OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments made between **1 January** and **31 March 2021**

Office of the Chief Coroner | 2021 (1)

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 54 recommendations and/or comments issued by Coroners between 1 January 2021 and 31 March 2021.

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1 January to 31 March 2021

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

Child Deaths

Jayet-Cole [2021] NZCorC 19 (9 February 2021)

CIRCUMSTANCES

Five-year-old Leon Jayet-Cole died in Christchurch Hospital on 28 May 2015 from global ischaemic head injuries.

At the time of his death Leon lived at an address in Christchurch with his mother Emere (also known as Emma) Jayet, stepfather James Roberts, and older siblings C and D. Emma was also heavily pregnant with Leon's half sibling.

In the afternoon of 27 May 2015, James discovered Leon unconscious, not breathing and without a pulse. He called emergency services and performed cardiopulmonary resuscitation until paramedics arrived. Resuscitation efforts achieved a return of spontaneous circulation. Leon was then intubated and transported to Christchurch Hospital Emergency Department ("ED").

Scans of Leon's head suggested he had suffered trauma and significant hypoxic ischaemic encephalopathy, meaning his brain had been starved of oxygen. Leon was subsequently transferred to the Intensive Care Unit. Further scans showed significant injuries to Leon's brain and cervical spine. The medical evidence was consistent with trauma, and that brain death was likely. On 28 May 2015, following a second examination, Leon was confirmed to be brain dead and he passed away.

Police commenced a criminal investigation and subsequently charged James with Leon's murder. James died while awaiting trial and the criminal proceedings were stayed. The coronial inquiry was resumed and included an inquest conducted in two phases. The first phase was focussed on the cause of Leon's death and the immediate circumstances of how his fatal injuries came to be inflicted. The medical evidence effectively discounted the possibility that Leon's fatal injuries were self-inflicted or from an accidental low-level fall from height. On the balance of probabilities standard of proof that applies in the coronial jurisdiction, the Coroner found Leon's fatal injuries were caused by the actions of another person and were sustained some time prior to 12:57pm on 27 May 2015 during a period when he was in the sole care of James.

The second phase was focused on whether, prior to Leon's fatal injuries, there was a disclosed risk of violence by James which presented opportunities for intervention, and whether Leon's death could accordingly have been avoided. The second phase included a detailed examination of whether the agencies which had dealings with Leon and his family in the months and years before Leon's death, and had responsibilities to safeguard Leon's health and wellbeing, appropriately discharged those responsibilities. More particularly, were there indications to Child Youth and Family Services (CYFS, now Oranga Tamariki), the Canterbury District Health Board (CDHB) or Police – or for that matter Emma herself, who had legal duties and responsibilities to protect Leon and C – that James presented a risk of violence to others, particularly Leon or C? If so, were those risks identified and responded to appropriately? The touchstone for the second phase was firmly confined to whether James presented a risk of violence.

The inquest examined the landscape of respective agency responsibilities, areas of expertise, and the processes and systems that were in place at the time to work collaboratively to identify and address child safety concerns, particularly in regard to effective information sharing. Specifically:

- A national Memorandum of Understanding agreed in 2010 between CYFS and Police which sets out a high-level commitment to a collaborative working relationship between CYFS and Police;
- The Child Protection Protocol: Joint Operating Procedures ("CPP") agreed at a national level between CYFS and Police sets out the respective responsibilities of Police and CYFS, and in what circumstances the agencies work jointly in relation to child safety concerns, specifically actions or behaviour that may constitute a criminal offence under the definitions of physical abuse, sexual abuse, or neglect as defined in the CPP. The CPP has no express application to DHBs.
- A standard form local level Memorandum of Understanding ("Local MoU") agreed between CYFS, Police and the CDHB. which records the respective agency roles, responsibilities, and relevant expertise, and sets out the procedure for making referrals or Reports of Concern from Police to CYFS, or vice versa. A "Report of Concern" under the Local MoU constitutes a notification under s 15 of the Children, Young Persons, and Their Families Act 1989.

The evidence before the Coroner was that Police and CYFS are each responsible for assessing any Report of Concern received and investigating within their own legislative mandate and powers as appropriate. It is the role of Police to investigate suspected or alleged criminal abuse of children or young people, while it is the role of CYFS to investigate reports of concern with respect to care and protection issues, although it is frequently the case that there is an overlap in the investigations. All agencies have a number of agency-specific policies and practices that inform the discharge of their respective responsibilities in relation to child safety.

The agency assessment includes whether the threshold for referral as a CPP case is met for a multi-agency approach. If confirmed to meet the threshold, an "Initial Joint Investigation Plan" along with other prescribed steps, including regular meetings, would be followed. The CPP records that CYFS should, as part of its investigation, identify any risks for the child and their need for safety. The CPP also addresses permissible information sharing between the agencies with reference to s15 of the Children, Young Persons, and Their Families Act, and as an exception to Information Privacy Principle 11(e)(i) (as set out in s 6 of the Privacy Act 1993), which permits disclosure where necessary to avoid prejudice to the maintenance of the law.

