsiness and vomiting.

On 28 September 2016, Master X was noted to have a fever, fast pulse and breathing. Meningitis was considered. Blood tests did not indicate a serious infection although there were subtle signs that could be consistent with infection developing. Master X's condition deteriorated the next day and he was diagnosed with haemophilus influenzae and streptococcus pneumoniae. He was commenced on antibiotics and a CT scan showed that his spleen was not functioning.

During the CT scan, Master X stopped breathing and his oxygen levels dropped. He was resuscitated and transferred to the Paediatric Intensive Care Unit (PICU). A repeat blood test that afternoon showed even more signs of severe infection that indicated a rapidly progressive fulminant infection. Despite full treatment measures, Master X progressed to brain death and was declared dead on the evening of 30 September 2016.

The tricycle Master X was riding had three wheels and a number of adjustments that enabled it to cater to a wider age range. These included bars around the seat of the tricycle, a 'parent handle', and a pedal lock 'for push along mode'. In an advertisement, The Warehouse described the parent handle as 'adjustable and removable'. This handle comprised of two parts:

a. a short steel stem on the back rear of the tricycle; and

b. a plastic handle for the parent to hold.

Part (b) slotted into part (a) and was held in place by two spring loaded steel balls. Master X's tricycle fell when these two pieces came apart at their point of connection, halfway down the handle. It is unclear whether the spring-loaded balls came apart as the tricycle rolled over the first step, or if this had happened as a result of previous use.

Standards New Zealand, a unit within the Ministry of Business, Innovation and Employment (MBIE), provided advice concerning the regulations around tricycles in New Zealand. Compliance with standards in New Zealand is voluntary. However, suppliers are responsible for the safety of their products under the Fair Trading Act 1986.

Toy Safety Standard AS/NZ 8124.1:2002 Safety of Toys: safety aspects relating to mechanical and physical properties (the Standard) encompasses safety regulations for tricycles. However, the tricycle had numerous features (including the parent handle, the pedal lock and the arms) that blurred the line between a child's toy and a mode of transportation (like a stroller). Standards New Zealand advised that "innovative cross-over type products have the potential to introduce hazards to a product that are not contemplated in existing standards".

When asked about the fact New Zealand standards are voluntary, Standards New Zealand advised the Coroner that compliance with a mandatory standard does not necessarily guarantee a product's safety. The opinion of Standards New Zealand is that whilst making a standard mandatory can give grounds for regulatory action, having a voluntary standard will still set a benchmark for safety.

Standards New Zealand noted that issues with a product may only become apparent once it is on the market and that compliance with a standard does not necessarily guarantee safety of a product. It gave as an example an automatic rocking cradle for small babies used in the United States. There have been a number of fatalities relating to this product, despite its compliance to the specific US standard.

The Coroner considered that, whilst it is not desirable to use the tricycle over terrain where a child might fall and injure themselves, if the tricycle ostensibly has certain desirable features of a stroller, it is reasonably foreseeable that the tricycle may be used in this way. It then seems prudent that the crossover type of tricycle in use when Master X had his fall should be subject to tests other than those usually required for a traditional tricycle.

The MBIE Standards team advised that when an incident occurs, a binary risk assessment method is used to assess the overall risk of the product involved. The overall risk is assessed by:

a. the severity of the outcome; and

b. the likelihood of a similar accident reoccurring.

Standards New Zealand could not find any examples of similar incidents. They advised that the United States injury database NEISS (National Electronic Injury Surveillance System), which provides estimates of product related injuries, indicated that the vast majority of tricycle injuries did not result in hospitalisation. The data recorded no tricycle related fatalities between 2008 and 2017.

Using the binary structure above, Standards New Zealand advise that the overall risk posed by the product is low as there have been no other reported incidents. As a result this incident was categorised as a 'one-off'. Standards New Zealand advised that a risk assessment rating as 'low' is not designed to downplay the seriousness and tragedy of the incident. Rather, the assessment is designed to add perspective into what, if any, regulatory response would be proportionate and appropriate.

