



OFFICE OF THE  
**CHIEF CORONER**  
OF NEW ZEALAND

# Recommendations Recap

A summary of coronial recommendations and comments  
made between **1 October** and **31 December 2020**

# Coroners' recommendations and comments

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

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

The Office of the Chief Coroner maintains a public register of these recommendations and comments and publishes summaries of those which are not prohibited from being published by order of court or law. Recommendations Recap includes all those recommendations and comments which have been summarised and published. This edition includes 43 recommendations and/or comments issued by Coroners between 1 October and 31 December 2020.

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

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# Recommendations and comments

## 1 October to 31 December 2020

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

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

### Drugs

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#### Amani [2020] NZCorC 109 (11 December 2020)

##### CIRCUMSTANCES

Kelly Sepa Amani, aged 15, of Otara, Auckland died on 11 August 2017 at Middlemore Hospital of a brain stem infarction (stroke). She had been admitted two months previously having suffered extensive burns after petrol had been spilled on her clothes and was ignited and exploded into fire.

Kelly occasionally used solvents. At around 2pm on 13 June 2017 Kelly was visiting friends at their home. Whilst there, Kelly and her friend went to the shed to sniff petrol (also called 'huffing gas'). Kelly's friend said that they were both "gone". At one point, Kelly was sniffing petrol from a Milo container, which spilled, causing her and her friend's clothes to become contaminated with petrol. They decided to go inside the property to remove their wet clothing and shower.

Kelly and her friend went upstairs to one of the bedrooms and sat on the floor within the doorway and shared a cigarette. As they did so Kelly's friend started playing with a cigarette lighter, exposing a naked flame. At some point Kelly's clothes caught fire and she jumped up screaming. There was a sound of an "explosion" and as Kelly moved around the bed to the window, the bed caught fire and she was engulfed in flames. Kelly jumped out of the window to escape the fire and fell onto the front lawn, breaking her upper arm in the process. Kelly's friends tried to douse the flames with water from a coke bottle and pot, when a passing motorist stopped and called the Fire Service who attended the scene.

Kelly was transferred to Middlemore Hospital where she underwent 28 major surgeries over the following 59 days. She suffered from recurrent infections which resulted in septic shock. On 6 August 2017 Kelly began to complain of a headache and neck pain. On 9 August 2017 her neck pain became severe and she experienced tingling sensations to her face. An MRI showed that Kelly had an extensive infarction of the brain stem, a region essential for life-sustaining processes such as breathing and regulating heart and blood pressure. Doctors described this as an unusual, but fatal complication. Kelly was maintained on life support which, with the consent of her immediate family, was withdrawn on 11 August 2017 and Kelly subsequently died.

## COMMENTS OF CORONER BORROWDALE

- I. Having given due consideration to all of the circumstances of this death, I do not consider there are any recommendations that could usefully be made pursuant to section 57(3) of the Coroners Act 2006.
- II. However, in the interests of public awareness, I make the following comments pursuant to section 57(3) of the Coroners Act 2006:
  - a. The New Zealand Drug Foundation has published informative and accessible guidance for teens and other young people as to the risks of huffing (inhaling) volatile substances. These risks include: aggression, depression, brain and organ damage, seizures, coma, and fire and explosion. That information can be found in both video and comic-book form on the Drug Foundation's website: <https://www.drugfoundation.org.nz/info/did-you-know/volatile-substances/>.
  - b. The Drug Foundation's online resources for volatile substances also include contact details for the Alcohol and Drug Helpline on 0800 787 797.
  - c. I urge all teachers and others who work with young adults and children to use these resources and others like them to educate the young about the many risks of huffing; that there is no safe level for inhaling solvents or other volatile substances; and about how young people can get help and support for their friends who may be at risk.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Kelly Amani entered into evidence during this inquiry in the interests of personal privacy and decency. An order under section 74 of the Coroners Act 2006 prohibits the publication of the address where the fire occurred along with the names of certain witnesses and any particulars that are likely to lead to their identification.

## Manukau [2020] NZCorC 105 (1 December 2020)

### CIRCUMSTANCES

Oliver Dwayne Jonathon Manukau of Auckland, aged 41, died on 4 August 2018 outside 87 Queen Street, Auckland Central of AMB-FUBINACA toxicity.

Around 1:15pm on 4 August 2018, a member of the public walking along Queen Street noticed Mr Manukau collapsed on the ground. The member of the public put Mr Manukau in the recovery position and others called emergency services. Mr Manukau soon went into cardiac arrest and ambulance staff performed CPR on him. Unfortunately, Mr Manukau could not be revived.

Mr Manukau was known to use synthetic cannabis and a post-mortem examination confirmed the presence of AMB-FUBINACA (a synthetic cannabinoid) and AMB-FUBINACA acid (a metabolite of AMB-FUBINACA) in his blood. The pathologist, Dr Kilak Keshu, commented that AMB-FUBINACA is reported to have an effect that is 75 times stronger than "THC" (tetrahydrocannabinol), which is the psychoactive compound found in cannabis. Dr Keshu also noted that the

majority of testing of synthetic cannabis submitted in New Zealand found the dangerous chemical AMB-FUBINACA to be present, and there was a cluster of AMB-FUBINACA related deaths reported in the middle of 2017.

#### COMMENTS OF CORONER WOOLLEY

- I. Unfortunately, Mr Manukau's consumption of synthetic cannabis has resulted in his death.
- II. The dangers of consuming synthetic drugs include:
  - a. It is promoted or sold as a form of synthetic cannabis, but that there is no cannabis in the product.
  - b. The synthetic drug can be made to look like cannabis by using dried plant or other material, but it is saturated in a synthetic drug not THC (tetrahydrocannabinol) the active ingredient in cannabis.
  - c. The pharmaceutical agents from which synthetic cannabis was developed were attempts to create new medications to treat spasms and epilepsy but were found to be unsuitable and were discarded. The nature of the synthetic drug is unknown to the purchaser and unknown or poorly understood by the manufactures/distributors in New Zealand.
  - d. The synthetic drugs, AMB-FUBINACA and 5F-ADB, have been the cause or contributing factor in a number of deaths in both the Waikato/BOP , elsewhere in New Zealand, and overseas .
  - e. The quantity and strength of AMB-FUBINACA and 5F-ADB is an unknown gamble which can have fatal consequences.
  - f. Individuals who fall unconscious after consumption of synthetic drugs can die if they do not receive timely and appropriate medical assistance; dying from cardiac event induced by consumption of the drug, or as a result of being comatose and asphyxiating on their own vomit, or they may suffer a hypoxic brain injury.
- III. Due to the circumstances and cause of this death I repeat the recommendations made by Coroner Matenga in reliance on the expert evidence of Dr Quigley in the coronial inquiry into the death of McAllister, CSU-2017-HAM-000336:
  - a. In order to prevent future deaths from synthetic cannabinoids, Dr Quigley suggested that an all-encompassing harm reduction approach which reduces demand, supply and easy access to treatment for those seeking assistance should be developed. He cautioned that any recommendations on increasing enforcement, targets manufacture, trafficking and supply, while not overly penalising users as this can create a barrier to those seeking medical attention, even in cases of emergency.
  - b. Dr Quigley submitted that efforts should be made to inform users of synthetic cannabis, their families and associates, of the dangers of synthetic cannabinoids and the need to get help immediately if someone collapses. I agree.

- c. Dr Quigley's advice for the families or associates of synthetic cannabis users was that if a person who has used synthetic cannabis collapses, that person should be immediately shaken to attempt to rouse that person. If the person rouses, that person should then be placed in the recovery position and a call for help should be made. If the person does not rouse, then call for help and commence chest compressions. The call taker who answers the emergency call for help will provide assistance. Do not delay.
- IV. Dr Quigley is a vocational specialist in Emergency Medicine, he has completed additional studies in clinical toxicology and conducted research in forensic toxicology. He is a recognised expert in emergency management and treatment of drug and alcohol presentations.
- V. While I agree with, and endorse, Dr Quigley's advice, I am unable to make any recommendations in this regard, as I have not heard any evidence. I am aware however, that Coroner Mills is conducting a joint inquiry into deaths from synthetic cannabis which occurred in Auckland. I will refer this suggestion to Coroner Mills to consider in the course of her joint inquiry. No recommendations will be made by me.
- VI. These findings will be distributed to the media for publication.

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

## Ms X [2020] NZCorC 92 (9 November 2020)

### CIRCUMSTANCES

Ms X of Avondale, Auckland died on 10 September 2017 at Auckland Hospital of hypoxic/ischaemic encephalopathy secondary to mixed drug toxicity (MDMA and 25I-NBOMe).

On 8 September 2017 Ms X, her partner and eight associates travelled from Auckland to Karikari for a short holiday. The night before the trip, Ms X purchased drugs to take with her. These included cannabis, MDMA (Ecstasy) and 25I-NBOMe (LSD) along with NOS or nitrous oxide gas.

Sometime between 10 and 11pm on 8 September 2017 the group arrived at a bach that they had hired and celebrated one of the associate's birthdays. Some attendees smoked cannabis and used NOS. At some point during the evening Ms X spoke to one of her friends about "candy flipping", that is, mixing LSD and MDMA.

The next morning, Ms X and her friend were in the kitchen and decided to try candy flipping by taking two MDMA tablets and two capsules of LSD. Afterwards Ms X's friend ate and drank water, but Ms X did not. Later that day Ms X became agitated and started screaming. She became physically aggressive. Her partner picked her up and put her in the shower to calm her down. She was calm for approximately 10 or 15 minutes. Her partner then got into the shower with her and noticed blood running down her chest from her tongue. He called out for help, but the others were out on a day trip.

Ms X began to have a seizure. Her partner took her out of the shower, laid her on her side on the floor and called emergency services. Ms X stopped breathing and he administered CPR until the emergency services arrived. Ms X was



taken to Whangarei Hospital where she lapsed into a coma. She was transferred to Auckland Hospital, where she died on 10 September 2017.

#### COMMENTS OF CORONER TETITAHA

- I. From reviewing the evidence in this file, I have determined to make the following comments to the Ministry of Health about the literature available to young people regarding the dangers of 25I NBOMe and “candy-flipping” pursuant to section 57A of the Coroners Act 2006.
- II. There is a gap in the available literature from reliable government sanctioned public health sources on the likely effects of 25I NBOMe taken singularly or in combination with MDMA i.e. “candy-flipping”.
- III. A google search of “25I NBOMe” and “candy-flipping” returned no New Zealand government approved websites that spoke about the health dangers of consuming this drug in combination with others. The only New Zealand government websites that returned any results were about the criminal penalty for being found in possession of the drugs.
- IV. This death exemplifies the lack of reliable information available to young people about the dangers of drugtaking including 25I NBOMe taken singularly or in combination with MDMA i.e. “candy-flipping”. This leaves them vulnerable when making decisions about drug taking to ad hoc advice garnered from potentially unreliable sources such as social media.
- V. The Ministry may be minded to consider providing literature targeting young people aged 18 to 25 years about the dangers of this drug and certain drug taking practices.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Ms X, as well as publication of her name and those of the witnesses in the interests of justice and decency.

## Drowning

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### English [2020] NZCorC 99 (23 November 2020)

#### CIRCUMSTANCES

Sarah Pauline English, aged 20, of Christchurch died on 2 July 2017 at Christchurch from an unwitnessed collapse and immersion in a bath, complicated by epilepsy and cerebral palsy.

Sarah had cerebral palsy and epilepsy as well as other medical issues, and required high level, 24-hour care. She was cared for by her parents, as well as by Renee Gardiner. Mrs Gardiner was employed by Sarah’s parents to care for her a few days each week.

On 2 July 2017, Sarah was staying at Mrs Gardiner’s house. At around 7:45pm, Mrs Gardiner ran a bath for Sarah. The bath had about 30cm of water and Mrs Gardiner helped Sarah in. Mrs Gardiner then returned to the kitchen to put away dishes but was listening out for Sarah while she was doing so. About ten minutes later, Sarah became silent and was no

longer making noises. Mrs Gardiner went to check on Sarah and found her submerged in the water. CPR was commenced, but sadly Sarah could not be revived.

It was unable to be ascertained whether a medical event preceded Sarah becoming immersed, or if the immersion occurred for some other reason.

#### COMMENTS OF CORONER TUTTON

- I. Sarah is unlikely to have died when she did if she had not been alone in the bathroom.
- II. Her death is a tragic reminder of the need for vigilance when vulnerable people are in or around water and of the speed with which tragedy can strike in those circumstances.
- III. The dangers of leaving vulnerable people alone in or around water are known. I do not consider there are any recommendations I could usefully make to reduce the chances of further deaths in similar circumstances.

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

## Zarifeh [2020] NZCorC 98 (19 November 2020)

#### CIRCUMSTANCES

Samuel Jacob Zarifeh, aged 27, of Christchurch died on 9 December 2017 at Landsborough River, West Coast of drowning.

On the weekend of 9 December 2017, Mr Zarifeh and a group of colleagues and friends were on a rafting and kayaking trip on the remote Landsborough River, which flows from the Southern Alps to Haast on the West Coast. The trip was organised by Jared Mitchell and the participants had varying levels of rafting and kayaking expertise. Mr Zarifeh had done one or two rafting trips prior to this one. Another participant, Edward Murphy, had decades of kayaking and rafting experience.

The night before the group entered the water there was a heavy rainfall. When they commenced their journey on 9 December 2017, the Landsborough River was in flood. Mr Zarifeh was inside a raft with five others while four other members of the group were in a kayak. About half an hour after setting forth, the raft hit a rough water feature in the river and flipped. Four of the raft crew were able to hold onto the raft and make it safely to shore, but Mr Zarifeh lost contact with the raft when it hit rough water in a gorge.

Later that day, Mr Zarifeh's body was recovered approximately 40km downriver. During the inquiry into Mr Zarifeh's death, the Coroner consulted two rafting and safety experts, Grant South and Steve Glassey.

## COMMENTS OF CORONER CUNNINGHAME

- I. According to the Annual Drowning Reports produced by Water Safety New Zealand website, there were 15 river fatalities in 2017, 12 in 2018, and 19 in 2019.<sup>1</sup> The introduction to the 2018 report discusses the popularity of recreational water activities in New Zealand and states:<sup>2</sup>

Recreation in, on and around the water is a cultural and popular pastime for millions of people in New Zealand. As an island nation, our beaches, rivers and lakes are some of the most magnificent in the world. A moderate climate, accessible waterways, including public and residential pools provide ample opportunities for Kiwis, immigrants and tourists alike to recreate and participate in water sports and activities year round. This is part of the New Zealand lifestyle.

With any water comes risk and sadly every year far too many people lose their lives or are injured in, on or around the water. The real tragedy is that most drownings and injuries are preventable.

- II. Mr Glassey considered that there is a lack of resources and guidelines available for recreational rafters. Both Mr South and Mr Glassey considered that more safety information and safety training courses for recreational rafters would assist in preventing deaths in similar circumstances.
- III. In accordance with s 57B of the Act, I engaged in consultation. Feedback was sought from Whitewater NZ, Maritime NZ, and Water Safety New Zealand. Whitewater NZ provided very helpful feedback, as did Mr South and Mr Glassey. Mr Murphy and Mr Mitchell also chose to provide feedback which I have duly considered. I am grateful to everyone who has assisted with this process.
- IV. I therefore make the following comment:

Recreational river rafting and kayaking trips are increasingly popular in New Zealand and every effort should be made to ensure that anyone on a river is as well prepared and as informed as possible.

Recreational river rafters and kayakers should consider the following points to ensure that they, and others with them, have the best chance at survival should they get themselves into danger:

- a. Know the ability, experience, and physical fitness of all members of your group and choose a grade of river for your trip which is appropriate for everyone.
- b. Check weather forecasts and monitor the weather and river conditions. Do not travel on a river in dangerous conditions.
- c. Using a Satellite Communications Device or a Personal Locator Beacon (PLB) is encouraged. Satellite Communications Devices and PLBs can be hired throughout New Zealand. They are

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<sup>1</sup> Water Safety New Zealand Drowning Report 2019 found at [www.watersafety.org.nz/drowning%20statistics](http://www.watersafety.org.nz/drowning%20statistics).

<sup>2</sup> Found at <https://drowningreport.watersafety.org.nz/>.

also relatively affordable to buy and can be registered for free. Information can be found on the [beacons.org.nz](http://beacons.org.nz) website.

- d. Personal safety gear including a flip line (if rafting), throwbags, pin extraction equipment (minimum 2 carabiners, 2 pulleys, and a prusik cord), whistle, survival kit and first aid kit, should be carried by each individual on a river trip. Additional trip-specific safety equipment should be carried as required by the group and the river. Members of the group should be confident in the use of this safety equipment.
- e. Discuss safety plans and practice safety drills with other members of your group before setting off on any river trip.
- f. Along with an approved lifejacket or personal flotation device (PFD) and helmet, it is best to wear a drysuit to help prolong body warmth and increase buoyancy in the event of water immersion. A wetsuit may be a suitable alternative. If neither option is available, ensure at the least that a dry top and pants and adequate thermal layers are worn.
- g. Before embarking on a river trip make sure you have up-to-date information about the river. This should be done by reading the online NZ River Guide and contacting local paddlers or commercial river guides.
- h. Consider attending a nationally or internationally recognised whitewater safety training course. Local examples currently include the NZOIA River Rescuer Courses run by the NZ Kayak School (Murchison), Peel Forest Outdoor Centre (Peel Forest) and the Hillary Outdoors Centre (Tongariro); and the raft guide training provided by the New Zealand Rivers Association.
- i. For any recreational trip in the outdoors, safety is both an individual and a group responsibility. Groups should engage in collaborative leadership processes and collective discussions in regard to decision-making about safety. Having experienced and able members in the group who are able to lead and help guide decision-making is highly recommended. In some circumstances, it will be appropriate to nominate a suitably informed and experienced trip leader to be present.

#### **RECOMMENDATIONS OF CORONER CUNNINGHAME**

- I. I recommend that Whitewater NZ, Maritime NZ, and Water Safety New Zealand include the above points in any safety information they provide to recreational river rafters and kayakers.

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

# Fall

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## Sandilands [2020] NZCorC 73 (7 October 2020)

### CIRCUMSTANCES

Ian Erskine Nimmo Sandilands, aged 60, died on 26 January 2019 at Ranfurly of a fractured cervical spine after an accidental fall from a ladder while cutting a tree branch.