The CPP also provides a specific co-ordinated management pathway for particularly serious cases where the child has been admitted to hospital, and the admission is related to suspected or confirmed abuse or neglect of the child. Under the CPP these particular cases require collaboration between CYFS, Police and the relevant "DHB" and are directed to be managed in accordance with Schedule 1 to the Local MoU. That management pathway was engaged in relation to Leon on 27 May 2015 following his hospitalisation with life-threatening injuries considered suspicious for abuse.

The evidence made clear that CYFS had engaged with and provided extensive ongoing support to Emma and her children for several years before Leon's death. The family also had a significant history of interactions with CDHB services, particularly as outpatients in relation to Leon and C's autism, but also as a result of acute physical injuries they had sustained. The family had also come to Police attention in relation to allegations involving James, as well as reports of child welfare concerns.

Notably, neither Leon nor C suffered any significant unexplained bruising prior to James's arrival in the household in 2012. A number of incidents that occurred after his arrival were detailed in the inquest evidence:

- In April 2012, an injury to Leon's tongue which required hospital treatment, was explained by Emma and James as resulting from a fall.
- On 11 June 2012, CYFS received an anonymous report of concern, alleging that Emma was verbally abusive to the children, that drugs were regularly consumed and sold from their address and that the home was filthy. The report suggested Emma had struck C on one occasion. James told CYFS that Leon had had substantial bruising to his ear, and that Emma could not explain it. Emma had Leon examined by his doctor. The doctor was not concerned and CYFS decided no further action was required.
- In September 2012, another report of concern was made by the respite carer for Leon and C. It included another allegation that Emma had slapped C across the head. The informant said Emma had also showed her bruises to Leon's ear. Like the earlier report, it alleged drug use and general neglect. CYFS notified Police of the report of concern. In evidence Police said that they had (erroneously) concluded it referred to the same events CYFS investigated in June 2012.
- On 16 January 2013, Emma brought C to Christchurch Hospital with extensive bruising to his forehead and to the area around his left eye. Round bruises and abrasions were also observed in the area of his left shoulder, and larger bruises and grazes were noted on his legs. Emma told Police that the injuries had occurred on 13 January when C fell, hitting his head on a television and television cabinet after spinning around the room. She did not think his injuries were serious and only sought medical attention after C's biological father saw the bruises to C's face on 15 and 16 January, and reported his concerns to both CYFS and Police. Those agencies investigated the injuries and implemented a safety plan for C. The Police Child Protection Team ("CPT"), did not consider further CPT involvement necessary given the support to the family being provided by CYFS. Paediatric medical advice following examination of C was that the explanation offered for the injuries was medically "plausible". CDHB medical clinicians undertaking an injury assessment are expected to commit to a clinical impression of the mechanism of injury classification being either: "clearly accidental", "unclear" or "inflicted". The

evidence suggested the meanings and limitations of the terms used by clinicians when assessing injuries were not fully understood by CYFS, Police, or even by CDHB social workers.

- On 2 September 2014, C was brought to hospital by Emma and a CYFS social worker following a Report of Concern to CYFS. C's left eyebrow was swollen, and there was a bruise in the hairline behind his left ear. The report suggested C's injuries could not be explained and noted C's inability to tell anyone what had happened due to his autism and being non-verbal. Hospital staff also observed bruises to his buttocks, back, chin and both ears, and grazes to his legs. Emma could not offer any explanation for C's injuries. Subsequent consideration of C's injuries, in light of the records of earlier injuries, appeared to be biased towards C's autism and attention deficit hyperactivity disorder – which suggested a propensity for accidental self-injury. Nevertheless, CYFS referred the matter to the Police, and it was agreed that the injury necessitated a CPP referral. However, Police action was limited and deferred to the social worker, and their conclusion that the injuries were explained by C's described behaviour. No further Police action was taken regarding that injury.

In the months that followed, CYFS and Police had several more interactions with the family. This included receiving further Reports of Concern from Leon's pre-school and the respite carer for Leon and C.

CYFS undertook a home visit in November 2014 and decided to refer the case to the Care & Protection Resource Panel. CYFS then prepared a Tuituia Assessment Framework Report. The Tuituia Report demonstrated what the Coroner characterised as a willingness by CYFS to accept, at face value, the explanations and assurances offered by James and Emma. The recommendation of the social worker in the Tuituia Report was that the "case be closed…".

On 21 December 2014 Leon was treated for a laceration to his face while he was in the care of James, who gave conflicting accounts for how the injury occurred. Despite the series of successive presentations with injury, many to the left side of the boys' heads, CDHB clinicians appear not to have identified any repeat features or linkages. While eProsafe was a tool readily available to clinicians to interrogate previous presentations of both C and Leon, the evidence suggested its capability to disclose potential patterns and risk was never given full effect.

A Report of Concern was made to CYFS and Police on 8 April 2015 following threatening behaviour by James towards a Ministry of Social Development investigator after he discovered Leon and his siblings home alone. On 5 May 2015, Police attended the address on three occasions regarding a dispute between James, Emma and their neighbour where it was alleged that James threatened the neighbour with a knife.

CYFS was still investigating the 8 April 2015 Report of Concern when Leon sustained his fatal injuries on 25 May 2015.