COMMENTS OF CORONER GREIG

I. While I recognise that the assessment of the overall risk of an incident such as happened to Master X is low, on the basis of the binary risk assessment method set out above, and that Standards New Zealand could not find any examples of similar incidents, Master X's tragic accident demonstrates that a cross-over product in which a handle is placed on a tricycle introduces the risk that it is used in a manner similar to a stroller. It also demonstrates that serious injury or tragedy such as Master X's death may result.

II. There were warning signs with the bicycle assembly instructions advising that it should not be used on roads, steps or steep slopes. Realistically, such information is often likely to be discarded once the tricycle is assembled and any warnings are then 'lost' to users who have not seen the instructions or taken in the warning. Other safety solutions are possible - including that there is a warning included on the handle of the tricycle, for adults to see when using the product, or preferably that, where possible, risks are mitigated by the modification of features of the product in question.

III. Standards New Zealand advised that while most Standard Committees dissolve once a standard has been published, CS-018 (a joint Australian and New Zealand committee relating to toys) runs continuously due to the new products, materials and innovations constantly being produced in the children's toy sector. The role of CS-018 is to align the New Zealand and Australian stance on any issues with the international standards.

IV. Standards New Zealand advised that any change to AS/NZS depends on CS-018 proposing it to the ISO (International Organisation for Standardisation), and their agreement.

RECOMMENDATIONS OF CORONER GREIG

I. I accept that on the basis of the currently available information, recommending the introduction of legally enforceable mandatory standards requirements in relation to cross over tricycles with push handles may not be viewed as a proportionate response to what appears to be an isolated incident – albeit a deeply tragic one. However, I remain concerned about the safety of the type of product at the heart of this incident and the capacity for the risks introduced in innovative cross over products to escape proper scrutiny.

II. Based on the evidence and advice I have received to this inquiry and in order to try and reduce the chances of deaths in similar circumstances in future, I make the following recommendations:

To the Chief Executive of the Ministry of Business, Innovation and Employment:

III. That Trading Standards:

a. considers the circumstances of the accident that led to Master X's injuries (as set out in these Findings) and assesses available incident data for the product type to establish whether there are significant and or systemic safety issues that need to be addressed.

IV. That Standards New Zealand:

a. refers the following recommendation to its representatives on the CS-018 (the joint Australian and New Zealand committee responsible for Standards development relating to toys which is administered by Standards Australia) to take to the CS-018 for deliberation:

i. that CS-018 considers ways to provide guidance to manage the risks that are introduced by innovative cross-over type products.

V. The Ministry of Business, Innovation and Employment has been consulted on these recommendations and had indicated its willingness to progress them. In relation to the first recommendation, it has advised that Trading Standards is comfortable with the recommendation and will look to include the recommendation in its work programme. In relation to the second recommendation, it has advised that while Standards New Zealand does not administer the CS-018 standards development committee, it will refer the recommendation to the committee in the manner set out above.

SafeKids Aotearoa

VI. A copy of these Findings are to be sent to SafeKids Aotearoa, a service of Starship Children's Health, whose mission is to reduce the incidence and severity of unintentional injuries to children ages 0 – 14 years. As recognised experts in unintentional child injury prevention SafeKids Aotearoa is well placed to give consideration to raising awareness of the safety issues raised in these findings and how best to promote safety messaging.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of the name or particulars likely to lead to the identification of Master X, his mother and his father in the interests of justice. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Master X taken during the investigation into his death on the grounds of personal privacy and decency.

Self-Inflicted

Cook [2020] NZCorC 39 (8 July 2020)

CIRCUMSTANCES

John Cecil Henry Cook, aged 53, of Auckland died on 17 June 2017 at Middlemore Hospital where he was being treated for self-inflicted injuries in circumstances amounting to suicide.

Mr Cook had a significant medical history which included (among other matters) complications from viral meningitis as a child that impacted his short to medium term memory. He also suffered a head injury in a motor vehicle collision in 2015. The effects of his medical conditions impaired his ability to recover from his injuries.

In 2015, Mr Cook self-harmed, was treated for his injuries and discharged into the care of his general practitioner Dr McArthur.