Mr Sandilands had repeatedly offered to trim a willow tree branch that was overhanging the clothesline at a neighbouring motel as an unpaid favour to the motel owner, Cindy McCallum. Ms McCallum eventually agreed and at about 10:50am on 26 January 2019 Mr Sandilands climbed a ladder to trim the branch. He set up a metal three metre “A” frame ladder and said that he had “all the gear”. A short time later a cleaner looked out of a window and saw that Mr Sandilands was on the ground. She had not seen him fall. At the same time another neighbour heard a crash and a scream and looked over the fence and saw someone tangled in a tipped-over ladder. Assistance was provided but Mr Sandilands had no pulse and was not breathing. He was pronounced dead at 12:24pm.

WorkSafe was notified and completed an investigation report, concluding that Mr Sandilands could have taken the following reasonably practicable actions:

Completed an adequate risk assessment and instructed Ms McCallum that he did not have the correct equipment to complete the task of trimming the willow branch.

- Used an adequate and approved method for the trimming of the willow branch such as:
  - o [Using] appropriate PPE.
  - o Trimming the branch using a pole saw, meaning all work would have been conducted from ground level.
  - o Cut the branch down in sections, these would have been more manageable than the eight-metre long willow branch.
  - o [Using] a working platform rather than an “A” frame ladder giving himself greater stability, if working at height was a must.

WorkSafe concluded that Mr Sandilands did not use a safe procedure for trimming the tree branch, and that inadequate work procedure and inadequate risk assessment were contributing factors to his death.

The report referred to guidelines which individuals who work in the forestry and arboriculture should be aware of.

*A Guide to Safety With Chainsaws (November 2011)*

### SOME DO'S AND DON'TS

Here are some basic do's and don'ts that apply no matter how experienced you are:

- Do not operate a chainsaw above shoulder height or above ground level, such as in a tree or off a ladder, unless qualified and experienced to do so.
- Always have someone within calling distance -never work alone while using a chainsaw.
- Never operate your chainsaw under the influence of alcohol or drugs.
- Never operate your chainsaw when you are fatigued. If you get tired when using your chainsaw, have a rest -you need to stay alert and be in control.
- Your chainsaw is designed to cut wood -never cut any other material or use your chainsaw guide bar for levering or digging.
- Always match the size of your chainsaw and bar with the material being cut. Don't try to use a small chainsaw and bar to fell a large tree.

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#### **WHAT YOU NEED**

**FOOTWEAR.** Boots should have steel toe caps and give firm ankle support. Lace-up types must be securely fastened so that you don't trip on the laces.

**LEG PROTECTION.** Wear good-quality chainsaw operators' safety trousers or chaps. These should be to AS/NZs 443.3:1997.

**SAFETY HELMET.** Wear a helmet to protect your head from falling objects and to minimise the risk of injury to the face in the event of a kickback

**EARMUFFS.** Wear earmuffs rated Class 5.

**EYE PROTECTION.** If you are working in very dusty conditions, wear goggles. If there's a danger of flying debris, use a helmet visor.

**GENERAL CLOTHING.** This should fit fairly closely but be comfortable and allow free movement.

*Safety and Health in Arboriculture (November 2012)*

#### **3.2.8 LADDERS**

Improper use of ladders is a major work hazard. The most common causes of accidents are ascending or descending improperly, failure to secure the ladder, holding objects while ascending or descending, or structural failure of the ladder.

All ladders shall comply with an appropriate industrial standard. For example:

- *NZS 3609:1978 Specification for timber ladders*
- *ANSI A14.1-1982, Ladders – Portable wood*

- *NZS 5233:1986 Specification for portable ladders other than timber*
- *ANSI A14.2-1990, Ladders – Portable metal.*

Ladders made of metal or other conductive material shall not be used where electrical hazards exist. Only non-metallic ladders equal to or exceeding the strength of wooden ladders shall be used.

Only ladders specifically designed as a working platform shall be used to work from. Other ladders may be used for access and egress.

### **3.3.1 TREE PRUNING GENERAL PROVISIONS**

Effective communication shall be established between the arborist in the tree and the ground crew before cutting and/or dropping branches.

In a climbing situation, the climber should be positioned at or above the branch to be worked on.

Avoid situations where there is a likelihood of the branch kicking back or striking the operator.

A separate lowering line shall be attached to limbs that cannot be dropped safely or controlled by hand. Arborist climbing lines and lowering lines shall not be run through the same crotch.

Partially cut branches or hangers shall not be left unsecured in trees upon completion of work.

Commonly accepted tree pruning standards include ANSI A300, BS 4373, and BS 3998.

*Approved Code of Practice for Safety and Health in Forest Operations (December 2012)*

## **PRUNING**

### **10.4.1**

When carrying out pruning from a ladder, the operator shall wear a fall restraint device once they reach three metres (the height of the operator's feet from the ground) unless they have been deemed competent.

For information on the process of deeming competence for ladder pruning refer to the Competenz Good Practice Guidelines for Silvicultural Pruning.

### **10.4.5**

All top handle saws shall have a cutter bar guard fitted.

### **10.4.6**

Only top handle saws shall be used when ladder pruning with a chainsaw.

## **COMMENTS OF CORONER CUNNINGHAME**

- I. The risks inherent in using chainsaws from ladders are well known. As can be seen from the excerpts quoted above, WorkSafe has endeavoured to promote safe practices in arboriculture and tree felling by way of the publication of guidelines.

- II. I endorse the advice given by the WorkSafe guidelines. This advice should be considered by all people who wish to work on trees, whether or not the work is paid.
- III. If individuals feel that a task is outside their level of competence or experience, or they do not have adequate equipment for the task, then they should consider involving a professional arborist.

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

## Fire

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### Halatanu [2020] NZCorC 112 (16 December 2020)

#### CIRCUMSTANCES

Henele Maafu Halatanu, aged 55, of Pukekohe, Auckland died on 28 July 2018 at Pukekohe, Auckland from the effects of fire (soot inhalation and carbon monoxide toxicity).

On 28 July 2018, Mr Halatanu and his partner, Teresa Turangakino, had briefly left Mr Halatanu's house in Pukekohe to go to the local store. Mr Halatanu's home, which he rented, was not connected to power. Instead he used candles for lighting.

When they arrived back, the pair saw that a fire had started inside the property. They both entered the house and encountered thick smoke and saw flames. Mr Halatanu told Ms Turangakino to leave, which she did but Mr Halatanu stayed inside the house. He was calling out to Ms Turangakino, but eventually stopped making noise.

Ms Turangakino tried to break into the house to assist Mr Halatanu but she was unable to do so. Fire Services eventually arrived, successfully put out the fire, and recovered Mr Halatanu's body.

#### COMMENTS OF CORONER GREIG

- I. Mr Halatanu's death highlights important safety messages in relation to the prevention of fires in the home; speedy detection of fires in the home and the need to take very prompt action to get out of a building that is burning.
- II. First, as noted on the Fire and Emergency New Zealand website,<sup>3</sup> if not used safely, candles can be a serious fire hazard. The website sets out the following safety message which I emphasise:
  - a. Burning candles should never be left unattended.

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<sup>3</sup> <https://fireandemergency.nz/at-home/in-the-bedroom/>.



- III. Secondly, the importance of working smoke alarms in residential homes. These devices sound an alarm when they first sense smoke. Properly installed and maintained smoke alarms are one of the best and least expensive means of providing an early warning of a potentially deadly fire.
- IV. All residential properties should have smoke detectors and in all rental homes working smoke alarms or detectors are compulsory. New smoke alarms must be photoelectric and have a long battery life or be hard-wired. The Residential Tenancies Act 1986 places obligations on both landlords and tenants. Landlords must ensure smoke alarms are working at the start of each new tenancy and remain in working order during the tenancy. Tenants must not damage, remove, or disconnect a smoke alarm; replace dead batteries during the tenancy if there are older-style smoke alarms with replaceable batteries and let the landlord know if there are any problems with the smoke alarms as soon as possible.<sup>4</sup> The importance of these obligations in ensuring that there are working smoke alarms to give early warning of a house fire cannot be underestimated.
- V. Finally, the importance of realising how fast fire spreads and the need to get out of a house quickly if there is a fire and not go into a burning house or back into a burning house cannot be overstated. Fire and Emergency New Zealand advises that if there is a fire in your house, you will have around 3 minutes to get out before the fire becomes unsurvivable. If there is smoke it will be hot and poisonous and that the best thing to do is get on your hands and knees and crawl low and fast to escape smoke. “Get down, get low, get out.”<sup>5</sup>
- VI. Fire and Emergency New Zealand’s advice is clear: you should not go into, or back into, a burning house. Again, I emphasise the importance of this message.

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

## Lowther [2020] NZCorC 113 (17 December 2020)

### CIRCUMSTANCES

Jeanne Henry Lowther, aged 73, of Amberley, died on 11 September 2016 at Amberley from the effects of fire.

Mr Lowther lived alone in his home in Amberley. He was a smoker, and was reported to drink regularly. He also received morphine tablets for back pain following an accident where he broke his back in 2008. Due to this pain, he slept on his chair in the lounge rather than in his bed. His neighbours reported that his lounge was usually cluttered with newspapers and other papers. Mr Lowther also used a heater to keep warm, and this was plugged into a power strip, along with a number of other items.

On the morning of 11 September 2016, Mr Lowther was seen with an unlit cigarette by his nurse who visited and gave him his morphine tablet. About an hour after the nurse’s visit, Mr Lowther’s neighbour saw flames inside Mr Lowther’s

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<sup>4</sup> <https://fireandemergency.nz/at-home/in-the-bedroom/>.

<sup>5</sup> <https://www.fireandemergency.nz/in-the-event-of-fire/what-to-do-in-a-house-fire/>.

house. The neighbour attempted to get inside, but the flames prevented him and other neighbours who had shown up to offer assistance from entering the house.

Fire Services eventually arrived and were successful in putting out the fire and retrieving Mr Lowther's body. The direct cause of the fire could not be ascertained, but Fire Services considered the likely cause was due to a flaming cigarette being dropped in the lounge or due to an electrical event.

## RECOMMENDATIONS OF CORONER WINDLEY

- I. In 2018 Fire and Emergency New Zealand commissioned the University of Otago to undertake research into the causes of unintentional domestic fatal fires in New Zealand, using case studies and coronial case statistics between 2007 and 2014.<sup>6</sup> The research focused on the two key questions: Who is at highest risk of fire-related fatal injury; and what are the common causes and circumstances of fire-related fatal injury? The research was intended to inform Fire and Emergency priorities and targeted action to effectively reduce fire-related fatalities in New Zealand.
- II. The research report found that the majority of residential fires were due to cigarettes, closely followed by electrical faults and combustibles being placed too close to a heat source. In addition, households with male residents aged 60 and over, in areas with high deprivation scores, were found to be overrepresented in fire fatalities. The research report also noted that victims under the influence of alcohol and/or drugs had an increased risk of unintentional fire-related fatal injury. These findings make clear that unfortunately the circumstances of Mr Lowther's death are not unusual in New Zealand.
- III. I have considered the recommendations made in the research report which are relevant to my findings as to the cause and circumstances of Mr Lowther's death. Those recommendations (reproduced below) are directed to reducing the number of unintentional fire-related fatalities with a focus on the implementation and promotion of passive interventions. They are concerned primarily with preventing fires in the first instance. I fully endorse these existing recommendations and make no further recommendations:
  - a. Smoking-related fire deaths are identified as a significant risk in the study and in previous case reviews in New Zealand. Accordingly, there is a strong case to aim strategies to the period prior to ignition (pre-event) by addressing the habitual smoker (host) and the cigarette (vector). As the most efficient means of preventing cigarette-related fire fatalities Fire and Emergency support and promotion of the comprehensive tobacco control Smoke Free 2025 initiatives, particularly those initiatives that create Smoke Free Homes. Fire and Emergency should promote and support an update of voluntary standards to require cigarette manufacturers to introduce Reduced Ignition Propensity cigarettes for sale in New Zealand along the lines of established legislation in the United States, Canada and Australia. Continued advocacy for the development of standard, implementation and enforcement for

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<sup>6</sup> Lilley, R, McNoe B, Duncanson, M. 2018. Unintentional Domestic Fire - Related Fatal Injury in New Zealand: 2007-2014. Fire and Emergency New Zealand Research Report Number 167. <https://fireandemergency.nz/assets/Documents/Files/Report-167-Unintentional-domestic-fire-related-injury-in-New-Zealand.pdf>.

consumer products involved in the ignitions of domestic fire incidents. This should include fabrics used for upholstered furniture, bedding and adult clothing, as well as cigarettes and heaters.

- b. Continued advocacy for the development of standards, implementation and enforcement for consumer products involved in the ignitions of domestic fire incidents. This should include fabrics used for upholstered furniture, bedding and adult clothing, as well as cigarettes and heaters.
- c. Fire risks associated with alcohol and drug consumption indicate a need for Fire and Emergency to continue participation in and support of intersectoral strategies and partnerships to improve the well-being of New Zealanders, including consideration of the social and economic policy on fire safety particularly among deprived communities and households at greatest risk of fire-related injury. Fire and Emergency should continue the development of further targeted education initiatives to address these significant contributors to fire fatalities to effect long term behavioural changes in 'at risk' populations. Fire and Emergency should build broader partnerships for fire prevention with older people personal care and health providers including the possibility of fire prevention training for personal carers.
- d. That Fire and Emergency continue support and advocacy for embedding fire safe design and materials as a means of primary prevention, including the installation of sprinkler systems into new and renovated residential dwellings, in future Building Code legislative and regulatory updates. That Fire and Emergency continue to promote the use of smoke alarms in domestic dwellings through public education and community-based fire safety programmes which intentionally include private rental properties. That Fire and Emergency support the extension of existing mandatory stipulations to include mandatory installation of smoke alarms in all private dwellings. Future Fire and Emergency promotion and awareness activities need to focus on supporting tenant maintenance of operational alarms in rental settings.

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

## Leisure

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### Hohaia [2020] NZCorC 89 (4 November 2020)

#### CIRCUMSTANCES

Tuwhakararo Hohaia (also known as Tuwhakararo Waera-Hohaia), aged 9, of Pungarehu, South Taranaki died on 27 March 2020 at Pungarehu of accidental asphyxiation resulting from ligature suspension involving a rope swing.

On 27 March 2020 Tuwhakararo was visiting his father's house at Pungarehu with his brother. At around 5:00pm, both boys were playing in the front yard, with Tuwhakararo playing on a 'Tarzan' rope swing tethered to a large tree. The rope swing is described as having a formed loop which is used to stand in while swinging.

While Tuwhakararo's father, Hohepa Hohaia, was chopping wood, Tuwhakararo was lying on a log that sits beneath the rope swing with the rope tied around his neck playing dead. Hohepa told him to stop doing this, and then went inside to take a phone call. A few minutes later Tuwhakararo's brother came inside and told his father that Tuwhakararo was on the ground and would not wake up. Hohepa went outside and found Tuwhakararo unresponsive. Despite CPR, Tuwhakararo could not be revived.

#### COMMENTS OF CORONER WINDLEY

- I. An important part of our children's learning and development involves getting outside to play, to explore, and to be adventurous. Parents and caregivers can take practical steps to enhance their child's safety through satisfying themselves that the play equipment is safe, and that the play activity is within their child's capabilities. Safe Kids recommends that for younger children, parents need to supervise them and be actively involved in teaching them responsible risk taking. For older children, parents and caregivers have to help them understand consequences of actions that they may take.<sup>7</sup>
- II. The Health Quality and Safety Commission's Child and Youth Mortality Review Committee's "Special Report: Unintentional suffocation, foreign body inhalation and strangulation" issued in March 2013<sup>8</sup> identifies the risk from dangerous play with ropes or cords. At the time of releasing that Report there had been six deaths of New Zealand children over the age of six years attributed to dangerous play with ropes. The Report also referenced deaths in Australia having been caused by homemade rope swings.
- III. The Report advises that children need to be educated about safe play with ropes and that messaging needs to be reinforced by parents, teachers, caregivers and the media. Put simply, if children are playing with ropes or cords then they themselves, their parents, caregivers and other responsible adults should make sure the rope is not put around the child's own neck or chest, or someone else's neck or chest.
- IV. The evidence before my inquiry is that Tuwhakararo was earlier observed by his father lying on the log with the rope tied around his neck, playing dead. Hohepa states he told Tuwhakararo to take the rope off his neck and to stop doing that, and Tuwhakararo complied and removed the rope from his neck. I am satisfied that on this occasion Hohepa followed the best practice advice detailed above. Despite that, however, while not under his father's direct supervision Tuwhakararo subsequently failed to appreciate the danger of his continued play with the swing rope around his neck.
- V. In these circumstances, and in light of existing advice detailed above, I do not propose to make any new comments or recommendations, but rather reiterate the need for children, their parents, caregivers, and other responsible adults to be educated about safe play with ropes.

<sup>7</sup> See <https://www.stuff.co.nz/southland-times/news/67633223/injured-girls-mum-calls-for-removal-of-rope-swing>.

<sup>8</sup> Available at <https://www.hqsc.govt.nz/assets/CYMRC/Publications/CMYRC-special-report-March-2013.pdf>.

- VI. I direct a copy of these Findings be sent to the following organisations for further dissemination as appropriate:
- a. Kids Safe; and
  - b. The Child and Youth Mortality Review Committee of the Health Quality and Safety Commission.

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

## Mr X [2020] NZCorC 91 (5 November 2020)

### CIRCUMSTANCES

Mr X, aged 52, died on 14 June 2019 in Canterbury of asphyxia following an accident during autoerotic strangulation.

Mr X's wife arrived home at about 11:15pm on 14 June 2019. Mr X was not in the house which was unusual. The house was searched without success. Mr X was found in the garage. He was suspended in a complex system he had set up that included a device to allow breath suppression. Mr X was deceased. His death was an accident that occurred in the context of a solo "kink" activity. In using the word "kink" the Coroner did not wish to cast any aspersions on those who choose to engage in non-conventional consensual sexual activities. Some of these activities carry risk, of which Mr X's death is a tragic example.

### RECOMMENDATIONS OF CORONER CUNNINGHAME

- I. If I had been able to identify a community or publication where Mr X had obtained information about, or had discussed, autoerotic asphyxiation, I would have recommended that clear advice about the risks inherent in the practice should be made freely available to members or readers. I would also have recommended that any relevant safety advice be publicised in the same manner.
- II. Any recommendations or comments in relation to this matter can therefore only be general in nature. I repeat my observation above. Those in the kink community should be aware of the high risk involved when they explore acts which involve suppression of breath.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of (i) the deceased's name and any other details that would allow him to be identified; (ii) any of the photographs of the deceased, or the garage in which his body was found, entered into evidence; (iii) the post-mortem report, and the summary of the same given at paragraphs [11] and [12] of the Findings; (iv) the specific details entered into evidence and set out in paragraphs [28], [29] and [33] of the Findings that describe the system the deceased constructed (it may be described as a "complex system" or "a device to allow breath suppression"); (v) the details set out in the application for non-publication; and (vi) the affidavit evidence filed in support of that application.