The Coroner ultimately found that prior to his death Leon was exposed to an escalating risk of violence by James that CYFS, Police and the CDHB should have collectively identified (having regard to the scope of their respective mandates) but did not. Had that risk been identified, that may have led to agency intervention. It was, however, impossible to say whether identification of the risk of violence would definitely have led to the type and scale of interventions that would have prevented Leon's death on 28 May 2015, but any intervention would plainly have reduced the likelihood of Leon being killed.

CONCLUSIONS AND COMMENTS OF CORONER WINDLEY

I. I acknowledge that the task of identifying and responding to child safety concerns is extraordinarily complex and challenging, and the consequences of the decisions that are made can be the practical difference between life and death. I also recognise that the state wields significant power which, if used without a good and proper basis, can cause significant harm to the wellbeing and functioning of individuals and families. The legislative and policy frameworks make clear that ultimately the welfare, interests and safety of children and young people is the paramount consideration.

II. All of the discussion above leads me to conclude that the systems and processes that existed at the relevant time within each agency, and as between the CDHB, CYFS and Police, for identifying and responding to child safety concerns were broadly adequate but were not utilised or optimised as they should have been. It has long been recognised that no one individual or agency should work in isolation in child protection and that agency collaboration will optimise outcomes for children and families affected by child abuse and neglect. Accordingly, there is a clear mandate for the sharing of relevant information between agencies to allow for more informed assessments of child safety concerns and risk to be undertaken.

III. In Leon's case the failure of the agencies to identify the risk of violence from James to others, including Leon, was fundamentally a product of assessments of incidents and information that were transactional rather than cumulative, that lacked critical analysis and rigour, that tended to default to the truth of the explanations offered by James and Emma when there was a clear basis for scepticism, and that reflected a cognitively biased mindset, namely that C and Leon were accident prone. It also reflected a significant degree of credulity and naivety, especially on the part of social workers.

IV. These factors meant there were only two occasions before Leon's fatal injuries when information was deemed of sufficient concern to be shared across all three agencies. Even in the context of multi-agency referrals or consultations, there was a focus only on the most recent incident, with little evidence of any cumulative assessment of risk having regard to the information held across all the agencies.

V. While I consider the policies and processes broadly adequate, and information sharing between agencies was clearly mandated and encouraged, there remains room for further improvement. My impression is that the Local MoU and CPP work reasonably effectively to appropriately engage all three agencies in cases at the serious end of the spectrum. But I accept Dr Doocey's point that there is a cohort of children who present (as C did in January 2013 and September 2014) with injury that raises suspicions of abuse and where CYFS are involved, but where the child is not hospitalised. Cases of that kind fall outside the Schedule 1 of Local MoU process which mandates a series of inter-agency meetings. The requirement for hospitalisation before a coordinated cross-agency information sharing and assessment process is engaged to better inform a medical opinion appears somewhat arbitrary and may lead to cases involving escalating risk being missed.

VI. Dr Doocey suggested in evidence that there would be value in a mandated inter-agency discussion in relation to those children during which additional information can be shared, and sought, to better inform the clinicians' assessment and, in turn, the CYFS risk assessment. In submissions, CDHB seeks a recommendation that the relevant policies be amended to ensure that whenever a Report of Concern is made in relation to physical

abuse and a medical assessment undertaken, there is a further meeting between Oranga Tamariki and medical clinicians before the Report of Concern is closed.

VII. Dr Doocey also considers there would be value in clinicians routinely attending CPP meetings involving a child or young person who has previously been referred for assessment. I endorse both suggested changes to policy and practice. Both would enhance opportunities for appropriate information sharing between agencies, as well as better informing the clinical assessments.

VIII. The need for ongoing training, in particular of junior doctors who may be the first to assess a presentation of a child with injury to the ED, is critical to ensure appropriate examination and assessment of children who present with injury. I am encouraged by Dr Doocey's optimism that the new CDHB facility where the Children's ED will be co-located with paediatrics will bring with it opportunities to enhance training and multi-disciplinary collaboration, in addition to new modes of training that will better suit the practicalities of a hospital setting.

IX. As Ms Blyth explained, "statutory child protection requires us to understand and pull apart incredibly complex families with incredibly complex dynamics". It follows that the information a social worker is given by caregivers must be critically assessed against any other relevant information that might be available, such as scepticism expressed by a non-custodial parent and any information held about previous incidents. Ms Blyth noted that development of the skills necessary to think critically and with an appropriate level of scepticism requires effective training and supervision. She said:

> When [social workers] start in the organisation there is an array of training around dynamics of abuse, different types of abuse, so there is that training, but it is a … skill that I think is developed over time and certainly it is really important that the social worker has really good supervision and is able to reflect and think about – the supervisor's role is that step-back person to be, allowing the social worker to think about what they're actually seeing.

X. The resourcing reality of all three agencies must also be recognised as a practical constraint that may hinder optimisation of child safety practices. As already noted, Ms Blyth gave evidence that a demonstrable increase in funding and workforce has translated into a tangible reduction in social worker caseloads, and as long as it is sustained that is an encouraging development.