COMMENTS OF CORONER BORROWDALE

I. Having given due consideration to the circumstances of this death, I consider that there are comments that could usefully be made pursuant to section 57(3) of the Coroners Act 2006. These comments are made for the purpose of reducing the chances of further deaths arising in similar circumstances.

II. I make the following comments pursuant to section 57(3) of the Act:

a. It can in no way be assumed that, had Dr McArthur contacted Mr Cook to check on his mental wellbeing following his 2015 hospital discharge, it would have changed Mr Cook's ultimate outcome. At and around his discharge Mr Cook was remorseful for what he had done, and adamant that it was an isolated event that would not be repeated. This is what Dr McArthur is likely to have heard had he made enquiries of Mr Cook, and until June 2017 no-one within the family circle had cause for concern that a further attempt on his life might be made. My findings additionally incorporate a recognition that there was an element of impulsiveness to Mr. Cook's death, which could not readily have been foreseen.

b. However, Mr Cook's death and the events leading up to it indicate the potential for a patient to have ongoing post-discharge mental health issues that are not captured in consultations with their GP unless the patient initiates a discussion on the issues.

c. It is possible that other GP practices could benefit from reviewing this finding and testing whether they have in place sufficient system prompts to ensure that they decide, within a reasonable time of discharge, whether to follow-up with a similarly-situated patient. A desirable future state would see each patient's discharge status considered by their GP as to the need for follow-up, and re-discussed with the patient at appropriate intervals thereafter.

d. These comments are not made by way of criticism of Dr McArthur who, as I note above, did not apprehend that Mr Cook had ongoing mental health issues. I accept that, with the benefit of hindsight, Mr Cook had an untreated mental vulnerability and had not experienced a "one-off" episode of suicidality. But I find no fault in Dr McArthur's treatment of Mr Cook in his not having identified this from the information given to him.

III. I consider that these comments are sufficient to draw these matters to the attention of medical practitioners (in combination with my distribution direction below), and do not make any recommendations under section 57(3) of the Act.

Note: Pursuant to section 71 of the Act no person may, unless the person is granted an exemption under section 71A of the Act or has permission under section 72, make public the matters referred to in section 71(2).

Pursuant to section 74 of the Act the publication of photographs taken of John Cecil Henry Cook during this inquiry (being photographs of a deceased person) is prohibited on the grounds that it is in the interests of decency or personal privacy.

Epapara [2020] NZCorC 67 (30 September 2020)

CIRCUMSTANCES

Dallas Hira Epapara, aged 53, died on 23 December 2018 from self-inflicted injuries.

Mr Epapara had earlier made threats of suicide or self-harm.

COMMENTS OF CORONER ROBB

I. Dallas' death is a reminder of the need to take threats of suicide or self-harm seriously. The Ministry of Health offers the following guidance, which I endorse:

> If someone has attempted suicide or you're worried about their immediate safety, do the following.
>
> > Call your local mental health crisis assessment team or go with them to the emergency department (ED) at your nearest hospital.
> >
> > If they are an immediate physical danger to themselves or others, call 111.
> >
> > Remain with them and help them to stay safe until support arrives.
> >
> > Try to stay calm and let them know you care.
> >
> > Keep them talking: listen and ask questions without judging.

II. I do not make any further comments or recommendations pursuant to section 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 Epapara taken by Police in the interests of decency or personal privacy.

Grose [2020] NZCorC 65 (25 September 2020)

CIRCUMSTANCES

Andrew Murray Grose, aged 43, of Whangarei died on 25 March 2017 at Whangarei in circumstances amounting to suicide.

Mr Grose was a beneficiary who lived in Whangarei. He had a multitude of health and mental health issues. He lived with chronic pain and had been diagnosed with severe depression.

On 25 March 2017, Mr Grose disclosed to his ex-wife that he was intending to take his own life. He also told her he had attempted to do so immediately before speaking to her, but this attempt had failed. He advised that he was about to make another attempt, and that his death was imminent. Mrs Grose was aware that Mr Grose was making a suicide attempt but did not report this to anyone.

Mr Grose was later found deceased.

COMMENTS OF CORONER BORROWDALE

I. What can be said following this recitation is that in not acting to summon emergency assistance Mrs Grose did not act consistently with what is now the response to urgent suicide risk recommended by the Ministry of Health. I

make this comment for public guidance only. Mrs Grose's response cannot be measured against guidance which may have been provided subsequently to these 2017 events.