# Medical Care

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## Cambie [2020] NZCorC 74 (12 October 2020)

### CIRCUMSTANCES

Daisy Ellen Cambie, aged 89, died at Waitakere Hospital on 6 December 2016 from complications of a pelvic fracture, with sepsis (related to a urinary tract infection) and dehydration as other significant conditions which also contributed to her death.

At the time of her death Mrs Cambie resided at Amberwood Rest Home in Auckland, a facility privately owned and operated by Oceania Healthcare. She had had a long history of severe mental illness which was treated by clozapine and on which she was stable. However, from 23 November 2016, her mood had reportedly altered and she was showing increased signs of paranoia and delusions.

Between 22 and 26 November 2016, Registered Nurse (RN) Kim was on duty at Amberwood and had responsibility for administering Mrs Cambie's medication. He admitted on 26 November 2016 that he had omitted to administer Mrs Cambie's medication for two consecutive nights, as he did not know where the medication was stored. RN Kim resigned soon after and no longer works at Amberwood. Mrs Cambie was resumed on her clozapine.

However, RN Kim's omission in administering Mrs Cambie's medication precipitated a deterioration in her mental state, an increase in her already high falls risk, and poor food and fluid intake. Despite fall management strategies and interventions, she fell from her bed and suffered a hip fracture. Although clozapine was restarted, Mrs Cambie continued to deteriorate. Her poor fluid intake left her clinically dehydrated, although blood test results were not available to confirm this until some days later. Despite this, there appeared to have been no escalation for medical review between 2 and 5 December and it was not until the Clinical Manager returned to work on 5 December that Mrs Cambie was admitted to Waitakere Hospital. While in hospital, Mrs Cambie's condition deteriorated further, and she passed away on 6 December 2016.

The Deputy Health and Disability Commissioner investigated the care and treatment provided to Mrs Cambie by Amberwood, in particular Amberwood's response to Mrs Cambie's mental and physical deterioration and recorded the outcome of that investigation in a report (the HDC Report).

The HDC Report concluded that Amberwood failed to escalate Mrs Cambie's care sooner once the extent of her deterioration was clear, and that staff did not put sufficient interventions in place to manage her poor food intake. There was also an inexplicable delay of several days in obtaining Mrs Cambie's blood tests, which affected the timeliness of escalation. In addition, the HDC Report criticised the fact that Amberwood did not start a short-term care plan for the management of Mrs Cambie's pelvic fracture and associated pain, and that the healthcare assistants who assessed her pain were not trained in pain assessment.

The HDC Report referred to information obtained in the course of the investigation in relation to administration of Mrs Cambie's medication. RN Kim is recorded as having told the HDC that the only day he did not administer Mrs Cambie's medication was 26 November 2016, despite signing the medication chart recording that Mrs Cambie's medication had been given to her. He explained that he was unable to find the medication in the treatment room and had notified the night duty nurse, RN Diaz, about this at the time of handover. He recalled that RN Diaz had shown him where clozapine was

stored in the fridge. RN Kim had undertaken to administer it to Mrs Cambie before finishing his shift, but RN Diaz had instead offered to do it.

RN Diaz told the HDC that RN Kim had told her at handover that he had not administered Mrs Cambie's medication because he could not find it. However, when she reviewed the medication chart, she saw RN Kim had signed the 9pm medication round and she therefore decided not to administer a further dose to Mrs Cambie to avoid the possibility of a double dose being given. RN Diaz reportedly tried to check with RN Kim by contacting him by telephone, but was unable to make contact with him. RN Kim denied having any missed calls from RN Diaz that night.

The HDC Report noted that Amberwood's Business and Care Manager told the HDC that she believed Mrs Cambie's doses were missed on 25 and 26 November 2016. As noted above, RN Kim remained adamant that only the 26 November dose was missed. Although RN Kim told the HDC his recollection and belief was that he had not signed the medication chart for 26 November 2016, he later acknowledged that the signature looked like his.

With respect to this issue, the HDC Report was highly critical of:

- a. RN Kim signing the medication chart on 26 November 2016 to say that he had administered Mrs Cambie's clozapine, when he had not done so;
- b. RN Diaz not documenting at the time her concerns about the medication given that day;
- c. RN Kim and RN Diaz failing to follow Amberwood's medication procedure; and
- d. Amberwood failing to provide RN Kim with adequate training in medication management before he started unsupervised medication rounds.

The HDC Report found that Amberwood failed to provide Mrs Cambie with an appropriate standard of care and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights. Specifically, Amberwood failed to provide Mrs Cambie with an adequate standard of care in relation to the management of her medication, pelvic fracture and pain, and care plan documentation. As a consequence, Mrs Cambie's deterioration and pain were not identified in a timely manner or addressed adequately.

#### **COMMENTS OF CORONER WINDLEY**

- I. A further issue for me to consider is whether there are any comments or recommendations I could make, pursuant to sections 57(3) and 57A of the Coroners Act 2006, that may reduce the chances of future deaths in similar circumstances.
- II. In this respect it is appropriate to consider the recommendations made the Deputy Health and Disability Commissioner and the response to those recommendations.
- III. The Deputy Health and Disability Commissioner made the following recommendations:
  - a. that Amberwood's owner, Oceania Healthcare, provide a written apology to Mrs Cambie's family, and review (a) the effectiveness of service changes it has implemented since these events; and (b) the timeliness and effectiveness of its staff induction training;

- b. that an audit on Amberwood be undertaken to ensure that (a) all monitoring charts have been completed and followed up as needed; and (b) all resident documentation has been updated to show family preferences for ongoing care should their family member's condition deteriorate significantly. Related to that, the Deputy Commissioner sought an update in relation to the roll-out of the new resident information system "eCase" across all Oceania Care Company Limited facilities;
  - c. that the Nursing Council of New Zealand consider whether a review of RN Kim's competence in the area of medication administration is warranted.
- IV. In response to the HDC's provisional opinion, Oceania Healthcare advised that a clinical governance review had been commenced in November 2019 and was expected to report to the CEO and Board in early 2020. The terms of reference for the independent review team encompass all areas of "clinical and care for Oceania." Oceania undertook that HDC's report would be considered not only in response to that review, but also by the Clinical Governance Committee which has oversight of all clinical and care activities within Oceania.
- V. In a response dated 7 October 2020 to advice of proposed adverse comment in these Findings, Dr Frances Hughes, General Manager Nursing and Clinical Strategy for Oceania Healthcare, provided the following update:
  - a. Oceania submitted a notification to the Nursing Council for RN Kim;
  - b. the clinical governance report had been completed and reported to the board of directors and recommendations presented to the Clinical Governance Committee in November 2019. A new clinical governance framework was adopted and accepted;
  - c. a review of the effectiveness of monitoring charts and timeliness of staff training was completed. A new Advance Directive form was developed to ensure relevant information is clear. Advance Directives are reviewed as part of six-monthly resident care reviews;
  - d. RN and healthcare assistant training now includes the new Frailty Care guides and the use of early warning system tools to escalate resident changes in a timely manner. These tools are currently being promoted across all Oceania Healthcare sites and form part of the mandatory annual training day;
  - e. the eCase resident management system has been rolled out nationally with the last Oceania Healthcare site to be completed by the end of this month.
- VI. The HDC Report highlights the importance of appropriate care planning, medication management, staff training, and timely escalation of care. In light of the HDC's targeted recommendations, appropriately informed by expert advice, and the reported uptake of those recommendations by Oceania Healthcare, I do not consider there to be any additional comments or recommendations that I can make which may reduce the chances of future deaths in circumstances similar to Mrs Cambie.



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

## Hassan [2020] NZCorC 76 (13 October 2020)

### CIRCUMSTANCES

Gloria Mary Romani Hassan, 93 years of age, of Stoke died on 18 May 2016 at Nelson Hospital, Tipahi Street, Nelson of a subdural haematoma due to a fall and head injury sustained on 14 May 2016. Mrs Hassan was a resident at the Whareama Rest Home (Rest Home), which is owned by Oceania Healthcare NZ Limited (Oceania).

At approximately 3:40pm on 14 May 2016 Mrs Hassan decided to go for a walk outside of the Rest Home. She was walking with the assistance of her four-wheeled low walking frame. As Mrs Hassan walked down the Rest Home driveway to the edge of the road, she lost control of her walking frame and fell backwards, hitting her head on the pavement. The fall resulted in a laceration to the back of her head. Mrs Hassan was conscious and lying on her back as assistance was provided. An ambulance transported Mrs Hassan to Nelson Hospital where a CT scan of her head showed a large subdural haematoma. Due to the severity of her head injury and the poor prognosis, the clinical team and members of Mrs Hassan's family discussed treatment options. It was decided that Mrs Hassan would receive palliative care. She died on 18 May 2016.

Rest Home records showed that Mrs Hassan fell 12 times between 12 March 2014 and 14 May 2016. Mrs Hassan's Person Centred Care Plan (Care Plan) contained relevant information relating to mobilisation and noted that she was a high falls risk that required assistance and supervision when going outside. The goal of the mobilisation was that Mrs Hassan would be able "to mobilise safely using her low frame walker over the next six months". The Care Plan contained a Risk Management Plan to ensure that: Mrs Hassan used her walking frame at all times, and for it to be placed close to her; the sensor mat (in her room) was in place at all times when she was in her room, plugged in and working correctly; any changes in mobility are reported to the Registered Nurse immediately; and falls or near misses are documented on an "incident form".

Following Mrs Hassan's fall a Sentinel Event investigation was undertaken and identified two causes of the fall. The first was that she was a frail resident who was still capable of independent mobility. This was a situation that was unable to be 'corrected', which reflected the reality that Mrs Hassan was unlikely to become less frail, and that for as long as she could mobilise independently, there was a risk of further falls. The second cause was the probability that the sensor mat was not plugged in at the time Mrs Hassan left her room, and that therefore staff were not alerted to the fact she was 'on the move'. The Registered Nurse on duty for the afternoon shift could not recall whether the sensor mat was checked when they took part in a 'bedside handover' (during which Mrs Hassan was sitting on the edge of her bed).

To address this second cause, the Sentinel Event investigation noted that sensor/bell mats were to remain active whenever high-risk residents were in their bedroom (both during the day and at night). To ensure that this occurred, Registered Nurses were to remind care staff and undertake their own checks. Furthermore, 'laser beam type technology', rather than the pressure mats, was to be trialled (this equipment had been ordered in the week prior to Mrs Hassan's fall but had not yet been delivered).

## RECOMMENDATIONS OF CORONER KAY

- I. The evidence indicates that whilst there was a sensor mat in Mrs Hassan's room on 14 May 2016, it was not working (either because it was unplugged, or it was plugged in but was defective). The evidence further indicates that the nurses who attended Mrs Hassan's room at approximately 3.00p.m., to facilitate a handover between the morning and afternoon nursing staff, cannot recall checking the sensor mat. Further, it was not a requirement of the Rest Home at that time that those nurses responsible for checking the sensor mats would make a note to show that they had completed the check and their findings.
- II. In the circumstances of Mrs Hassan's death, I considered it necessary to make the following recommendations to Oceania:
  - a. when a resident's care plan includes the use of a sensor mat, its operation should be checked at each nursing handover and a record made in the resident's notes that the mat was present and was functioning properly;
  - b. should a mat be identified as defective, the Registered Nurse on duty who is responsible for the resident's care must be informed (unless that nurse has undertaken the check herself/himself) and a replacement mat should be substituted as soon as reasonably practicable; and
  - c. if a replacement mat is not immediately available, the responsible Registered Nurse should consider what steps can be taken to meet the resident's mobilisation and safety needs in the interim, and should communicate those steps to the remainder of the relevant nursing team on duty.
- III. A draft copy of these findings, including the above recommendations, were provided to Oceania, to enable it to provide this Inquiry with any comments it wished to make. Dr Frances Hughes, General Manager of Nursing and Clinical Strategy for Oceania, replied to advise:
  - a. Oceania has included in its Falls Policy a requirement that the Registered Nurse on duty is responsible for ensuring that a sensor mat, if used as part of the falls prevention strategy for a resident, is checked;
  - b. a record of those checks is made in eCase (described as a Resident Management system);
  - c. should a sensor mat be found to be defective, it will be removed and replaced with a working sensor mat as soon as it is possible;
  - d. if a replacement sensor mat is not immediately available, the relevant resident will be placed in an area that allows increased visibility, such as a lounge or an area where staff are present. If the resident remains in their room, increased intentional rounding is undertaken (intentional rounding involves staff carrying out regular checks with individuals at set intervals);

- e. at night-time, if possible, a member of staff will be allocated to watch a resident, if staff deem that resident to have unpredictable behaviours; and
  - f. sensor mat checks are now included in the maintenance schedule at the same time that the call bell checks are completed, and the findings are documented in the maintenance records.
- IV. It is reassuring to see the steps that Oceania has taken to reduce the likelihood of further deaths occurring in similar circumstances.

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

## Milicich [2020] NZCorC 103 (30 November 2020)

### CIRCUMSTANCES

Joan Marion Milicich, aged 82, of Glen Innes died on 12 November 2017 at Auckland City Hospital of left-sided acute subdural haemorrhage as a consequence of a fall.

Mrs Milicich was admitted to Auckland City Hospital on 8 November 2017 with a history of a progressively unsteady gait over the previous month. In the week prior to her admission Mrs Milicich suffered a number of falls and was noted to be ignoring her left side with worsening condition.

A CT scan confirmed the presence of a subdural haematoma. Mrs Milicich underwent an operation which was performed without complication. However, on 11 November 2017 she suffered another fall. A nurse saw Mrs Milicich collapse onto the floor and she was unresponsive when checked. It appeared that she had climbed from the low bed without seeking assistance. She was attached to the Flotrons at the side of her bed when she was found unconscious. It was unclear whether the bed rails were elevated or lowered.

A further CT scan demonstrated another large subdural haematoma as a consequence of this fall. Mrs Milicich's management was discussed, and it was decided that her clinical condition suggested brain stem compression, incompatible with a satisfactory recovery. Palliative care was commenced and Mrs Milicich died on 12 November 2017.

### COMMENTS OF CORONER BELL

- I. Given Mrs Milicich's death was as a result of fall with a pneumatic compression device (PCD) attached, the Auckland District Health Board (ADHB) conducted an investigation into Mrs Milicich's death. I am in receipt of the report from that investigation. The purpose of the investigation and report was to outline the details of the events, identify causation factors and system issues that resulted in death after fall. The report also made recommendations aimed at reducing the risk of recurrence.
- II. The risk of death related to a fall from being tethered to a PCD had not been previously identified, due to death from a fall in this manner being a very seldom occurring event at ADHB. The rarity of such falls is also consistent with international literature, where it is cited in one study, as being less than 1 % of more than 100,000 fall reports.

- III. The report details a number of recommendations, in particular a decision matrix as to when to remove PCDs and to identify high risk patients who should have their PCDs removed at the beginning of mobilisation, after surgery. A Falls Needs Assessment and Care Plan Policy will include risk due to a tethering device (e.g. PCDs). Further medical reviews of the necessity of continuation of PCDs in the high-risk group will occur every morning including on weekends.
- IV. ADHB opine that providing the recommendations are implemented the residual risk of this reoccurring is minimal.
- V. I note the rarity of falls in this manner, nonetheless I urge all hospitals to take care and adhere to the recommendations implemented by ADHB, to prevent any further falls in this manner.

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

## Salmond [2020] NZCorC 97 (16 December 2020)

### CIRCUMSTANCES

Judith Margaret Salmond, aged 86 years, of Auckland died on 25 January 2018 at Sir Edmund Hillary retirement village, Auckland (the retirement village) of a ruptured haematoma of her left lower leg and bilateral acute bronchopneumonia (probable aspiration).

Mrs Salmond was living in hospital level care at the retirement village. She had a degree of dementia and mobilised with a gutterframe with the assistance of one staff member. She had experienced past transient ischaemic attacks (TIAs) and was prescribed warfarin to prevent the obstruction of coronary arteries and to thin the blood for prevention of a stroke.

On 21 January 2018 at 11:15pm, nursing staff observed that Mrs Salmond had a large bruise to her left lower leg. They checked the bruise throughout the night, which had become very bulged. Clinical notes from the next morning indicated that Mrs Salmond was experiencing pain and was given analgesia and her leg was elevated on a soft pillow. Compression bandaging was not applied by staff for fear of causing a skin tear.

On 23 January 2018 at 2:30pm a nurse practitioner reviewed the bruise and noted that it had increased in size to 22 cm by 32 cm in circumference. Compression bandaging was applied.

On 24 January 2018 arnica cream was charted by Dr Graham, Mrs Salmond's GP, at a nurse's request. However, he did not make any inquiries as to why it was requested and was, therefore, unaware of Mrs Salmond's large bruise. At 8:54pm Mrs Salmond complained of severe pain in her left leg and morphine was prescribed.

On 25 January 2018 at 2:15pm the nursing notes recorded that a healthcare assistant had observed a massive bleed, of approximately 400ml, from Mrs Salmond's left leg at 8:20am. She was responsive to touch, but was very pale, weak and had very low blood pressure. A nurse practitioner was contacted and gave a verbal order to give Mrs Salmond vitamin K. There was none in stock at the retirement village, therefore, it was subsequently ordered from a pharmacy and later administered intramuscularly.

Dr Graham assessed Mrs Salmond at 1:20pm and noted that the bleeding in her leg had stopped. Vitamin K was to continue the next day and warfarin ceased. Dr Graham left at 6:00pm. Mrs Salmond remained stable that evening with half hourly checks until 10:30pm. However, Mrs Salmond was found deceased when she was checked at 11:00pm.

Dr Stables, a forensic pathologist, said that while the cause of the haematoma was not clearly established, it was most probable that there was a trauma which led to some bleeding into the soft tissue, and because Mrs Salmond was taking warfarin, this continued to bleed. He noted that there was an apparent delay in the administration of vitamin K to correct the effects of the warfarin.

Dr Stables was unable to accurately determine if it was the acute bronchopneumonia or the effects of the warfarin that was the primary cause of death, but most likely both played a role.

Expert opinion was sought during the course of the coronial inquiry from Dr Lynette Murdoch, a general practitioner and medical advisor. Dr Murdoch noted that the judgement that the bruise was a minor bleed on 23 January 2018 was acceptable in the circumstances.