XI. I acknowledge however Dr Doocey's candid advice that this area of medicine is complex and challenging, and that the pressures on resources and clinicians' time create a practical constraint on their cognitive headspace and capacity to evaluate these situations more thoroughly. To the extent this can be recognised and accommodated in hospital rostering, then it should be.

XII. While I have no doubt that additional inter-agency meetings and better resourcing would have improved the chances of the risk to Leon being identified, I am not persuaded that the decisive failures in this case were the result either of inadequate information-sharing policies or inadequate resources. CYFS devoted enormous resources to Leon and his family, and there were systems in place which should have avoided the agencies becoming information silos.

XIII. The failures which led to the risks to C and Leon going undetected were the result of a lack of open-minded and critical thinking. They stemmed from the early adoption of a fixed mindset and a transactional approach to a series of incidents which were never reassessed or considered in the round, even as a disturbing cumulative

picture began to emerge. The failures also reflected an inability to see connections, along with a naïve willingness to believe James and Emma, and to accept the self-serving assurances they offered when any objective analysis would have indicated that caution and scepticism were required. This criticism extends to CYFS, but also to the Police, whose unwillingness to act upon the serious threats James made on two separate occasions contributed to James never being identified as a source of danger to the boys.

XIV. Indeed, it is telling that prior to Leon's death it did not occur to anyone, with the possible exception of Mr Cole whose concerns were minimised or ignored, that James – who had a violent history, was making ongoing and serious threats and was present on every occasion when Leon and C were hurt – might have had a hand in the string of injuries which preceded Leon's death.

XV. It is difficult, in those circumstances, to make recommendations to prevent further deaths in similar circumstances. I acknowledge that many of the recommendations I do make propose relatively minor refinements to policy documents already in force, and that Oranga Tamariki, in particular, has already improved its practice standards across a range of relevant areas since Leon died. For example, Oranga Tamariki's enhanced quality assurance programme, which it explained in its written submissions, indicates it understands the nature of the problem. To the extent the recommendations set out below suggest things which have already been implemented or addressed, it may be that little more needs to be done, other than ongoing auditing to make sure the new practices and arrangements are functioning as they should, and that there continues to be sustained improvement.

XVI. In any event, I hope the lessons from this case are clear. Policy improvements alone would probably not have prevented Leon's death. The problem was not that there were inadequate systems to deal with identified family violence, but rather that the risk of violence in this case went undetected until Leon was killed. To be blunt, the individuals applying the relevant policies, across all three agencies, failed to undertake the depth of analysis needed in respect of what I accept was a complex and challenging family situation.

XVII. My inquiry has demonstrated the fundamental need for individuals tasked with detecting and responding to the risk of violence to children to be open-minded, critical analysts capable of assessing and reassessing information as new incidents occur, even where earlier incidents have been formally resolved and classified as benign. This in turn will enable robust risk assessments and the sharing of relevant information between agencies.

XVIII. I preface the following recommendations by recognising they are necessarily broadly expressed but essentially directed at enhancing rigour in information gathering, recording, analysis and interpretation by each individual tasked with detecting and responding to the risk of violence that threatens the safety of children. It is my firm expectation that each agency will undertake a review of their child safety-related work practices, policies and guidelines, and staff training with that lens.

XIX. I therefore make the following recommendations pursuant to ss 57(3) and 57A of the Act, and set out alongside relevant responses received in the course of the consultation mandated by s 57B of the Act.

RECOMMENDATIONS OF CORONER WINDLEY

Recommendation 1

That policy, practice standards, and procedures of Oranga Tamariki and Police CPT:

(i) expressly recognise the importance of, and set out as a requirement, that each new Report of Concern, or information indicating a concern, is expressly considered against a background of any preceding involvement or known concerns with the family, and that a documented cumulative harm assessment identifying any risk factors for violence take place in each case; and

(ii) make clear an expectation of critical and robust thinking by staff in assessing cumulative harm and risk of violence, and that Oranga Tamariki and Police provide ongoing staff training and regular monitoring of the quality of relevant decision making.

I. In its response to this proposed recommendation, Oranga Tamariki submitted that both limbs of this recommendation have already been implemented by way of:

a. Implementing a new Intake and Early Assessment model (full implementation completed in March 2020) which strengthens assessment (involving three key stages: initial, core, and full) and decision-making practice by focusing on early and accurate identification of tamariki whose safety and needs are best addressed through the child protection system;

b. Requiring a chronology to be completed (supported by improvements to CYRAS) as part of the initial assessment when a report of concern is received. This ensures a full understanding of prior history and exploration of past patterns of concerns and any potential impact of trauma or cumulative harm;

c. Social workers utilising the Tuituia Assessment Framework during the Core Assessment Phase to gather information by engaging with whanau, tamariki, and other professionals, and to critically analyse/understand the associated risks to determine (in consultation with a supervisor) next steps. Testing decision-making is considered an important aspect of supervision with a learning module delivered in December 2019 and quality assurance mechanisms used to monitor adherence to the associated practice standard;

d. A Quality Assurance team that sits within the Professional Practice Group and is responsible for evaluating practice on sites by way of Practice Checks analysing annual self-assessments, and regular case file analysis. This analysis helps inform the focus of improvement support;

e. Monthly Site Practice Leader-led case file analysis to monitor the quality of practice in a random sample of cases. In addition, there are quarterly sessions covering Practice Standards, Care Standards and one thematic area of interest. This process informs feedback to practitioners and the identification of wider site trends to support improvement initiatives.