II. I urge all persons who witness someone taking steps towards suicide, and who may be known to have expressed suicidal thoughts, to call emergency services as soon as possible and it is safe to do so. In some circumstances such a call may maximise the opportunity for survival.

III. In the interests of public awareness, I note that help is also available to anyone who is concerned or aware that a friend, family member or anyone else is feeling suicidal:

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

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

Note: Section 71 of the Coroners Act 2006 applies in this case. Accordingly, no person may, unless the person is granted an exemption under section 71A of the Act or has permission under section 72, make public the matters referred to in section 71(2).

An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Andrew Murray Grose in the interests of decency or personal privacy.

Harding [2020] NZCorC 43 (20 July 2020)

CIRCUMSTANCES

On 23 December 2017 Dr Richard Harding, aged 47, of Whangarei, was found by his wife unresponsive. The Coroner was satisfied to the requisite standard that Dr Harding's death was a suicide.

COMMENTS OF CORONER GREIG

I. People who take their own lives usually do so as a result of a complex range of factors. The Ministry of Health has reported that "it is usually the end result of interactions between many different factors and experiences across a person's life".

II. Consideration of the circumstances of Dr Harding's tragic death has highlighted a constellation of factors that likely played a role in his decision to take his life, many of which were associated with his work. In saying this I mean no criticism of his new role at Whangarei Hospital, which his wife reported he was enjoying. Rather it is a comment on the systemic environment. Many of the particular stressors highlighted in the circumstances of Dr Harding's death have been well researched internationally and have been identified in the reports I have received in this inquiry - with some of those factors conceivably exacerbated for intensivists and anaesthetists. These highly trained senior health

professionals work in specialised and high stress environments in which life and death decisions are part and parcel of their working days as is the risk of long hours and sleep disruption. […]

III. The NHS Practitioner Health website states that that research has shown that the rates of mental illness in doctors are higher than those of the general population and that research literature about the problems facing health professionals shows:

- mental illness is common amongst doctors, with around 25% at risk;
- suicide rates are between 2 and 4 times those of other professional groups, and in some specialties, there appears to be increased risk;
- the culture of medicine is not generally supportive;
- stigma and prejudice exacerbate mental health conditions;
- patient complaints are a significant factor in leading to suicide amongst doctors;
- even with the high levels of resilience that many doctors have, the combination of these numerous factors with regards to the profession and its stresses result in the mental health of doctors being more at risk.

IV. I received a number of suggestions as to recommendations I could make from those who provided me with reports. The suggestions were wide ranging and thoughtful. As one commentator noted, the increased rate of suicide among anaesthetists [and I add intensivists] is a multifaceted issue, which no single measure will fix.

V. The evidence suggests that New Zealand has a somewhat fragmented response to dealing with the range of factors that impact on the wellbeing of doctors working as intensivists and anaesthetists. The research I have been referred to suggests that most of the factors identified may extend to doctors outside these two specialist groups – but consideration of this is outside the scope of this inquiry.

VI. The responses from those who provided reports to this inquiry (who represent medical colleges, the Medical Council and Association of Salaried Medical Specialists) show that factors that impact on wellbeing are well identified and that good work has been, and is being, done to provide support to doctors in some circumstances. However, access to, and the quality of, support and ensuring systems that are responsive to or mitigate the factors identified, appear to be constrained for a variety of reasons. There is certainly no equivalent of NHS Practitioner Health in New Zealand to support doctors with mental health issues or those who are undergoing complaints processes.

RECOMMENDATIONS OF CORONER GREIG

I. The issues raised in my inquiry into Dr Harding's death suggest that further deliberation is required into the complex range of factors at play which may increase the vulnerability of intensivists and anaesthetists to suicide and how these can be addressed systemically to reduce the chances of further deaths occurring in similar circumstances. For this reason, I do not consider it prudent to make specific recommendations.