Dr Murdoch referred to the clinical guidelines from the Canterbury Community Health Pathways website that advise that in the event of a minor bleeding on warfarin the International Normalised Ratio (INR) should be checked, and warfarin omitted. She considered that the decision to continue Mrs Salmond's warfarin and omit to conduct blood tests to check her INR levels, was borderline acceptable.

#### **COMMENTS OF CORONER MILLS**

- I. The guidelines referred to by Dr Murdoch are well established and the potential bleeding effect of warfarin is also well known. I accept Dr Murdoch's opinion that a better course of action would have been for the medical team to have reviewed Mrs Salmond's INR and stop the warfarin in accordance with the guidelines. This would have provided a firm basis for further decisions such as the need for vitamin K. However, I accept that the initial bruise did not appear to be serious and there was a need to balance Mrs Salmond's stroke risk (the reason she was on warfarin) with her bleeding risk. Unfortunately, Mrs Salmond's frailty always meant she was at risk of rapid deterioration in the event of any injury.
- II. I do consider it would have been preferable for Dr Graham to have viewed Mrs Salmond's bruise when he was asked to chart arnica, however I also accept it was appropriate for him to rely on the nursing staff's assessment of whether it was necessary for him to do so.
- III. Warfarin is a commonly used medication. There are already clear and well-known guidelines about monitoring its use. I therefore do not consider it necessary for me to make any specific recommendations or further comment on this issue.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Mrs Salmond during the course of this inquiry in the interests of decency and public interest.

## Turton [2020] NZCorC 87 (30 October 2020)

### CIRCUMSTANCES

John Dean Turton of Papatoetoe, aged 82, died on 17 October 2016 at Middlemore Hospital of profound bradycardia.

Mr Turton was diagnosed with a kidney problem 20 years before his death but was still able to do things on his own. Six months prior to his death his health deteriorated, and he was legally blind within that time. He was on a lot of medication. His family knew his kidneys were not functioning and that his heart was operating poorly. Mr Turton had told his daughter he wanted to die, and the family knew it was due to his poor health.

On 16 October 2016, Mr Turton had no energy and looked very weak. His wife rang for an ambulance that day as she was concerned about his deterioration. Mr Turton was admitted to Middlemore Hospital and found to have anaemia and a chest infection. The following day, 17 October 2016, Mr Turton's heart rate was very low and he subsequently died.

Dr Boyle, a doctor at Middlemore Hospital, was concerned about Mr Turton's pre-hospital care as his kidney issues had been previously well-managed and maintained. Dr Boyle noted that Mr Turton was prescribed a very large dosage of frusemide which should have been monitored and tested each month. Whilst Mr Turton had seen his doctor regularly, the last blood test was back in March 2016.

Mr Turton's general practitioner, Dr Gross, reported that Mr Turton's general condition deteriorated over the year prior to his death. In January 2016, his dose of frusemide was increased and spironolactone was added a couple of months later. Dr Gross last saw Mr Turton on 22 July 2016. On 16 September 2016, Dr Gross was requested to arrange some home assistance due to Mr Turton not coping at home.

Dr Murdoch, Medical Advisor to the Chief Coroner and Coroners, reviewed Mr Turton's file and provided an opinion regarding the care provided to Mr Turton by Dr Gross. Dr Murdoch noted the New Zealand Formulary which advises that patients such as Mr Turton should have blood tests to check kidney function and potassium levels one week after starting spironolactone, then each month for three months, and thereafter three monthly, for a year. Dr Murdoch further stated that the dose of frusemide Dr Gross had prescribed Mr Turton was appropriate up until the last time Dr Gross saw Mr Turton on 22 July 2016. However, when Mr Turton was admitted to Middlemore Hospital the dose was inappropriately high. Something had happened to 'tip the balance' unfavourably causing excessive loss of fluid and consequent significant hypovolaemia. But Dr Gross had had no opportunity to review the dose because he did not see Mr Turton after 22 July 2016. Had Mr Turton had regular blood tests after starting spironolactone, as per the New Zealand Formulary guidelines, it is possible that abnormal results would have prompted Dr Gross to review his dose of frusemide and spironolactone, which may have averted Mr Turton's final illness.

Dr Gross responded to Dr Murdoch's comments and stated that Mr Turton was provided with a form for blood tests on 22 July 2016 but failed to have it done. That was the last time Dr Gross saw him. Dr Gross agreed that if he had been doing bloods more often then it would have been easier to monitor Mr Turton's medication. Further comment was sought from Dr Gross in May 2020 about other questions that arose from Dr Murdoch's report. In September 2020 Dr Gross responded briefly that he agreed with "most of Dr Murdoch's comments" and stated that "unfortunately there were no monthly blood tests". No follow up appointment was made as Mr Turton would normally come in for his three-monthly check.

## COMMENTS OF CORONER BELL

- I. Dr Murdoch's conclusion is of concern to me. Dr Murdoch opines that had Mr Turton had regular blood tests as per the New Zealand Formulary guidelines, it is possible that abnormal results may have prompted Dr Gross to review Mr Turton's dose of frusemide and spironolactone and this may have averted Mr Turton's final illness.
- II. Dr Gross failed to ensure Mr Turton had regular blood tests in accordance with the New Zealand Formulary guidelines.
- III. Further Dr Gross' brief email response to me does not provide an explanation as to why the guidelines were not complied with.
- IV. Dr Gross' failure to ensure that Mr Turton was monitored correctly has resulted in the missed opportunity of reviewing Mr Turton's possible abnormal blood tests and the dose of frusemide and spironolactone, which may have averted Mr Turton's final illness.
- V. In accordance with section 58 of the Coroners Act 2006 I forwarded a draft copy of the above comment to Dr Gross. I sought his comments. Dr Gross' response was to reiterate that Mr Turton was a difficult patient and that he requested that Mr Turton have his bloods completed but Mr Turton did not do so. Dr Gross does not address my concern that he did not comply with the New Zealand Formulary guidelines.
- VI. I direct that a copy of this finding be forwarded to the New Zealand Medical Council.

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.

## Watson [2020] NZCorC 107 (8 December 2020)

### CIRCUMSTANCES

Michael Hayes Watson, aged 82, died at Hawke's Bay Fallen Soldiers' Memorial Hospital on 26 August 2017 due to a major brain stem stroke caused by complications of a medical procedure.

On 15 August 2017 Mr Watson underwent hip-replacement surgery at Hawke's Bay Fallen Soldiers' Memorial Hospital. The procedure itself was uneventful, and he remained in hospital for monitoring and recovery. Later that evening he was discovered on the floor of his hospital room, having fallen while attempting to get out of bed unassisted. Mr Watson later said that he was attempting to go to the bathroom to vomit. The fall resulted in a fracture to Mr Watson's hip.

On 16 August 2017 Mr Watson underwent revision hip surgery. Again, the procedure itself was uneventful, and Mr Watson remained in hospital for monitoring and recovery. While recovering Mr Watson experienced some health issues, including a series of cardiac events. He underwent cardiac surgery on 24 August 2017. During the surgery, he suffered a neurological event that he did not recover from. As a result of that event, Mr Watson passed away on 26 August 2017.

## COMMENTS OF CORONER BATES

- I. I am acutely aware of the length of time it has taken for this inquiry to reach its conclusion. The delay has no doubt added to the stress experienced by the Watson family in relation to Mr Watson's passing. For that I am sorry. I hope that receipt by the Watson family of these findings enables some further closure for them.
- II. Pursuant to s 57(3) of the Coroners Act 2006, I make the following recommendations:
  - a. Nausea is a common side-effect following surgery/anaesthetic. I recommend that vomit bowls be placed within sight and reach of all patients receiving post-operative care, regardless of whether the patient has reported feeling nauseous. Where this is not already standard, DHBs are to consider implementing this as standard practice.
  - b. DHBs should examine whether more detailed questioning of patients, and where possible, close family members and support persons, regarding falls risk is appropriate upon admission to hospital for surgical procedures under anaesthetic. As demonstrated by Mr Watson's case, the provision of more detailed patient background information may alter the risk assessment and patient management plan.
  - c. Falls in hospital are common. DHBs have devised risk assessment forms not only to identify risk but to provide guidance regarding what strategies may be implemented when it is present. I recommend that DHB management remind staff of the need to complete these forms thoroughly, seeking as much detail from the patient, family and/or support persons as possible, and making sure that all sections are complete. When considering falls risk, matters to check and record answers for each time should include impulsivity, restlessness, sleep-walking, reluctance to seek assistance, reluctance or inability to follow-direction, an extreme sense independence, to name a few. Essentially, staff should be looking for anything that may elevate an individual's falls risk above that of other routine post-operative patients administered strong anaesthetic. Responses to the risk factors discussed with patients/family should be recorded on the form and should comprise more than a checked box. DHBs should consider whether their current checklists require revision to include matters such as those I have noted.
  - d. When a patient risk score indicates use of a falls risk alert bracelet and recording the risk, so staff can see it (e.g. on a staff whiteboard), these things should be done. It may be timely for DHBs to remind staff of the importance of following-through with these procedures.
  - e. I make no recommendation in relation to a minimum requirement for constant and direct supervision of all patients' post-surgery for a prescribed amount of time. The response of HBDHB in relation to that suggestion explains why a flexible and patient-tailored approach is appropriate.

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



# Motor Vehicle

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## Armitage and Parsons [2020] NZCorC 110 (11 December 2020)

### CIRCUMSTANCES

Wiremu John Armitage of 634 Taihape Road, Pukehomoamoā, Hastings, and Kirsty Michelle Parsons of 7 Keryn Place, Frimley, Hastings, died at Taihape Road, Pukehomoamoā, Hastings on 10 May 2019. The cause of death for both was multiple injuries sustained in a motor vehicle incident, with mechanical asphyxia additionally a cause of death for Mr Armitage.

At about 10.15pm, Ms Parsons was travelling east on Taihape Road in her Mazda hatchback, while Mr Armitage was travelling west in his Toyota utility vehicle. Mr Armitage failed to negotiate an easy left-hand bend, crossing the centre line into the path of Ms Parsons' vehicle. An examination of the rear bulbs from each vehicle showed that Ms Parsons had her brake lights activated, while Mr Armitage did not.

Mr Armitage and Ms Parsons both died at the scene. Mr Armitage was not wearing a seatbelt and had been ejected from his vehicle. He was located under the rear axle of the Toyota. Toxicology analysis reported a high level of alcohol in Mr Armitage's blood (241mg/100mL), but no medications or drugs of concern. No alcohol or drugs of concern were detected in Ms Parsons' blood.

A Police Serious Crash Unit investigation found that in addition to alcohol, fatigue was also possibly a factor resulting in Mr Armitage crossing the centre line and crashing into Ms Parsons' vehicle. Mr Armitage had been working in hot conditions on his boat for most of the day. The Coroner concluded that the actions of Mr Armitage were the main causative factors in the crash, which was likely due to his fatigue, distraction or intoxication (or a combination of all three).

### COMMENTS OF CORONER FITZGIBBON

- I. Driving while under the influence of alcohol, driver fatigue and "Seatbelts save lives" have been the subject of multiple road safety messages over many years. Everyone's perception of how much they can drink is different, but the law is precise: if you're over 20 years of age the legal blood alcohol limit for driving is no more than 50 milligrams of alcohol for every 100mls of blood.<sup>9</sup>
- II. Fatigue is tiredness, weariness or exhaustion. You can be fatigued enough for it to impair your driving long before you 'nod off' at the wheel – which is an extreme form of fatigue. Drink-driving is particularly dangerous in combination with fatigue. Alcohol can affect a driver's alertness long before the legal limit is reached. Any amount of alcohol can combine with fatigue to affect your driving.<sup>10</sup>
- III. In the context of those past and ongoing messages I make no additional comment or recommendation for change pursuant to s 57(3) of the Coroners Act 2006.

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<sup>9</sup> <https://www.nzta.govt.nz/safety/driving-safely/alcohol-and-drugs/>.

<sup>10</sup> <https://www.nzta.govt.nz/safety/driving-safely/fatigue/>.

Note: Orders under section 74 of the Coroners Act 2006 prohibit the publication of photographs of Kirsty Parsons and Wiremu John Armitage taken by Police, in the interests of decency and personal privacy.

## **Bonser [2020] NZCorC 94 (11 November 2020)**

### **CIRCUMSTANCES**

Patricia Bonser, aged 78 years, of 719 Gloucester Road, Papamoa died on 20 August 2018 at Gravatt Road, Papamoa from a ligature compression of her neck when her scarf became entangled in a rear wheel of her mobility scooter.

On 20 August 2018, Patricia was riding her mobility scooter from her home address to an aqua aerobics class at Papamoa Plaza. She was riding on the footpath on Gravatt Road. The weather was overcast so she wore a scarf around her neck and a poncho raincoat.

Andrea Moffat was driving on Gravatt Road and observed the mobility scooter shudder and come to a stop. She sensed something was wrong so she pulled her car over and went to assist Patricia. She found Patricia slumped in the mobility scooter and unresponsive. Ms Moffat ran to a nearby house to contact emergency services and on her return tried to support Patricia's upper torso and head. She felt for Patricia's pulse which was weak and slow. Ambulance officers attended, however Patricia could not be revived and died at the scene. When her poncho was removed it became apparent that her scarf had wrapped itself around her back rear left wheel of the mobility scooter and had tightened around her neck, strangling her.

Patricia had purchased the mobility scooter from Gary Darkes, the owner and operator of Home Health and Mobility. Mr Darkes provided three sessions of training to Patricia on how to operate the mobility scooter, each session lasting between 20 to 25 minutes. At the conclusion of the training, Mr Darkes was satisfied that Patricia could competently ride the scooter.

The mobility scooter ridden by Patricia was model Cutie S17. The user manual provides comprehensive advice as to riding and operating the mobility scooter including advice as to where to ride the scooter and what hazards to avoid. The manual states at paragraph 9 "Keep your hands away from the wheels (tires) while driving scooters. Be aware that loose fitting clothing can become caught in the drive tires."

There is a New Zealand Transport Agency booklet titled, "Ready to Ride: Keeping safe on your mobility scooter". It is a 16-page booklet containing information and photographs on choosing a mobility scooter, safety tips, road user safety, legal requirements and looking after and transporting mobility scooters. The language and content of the booklet is clear and simple. The section titled "Using the road safely" contains advice on how to travel safely and consideration for pedestrians and other traffic. There is however no reference within the 16-page booklet of any warning as to the dangers of loose clothing becoming entangled in the tyres.

### **RECOMMENDATIONS OF CORONER DUNN**

- I. Mr Darkes advises that over his 22 years in the industry he has never known any injury, or deaths, resulting from loose clothing becoming entangled in the tyres. I accept that Patricia's accident was rare however my concern is that persons riding mobility scooters are generally older and vulnerable. As such their ability to react may be slower or impeded due to their physical limitations. I consider that it is

appropriate that Waka Kotahi NZ Transport Agency provide a warning to persons using, or considering using, a mobility scooter to the effect that loose or long clothing has the potential to cause injury or death. It is possible that clothing can get caught in the moving wheels and cause a rider to be thrown from the mobility scooter. This has the potential to cause injury or death. The obvious injury that could be caused by an elderly person in this situation is potentially life threatening.

- II. I have recommended that the Waka Kotahi NZ Transport Agency booklet “Ready to Ride: Keeping safe on your mobility scooter” include under the section “Using the road safely” a warning to the effect, “Be aware when riding on a mobility scooter that loose and long clothing may get caught in the tyres and could potentially cause the rider serious or fatal injury”. They were provided with a draft copy of my finding including this recommendation.
- III. Waka Kotahi NZ Transport Agency have since receiving my draft finding advised me that they accept the recommendation. Waka Kotahi NZ Transport Agency advise that a new resource will be available in February 2021 titled ‘Getting Around as a Senior’. It will include the warning “Be aware when riding a mobility scooter that loose and long clothing may get caught in the tyres and could potentially cause the rider serious or fatal injury”.
- IV. I commend Waka Kotahi NZ Transport Agency for including the warning in their new resource and for their prompt response to my recommendation.

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

## Edgecombe [2020] NZCorC 79 (20 October 2020)

### CIRCUMSTANCES

Tihioterangi Rei Edgecombe, aged 33 years, died on 31 December 2016 at Downs Road, Spotswood, Cheviot from high-energy impact injuries sustained in a motor vehicle accident.

At about 9.10pm, Mr Edgecombe was driving his vehicle northeast on Downs Road, Spotswood, towards Cheviot. Two of his friends, Saxon Rogers and Scott Hicks, were driving in a vehicle in front of him. Mr Edgecombe overtook them at high speed, which they estimated at between 130-150km/h, just before a right-hand bend. His vehicle drifted across the road and spun around, before crashing into a tree directly at the point of the driver’s door. Mr Edgecombe was pronounced dead at the scene.

Toxicology testing revealed that Mr Edgecombe had recently consumed alcohol and cannabis. Although he was under the legal blood alcohol limit for an adult driver, it was noted that the combined use of cannabis and alcohol tends to accentuate the effects of alcohol.

The Police Serious Crash Unit (SCU) investigation concluded that Mr Edgecombe had reacted to the bend in the road too late, due to his speed and his overtaking manoeuvre when approaching it. Police attributed this failing to his inattention to the road and the effects of intoxication. It noted that there are no advisory signs indicating the upcoming bend, meaning it should be able to be navigated at or around the applicable 100km/h speed limit. While Mr Edgecombe

was driving at 100km/h when entering the bend he had probably been travelling faster before braking at that point. Police concluded that Mr Edgecombe completed overtaking just before the bend, leaving him little time to react.

The Coroner was satisfied that the primary cause of the crash was Mr Edgecombe's high speed while overtaking, with inadequate time to react to and navigate the bend in the road that followed. The cannabis consumed by Mr Edgecombe, in combination with alcohol, was also likely to have compromised his perceptions, coordination and reactions. These factors taken together operated to cause Mr Edgecombe to lose control of his vehicle.