Recommendation 2

That Oranga Tamariki policy, practice standards, and procedures make clear an expectation of taking early steps to understand the background and role within the family of any new family members it is dealing with, and in particular any new partner of a caregiver who may play some role in providing care for vulnerable children.

II. In its response to this proposed recommendation, Oranga Tamariki acknowledged the importance of understanding the role of any new family member it is dealing with, in particular any new partner or caregiver who may play some role in providing care for children at risk of harm. Oranga Tamariki submitted that this recommendation has already been implemented by way of:

a. Using the Tuituia Assessment Framework to consider the role of other household members;

b. Implementation of eight core practice standards for social workers in November 2017 which include seeing and engaging with family, whanau, caregivers and victims in order to understand their needs and ensure they have a say in decision about te tamaiti;

c. A suite of guidance available to support practice staff to implement the practice standards in their day-to-day work. The practice standards are frequently discussed on sites, and used by the Quality Systems team as one measure of quality practice;

d. Recent introduction of guidance to support the core assessment phase including early and ongoing engagement with family/whanau, central to which is holding hui a-whanau and family meetings initiated and facilitated by either whanau themselves or Oranga Tamariki. These provide an opportunity to gather, to explore and identify resources and protective factors to keep children safe, and for all parties attending to convey issues or concerns, to co-ordinate support and resources.

Recommendation 3

That the Local MoU include a mandated inter-agency meeting of CYFS, CDHB medical clinicians, and Police following a referral of a child or young person to CDHB for injury assessment in all cases where the mechanism of injury is non-accidental or unclear, and suspicious for abuse, even where that child or young person is not hospitalised.

III. In its response Oranga Tamariki expressed support for this recommendation and undertook to consider the most appropriate mechanism, together with the Ministry of Health and Police, to ensure interagency meetings take place to secure the safety of tamariki whether hospitalised or not.

IV. The CDHB submissions record this would be a useful recommendation but in light of the standard form of MoU being negotiated on a national basis, the recommendation ought to be directed to the Ministry of Health instead of the CDHB. CDHB further cautioned that while it sees merit in the recommendation, it is questionable whether there are sufficient resources available to meet this recommendation. Rather than mandating an inter-agency

meeting, the CDHB submitted the recommendation should be diluted to require only that consideration be given to such a meeting so that resource availability can be factored in.

V. The Ministry of Health was subsequently advised of this proposed recommendation and invited to comment. In its response, the Ministry of Health acknowledged: "*This case highlights the importance of the Ministry of Health working with other lead agencies to strengthen existing systems and frameworks of practice with the purpose of preventing mortality and morbidity*."

VI. The Ministry of Health further advised that the national MoU between Oranga Tamariki, Police, and each DHB that was published in 2016 is currently in the final stages of being updated.

VII. To the extent this recommendation would see an expansion of the Schedule 1 process to mandate a formal inter-agency meeting for all children referred to the DHB with injuries where the mechanism is non-accidental or unclear, the Ministry of Health submitted:

a. DHB child protection policies now mandate that:

i. such children be discussed with the on-call paediatrician, and unless the ED doctor was very experienced, a paediatric doctor would usually assess the child. The assessment includes taking the history again and reviewing all previous clinical records and national Child Protection Alert System (CPAS) which directs the hospital doctor to records available in other hospitals. CPAS is a national system to ensure background concerns about children are flagged at presentation to DHB services;

ii. if the hospital doctor believes the injury is unexplained or suspicious, the case is to be discussed with the Oranga Tamariki Call Centre and a Report of Concern made – multi-agency meetings are not currently required.

b. Broadening the scope of Schedule 1 of the MoU to mandate a formal inter-agency meeting for all children assessed in the DHB with injuries whose mechanism was unclear or suspicious would significantly increase the time demands on all involved. The Ministry of Health further advised: "*In our experience the conversation between the DHB clinician and the Oranga Tamariki Call Centre social worker is always valuable and leads to a clear plan to keep the child safe, but a face-to-face meeting is not always necessary or possible, given the other acute demands on on-call paediatricians*".

c. The Ministry of Health also advises that: "*A brief scan online of DHB child protection policies suggests further work is required to establish a degree of consistency nationally and implement further work to ensure alignment with the MoU and Schedules*."

VIII. The existence and utilisation of CPAS, and how that system fits with CDHB's eProsafe was not canvassed in evidence before my inquiry. As I record above, the evidence would suggest eProsafe's capability to disclose potential patterns and risk was never given full effect. Dr Doocey expressed a concern that the eProsafe system "wasn't appropriately interrogated" or at least there was no documentation to indicate it was. A failure to appropriately interrogate a database specifically designed to draw together information relevant to child safety

assessments, especially in a case where familiarity with the cumulative picture was critically important, is particularly troubling. Again, while I accept the tools are available to a clinician to access relevant past presentation information that will assist in informing their assessment, the evidence before me does not give me confidence that in day-to-day practice such systems were routinely and appropriately interrogated by clinicians (or other delegated staff) to inform their assessments, at least during the time period relevant to this inquiry. It is not possible for me to assess whether clinical utilisation of such systems has improved in the interim.