II. However, I am sending these findings to key organisations in the sector for their consideration of how the issues highlighted can be progressed sector wide. In particular the findings will be sent to:

- Director General of Health, Ministry of Health
    - The Australian and New Zealand College of Anaesthetists
    - President New Zealand Society of Anaesthetists
    - Chair of the New Zealand Committee of the College of Intensive Care Medicine of Australia and New Zealand
    - Chief Executive Medical Council of New Zealand
    - Executive Director of Association of Salaried Medical Specialists
    - Chairs and Chief Medical Officers of Auckland, Bay of Plenty, Canterbury, Capital & Coast, Counties Manukau, Hawke's Bay, Hutt Valley, Lakes, MidCentral, Nelson Marlborough, Northland, South Canterbury, Southern, Tairawhiti, Taranaki, Wairarapa, Waitemata, West Coast, Whanganui DHB
    - The Health and Disability Commissioner
    - Chair Health Quality and Safety Commission

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 any photographs of Dr Harding taken during the investigation into his death in the interests of decency and personal privacy.

Spankie [2020] NZCorC 47 (30 July 2020)

CIRCUMSTANCES

Alannah Lee Spankie, aged 20, died at the Intensive Care Unit, Dunedin Hospital on 21 June 2017 of a massive hepatic necrosis, presenting as acute liver failure secondary to a paracetamol overdose. The manner of death was accidental.

RECOMMENDATIONS OF CORONER ROBINSON

I. I recommend to the Chair of the Medicines Classification Committee that the following restrictions be implemented as to the quantities of paracetamol available for purchase in New Zealand:

a. Pharmacy sales: 16 g per transaction (i.e. 32×500 mg tablets).

b. All other outlets 8 g per transaction (i.e. 16×500 mg tablets).

c. A maximum of 50 g (i.e. 100 x 500 mg tablets) by prescription.

II. Pursuant to section 57A(3)(c) Coroners Act 2006, I consider that the implementation of the recommendation will reduce the likelihood of deaths in similar circumstances by restricting the availability of lethal quantities of

paracetamol, which, on the basis of overseas research has been established to be effective in reducing fatalities occurring in impulsive overdoses.

III. As required by section 57B Coroners Act 2006 my draft recommendation was made available to the chair of the Medicines Classification Committee. The response of the Committee to the draft recommendation is appended to this finding. It suffices to record the following passages:

> In 2016 the committee concluded that they were satisfied that overall, the benefit of access outweighed the risks and that the classification of paracetamol was appropriate. I am not aware of any new evidence in this area that would require the committee to reconsider the classification of paracetamol pack sizes.
>
> …
>
> I would support your recommendation to limit the number of packs per transaction and would suggest that you engage with the Food and Grocery Council to encourage them to restrict the number of packs per transaction.

IV. Given that comment, and without detracting from my primary recommendation as to the appropriate restrictions on the availability of paracetamol, I recommend that the Food and Grocery Council endorse a voluntary limit of one packet containing not more than 10 grams or in powder form in sachets containing 1 gram or less and not more than 10 grams per customer per transaction. I immediately recognise the variability of compliance with a voluntary code evident in UK research, and the fact that even ingestion of 10 g of paracetamol is sufficient to require medical intervention.[17]

V. Pursuant to section 57A(3)(c) Coroners Act 2006, I consider that the implementation of a voluntary limit may reduce the likelihood of deaths in similar circumstances by restricting the availability of lethal quantities of paracetamol.

Note: Because Ms Spankie's death was self-inflicted (but not suicide), orders under section 71 of the Coroners Act 2006 were imposed by the Coroner stating that no person may make public the method of death, or any detail that suggests the method of death unless an exemption was granted by the Chief Coroner under section 71A of the Act. Subsequently, the Chief Coroner authorised the publication of the manner of Ms Spankie's death or any details that suggest the method of death.

An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Ms Spankie taken by Police in the interests of decency or personal privacy.

17 N Freeman, Paul Quigley "Care vs convenience: Examining paracetamol overdose in New Zealand and harm reduction strategies through sale and supply" Vol 128 No 1424 NZMJ.

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.