#### **COMMENTS AND RECOMMENDATIONS OF CORONER BORROWDALE**

- I. Having given due consideration to all of the circumstances of this death, I make the following comments pursuant to section 57(3) of the Coroners Act 2006:
  - a. While the Serious Crash Unit report may be right that the bend in this area of Downs Road, Spotswood ought to be navigable by a driver travelling at or around the 100km/h speed limit, it may assist drivers to anticipate this bend if signage was placed at each approach to the bend advising of it.
  - b. Similarly, Police recorded their view that the bend became difficult for Mr Edgecombe to navigate, given the late completion of his overtaking manoeuvre. It may assist drivers in future to avoid this tragic consequence if no-passing signage is placed before the approaches to this bend.
  - c. Finally, it may assist drivers to safely navigate the bend if the centre lines are painted on the roadway along this stretch of rural road.
- II. These comments are directed to the Hurunui District Council.
- III. I notified these suggested roading improvements to the Hurunui District Council, the public authority responsible for this roading area. The Council advised that when it establishes its next roading works programme these proposed improvements will be considered.
- IV. I also consulted with the Serious Crash Unit about these potential improvements, and the Unit expressed its support for them.
- V. I therefore make the following recommendations pursuant to section 57(3) of the Coroners Act 2006:
  - a. That signage should be added at the approaches to the bend around 270 Downs Rd, Spotswood indicating the road curvature ahead.
  - b. That signage should be added before the approaches to the bend around 270 Downs Rd, Spotswood to prohibit vehicles from overtaking within an unsafe distance of the bend.
  - c. That centre lines should be painted on the stretch of road around and within a reasonable distance of 270 Downs Road, Spotswood.
- VI. The purpose of these recommendations is to reduce the chances of a further fatal or serious accident occurring in this roading area in future.

- VII. This death may have been prevented if signage had warned of the potential hazard represented by the roading bend, and assisted drivers to navigate the bend, notwithstanding that Mr Edgecombe was additionally affected by the substances he had recently consumed.

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

## Gribble [2020] NZCorC 95 (13 November 2020)

### CIRCUMSTANCES

Ellie Dawn Gribble, a newborn, died shortly after birth on 27 April 2017 at Auckland City Hospital, 2 Park Road, Grafton, Auckland of perinatal asphyxia of undetermined cause.

Auckland District Health Board (ADHB) undertook an in-depth review (root cause analysis) of the events leading up to Ellie's death. The review team noted that the first indication of possible foetal compromise came at 6.52pm when the cardiotocography (CTG) was recommenced (intermittent auscultation was used prior) and showed a baseline tachycardia of 185 bpm. Mrs Gribble's labour was progressing fast with five to six contractions in a ten minute period. She was nearly fully dilated with just an anterior lip of cervix present. The CTG was of sufficient concern at 7.15pm, with the elevated baseline and acute late decelerations for her obstetrician to recommend immediate delivery of her baby by forceps delivery under a pudendal block. The review team noted that this was a potentially challenging situation given that Mrs Gribble was just transitioning into second stage, with no regional anaesthesia.

Five minutes later, the midwife and obstetrician observed an apparent recovery of the foetal heart. Consequently, nine minutes after the decision to assist delivery with forceps, the obstetrician decided not to proceed. Anticipating that Mrs Gribble would deliver soon, the obstetrician remained at the end of the delivery bed, with Mrs Gribble remaining in a lithotomy position. The CTG was not easily visible from the obstetrician's position and no concern was signalled by the midwife. Foetal blood sampling to check lactate level was not considered because the clinicians believed the foetal heart rate had improved. The review team noted that foetal blood sampling would have provided the objective evidence of foetal oxygenation and would have resulted in an expedited birth.

The midwife and obstetrician were convinced that the foetal heart rate had normalised and thus by implication the baby was no longer at immediate risk if the labour continued. Potentially a delay would allow an easier forceps delivery, if it was thought necessary, or may achieve a normal birth. The midwife recorded the maternal pulse at 70 beats per minute and did not recognise or raise a query about whether the origin of the heart beat on the CTG was maternal or foetal.

The review team concluded that the CTG was misinterpreted by the practitioners when they thought that the abnormal CTG (which triggered the decision to do a forceps delivery) normalised, thus negating the need for immediate instrumental delivery. The review team concluded that the CTG at that stage was maternal in origin.

The review team identified a number of factors that contributed to the misinterpretation of the CTG. They noted that inadvertent continuous recording of the maternal heartbeat on CTG is not a very common occurrence but can happen. They also cited a Royal Australian and New Zealand College of Obstetricians and Gynaecologists endorsed publication on assessing foetal wellbeing that states "We need to be aware of this pitfall so that we are not misled by an apparently

normal 'foetal' heart rate pattern which is actually a recording of the MHR [maternal heart rate]. The authors are aware of many cases where serious adverse outcomes have resulted from this mistake."

The review team highlighted that there were important lessons that should be communicated to maternity practitioners regarding inadvertent maternal heart recording and made a number of recommendations aimed at reducing the risks of a similar event in future and ensured a plan in place for implementation of these recommendations.

The review team recommended that the ADHB purchase CTG monitors which have both maternal and foetal heart rate tracing and a coincidence detector, as such monitors assist significantly in being able to distinguish between the two heart rates. Such a monitor was not used when Mrs Gribble was in labour and there were only three on the unit. Mrs Gribble asked that the DHB consider wireless/waterproof CTG machines be purchased to allow continuous monitoring to women who are mobile during labour. Mr and Mrs Gribble both felt, based on the tragedy of Ellie's death following an apparently normal pregnancy and labour, that continuous CTG monitoring throughout labour would enhance the chance of picking up foetal distress and having a healthy baby. They raised this matter with the review team who have included a 'family feedback' section in the root cause analysis report.

#### COMMENTS OF CORONER GREIG

- I. In view of the recommendations in the Auckland District Health Board Root Cause Analysis Review Report that have specifically been made to reduce the risk of a similar event in future, I do not consider that further recommendations are necessary.
- II. In the paragraphs above I have highlighted Mrs and Mr Gribbles' suggestion about CTG monitoring and ask that the LMC involved in this case (Dr Buddicom) and Auckland DHB actively consider their proposal.

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

## Hall [2020] NZCorC 106 (8 December 2020)

#### CIRCUMSTANCES

Bruce Edwin Hall, aged 53, of Onehunga, Auckland, died on 12 August 2017 at Onehunga Mall, Auckland, of multiple injuries sustained in a collision between his unicycle and a truck.

Mr Hall, aged 53, was an experienced unicyclist who typically rode his unicycle about once a week. He was described by his wife as "very careful" and had been injured only once, around 20 years ago. His unicycle had a handbrake, distinguishing it from many unicycles that depend on reverse pedalling to brake.

When the collision occurred, Mr Hall was cycling south along Onehunga Mall towards Onehunga Wharf at around 9:25am. There was a heavy traffic flow, fine weather and good visibility. Mr Hall was observed cycling about one metre into the road from the yellow roadside markings. With a truck about one to two metres behind him, Mr Hall made a sudden right turn into the middle of the road, as if to turn into the no-exit Onehunga Mall side street. The truck driver

reported that Mr Hall gave no indication, and did not look back to check if there was any traffic behind him. Despite the driver's hard brake, he hit Mr Hall by the left front wheels of the truck. Mr Hall suffered fatal head and chest injuries.

The Police Serious Crash Unit concluded that while Mr Hall may have indicated, his sudden turn into the path of the truck was the primary causative factor of the crash, as it left the driver insufficient time to react and avoid the collision.

Auckland Transport also investigated the crash. It noted that the Onehunga Mall roadway is an over-dimensional route, meaning it is a road identified as suitable for high and wide vehicles to travel. The road had never previously included a cycleway, and Auckland Transport did not support installing one. However, in the 2020-2021 financial year Auckland Transport planned to investigate whether vulnerable road users could be signposted to use areas of lighter traffic volumes, with existing facilities connecting to Onehunga Bridge.

#### COMMENTS OF CORONER BORROWDALE

- I. Having given due consideration to all of the circumstances of this death, I do not consider there are any comments or recommendations that could usefully be made pursuant to section 57(3) of the Coroners Act 2006.
- II. I encourage Auckland Transport to continue its indicated consideration of whether cyclists along this Onehunga Mall route can be encouraged away from this site, given that it is designed to carry wide and high vehicles.

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

## Greig and Watene [2020] NZCorC 84 (28 October 2020)

#### CIRCUMSTANCES

Jessica Aroha Greig, aged 26, and Reign Hare Michael Watene, aged 3, both of Pahiatua died on 1 August 2018 on Troup Road, near Woodville due to multiple injuries they sustained in a motor vehicle incident involving a train.

On 1 August 2018, Mr Watene was driving Ms Greig and Reign to Pahiatua after they had spent the day in Levin. Ms Greig was in the front passenger seat and Reign was in the rear seat behind Ms Greig. At the time of her death Ms Greig was in a relationship with Luke Watene. Reign was Mr Watene's son.

While Mr Watene was approaching the Troup Road railway crossing, a KiwiRail freight train was travelling west from Napier towards Palmerston North. As the train approached the crossing, the train driver looked out his windows to check for traffic at the crossing but could see none. The train proceeded through the crossing at the same time as Mr Watene entered the crossing from the north side of the tracks. The train and Mr Watene's vehicle collided, with the train striking the vehicle's left passenger side. Both Ms Greig and Reign died at the scene.

Following their deaths, Mr Watene was charged with two counts of careless driving causing Ms Greig and Reign's deaths, to which he pleaded guilty.

## COMMENTS OF CORONER WINDLEY

- I. This tragic case highlights the need for drivers to exercise particular caution and care when approaching all level crossings. The NZTA Rail Safety Statistics disclose that between 2010 and 2019 there were 22 fatalities in incidents involving motor vehicles and trains at level crossings.<sup>11</sup>
- II. The official New Zealand Road Code issued by the NZTA includes helpful information for drivers in relation to level crossings controlled by Stop or Give Way signs which is reproduced in part below.<sup>12</sup>

A railway level crossing is a point where the road crosses over a railway line. This means you drive over the railway tracks and could come into the path of a train. Because of this, you need to be very careful around railway level crossings to avoid a very serious crash.

### Crossing a railway level crossing

The signs below are some of the signs you may see when coming up to a railway level crossing.



When you see one of these signs:

- slow down and be ready to stop
- as you come up to the railway crossing, search up and down the railway line. You will need to search further up the railway line, as trains often travel at a higher speed than vehicles on the road
- cross only if you are sure there are no trains coming in either direction and there are no vehicles stopped in front of you on the other side of the crossing.

<sup>11</sup> See <https://www.nzta.govt.nz/assets/resources/rail-safety-statistics/rail-safety-statistics-end-31-December-2019.pdf>.

<sup>12</sup> See <https://www.nzta.govt.nz/resources/roadcode/about-driving/giving-way-at-railway-level-crossings>.



#### At railway level crossings controlled by a Stop sign or Give Way sign

Railway level crossings that aren't controlled by signals, bells or barrier arms may be controlled by a Stop sign or a Give Way sign.

At railway crossings controlled by Stop or Give Way signs:

- make sure you can see in both directions along the railway line
- if there is a Stop sign, come to a complete stop before the railway line (there will usually be one or two yellow lines showing you where to stop)
- only cross the railway line if you are sure that there are no trains coming in either direction and there are no vehicles stopped in front of you on the other side of the crossing
- take extra care if there is more than one railway line.



#### Important safety advice for railway level crossings

- Never try to cross the railway line unless there is enough space for your vehicle on the other side of the line.
- Never pass a vehicle that has stopped for a train.
- Never try to race a train over the crossing.

- III. In light of the clear existing legal driving requirements which Mr Watene was found to be in breach of, and the evidence detailed in the Police crash investigation and KiwiRail's own investigation which discounts the environment, the train and its driver, and Mr Watene's vehicle as contributing factors to the incident, I make no further comments or recommendations.

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

## Herewini [2020] NZCorC 82 (27 October 2020)

### CIRCUMSTANCES

Te Paina Pene Herewini, aged 9 years, of Houhora died on 23 September 2017 at Kimberley Road, Houhora of a severe chest injury consistent with impact by a motor vehicle.

On the afternoon of 23 September 2017, Te Paina was riding a bicycle up and down Kimberley Road. A member of his whānau, who was unlicensed and underage, was driving a car on Kimberley Road with a passenger. The driver unintentionally hit Te Paina with the vehicle and he died at the scene.

## COMMENTS OF CORONER MCKENZIE

- I. Te Paina's death raises concerns about underage and unlicensed driving in rural New Zealand.
- II. Police have provided this inquiry with information on the steps they have taken to address unlicensed driving in the Far North region. They have advised that a programme called Automotivate was designed and delivered under the umbrella of the Far North Safer Community Council to focus on unlicensed drivers aged 16 to 24 years. They have provided background information on Automotivate. The programme is in its fourth year of operation and Police advise it has been highly successful for participants.
- III. Oranga Tamariki (OT) advised this inquiry that it supports rangatahi/youths in care who are old enough to get their driver's licence through its 'Transition to Independence' support services. In August 2019, OT partnered with the NZTA and MSD to financially support rangatahi through the graduated driver licence process. OT worked with its partners to focus on improving young people's safety and providing pathways for rangatahi to access a driver's licence. There is financial support including for obtaining a birth certificate and driver's licence, for twenty professional driving lessons, and for test fees. Transition workers can help ensure rangatahi are supported to make and get to appointments, lessons, and tests; and that they can access the relevant online tools. I thank OT for the ongoing information and assistance it has provided this inquiry.
- IV. I sought further information from Police, as the principal relevant authority, more specifically on underage driving. I sought their comment regarding the following proposed recommendation directed towards Police in accordance with s 57B of the Act:  
  
"I recommend that the NZ Police assess the need for an educative programme in Far North communities regarding under-age driving and, if such need exists, give consideration to implementing such programme and to promoting policing to support elimination of under-age driving."
- V. I consider that this recommendation is consistent with the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which Te Paina died. If drawn to public attention, the recommendation may reduce the chances of further deaths in similar circumstances because implementation of any educative programme would directly help support elimination of under-age driving and thereby lessen the chances of further deaths occurring in this setting.
- VI. Police did not have any comment on the proposed recommendation. I thank them for the information they provided regarding unlicensed driving and for their ongoing assistance to this inquiry more generally.

## RECOMMENDATIONS OF CORONER MCKENZIE

- I. I make the following recommendation pursuant to s 57A of the Act:  
  
I recommend that the NZ Police assess the need for an educative programme in Far North communities regarding under-age driving and, if such need exists, give consideration to implementing such programme and to promoting policing to support elimination of under-age driving.

- II. I reiterate the well-known requirement for all drivers in New Zealand to have the correct class of driver's licence. Further, I observe the importance of children under the legal driving age not driving, no matter how short the distance or how quiet the road. Having

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Te Paina taken by Police or any other party in the interests of decency and personal privacy. An order under section 74 of the Coroners Act 2006 prohibits the publication of two specific street addresses on Kimberley Road and the name or any other information that might identify the driver of the vehicle that hit Te Paina in the interests of personal privacy.

## Hutchings [2020] NZCorC 90 (4 November 2020)

### CIRCUMSTANCES

Adrian Hutchings of Mamaku, aged 20, died on 16 September 2019 at Waikato Hospital from a traumatic brain injury sustained in a motor vehicle crash.

On 13 September 2019 Mr Hutchings attended a social gathering with friends at a rural address in Waikiti Valley near Rotorua, where he was observed to drink around three cans of pre-mixed spirit and cola. At around 2:15am on 14 September 2019 Mr Hutchings was driving home with two other passengers, when his vehicle collided with a concrete bridge abutment on the one-lane bridge on Whirinaki Valley Road, Ngakuru.

All three vehicle occupants were transported to Rotorua Hospital. Mr Hutchings was unconscious and a CT determined that he had suffered a brain injury. He was subsequently airlifted to Waikato Hospital where investigations found that his brain injury was severe and he underwent emergency brain surgery. Mr Hutchings' condition did not improve and he died on 16 September 2019.

Police Serious Crash Unit (SCU) conducted an investigation into the crash and concluded that excess blood-alcohol concentration and citalopram found in Mr Hutchings' blood were factors in the crash. The SCU advised that a person prescribed citalopram should not consume cannabis or alcohol as these increase the severity of the side effects. It also strongly recommended that such a person does not drive a motor vehicle.

The SCU concluded that the crash was due to a fatigued and/or intoxicated driver, who failed to realise he was approaching the bridge abutment until the last moment. In addition, Mr Hutchings was not adequately restrained within the vehicle. If he had been, it is likely he would have survived the crash. The SCU further noted that the bridge abutment at the scene of the crash was not protected in any way. Given that the severity of the impact of Mr Hutchings' vehicle with the abutment resulted in his fatal injuries, the SCU recommended that consideration be given to installing a crash barrier along the roadside and around the bridge abutments.

### COMMENTS OF CORONER RYAN

- I. Having given due consideration to all of the circumstances of this death, I do not consider there are any comments or recommendations that could usefully be made pursuant to section 57A of the Act, for the purposes set out in section 4.

- II. The [SCU] recommends the installation of a crash barrier around the bridge abutment, but informs that there is no other crash history in the area where the crash occurred. Nevertheless, a copy of this Finding is to be provided to the local authority responsible for the section of road in the expectation that the authority will consider whether the analyst's recommendation should be acted upon.

## Lindsay and Peters [2020] NZCorC 111 (14 December 2020)

### CIRCUMSTANCES

James Joseph Peters, aged 26, of Te Kauwhata and David James Lindsay, aged 65, of Karikari Peninsula died on 21 March 2019 from non-survivable injuries sustained in a motor vehicle collision on Waerenga Road, Te Kauwhata.

On the morning of 21 March 2019, David was transporting road gravel from the quarry on Falls Road to a worksite stockpile on Scott Road. At approximately 10.54am, he was transporting his fourth load of the morning. He left the quarry at approximately 11.00am heading west along Waerenga Road. At the same time, James was travelling east on Waerenga Road.

At approximately 11.05am, David came down a hilled section of Waerenga Road. At the bottom of the hill is a short bridge. Towards the end of that bridge there was a noticeable deformity in the road surface consisting of a bulge and depression which started on the outer line of the western lane and spread to the centre of the road. The shoulder of the eastbound lane of the road is narrow and flanked to the left by a steep drop-off.

As David came off the bridge his truck suddenly swerved out of the western lane into the eastern lane, directly into James' path. The vehicles collided and both David and James died from their injuries at the scene. A full investigation into the collision was made by the Waikato District Police's Serious Crash Unit (SCU), which determined that the likely cause for the truck's sudden lane departure was a blowout of the right front tyre. In addition to the blowout, the SCU also identified several contributing factors to the collision, specifically:

- 1) The truck was travelling at 16km/h over the heavy vehicle speed-limit of 90km/h.
- 2) The truck was destabilised. The most likely cause being the deformity in the road surface on the bridge. Together, 1) and 2) would have added pressure to the right front tyre which failed.
- 3) The narrow shoulder of the eastbound lane coupled with the steep drop off.