IX. While I accept there are inevitable resourcing implications for expanding the scope of Schedule 1 to encompass non-hospitalised children whose injuries are assessed to be non-accidental or unclear, I maintain the view that this particular cohort of children also deserve a robust inter-agency framework for developing informed risk assessments. While I have no doubt that the discussions between the paediatrician and the Oranga Tamariki Call Centre social worker are valuable, as the Ministry of Health says, the fact that Dr Doocey volunteered this as a current area of risk on the basis of her own clinical experience ought to carry some weight that this is not an imagined concern to be easily dismissed on a resourcing constraints basis.

Recommendation 4

That consideration be given to including a CDHB medical clinician in any CPP meetings in relation to a child or young person that has been referred to CDHB for assessment of an injury.

X. In its submission CDHB advises it supports this recommendation in principle but again considered it a recommendation more appropriately directed to the Ministry of Health for consideration of implementation at a national level. CDHB again expressed concern that the availability of resources could be a significant issue in giving effect to this recommendation.

XI. Oranga Tamariki expresses support for consideration being given to this recommendation but submits that engagement with Police and CDHB would be necessary to consider whether there are any circumstances when it would be inappropriate for a CDHB clinician to attend a CPP meeting. Oranga Tamariki further suggest it may not be necessary for a CDHB clinician to attend an initial CPP meeting where it is clear that the CPP investigation threshold is met. I note Police make no submissions.

XII. In its response, the Ministry of Health agreed that Child Protection Clinical expertise is an essential component for the multiagency team to interpret emerging patterns of concern and is highly desirable, but an assessment of effectiveness and resource implications is needed. The Ministry of Health notes current demands on paediatricians' time are such that taking an hour away from clinics, plus travel time either side, make these very difficult to schedule.

XIII. Again, while I acknowledge there are inevitable resourcing implications, this recommendation was also one endorsed by Dr Doocey on the basis of her own clinical experience and it can therefore be inferred that she considers there to be value in extending clinician involvement in CPPs. I note also that recent times have provided an opportunity to discover innovative ways of collaborative working beyond in-person meetings which may lend themselves to time-efficiency gains in these types of forums.

Recommendation 5

That CDHB adopt rostering arrangements of specialist consultant paediatricians which adequately reflect that the area of medicine relating to the clinical assessment of injuries in children and young people which are suspicious for abuse is complex and challenging, and thorough evaluations require dedicated cognitive headspace and time.

XIV. In CDHB's submission this recommendation is "*laudable*" but "*simply unrealistic and unable to be achieved in the current environment that CDHB operates with*". Mr White cites the "*well-known*" lack of resourcing afflicting the CDHB. It will of course be for CDHB to consider whether its current resourcing priorities and funding agreements align with this recommendation, which is simply that specialists need to be given adequate time to do clinical assessments of injuries to children properly. This recommendation was also suggested by Dr Doocey on the basis of her own clinical experience and understanding of both the challenges and importance of this task.

XV. In its response the Ministry of Health agreed it would be desirable to have dedicated and protected paediatrician time in all 20 DHBs for leadership in child protection and that this is something paediatricians themselves have advocated for over several years. The Ministry recognised dedicated time would allow the paediatricians to take part in both strategic multi-agency meetings (e.g. implementing the MoU, and joint planning and training of staff) and for individual children under the CPP. The Ministry also noted it is well known that DHBs are under severe pressure due to clinical demands and finances.

XVI. The Ministry of Health stated that further work is required within the Ministry to update accountability documents which set the expectations for DHB services. The Ministry advises these recommendations have prompted an examination of the MoU and its referencing within the Ministry's accountability documentation (in particular Crown Funding Agreements) as a basis for national consistency and to enable the intended effective participation of the paediatrician in the clinical assessment of a child or young person with injury which is suspicious for abuse.

Recommendation 6

That CDHB, Oranga Tamariki and Police review the collection of terminology used in association with medical assessments of injuries to children and young people suspicious for abuse, with a view to ensuring consistency both within each agency's own policies, guidelines, practices and reporting, and that there is clarity of understanding in the limitations of each term.

XVII. CDHB submitted there was a need for national consistency of terminology used in this context. The Ministry of Health agreed that having a common understanding of the terminology used between all three agencies involved in child protection would be beneficial.

XVIII. Oranga Tamariki expressed support for the recommendation and noted this recommendation aligns with the core practice standard, introduced in 2017 to: work closely in partnership with others; engage and collaborate with key people working with each tamaiti in order to ensure their full range of needs are identified and addressed in a co-ordinated way. Oranga Tamariki also noted it would be important for inter-agency discussions on this issue to be undertaken at a national and regional level so that any changes to policy and practice tease out areas where there is room for misunderstanding and professionals are encouraged to challenge opinions.