Sonny [2020] NZCorC 55 (28 August 2020)

CIRCUMSTANCES

Micah-J Alofagia Sonny, aged 6 weeks, died on 10 March 2018 at 59 Carisbrooke Street, Christchurch on 10 March 2018 from Sudden Unexpected Death in Infancy in the context of an unsafe sleeping environment.

Micah-J's parents, Dodiana Elia and Sonny Mika, were staying at Ms Elia's family's house to look after her brother while her parents worked nightshift. They all slept on mattresses on the floor in the living room. At 9:00am on 9 March 2018, Ms Elia's aunty visited. Micah-J was observed to be breathing "a bit strange". Ms Elia told her aunty that Micah-J's breathing was like that since birth.

At about midnight, Ms Elia put Micah-J on his own mattress in the living room, next to another mattress for her and Mr Mika, where he slept until between 5:00am and 6:00am, and woke for a feed. Afterwards Ms Elia lay Micah-J in the crook of her elbow until he fell asleep before lying him on his right side on his own mattress.

At around 9:00am on 10 March 2018 Ms Elia's aunty visited again. Ms Elia was still lying on her side cuddling Micah-J with a blanket completely covering him. Ms Elia and her aunty spoke for a few minutes before Ms Elia turned and looked at Micah-J, who was still on his side. She picked him up to give him a cuddle and noticed that he was purple on the right side of his face and was not breathing. Ms Elia also noticed dried blood on his nose. Emergency services were notified and CPR commenced, however Micah-J was unable to be revived.

COMMENTS OF CORONER TUTTON

I. In terms of formal comments pursuant to the Coroners Act 2006, I note the safe sleeping practices which are recommended in information published by various agencies and organisations. The Ministry of Health has information on its website and an extract is reproduced below:[18]

> **Make every sleep a safe sleep**
>
> Sudden unexpected death is a risk to babies until they are about 12 months old, but most deaths can be prevented. There are things that we can do to protect our babies. Although for some babies the cause of death is never found, most deaths happen when the babies are sleeping in an unsafe way.
>
> Always follow these safe-sleep routines for your baby and your baby's bed.

[18] http://www.health.govt.nz/your-health, "The first year" and "Keeping baby safe in bed".

Make sure that your baby is safe

To keep your baby safe while sleeping, make sure:

- they always sleep on their back to keep their airways clear
- they are in their own bassinet, cot or other baby bed (eg, a pēpi-pod® or wahakura) - free from adults or children who might accidentally suffocate them
- they are put back in their own bed after feeding - don't fall asleep with them (to protect your back, feed your baby in a chair rather than in your bed)
- they have someone looking after them who is alert to their needs and free from alcohol or drugs
- they have clothing and bedding that keep them at a comfortable temperature - one more layer of clothing than you would wear is enough; too many layers can make your baby hot and upset them
- they are in a room where the temperature is kept at 20°C.

You can check that your baby is warm but not too hot by feeling the back of their neck or their tummy (under the clothes). Baby should feel warm, but not hot or cold. Your baby will be comfortable when their hands and feet are a bit colder than their body.

Make sure that your baby's bed is safe

Baby's bed is safe when:

- it has a firm and flat mattress to keep your baby's airways open
- there are no gaps between the bed frame and the mattress that could trap or wedge your baby
- the gaps between the bars of baby's cot are between 50 mm and 95 mm - try to get one with the gaps closer to 50 mm if you can
- there is nothing in the bed that might cover your baby's face, lift their head or choke them - no pillows, toys, loose bedding, bumper pads or necklaces (including amber beads and 'teething' necklaces)
- baby is in the same room as you or the person looking after them at night for their first 6 months of life.

It is never safe to put your baby to sleep in an adult bed, on a couch or on a chair. If you choose to sleep in bed with your baby, put them in their own baby bed beside you - for example, a pēpi-pod® or wahakura. This will help to reduce the risk of your baby suffocating while they are asleep. Information about using a pēpi-pod® or wahakura is available online; see the Whakawhetu and Pēpi-Pod® Sleep Space Programme websites.

Car seats and capsules protect your baby when travelling in the car. Don't use them as a cot or bassinet. Car seats and capsules are not safe for your baby to sleep in when you are at home or at your destination.