### COMMENTS AND RECOMMENDATIONS OF CORONER ROBB

- I. This collision is a tragic accident that has sadly taken two lives. The factors contributing to that collision have been detailed above. These include the road surface, speed, and failure of the tyre that blew out. In addition, a narrow shoulder provided James with no realistic opportunity to avoid the collision.
- II. I note the recommendations suggested by the SCU but remind myself that I am only able to make recommendations where I have concluded these to have been a factor in the collision and as a result a factor in the death of the drivers. The recommendations that I make are only those that flow directly out of those factors.

- III. I provided the Waikato District Council (the Council) with a draft of my recommendations to provide them with an opportunity for them to respond in accordance with the requirements of the Coroners Act. Those recommendations are:
- a. resurfacing of Waerenga Road between Kelly Road and the end of the bridge 500 metres west of Kelly Road;
  - b. to review the posted speed limit for the section of Waerenga Road where this collision occurred, noting this was on a downhill section where speed may be inadvertently increased by the forces of gravity; and
  - c. to widen the shoulder of the east bound lane of Waerenga Road to provide drivers the opportunity to take evasive action if required.
- IV. The Council have informed me that resurfacing works in the area of the culvert were carried out in the first week of April 2019. Consequently, I consider that recommendation addressed.
- V. In respect of widening the shoulder the Council advised:
- "Widening of the road shoulder at the location is problematic, due to the topography and proximity of the culvert. This would not be possible without significant earthworks and land acquisition. The roadside barrier was repaired in April 2019, and council is undertaking investigations as to whether relocation of the roadside barrier could be relocated to provide additional space. These investigations are due to be completed early 2021, and council would be in a position to report on the outcomes by February 2021."*
- I look forward to an update on the possibility of widening the road shoulder as recommended above.
- VI. As to the reduction in speed the Council advised:
- "... Council is proposing to consult on a reduction in the posted speed limited on Waerenga Road as part of the Waikato District Council's 2021 speed Bylaw review, which commences in June 2021."*
- I look forward to an update on those consultations as they relate to the recommendation on reducing the speed limit in the area.
- VII. I record that as part of their response to me the Council wished to take the opportunity to extend their sincere condolences to the family and friends of Mr Peters and Mr Lindsay.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of James and David taken during the investigation into their deaths, on the grounds that it is in the interests of decency and personal privacy.

## Maker [2020] NZCorC 72 (7 October 2020)

### CIRCUMSTANCES

Dwayne Adam John Maker, aged 37, died on State Highway 1, Atiamuri on 29 March 2019, from significant blood loss secondary to extensive abdominal, pelvic and limb injuries sustained in a head-on truck versus truck collision.

On 29 March 2019, Mr Maker was driving south on State Highway 1, Atiamuri, Taupo when his truck crossed the centre line and collided head-on with another truck travelling north. As a result of the collision, Mr Maker suffered fatal injuries and passed away at the scene. The driver of the other truck was uninjured.

The Serious Crash Unit report noted that it was possible that Mr Maker was fatigued and may have fallen asleep at the time of the accident. The report also noted that there are no Audible Tactile Profile Markings (ATPM), also known as rumble strips, running through the centreline of this section of State Highway 1. When a vehicle passes over ATPM, the driver should experience a vibration through their vehicle and through the steering wheel. The driver should also hear the sound of rumbling, and hopefully be able to correct their direction of travel before coming into contact with another object.

### COMMENTS OF CORONER BATES

- I. I make the following comments pursuant to s 57(3) of the Coroners Act 2006:
  - a. There are devices available for most motor vehicles, including heavy commercial vehicles, that alert drivers if they are deviating from their lane. There are also in-vehicle cameras that detect specific characteristics of fatigued drivers, such as drooping eyelids and nodding heads. Both devices alert the driver either through sound and/or vibration. Mr Maker's truck was not fitted with either device. Either one of them may have alerted Mr Maker when his truck began to deviate from its lane, resulting in him taking corrective action.
  - b. There were no ATPM on the section of road where the crash occurred. The presence of ATPM may have alerted Mr Maker that his truck was crossing the centre line and resulted in him taking corrective action.

### RECOMMENDATIONS OF CORONER BATES

- I. I make the follow recommendations to Waka Kotahi, the New Zealand Transport Agency:
  - a. Statistics should be gathered relating to vehicle crashes where crossing the centreline has been the primary or sole factor, quite possibly due to fatigue (where there is an absence of factors such as inattention, road conditions, mechanical defect, speed, medical event or driver impediment due to drugs/alcohol) and where there were no lane deviation or driver fatigue devices fitted to the offending vehicle. Statistical data could be used to facilitate introducing a safety standard requirement that new vehicles (vehicle classes to be determined by Waka Kotahi following statistical analysis) are equipped with one or both such devices. Fitting such devices would appear to have greater application in a commercial setting, particularly where long and repetitive journeys are commonplace, leading to fatigue or inattention;

- b. Statistics should be gathered in relation to vehicle crashes where crossing the centreline has been a factor and where there are no ATPM present, to investigate a programme of applying ATPM to all major highway centrelines.

*Response from Waka Kotahi*

- II. My provisional findings, comments and recommendations were provided to Waka Kotahi for comment. On 25 September 2020 Waka Kotahi responded. The following is a summary of that response.
- III. In December 2019 the Government launched Road to Zero; NZ's road safety strategy 2020-2030. That strategy includes specific focus on strengthening regulatory settings applying to commercial operators. Opportunities to improve fatigue management are a priority area for the 2020-2022 period.
- IV. In the longer term the Ministry of Transport will undertake a broader work, examining the future role of transport technology, particularly telematics (vehicle tracking and fatigue monitoring technology), to address safety risks in the course of commercial driving.
- V. Waka Kotahi is aware of the benefits of ATPM and their role in alerting inattentive or fatigued drivers of departure from their lane, be it edge-line or centre-line. ATPM represent a very high value treatment and Waka Kotahi have been installing them on the State Highway network for the last 9 years, more recently as part of the Safe Network Programme. Waka Kotahi is continuing to invest in the installation of ATPM on State Highway corridors as part of their focus on the infrastructure and speed management area. They identify and prioritise high risk corridors based on the crash history and risk profiles of roads. The ATPM are installed as a mixture of edge-line and centre-line markings, depending on the risk identified for the particular corridor.
- VI. The intention of Waka Kotahi is that ATPM will become universal over time.
- VII. Waka Kotahi's response is encouraging, and I commend the approach being taken, particularly as it relates to ATPM. What the future holds regarding telematic technology and its regulated application to (commercial) vehicles on our roads remains unclear at this stage. For that reason, I repeat the recommendation at [II above].

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

## **Ong and Chin [2020] NZCorC 81 (22 October 2020)**

### **CIRCUMSTANCES**

See Yee Ong, aged 29, died at Main South Road, part of State Highway 1, in Bankside on 4 May 2017 from very high energy impact injuries to the head, chest, and abdomen, sustained as a passenger in a van vs ute collision. Tze Hau Chin, aged 38, died at the same location and on the same day from severe high energy impact injuries to the head, thorax, and abdomen, sustained as a driver in a van vs ute collision.

Ms Ong and Mr Chin had travelled from Singapore to New Zealand on a flight that was approximately 9 hours and 50 minutes long. They arrived at Christchurch Airport at around 8.30am on 4 May 2017. At around 10.30am, they hired a Toyota van and began to travel.

At around 1pm, while travelling on State Highway 1, in the Bankside, Selwyn area, Canterbury, the van, driven by Mr Chin, drifted off the road. When attempting to turn back on to the road, the van rolled onto its side and was struck by an oncoming ute. As a result of the collision, Ms Ong and Mr Chin suffered fatal injuries and passed away. The Police considered that Mr Chin may have been fatigued and was either driving without awareness or having a micro-sleep at the time of the accident.

### COMMENTS OF CORONER TUTTON

- I. Ms Ong and Mr Chin were provided with advice to get good quality sleep after a long flight. The dangers of driving while fatigued are evidenced by their deaths.
- II. The NZTA identifies the following warning signs of fatigue:
  - a. having trouble focusing, keeping your eyes open or holding your head up;
  - b. daydreaming, wandering or disconnected thoughts, loss of memory;
  - c. yawning or rubbing your eyes repeatedly;
  - d. drifting from your lane, tailgating and missing signs or exits; and
  - e. feeling restless and irritable.
- III. The NZTA advises that stopping and getting a good night's sleep is the only cure for fatigue. Where stopping overnight is not practical, a break every two hours, or every 100 kilometres, should be incorporated into the journey.

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

## Procter [2020] NZCorC 93 (10 November 2020)

### CIRCUMSTANCES

Sheree Jayne Procter, aged 35, of Highcliff Road, Dunedin died on 4 January 2017 at Dunedin Hospital of a massive pulmonary embolism secondary to deep vein thrombosis and post trauma hospitalisation, in a setting of obesity.

On 14 December 2016, Sheree was admitted to hospital for injuries she sustained in a serious single vehicle crash when she lost control of her car causing it to barrel roll off the road and into a paddock. She was unrestrained at the time of the crash and was ejected from the vehicle.

Sheree received treatment for her multiple orthopaedic injuries, from which she was recovering from slowly. However, at 9:28am on 4 January 2017 Sheree had a cardiac arrest and despite resuscitation efforts she died at 10:25am.



Sheree had been issued with a medical exemption to drive unrestrained. Two of the issues before the Coroner were a) whether Sheree's medical exemption from wearing a seatbelt was compliant with relevant legislation and b) if there were any other options short of a seatbelt exemption, which may have relieved her discomfort whilst maintaining her safety.

The granting of an exemption is at the complete discretion of the medical practitioner on the basis of their clinical judgement. Waka Kotahi NZ Transport Agency has no oversight role in relation to such exemptions. Waka Kotahi NZ Transport Agency has however issued a publication to guide medical practitioners titled 'Medical aspects of fitness to drive – A guide for health practitioners' (the Guide). The current edition of the Guide details at Chapter 13.1:

The use of safety belts and child restraints is compulsory in New Zealand. However, the law recognises that it is not always practical for some individuals to wear a seatbelt for medical reasons, eg children with hip spica casts often cannot be restrained in a child restraint. Medical practitioners can provide exemptions from wearing a safety belt for medical reasons by writing a letter for the individual to carry with them. However, this should only be done in exceptional circumstances, as there are few medical conditions that this applies to. It is important to recognise that granting an exemption from the use of safety belts places an individual's safety and that of other passengers at considerable risk in the event of a crash.

Clause 7.11(2A) of the Land Transport (Road User) Rule 2004 requires that exemptions must specify the date on which they were issued, as well as the expiry date. Sheree's document had no stipulated expiry date and consequently appeared open-ended. The Coroner opined that the absence of a stipulated expiry date appeared to render the exemption non-compliant with the Rule and was technically invalid.

Dr Millar-Coote, the issuing doctor, told the Coroner that Sheree had sustained injuries to her right shoulder in October 2010 and June 2016 and complained that wearing a seatbelt aggravated her pain to an intolerable level. He believed that at the time of Sheree's crash in December 2016 her medical condition was such that a continuation of the seatbelt exemption was medically appropriate.

#### **COMMENTS OF CORONER WINDLEY**

- I. One of the purposes of my inquiry is to consider whether there are any comments or recommendations I can make that may reduce the chances of future deaths in circumstances like Sheree's.
- II. The evidence from Dr Millar-Coote is that notwithstanding the absence of an expiry date on the seatbelt exemption rendering it deficient and non-compliant with the Rule, the exemption was nevertheless medically indicated and appropriate at the time Sheree crashed her vehicle and sustained serious injuries. It is not for me to second guess Dr Millar-Coote's clinical judgment in that respect but I cannot reiterate strongly enough that the exercise of the clinical judgment must balance the significant exposure to risk of injury, or worse, that an unrestrained occupant of a motor vehicle is exposed to. For that reason, the Guide properly reserves such exemptions for "exceptional cases" and ensures, through a mandated expiry date, that the continued exposure to such a risk is regularly reassessed with reference to the current state of the individual's medical condition. Whether there might be adequate alternatives short of a complete exemption, such as use of a factory fitted seatbelt height adjusters or seatbelt extenders, ought to be queried by a GP before issuing a seatbelt exemption.

- III. Because I am unable to conclude that had Dr Miller-Coote stipulated an expiry date on Sheree's exemption, the train of events that led to Sheree's death may have been avoided, I am unable to make any formal recommendations on this aspect with reference to s 57(3) and 57A of the Coroners Act 2006. There would, however, appear to be a demonstrated need for further education of GPs in the exercise of this authority to issue seatbelt exemptions. Compliant seatbelt exemptions will at least ensure that the continued need for an exemption (and the associated safety risk that carries) is regularly reassessed by a GP.
- IV. I therefore strongly encourage the Waka Kotahi NZ Transport Agency and the Royal New Zealand College of General Practitioners to identify forums and modes to deliver, potentially in a collaborative effort, education opportunities for GPs on this important safety issue.
- V. I therefore direct that a copy of these Findings be sent to both the Waka Kotahi NZ Transport Agency and the Royal New Zealand College of General Practitioners.

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

## Schweizer and Isenmann [2020] NZCorC 71 (4 October 2020)

### CIRCUMSTANCES

Simon Daniel Schweizer, aged 35, and Rebekka Maria Isenmann, aged 31, both from Germany died on 10 March 2018 on State Highway 47, near Tongariro National Park of multiple injuries sustained in a motor vehicle crash.

Both Mr Schweizer and Ms Isenmann arrived in New Zealand in mid-February 2018. They were holidaying and had the use of a campervan. At about 6.45am on 10 March 2018, Mr Schweizer and Ms Isenmann were travelling north in their campervan, on State Highway 47. Mr Schweizer was driving and Ms Isenmann was in the front passenger's seat. It is likely that they both had spent the previous evening at a campsite at Mangahuaia which is located some 250 metres south of what became the scene of a fatal crash. On the road outside the entrance to the campsite are two tourist arrows. One is 50 metres to the north of the entrance, and the other is 32 metres to the south of the entrance. Both delineate the correct side of the road for drivers in New Zealand.

At the same time, Mr Robert Brown, a professional truck driver was travelling southbound on State Highway 47. As Mr Brown approached the Whakapapa River bridge he saw the campervan approaching him on the wrong side of the road. Despite attempts to evade each other, Mr Brown collided with the campervan, resulting in the death of Mr Schweizer and Ms Isenmann.

### COMMENTS OF JUDGE THOMPSON

- I. It is possible that had there been a Tourist Arrow on the south-bound lane of SH47, north of the campsite where it is presumed they spent the night, Mr Schweizer and/or Ms Isenmann might have realised that they were on the wrong side of the road, and been able to avoid the collision by crossing to the correct side.

- II. Of course even if such a Tourist Arrow had been in place at the time of the crash, it may still have been the case that it was not observed by the couple. There remains, however, a possibility that it may have assisted in redirecting Mr Schweizer onto the correct side of the road and out of the path of south-bound traffic.
- III. On that basis, and given the campsite is presumably a place regularly used by overseas tourists, a copy of this Finding will be sent to Waka Kotahi/New Zealand Transport Agency, to consider the need for an additional Tourist Arrow road-marking on the south-bound lane, north of the campsite and level with the north-bound Tourist Arrow road-marking.

## Sharma [2020] NZCorC 101 (23 November 2020)

### CIRCUMSTANCES

Neeraj Sharma, aged 27, of Auckland died on 22 March 2019 at Waikato Hospital from non-survivable traumatic head and brain injuries received in a motor vehicle collision on 20 March 2019 at the intersection of Diagonal Road, State Highway 27 and Kereone Road, Ngarua.

Neeraj was an Indian national who immigrated to New Zealand in 2012. He held a full New Zealand driver's licence. In the morning of 20 March 2019, Neeraj was travelling alone in his vehicle from Taupō to Auckland. At approximately 11:35am, he approached a compulsory stop at the intersection of Diagonal Road and State Highway 27. The evidence suggested Neeraj intended to turn right onto State Highway 27 before turning left into Kereone Road. As he drove up to the intersection, he came to a vehicle which had already stopped at the intersection. The driver of the stationary vehicle was waiting for a truck, travelling on State Highway 27 and approaching from the north of the intersection, to pass. Neeraj drove to the right of the stationary vehicle but did not stop at the intersection entering the path of the truck. The truck driver started to brake but was unable to stop before colliding with the driver side of Neeraj's vehicle.

Members of the public and emergency services applied first-aid to Neeraj until he was eventually airlifted to Waikato Hospital and admitted to the intensive care unit. His injuries included non-survivable traumatic head and brain injuries. On 22 March 2019, the treatment team performed a brainstem reflex test which confirmed Neeraj was brainstem dead, and at 2:34pm he passed away.

### COMMENTS OF CORONER ROBB

- I. Pursuant to section 57A of the Coroners Act 2006 I make the following comment. Neeraj's death highlights the present and real dangers that exist at intersections, and it serves as a tragic reminder of why mandatory stop signs must be complied with, "stop means stop". That is the message the Police have campaigned on and one I reiterate and urge to the public to heed. In light of the above, I do not make any formal recommendation under section 57(3) of the Coroners Act 2006.

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

# Self-Inflicted

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## Baxter [2020] NZCorC 104 (1 December 2020)

### CIRCUMSTANCES

Levi Conrad Baxter, aged 17, died near his home in Porirua on 4 July 2018 in circumstances amounting to suicide.

Levi was a Year 13 student at Tawa College and lived with his mother, Christina Baxter. He was achieving well at school and his teachers had not noticed anything untoward in Levi's behaviour, although he had occasionally mentioned having headaches and trouble sleeping. His only sign of stress related to what he was going to do in the future, once school finished. Mrs Baxter was aware that Levi was feeling stressed about his upcoming exams, as well as applying for jobs once exams were over.

A long-term friend reported that Levi had not seemed happy recently and had drifted away towards a different group of friends, who had assaulted him. Levi had started using cannabis, and had made references to ending his life on social media. Examination of Levi's recent text messages confirmed that he was experimenting with drugs, and had been expressing suicidal thoughts. Levi texted a friend on the evening of 2 July 2018 saying that he was thinking about suicide. The friend responded immediately, expressing concern and telling Levi that many people cared about him. They continued to text into the early morning of 3 July 2018, with the friend encouraging Levi to work through his feelings and focus on positive things. Another friend offered to come and get Levi, but he declined.

At school on 3 July 2018, Levi's behaviour seemed normal and he gave no further signs he was thinking of suicide. However, later that day his friend became worried about Levi's texts earlier that morning and told his own parents about them. As it was late at night, the friend's parents decided to contact Mrs Baxter the next day. Tragically, Levi decided to act on his suicidal thoughts, leaving his home in the early hours of 4 July 2018 before Mrs Baxter could be alerted. Levi texted two people to say goodbye and that he was sorry before his death.