Note: There are permanent non-publication orders under section 74 of the Coroners Act 2006 which prevent publication of: the contents of the inquest document bundles for Phase 1 and Phase 2 with the exception of those parts which were referred to in evidence at inquest or which are reproduced in the Findings; the names and any particulars likely to lead to the identification of Leon's siblings and half siblings referred to in the Findings as 'C', 'D', and 'P'; the names and any identifying particulars of the CDHB health professionals involved in the treatment of Leon's or C's injuries other than the fatal injuries to Leon referred to in the Findings, namely 'Dr G', 'Dr F', 'Dr B', and 'Dr T'; the names and any identifying particulars of the current or former Oranga Tamariki employees who were directly involved with Leon and his family in the period prior to Leon's death that is relevant to my inquiry; the name and any identifying particulars of 'Ms A'; and any photographs taken of Leon associated with clinical injury assessment or the post mortem examination.

Subject to the above specific prohibitions, the oral evidence given during the first and second phase hearings, and the evidence reproduced in the Findings, including the names of Leon, James Robert, Emma Jayet, the witnesses who gave oral evidence, and the entities CDHB, Police and CYFS/Oranga Tamariki may be published.

On 2 November 2019, an interim non-publication order under section 74 of the Coroners Act 2006 prohibited the publication of the note and audio recordings James Roberts left at the time of his death. That interim order remains in place until a further decision on non-publication is made in the inquiry into James Roberts's death. Furthermore, restrictions on publishing details of the manner and circumstances of James Roberts's death continue to apply pursuant to s 71 (pre-amendment) of the Coroners Act 2006.

Ruru [2021] NZCorC 5 (7 January 2021)

CIRCUMSTANCES

Sebastian Mark Ruru, aged 13 months, died on 4 October 2019 at his home in Porirua when a wooden dresser fell on top of him. Sebastian lived with his mother, Deborah Ruru, and 2-year-old brother. His father did not live with them, but visited regularly.

On the evening of 4 October 2019, Sebastian and T were in a bedroom playing together on a rug on the floor. Mrs Ruru left the boys in the bedroom while she went out to the kitchen to prepare food for them.

After approximately five minutes, she returned to the bedroom and discovered that a dresser (wooden chest of five drawers) had fallen on top of the boys. Mrs Ruru immediately lifted the draws off Sebastian, and found him unresponsive. She called for an ambulance and began CPR, however, Sebastian could not be revived.

Sebastian's death occurred as a result of the dresser causing compression of his chest, which effectively prevented him from breathing. The drawers were full of children's clothing, and were heavy. They were mounted on sliders which made them open easily. Mrs Ruru believed that the dresser was stable because it was heavy and had never shown instability before this incident. The Coroner noted that Mr and Mrs Ruru demonstrated significant efforts to ensure the safety of their boys. They had assessed the dresser as being stable because of its weight and had made a considered decision not to fasten the dresser to the wall.

Mrs Ruru reported that Sebastian had started walking and was going through a phase of opening things and going through the drawers or emptying them out. It appears likely that, in the short time that Mrs Ruru left the boys in the bedroom, Sebastian pulled open some of the drawers, which caused the dresser to fall.

COMMENTS OF CORONER RYAN

I. I make the following comments pursuant to section 57A of the Act, for the purpose of reducing the chances of further deaths occurring in similar circumstances.

II. Sebastian's death occurred in very unusual circumstances, despite extensive efforts made by his parents to provide a safe environment for him. It is especially sad that Mr and Mrs Ruru had specifically considered fastening this dresser to the wall, but decided not to as they considered it was stable and may have to be moved on occasion. This was a considered and apparently reasonable decision on their part. But it is likely that they had not considered the possibility of the dresser becoming unstable when the drawers had been pulled out by an inquisitive one-year old child. Given that their first child had not demonstrated an interest in opening drawers, they had no experience to warn them that Sebastian may have such an interest.

III. This death highlights a significant risk associated with items of furniture that may be prone to topple over, either through inadvertent human intervention or by earthquake. The lesson to be learned from the tragic circumstances of this death is that any heavy item of furniture capable of toppling over should be secured to prevent it falling or being pulled over.

Sherwood [2021] NZCorC 54 (31 March 2021)

CIRCUMSTANCES

Nico Rose Sherwood, a newborn, died on 22 March 2016 at Waitakere Hospital, Auckland of intrapartum asphyxia and early neonatal death.

Nico was born on 22 March 2016 at Waitakere Hospital, Auckland. She was born at 7:40am with thick meconium present and in a poor condition. She was pale, floppy, had no spontaneous breathing and despite emergency and resuscitative efforts she died at 8:10am. The cause of death was established as being due to intrapartum asphyxia and early neonatal death, which is where a baby has been deprived of oxygen during labour and delivery.

Expert evidence from Dr Sarah Tout established that the second stage of labour was problematic. In particular, the CTG monitoring (method used to monitor the fetal heart rate and contractions) showed no satisfactory baseline heart rate. It was also noted that there was no clinical review (meaning an in-person review) of Nico's mother during the second stage of labour.