If you don't have a baby bed, talk to your nurse. If you are on a low income, you may be able to get a Special Needs Grant from Work and Income to buy a bed. See the Work and Income website or call 0800 559 009.

RECOMMENDATIONS OF CORONER TUTTON

I. There have been a number of recommendations and comments made by Coroners focussed on the issue of safe sleep. Given this, I do not consider that it is necessary to repeat safe sleep recommendations in this finding. However, a copy of these findings will be sent to the Ministry of Health, the Child Youth Mortality Review Committee, and Change for our Children, all organisations actively involved in working to strengthen and make consistent the safe sleeping message.

Note: Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Micah-J taken during the investigation by Police in the interests of decency or personal privacy.

Workplace

Cleugh [2020] NZCorC 57 (7 September 2020)

CIRCUMSTANCES

Duncan Bruce Cleugh, aged 46, died at 15 Becker Road, Patearoa on 9 March 2017. The cause of death was a gunshot wound to the chest, which the Coroner concluded was an accident.

Mr Cleugh and his partner, Natasha Burrell, had been farming their property for eight years. Mr Cleugh had a firearms licence and used a gun for pest control on the farm, but did not go hunting.

On 9 March 2017, Mr Cleugh left the house at around 8:30am to work on the farm. When he did not return for lunch, Ms Burrell began to worry. After 3:30pm, she went looking for him with their three young children. Ms Burrell tried to ring Mr Cleugh and left messages on his phone, but received no reply.

At around 4:45pm, as Ms Burrell drove across the farm on the main access track, she saw Mr Cleugh's truck in a paddock north of a mine on the property. Ms Burrell could not see Mr Cleugh and started searching in the area around his car. She eventually saw him lying on his front with his feet caught in a wire fence. His rifle and pair of ear muffs were next to him. Ms Burrell ran down the hill towards Mr Cleugh and climbed over the fence. She could not locate a pulse and rolled him over to check his breathing. On lifting up his shirt, Ms Burrell saw a wound. She called emergency services and when they arrived, it was confirmed that Mr Cleugh had died.

The Coroner considered whether Mr Cleugh's death was a suicide. While Mr Cleugh had some mental health history, this was related to anxiety rather than to depression. No suicide note was found, and there was no evidence that he was suicidal on the day he died.

The position of Mr Cleugh's body, the gunshot wound, blood on the ground, and the location of the rifle next to him, led Police to conclude that his firearm had discharged by accident while he was climbing over the fence. The rifle was inspected

by a Police armourer, with no problems found when test fired. It did not have a magazine inside. The rifle was in a good state mechanically and passed all safety tests. Based on all of the evidence and on the balance of probabilities, the Coroner also concluded Mr Cleugh's death was an accident.

COMMENTS OF CORONER CUNNINGHAME

I. A similar death occurred in 2015 and was also the subject of coroner's findings.[19] In that case three friends were hunting. When they came to a fence they departed from their usual practice and a young man carried his rifle with him as he climbed through. As he did so, the rifle discharged, shooting him in the chest.

II. In light of this, I consider that the advice in regard to crossing fences which is set out in the New Zealand Mountain Safety Council "Hunting: Know Before You Go" activity guide (Guide) bears repeating. The Guide complements the New Zealand Police Arms Code which sets out the seven basic rules of firearm safety.

III. Rule Two in the Arms Code is "Always point firearms in a safe direction". The Guide addresses crossing fences in the context of this rule and sets out the following procedure:

> If you are with another hunter, have one person climb over the fence without a firearm. Then, pass the unloaded firearms across, making sure that the actions are open and the muzzles are pointing in a safe direction.
>
> If you are on your own, unload your firearm, pass it through the fence muzzle first and lie it on the ground on the other side. Then climb over the fence.
>
> Take special care when crossing electric fences. Have your firearm unloaded and the action open before you get near an electric fence. An electric shock can make your muscles contract and your hand could clench shut around the trigger.

IV. The Guide states "NEVER climb a fence while carrying a firearm". I endorse this advice.

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

[19] *In the matter of an inquiry into the death of Joshua Hunter Hill*, CSU-2015-PNO-000259, Coroner Tim Scott, 22 January 2016 (In Chambers).

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