Having regard to all the facts, the Coroner was satisfied that Levi had acted with the intention of taking his own life and knowing the probable consequences of his actions.

### COMMENTS OF CORONER BORROWDALE

- I. From the evidence gathered in this inquiry it is apparent that Levi had voiced suicidal ideation on several occasions to friends. [...]
- II. It is likely that Levi's friends did not think that he would end his life, and they were also untrained in helping him – and unsure how to – when he talked about issues pertaining to his emotional wellbeing and mental health. The evidence before me is clear, however, that while Levi had of late drifted into a new circle that was harmful to his wellbeing, his schoolfriends were supportive and very much wanted to help him.

- III. It is clear that it was very difficult for Levi's young friends to deal with the issues they faced, and that they were greatly upset by his death. It is important that Levi's friends know that none of them are responsible for the decision he made – they are not to blame for his death.
- IV. Help is available to anyone who is struggling and thinking of harming themselves. Help is also available to anyone who is concerned or aware that a friend, family member or anyone else is thinking that way.
- V. Information about the ways you can support someone who is thinking of harming themselves is available at <https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide>.
- VI. The website contains information about what to do if you think someone needs urgent help, which I repeat here:

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

- **Call your local mental health crisis service** or go with the person to the emergency department at the nearest hospital.
- **If they are an immediate 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 that you care.
- Keep them talking: listen and ask questions without judging.

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

**For counselling and support** – these are free and generally available anytime:

- Lifeline – 0800 543 354
- Samaritans – 0800 726 666

**For children and young people**

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

- VIII. I do not consider it necessary to make any recommendations pursuant to s 57(3) of the Coroners Act 2006.

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

An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Levi Conrad Baxter in the interests of personal privacy and decency.

## Crawford [2020] NZCorC 83 (28 October 2020)

### CIRCUMSTANCES

Kenneth Raymond Eric Crawford, aged 48, died overnight 6/7 November 2018 at 16 Dunbarton Street, Redwood, Christchurch in circumstances amounting to suicide.

On 6 November 2018, Mr Crawford played YouTube music videos from A Star is Born repeatedly. He also sent a link to a friend to the YouTube video for “I’ll Never Love Again”, in which the protagonist in the film enters the garage to kill himself. The Coroner concluded that there was a copycat element in Mr Crawford’s actions.

A Star is Born was initially rated M (unrestricted, suitable for 16 years and over). The classification carried the descriptive note “sex scenes, offensive language and drug use.” Subsequently, the Chief Censor required that the warning note be updated to include reference to “suicide” after receiving complaints from members of the public, including from healthcare providers. The Classification Office noted complaints by Victim Support after it responded to vulnerable young people who had been “severely triggered by this scene”, and complaints notified by the Mental Health Foundation.

The potential link between the portrayal of suicide in news or other media has been the subject of much research, some of which indicates that “copy cat” suicide can result where the deceased had some affinity for the character who dies by suicide in the fictional work.

### COMMENTS OF CORONER ROBINSON

- I. It is appropriate to conclude by repeating the caution expressed in the research cited above:

Further research in this area is warranted but, in the meantime, *there is a need to err on the side of caution*. Mental health professionals and suicide experts should collaborate with film makers, television producers, members of the music industry and playwrights to try to *balance entertainment against the risk of harm*, and to promote opportunities for education. Sensitive portrayal of suicide that does not glorify or romanticise it and does not provide detail of the exact method is likely to be preferable, as are depictions that stress consequences for others, potential hazards of particular methods, and sources of help for vulnerable viewers.  
(emphasis added)

- II. Given the potential harm that can result, and the risk of a causative relationship between a fictional portrayal and copycat acts, I consider that those contemplating including a portrayal of suicide in

fiction, or making available a fictional portrayal of suicide (regardless of medium) ought to think long and hard about whether it is really worth the risk.

#### **RECOMMENDATIONS OF CORONER ROBINSON**

- I. I accept that the evidence is not clear as to the association between portrayal of suicide in fiction and completed suicide. The research however points to the risk of there being a causative relationship.
- II. I think the Chief Censor acted appropriately in amending of the rating for A Star Is Born. Because of the potential for harm, I recommend that the rating for any publication that includes a portrayal of suicide include a specific warning as to that fact.

Note: Because Mr Crawford's death was self-inflicted, 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 Mr Crawford'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 Mr Crawford taken by Police in the interests of decency and personal privacy.

## **Fasitaue-Rudolph [2020] NZCorC 100 (23 November 2020)**

#### **CIRCUMSTANCES**

Veronica Frances Fuganikula Fasitaue-Rudolph, aged 19, of Ōrākei died between 5 and 6 December 2017 in circumstances that amounted to suicide.

Veronica had struggled with mental health challenges for a long period of time beginning in July 2007. Other mental health crisis events occurred in 2015 and 2016, the latter of which resulted in inpatient treatment. On 24 October 2017 Veronica was referred by her general practitioner to the Auckland District Health Board (ADHB) Manaaki House Mental Health Team (Manaaki MHT). The Planned Acute Care team (PAC) within Manaaki MHT, telephoned Veronica eventually connecting with her on 30 October 2017. She reported re-starting an anti-depressant and an improved mood. It was agreed that the PAC team would stay in touch with her by phone to confirm that her improvement was maintained.

On 14 November 2017 Veronica was admitted to a youth respite facility, staying there until 18 November 2017 whilst remaining under the care of the PAC. On 20 November 2017, the Manaaki House MHT determined that cultural and whānau support was important for Veronica's treatment. Accordingly, she was referred to Manawanui Oranga Hinengaro (Manawanui), a kaupapa Māori community mental health service run by the ADHB. An assessment with Manawanui was scheduled for 8 December 2017. The PAC Team planned to remain in telephone contact with Veronica in the interim.

On 29 November 2017, concerns for Veronica's well-being resulted in her admission to Te Whetu Tawera Adult Acute Mental Health Unit at Auckland Hospital (Te Whetu Tawera) under the Mental Health (Compulsory Assessment and Treatment) Act 1992. She was discharged from Te Whetu Tawera on 5 December 2017 as she had improved but she had had poor engagement with non-Māori staff. The intention was that following discharge, she would stay at the youth

respite facility before returning home. The assessment with Manawanui was cancelled by that service because it was unable to accept her due to her clinical activity and the ongoing involvement of PAC.

On the day of discharge, Te Whetu Tawera staff had difficulty contacting the respite facility to hand over information about Veronica's care. It was agreed that Veronica would go home with her family for a short period of time and that her mother would take her to the respite facility later that day once the handover had been completed. At home Veronica was cared for by family members but, at around 6.00pm, she walked away without telling anyone. At 6:30pm Veronica spoke with an aunty before continuing to walk towards Tāmaki Drive. About that time, her disappearance was noticed, and the Police were called. A search located Veronica at around 6.00am on 6 December 2017 in Michael Joseph Savage Memorial Park. She was deceased.

The ADHB reviewed the care provided to Veronica and a component of the review focused on the cultural context of her presentation. The report issued by the ADHB concluded there was a good standard of care. However, it identified two areas of concern: rotation of staff through the PAC team and poor Māori cultural support, notably the absence of Māori cultural support through the Community Mental Health Centre (CMHC). Both these factors appeared to contribute to the lack of Veronica's engagement but could not be confirmed.

The report made the following specific recommendations, which the ADHB responded to in July 2020:

- 1) Recommendation 1: The PAC/URS shift model of staffing should be reviewed to give more consistency of staff contact with patients.
  - a. *High levels of staff vacancies have made it difficult to address this recommendation. The CAS (Community Acute Service) staffing model was being reviewed early in 2020. This included exploring options for staff to be rostered to work for longer periods in the Urgent Response Team and Planned Acute Care team. The impact of COVID 19 and the level of staff vacancies has limited further progress in this area. The service is continuing to explore ways to improve continuity of care through improved roster cycles.*
- 2) Recommendation 2: Review the provision of Māori cultural support within Mental Health Services with an initial focus on the CMHCs.
  - a. *This recommendation is still being implemented and has been incorporated into a wider piece of work in the Mental Health and Addictions Directorate in terms of equity and Māori cultural responsiveness. As part of this process a Māori lead role (Service Clinical Director, Manwanui Māori Mental Health) has been created in the Mental Health Directorate and was appointed in January 2020. More recently, a Co-Director (Māori) of Mental Health and Addiction services has been appointed and she will be leading a piece of work on the provision of Māori cultural support to the CMHCs (community mental health centres). At the same time, capacity within the ADHB Kaupapa Māori service has increased so that more Māori have the opportunity to choose a combined cultural-clinical support service.*

## RECOMMENDATIONS OF CORONER ANDERSON

- I. The outcome of the Incident Review conducted by ADHB in relation to the care provided to Veronica demonstrates the importance of providing culturally appropriate and responsive care for people who



experience mental illness. This has also been recognised in He Ara Oranga, the 2018 Report of the Government Inquiry into Mental Health and Addiction. The He Ara Oranga Report noted that while there have been Māori health gains, evidence is mounting that the current system in Aotearoa is not working for Māori and that fundamental changes are needed.<sup>13</sup>

- II. It is encouraging to see that some steps are being taken by ADHB to address issues of health equity and to improve the provision of culturally responsive care and treatment for Māori mental health service users. However, it is important for momentum in this area to continue and for the recommendations made following the DHB's own Incident Review to translate into meaningful change for those experiencing mental illness and distress who come into contact with ADHB mental health teams.
- III. As a result, I recommend that Auckland District Health Board:
  - a. Continues to explore, and then implement, models designed to provide culturally responsive mental health and wellbeing services to Māori service users and their whānau; and
  - b. Takes further steps to improve continuity of care for Planned Acute Care and Urgent Response Service users.

#### Distribution

- IV. A copy of these findings will be provided to:
  - a. The Mental Health and Wellbeing Commission.
  - b. The Suicide Prevention Office.
  - c. The Ministry of Health.

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

Order under section 74 of the Coroner Act 2006 applies and no person may publish photographs taken of Veronica during the investigation into her death, in the interests of decency and personal privacy.

## Flavelle [2020] NZCorC 75 (13 October 2020)

### CIRCUMSTANCES

Jason Sitivi Flavelle, aged 19, died on 18 September 2017 at House Park, Kirkbride Road, Mangere, Auckland in circumstances amounting to suicide.

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<sup>13</sup> Para 3.4, page 82.

Some four months before his death, Jason had attempted suicide but was found by his partner. On 15 September 2017 he argued with his partner. He was angry and crying and said, “I’m just going to do it, good bye” and left the house.

#### 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. Jason had previously made an attempt to take his life in the months leading up to his death but afterwards he had not talked to his doctor about it and there is no evidence that he sought or received any other help or support to work through factors affecting him. He was overwrought and sad at the time he left home on the morning of his death and indicated again that he was thinking about suicide. He left home with the means to end his life.
- III. An important message that Jason’s death highlights is that when a person speaks about suicide or makes an attempt to take their life it should be taken seriously, support should be given to the person and they should be helped to find assistance. If a person seems to be in imminent danger of taking their life, seek emergency help such as calling 111 or going with the person to the nearest Emergency Department.

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

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

## Peng [2020] NZCorC 80 (20 October 2020)

#### CIRCUMSTANCES

Chengan Peng, a 20-year-old Chinese student, was found deceased at his UniLodge accommodation in Auckland on 2 July 2017. The Coroner found that his death was self-inflicted.

Chengan was described as coming from a caring and stable family, and had no history of any physical or mental health issues. He arrived in New Zealand in January 2017 and had just completed a course at the Academic Colleges Group (ACG), now under the ownership of UP International College (UP). Chengan’s teachers described him as a pleasant, polite student, who gave no indications that he may have been depressed or at risk of self-harm.

As part of his studies, Chengan was required to complete a writing journal. His journal entries indicate that he felt negatively about the Chinese government and education systems, and distaste for the “manners” of Chinese people. While he liked New Zealand and its people, he also recorded concerns on multiple occasions about his finances and the high cost of living in New Zealand compared with China. Several months before his death, Chengan also drew two

doodles of a deceased figure next to entries in his journal. His tutor did not discern any dangerous intent behind the doodles, instead interpreting them as a reference to word-games they had played in class.

The Coroner noted Chengan's possible expressions of suicidal ideation in the form of the two doodles, and inquired with ACG whether it had sufficient resources or policies for teaching staff to apply to identify and help students at risk of suicide. The Coroner also inquired whether ACG had implemented any policies to manage the risk of student mental health issues since Chengan's death. A reply was provided by Mr Mark Haines, Executive Principal NZ Schools.

#### COMMENTS OF CORONER BORROWDALE

- I. Having given due consideration to the circumstances of Chengan's death, I consider that there are comments that can usefully be made pursuant to section 57(3) of the Coroners Act 2006.
- II. I have considered all of the evidence, and the submissions made to me by UP and [Chengan's tutor], and I am of the view that at the time of Chengan's suicide in July 2017 ACG was insufficiently attuned to and equipped to address the risks of student depression and self-harm.
- III. While Mr Haines says that there is "not a lot of difference" between the resources available to teachers before Chengan's death and afterwards, I am satisfied that the current resources are a material improvement.
- IV. Mr Haines states that the improvements made "*were important in light of the tragic circumstances surrounding Mr Peng's death and the increased prominence of mental health issues among young people.*" However, he encourages me to abstain from criticism of the resources and policies that were in place in July 2017, saying that they "*reflected a well-resourced and reasoned approach to the support of students suffering from mental health issues and they were consistent with industry guidelines in place at the time. They were also consistent with the risk factors known to UP which included that there had been no prior incidents of suicide or serious mental health issues amongst our students.*"
- V. I appreciate Mr Haines' engagement with my inquiry, which has been fulsome. However, in the interests of preventing further tragic incidents of this kind and taking a robust view of matters, I cannot agree with Mr Haines on this. I believe that ACG's 2017 resources fell short of what should reasonably be expected of a tertiary education provider who seeks enrolments from young overseas students. I make the point that these students were predominantly foreign students, because in my view that places an extra obligation of care on the provider, knowing that these young people will be far from home, many of them for the first time.
- VI. It is not far-fetched to expect that some young people in that situation may experience feelings of loneliness, dislocation and stress. The Stuff media research bears that out, but this was also known at the time. I refer to the 2016 Code on the pastoral care of international students. The Code requires that providers adequately support the well-being of their international students. It includes a wealth of good advice, such as being proactive to look for signs that something is not right; creating a 'linked chain' between faculty, residential caregivers, etc; 'expect the unexpected'; and allow the time and resources for handling wellbeing issues. Mr Haines does not dispute that these risks were well-known in 2017.

ACG was a signatory to the Code, and Mr Haines points to the “culture shock” section of the 2017 Handbook for recognition of these risks.

VII. How, then, did ACG fall short in its resources to manage these risks? The specific shortcomings that in my assessment the 2017 resources had were as follows:

- a. The resources were predicated on a student seeking help if they needed it, and busy teaching staff were not adequately coached in identifying at-risk students.
- b. The Handbook did not advise students that a doctor was available for an initial consultation, and how his services could be accessed.
- c. The Handbook did disclose that students could access the College nurse, but required that they do so by first talking to a senior manager or the Dean. In my opinion, a direct student-patient consultation should have been available without this additional step. It is likely to be the case that for many young students, from diverse cultures, holding a conversation about their mental health with senior staff might feel highly unfamiliar and uncomfortable.
- d. The Handbook mentioned that psychological services would come at a cost to the student. Students are often under financial pressure. The cost of accessing mental health support is likely to represent an access barrier to some students.
- e. The Directory of Services in the Handbook did not refer to agencies and services that provided emotional or mental health support.
- f. The Handbook was available only in English.

VIII. I accept that ACG thought in 2017 that it was well-resourced to deal with student wellbeing issues, but the measures adopted since reveal a heightened sensitivity to the risks of student depression and self-harm in a population of international students who may be far from their home and usual support networks. It is pleasing to see that ACG has improved the Handbook in many respects, but also that it has made the following key changes:

- a. Staff now have the Mental Health Flow Chart to help them identify mental health issues and obtain support for students. Staff have received additional training as to how to communicate any wellbeing concerns, and also as to the sorts of behaviours that may indicate that a student is struggling.
- b. Selected staff have attended further specific training sessions by Lifekeepers Suicide Training.
- c. [A counsellor] is now made available for student counselling. I urge UP to consider promoting to the students the commendable development that UP now offers three free counselling sessions [with the counsellor] to students in need, to ensure that cost is not a barrier to students seeking help. UP’s delivery of this service is a genuine improvement and a real benefit to struggling students, but to access it they need to be aware of it.

- d. The Sonder Safe online self-reporting system is in place, accessible by all students at any time.
- IX. UP advises that it annually reviews these resources to ensure that they align with the NZQA Code, “with our intention being that what we do exceeds the requirements” (Mr Haines’s words). This is a welcome development and a laudable posture.
- X. Mr Haines also advises, and I applaud, that the 2020 UPIC Student Welfare Handbook, dealing with medical and emotional help, will shortly be offered in translations into other common student languages.
- XI. I find no fault with the text of UP’s current resources, but suggest that the language/organisational names (e.g. “Samaritans”) may be obtuse to speakers of foreign languages, and that future editions may be improved if UP describes what these services offer.
- XII. I decline to make any adverse comment regarding [his tutor’s] response to Chengan’s doodles and journal entries in which he expressed his stressors.
- XIII. [...] I also accept [Chengan’s tutor’s] statements of sincere regret that he may have misinterpreted the drawings. [He] states, and I accept, that if he had known Chengan had any suicidal inclinations he would have done anything he could to get him the help he needed.
- XIV. In his journals, Chengan expressed self-negativity about making bad purchases and wasting money; and was negative about his financial situation and his Chinese homeland.
- XV. I accept that hindsight provides a lens on these events that was unavailable at the time. It is important not to set teachers an impossible standard with respect to the pastoral care owed to their students, some of whom may be resistant to holding personal conversations with their teacher. So, I take this no further than to say that, in my assessment, there was in these writings enough to cause a perceptive teacher to make enquiry of Chengan as to his wellbeing.
- XVI. When students are required to keep an autobiographical journal, with topics that reflect on how they are, what makes them angry/sad etc, it is not unlikely that the teacher will gain an insight into their students’ state of mind and may read content of concern. It is pleasing that UP has now rolled out training on how to identify students who may be at risk or struggling, rather than relying solely on the mechanism of students seeking self-help.

Note: Because Chengan’s death is self-inflicted, section 71(2) of the Coroners Act 2006 applies, which prohibits publication of any particulars of his death, other than his name, address and occupation and the fact that his death was self-inflicted.

An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Chengan Peng entered into evidence in the interests of personal privacy and decency. In addition, it prohibits the publication of the name of Chengan’s tutor and any particulars that may identify him.

## Te Kuru [2020] NZCorC 102 (27 November 2020)

### CIRCUMSTANCES

Raymond James Te Kuru, aged 55, died at 83 Arawa Street, Whakatane, on 30 December 2018 in circumstances amounting to suicide.

On the day of his death Mr Te Kuru was arguing with a family member. During this argument, he made threats of self-harm.

### COMMENTS OF CORONER ROBB

- I. Raymond's 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:<sup>14</sup>
  - a. If someone has attempted suicide or you're worried about their immediate safety, do the following.
  - b. Call your local mental health crisis assessment team or go with them to the emergency department (ED) at your nearest hospital.
  - c. If they are an immediate physical danger to themselves or others, call 111.
  - d. Remain with them and help them to stay safe until support arrives.
  - e. Try to stay calm and let them know you care.
  - f. 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: Pursuant to section 71 of the Coroners Act 2006, no person may, unless granted an exemption under section 71A of the Coroners Act, make public the method or suspected method of a death, or any details that suggest the method or suspected method of the death. See section 71 for the full restrictions.

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

## Sudden Unexpected Death in Infancy (SUDI)

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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.

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<sup>14</sup> At <https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal>.

## Ahmed [2020] NZCorC 86 (30 October 2020)

### CIRCUMSTANCES

Zayn Ahmed, aged nine months, of Blockhouse Bay died on 29 March 2018 at Staverley Avenue, Mount Roskill of asphyxia (choking) with contributing probable chronic aspiration. This was a natural death not accidental.

Zayn was bottle fed and experienced reflux and diarrhoea from birth. He was seen by a paediatrician, Dr Nobbs, when he was four months old. Dr Nobbs considered that Zayn presented with symptoms consistent with a dairy milk protein intolerance and reflux oesophagitis and prescribed Pepti Junior formula as well as Losec medication. Over the next two months, Zayn remained on the formula and was introduced to small amounts of dairy as recommended by Dr Nobbs. He was doing well, and so was weaned onto a different formula. However, Zayn continued to experience reflux, and was taken to a second paediatrician, Dr Allan Liang.

Dr Liang noted that Zayn had mild allergy symptoms and a variable appetite, and his parents were interested in stimulating his appetite. He also noted that Zayn's parents both smoked. Examination confirmed mild gastroesophageal reflux with mildly separated anterior abdominal muscles. Dr Liang prescribed Periactin to increase Zayn's appetite. After about four weeks, Zayn's appetite had improved. He started on solids at six months old and his reflux was more settled.

On 29 March 2018, whilst his parents worked, Zayn was in the care of Ms Sharma, who was well-known to the family. He was dropped off at Ms Sharma's house around 8:00am and had breakfast at 9:30am. He had a cold for a few days prior and Ms Sharma noted his nose was very runny while he was eating. He also appeared sleepy, often closing his eyes. At 10:00am, Ms Sharma lay Zayn on the couch to sleep, with a cushion wedged under his bottom. She checked on Zayn periodically. At 10.05am he had rolled onto his side so Ms Sharma laid him flat on his back again, then moved the pillow under him away. About ten minutes later, Ms Sharma checked on Zayn, who had rolled onto his front. Ms Sharma thought he was fast asleep and did not want to wake him. She put him back on his back and he kept sleeping.

Sometime between 11.00 and 11.30am, Ms Sharma realised Zayn had been sleeping longer than usual and was not responding to her voice. She checked on him again and noticed there was vomit coming from his mouth and nose. Ms Sharma picked Zayn up, cleaned his face and attempted resuscitation. In a panic, she called her husband for advice and he contacted emergency services. An ambulance attended, and paramedics attempted to resuscitate Zayn but were unsuccessful.

Dr Vertes conducted a post-mortem examination and noted frothy fluid in Zayn's airway and chronic inflammatory cells in his lungs. She considered that the most likely explanation for these cells would be previous instances of aspiration of vomit. She found no other abnormalities, injuries or disease process that would have caused or contributed to Zayn's death. Dr Vertes therefore considered that the direct cause of death was asphyxia (choking) with contributing probable chronic aspiration.

Since Dr Nobbs considered that nine months was an unusual age for cot death to occur the Coroner consulted Professor Mitchell, a paediatrician since 1983. Professor Mitchell explained that Zayn's age was within the age that SUDI occurs but relatively old for this condition. He also noted that parental smoking increases the risk about 4-fold. Sleeping on a couch has also been identified as a risk for SUDI and in Professor Mitchell's opinion this is due to two factors, namely there is often an adult sharing the couch with the baby (not the case here), the seat surface is not horizontal, the baby rolls and becomes wedged against the back of the seat (the photos indicate the seat surface is horizontal).

While Professor Mitchell did not dispute the findings of Dr Vertes, he did not agree with her conclusions. In his opinion there was no evidence that Zayn died of asphyxia, rather this was an unexplained natural death. He noted that if Zayn's cause of death was classified as asphyxia it would be certified as an accidental death which is preventable, and for which blame may be affected or inferred. He was of the opinion that Zayn was at low risk of death, but noted that low risk is not no risk.

Professor Mitchell's comments were forwarded to Dr Vertes, who agreed with many of his points, including that Zayn's death was natural. However, she disagreed that asphyxia necessarily dictates an accidental manner of death. In her view the repeated bouts of aspiration put Zayn in a higher risk category for sudden death. Her preference for the cause of death remained asphyxia due to aspiration but she favoured defining it as a natural death.

#### **COMMENTS OF CORONER BELL**

- I. Although the mechanism of Zayn's death has been determined as asphyxia, with contributing probable chronic aspiration, it occurred in the context of an unsafe sleeping environment.
- II. Considerable effort is being made in New Zealand to promote the message that every sleep for a baby should be a safe sleep. That is, for every sleep, babies up to one year of age should be put to sleep on their backs, in their own sleeping space (a firm, flat and level surface with no pillow), with their face clear. The challenge is to ensure the safe sleep message, and what research shows safe sleep means for a baby, is clear to all parents and caregivers. It must also be delivered in a way that is understood, and the importance of the message appreciated. In the context of many other Coronial recommendations and comments being made about this issue, further recommendations or comments are not called for.
- III. Nevertheless, 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: 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.

## **Healey [2020] NZCorC 96 (13 November 2020)**

#### **CIRCUMSTANCES**

Majesty Kay Cheyann Airini Healey, aged 1 month and 4 days, died at Massey, Auckland on 12 April 2018 due to sudden unexpected death in infancy in the setting of unsafe sleep environment.

Majesty's mother, Ms Thompson, did not have a Lead Maternity Carer or receive antenatal education prior to Majesty's birth and had no post-natal care. However, she had been given one structured education session about safe sleep and had been provided with some written material and a pepi-pod while she was in hospital after Majesty's birth.

Although Majesty's parents often used the pepi-pod, on 12 April 2018, Majesty was found unresponsive in a double bed next to her mother, who had fallen asleep while breastfeeding her.



## COMMENTS OF CORONER GREIG

- I. In the past Coroners have made multiple recommendations to agencies to ensure that the safe-sleeping message is consistent between health professionals, and appropriately given to new parents. It is an important message as it is effective in preventing infant death.
- II. As has been outlined, there were limited opportunities for Majesty's parents to be given safe sleep information as Ms Thompson did not have a Lead Maternity Carer or receive antenatal education prior to Majesty's birth and had no post-natal care. However, I am satisfied that she had been given one structured education session about safe sleep and been provided with some written material and a pepi-pod (which it appears was generally used) whilst she was in hospital after Majesty's birth.
- III. During Ms Thompson's pregnancy there was concern about the safety of her unborn child and once Majesty was born, there was concern about the environment in which she and her mother were living and how best to ensure Majesty's ongoing wellbeing. Despite this, at the time she died Majesty had had none of the usual regular assessments of her health, development and wellbeing that new-borns normally routinely receive in New Zealand - usually through a series of regular home visits from a midwife and then a well child provider. Nor had Ms Thompson had the support, reassurance and expertise of a midwife or well child provider as she cared for her new baby. The agencies who would normally have provided this care and support (the DHB and Plunket) had determined that it was not safe for staff to visit Majesty and Ms Thompson at home. As an alternative Ms Thompson had been offered appointments at the clinics of the health professionals. Apart from a single visit to the GP, Ms Thompson had not taken Majesty for any checks. Oranga Tamariki had met with Ms Thompson once and were planning towards putting some supportive structures in place. It appears this had not occurred when Majesty died. A safety assessment was also planned.
- IV. The lack of ongoing monitoring and assessment of Majesty after her birth is very concerning but is not directly linked to the circumstances of her death. Accordingly, it is not a matter on which it is appropriate for me to seek further evidence or make recommendations. However, a copy of these findings will be sent to the Ministry of Health, Waitemata District Health Board, the Child & Youth Mortality Review Committee and Oranga Tamariki to highlight the issues identified and, in the hope that solutions can be found to ensure that the care and monitoring of vulnerable babies like Majesty does not 'slip through the cracks', whilst ensuring that the safety of health care providers is not compromised.
- V. A copy of these findings will also be sent to Change for our Children.

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

## Kerehoma [2020] NZCorC 77 (13 October 2020)

### CIRCUMSTANCES

Harmony Josephine Ella Kerehoma, aged three and a half months, died on 26 January 2019 at 14 Oriana Place, Palmerston North of Sudden Unexpected Death in Infancy associated with an unsafe sleeping environment.

Harmony was bottle-fed by her mother at 10:30pm on 25 January 2019. She was placed between two pillows at the bottom of the queen size bed in her parents' room and went to sleep. She was positioned at the end of the bed on her father's side. Harmony was sharing the bed with her mother, father and one-year-old brother. Her father woke at 1:55am and woke Harmony's mother who checked on Harmony. She noticed foam on Harmony's mouth and felt that Harmony's body was floppy. Emergency services were notified and CPR commenced. Ambulance staff arrived and took over CPR. Despite all efforts Harmony could not be revived.

During her antenatal period, Harmony's mother told her lead maternity carer (LMC) that she was aware of safe sleep practices, including that her baby should be sleeping in her own sleep space, on baby's back, face up, face clear and in a smokefree environment.

The Coroner was conscious from research undertaken, that concern had been expressed at the level of awareness of these commonly promoted healthy sleep messages as there was a lack of understanding by some of the importance of the safe sleep practices due to conflicting experiences within families, which become barriers to implementing the messages. The research questioned whether additional support or information may be needed and how this can best be shared with families, particularly amongst Māori whānau and Pasifika families.

### RECOMMENDATIONS OF CORONER HESKETH

- I. Coroners have made recommendations to various agencies in the past to ensure that the safe-sleep message is consistent between health professionals and community organisations to ensure it is appropriately given to new parents. As set out in the recent decision of Coroner McDowell<sup>15</sup> it is an important message as it is effective in preventing infant death.
- II. The Ministry of Health guidelines were launched to reduce the sudden unexpected deaths of infants.<sup>16</sup> The guidelines' key focus is to target the two key modifiable risks for SUDI: exposure to tobacco smoke during pregnancy (which includes the period following birth in the whanau/family, in the home and in the waka/car) and unsafe bed sharing (i.e. co-sleeping in the bed with baby). However, the message has clearly given rise to some confusion for the reasons set out above.
- III. Given the importance of the safe sleep message, it should be consistent throughout and not be conflicting. Any barriers that exist through inequities in social, cultural, collective and economic disparity must be addressed through appropriate funding levels to ensure the importance of the safe

<sup>15</sup> Ngatuakana [2020] NZCorC (27 February 2020).

<sup>16</sup> Ministry of Health – National SUDI Prevention Programme: National Safe Sleep Device Quality Specification Guidelines. Wellington: Ministry of Health - published 08 May 2019; Ministry of Health. 2019. National SUDI Prevention Programme: Needs assessment and care planning guide. Wellington: Ministry of Health - published April 2019.

sleep message is communicated consistently and understood. Families who understand the message will ensure it is passed on and adhered to.

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

## Matthews [2020] NZCorC 85 (29 October 2020)

### CIRCUMSTANCES

John Junior Matthews (known as JJ), aged eight weeks, of Papamoa died on 22 February 2020 at his family home in Papamoa of Sudden Infant Death Syndrome.

On 21 February 2020, baby JJ fed, played and slept as normal. At approximately 10.30pm he was put to sleep in his bassinet for the night while his parents entertained friends. At around 1:00am on 22 February 2020, JJ woke, was fed and placed on his back in the middle of his parents' bed, next to his mother. He woke again at approximately 4.30am and was again fed and changed before being settled back into his parents' bed.

At around 8:30am, JJ's father woke and discovered JJ next to him unresponsive. Help was sought and resuscitation commenced but was unsuccessful.

### COMMENTS OF CORONER ROBB

- I. This is a tragic case where JJ, a well-cared for baby, has passed away in his parents' bed. It is clear that this was not his normal sleeping space. In considering whether to make formal recommendations under the Act, I note the safe sleeping practices which are recommended and published by various agencies and organisations. For example, the Ministry of Health has useful information on its website, including the following:<sup>17</sup>

#### **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.

#### **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 cot or other baby bed**

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<sup>17</sup> Ministry of Health "Keeping baby safe in their own bed: 6 to 12 months" (8 January 2020) [www.health.govt.nz](http://www.health.govt.nz).

- 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.

If you are out somewhere, or if you are sleeping with your baby, make sure that they have their own safe space to sleep. It is never safe to put your baby to sleep in an adult bed, on a couch or a chair or in their car seat.

**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
- there is nothing in the bed that might cover your baby's face, lift their head or choke them.

Your baby may begin to roll over from their back to their front when they get to 5–6 months old. You don't need to try to stop this happening, as long as their cot is free of things that might suffocate them, such as pillows, large soft toys and cot bumpers.

Make sure that your baby's cot is put together correctly. The tops on the corner posts of wooden cots may need to be sawn off so that your baby can't hang themselves by their clothing. The spaces between the bars of the cot must be between 50 mm and 95 mm – try to make the spaces closer to 50 mm if you can. If you have a cot with adjustable levels, make sure that you lower it before your baby can pull themselves up (at about 9–10 months).

- II. In the context of the above recommendations, as well as coronial recommendations and comments that have been made on the issue of safe sleeping, further recommendations are not called for.
- III. A copy of these findings will be sent to the Ministry of Health, the Child Youth Mortality Review Committee, Change for our Children and Hāpai te Hauora. These organisations are actively involved in working to strengthen and make consistent the safe sleeping

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of baby JJ following his death, in the interests of decency.

## Te Whaiti-Howe [2020] NZCorC 78 (14 October 2020)

### CIRCUMSTANCES

Treyzarn Nga-Pu-O-Te-Rangi Te Whaiti-Howe, aged three weeks, of Waiohiki, Napier, died at his home on 27 November 2017. The cause of death was unascertained, although it was probable that Treyzarn died due to an unsafe sleeping position.

Treyzarn's mother, Shannyn Howe, could not recall specifically what occurred but thought she may have fallen asleep while breastfeeding, and that he may have rolled against her in the bed. Ms Howe recalled waking and finding Treyzarn beside her, with his mouth open. She recalled that his colour had changed, but that his heart was still beating and he was breathing slowly. She put him back in his bassinet next to the bed. When Ms Howe woke up several hours later, she found Treyzarn unresponsive in the bassinet. The scene investigation did not identify any concerns about the room and environment in which Treyzarn was sleeping.

### COMMENTS OF CORONER FITZGIBBON

- I. Considerable effort is being made in New Zealand to promote the message that every sleep for a baby should be a safe sleep. That is, for every sleep, babies up to one year of age should be put to sleep on their backs, in their own sleeping space (a firm, flat and level surface with no pillow), with their face clear. The challenge is to ensure the safe sleep message, and what research shows safe sleep means for a baby, is clear to all parents and caregivers. It must also be delivered in a way that is understood, and the importance of the message appreciated. In the context of many other Coronial recommendations and comments being made about this issue, further recommendations or comments are not called for.

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

## Welsh-Coughlan [2020] NZCorC 88 (3 November 2020)

### CIRCUMSTANCES

Lyric Jay Arikinui Welsh-Coughlan, aged 15 months, died at Mangakino on 27 October 2019 due to sudden unexplained death in infancy (SUDI).

On 27 October 2019, Lyric was found unresponsive in the bed he was sharing with his mother. Unfortunately, and despite resuscitation efforts, he could not be revived. Lyric had recently been well and there was no evidence of any illness or disease.

### COMMENTS OF CORONER BATES

- I. In the past Coroners have made multiple recommendations to agencies to ensure the safe-sleeping message from health professionals is consistent, and appropriately given to new parents. It is an important message because it is effective in preventing infant deaths.

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

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

## Yu [2020] NZCorC 108 (10 December 2020)

### CIRCUMSTANCES

Gabriella Yu of Fielding, aged four months, died on 7 August 2019 at Palmerston North Hospital of Sudden Unexpected Death in Infancy.

At around 11:00am on 6 August 2019 Gabriella had been breastfed by her mother Kelly Cao and fallen asleep. Approximately 30 minutes later she was put down in the middle of her parents' bed with her head resting on a pillow. Ms Cao wanted Gabriella to sleep with her head propped up as she had a cough.

Ms Cao left the house at 12:10pm, leaving Gabriella in the care of her grandparents. At around 1:15pm Gabriella's grandmother checked on her and noticed that she had slipped off the pillow and under the duvet, which was covering her face from her nose down. Gabriella was unresponsive and not breathing. Gabriella's grandfather commenced CPR and felt a faint heartbeat.

Ms Cao returned to the property around 1:35pm and was informed of the situation. They all got into Ms Cao's car, called an ambulance and headed to the Fielding Health Centre for assistance.

Medical assistance was given at the Fielding Health Centre before the ambulance arrived. Gabriella was transferred to Palmerston North Hospital, where she sadly passed away shortly after midnight on 7 August 2019.

### COMMENTS OF CORONER FITZGIBBON

- I. Considerable effort is being made in New Zealand to promote the message that every sleep for a baby should be a safe sleep. That is, for every sleep, babies up to one year of age should be put to sleep on their backs, in their own sleeping space (a firm, flat and level surface with no pillow), with their face clear. The challenge is to ensure the safe sleep message, and what research shows safe sleep means for a baby, is clear to all parents and caregivers. It must also be delivered in a way that is understood, and the importance of the message appreciated. In the context of many other Coronial recommendations and comments being made about this issue, further recommendations or comments are not called for.



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