RECOMMENDATIONS OF CORONER HERDSON

I. Having weighed the totality of the available evidence, I am satisfied that there is a need to make a recommendation as contemplated by the Coroners Act 2006. This is a reiteration of part of Dr Tout's recommendation relating to CTG interpretation, set out at the conclusion of her report under the heading "Future Recommendations".

II. The recommendation reads:[1]

a. **CTG interpretation** (Paragraph 85)

I am aware that Waitemata DHB make fetal surveillance teaching available to staff by subscribing to an online learning package intellilearn ... This is based on the RANZCOG guidelines and is free to all DHB staff and Self Employed midwives. There is an annual requirement for all DHB midwives to undertake this training and this is monitored by Midwife Educators. It is free for Self Employed midwives to access using the DHB account but it is not a mandatory requirement for them. In light of this case I have the additional recommendations:

i I recommend that all staff involved in this case attend a multidisciplinary CTG workshop within the next 5 months, such as the face-face fetal surveillance education program provided by RANZCOG.... And used by many institutions around New Zealand.

ii I recommend that the requirement of attending a fetal surveillance workshop be mandated every 3 years for all DHB Obstetric and Midwifery staff and it be encouraged for all Self Employed midwives to attend. This would complement the annual on-line training.

iii To consolidate these workshops, I recommend that local multi-disciplinary CTG teaching takes place on a frequent (weekly/fortnightly) basis and that Self Employed midwives and DHB midwives, along with Obstetric staff, are encouraged to attend.

iv That [the Coroner makes] a recommendation to the Midwifery Council that CTG training be made a mandatory requirement for all midwives including Self Employed midwives. Currently there is not a requirement from the Midwifery Council for midwives to undertake any CTG training for re-certification.

Preliminary observations

III. Waitemata District Health Board and the relevant health practitioners involved in this case, confirmed there were already procedures in place, or that they had followed up, in relation to the matters set out in the recommendation. Therefore, it is paragraph (d) above that is the focus of the proposed recommendation in this written decision.

IV. I note that the recently updated RANZCOG guideline has the explicit statement that there is universal acceptance that the fetus is at risk of hypoxic injury during labour.[2] A review of the guideline (whether the version in place at the time of Nico's delivery, or the most recent version) shows that the document is aimed at providing assistance for the full range of health practitioners involved with management of fetal surveillance during labour, with the overall aim of improved outcomes for babies (and mothers).

[1] Report of Dr Tout, at paragraph 85.
[2] *Intrapartum Fetal Surveillance Clinical Guideline - Fourth Edition 2019*, page 10.

V. The evidence in this case has demonstrated the importance of electronic fetal surveillance, in particular CTG monitoring, during the intrapartum stage. The recognition of the need to assess the wellbeing of the baby (and mother) in this way as part of the management of labour and delivery, accords with the tenor of such guidelines.

VI. Therefore, in keeping with the need to minimise the known risk of such an injury during labour, it seems useful to ensure that the various methods of training which encompass both remote (online) and in-person training, are treated with equal importance across all stages of midwifery practice: for certification, during practice, and at the time of re-certification.

Opportunity for parties to consider mandatory recommendation

VII. The proposal for mandatory training being a recommendation in this decision, was notified to all parties involved in this inquiry, in keeping with the statutory obligations to notify such a matter, pursuant to the Coroners Act 2006. All parties responded, even if to confirm there was no specific response offered.

VIII. The topic of mandatory CTG education or training for midwives, and any response to a proposed recommendation, rested with the Midwifery Council of New Zealand Te Tatau o te Whare Kahu (Midwifery Council). It provided a considered response, following a meeting of the Midwifery Council in February 2021. In its response the Midwifery Council confirmed the importance of fetal monitoring, and associated matters such as the need for a well educated multidisciplinary team. It noted the existing work initiated several years ago by the Accident Compensation Corporation (ACC) and the multi-agency multidisciplinary taskforce set up in this area, known as the Neonatal Encephalopathy Taskforce, aimed at improving outcomes for babies and reducing preventable harm. It further noted the four work streams arising from the creation of that taskforce and the representation of the Midwifery Council on relevant workstreams (relevant to the proposed recommendation).

IX. The Midwifery Council took into consideration matters such as fetal heart rate monitoring being one component of the assessment of wellbeing before and during labour, matters relating to access to education (whether face to face or online), developments in education including the Neonatal Encephalopathy Taskforce, and the fact the Midwifery Council is currently engaged in a review of its competencies and standards of competencies as part of its regulatory framework review; this will include a review of the recertification programme.

X. Consequently, the Midwifery Council decided it will not make such education mandatory at this time.

Outcome of opportunity to respond to proposed recommendation

XI. Having provided a provisional recommendation and the opportunity for responses, and having reviewed this aspect of the coronial inquiry again, I have reached the decision that it is appropriate to amend the provisional recommendation.

XII. The recommendation will be amended to recognise that the Midwifery Council is currently reviewing its competencies and regulatory framework and to recommend it keep the proposition of mandatory CTG training under active consideration.

Recommendation

XIII. I recommend: the Midwifery Council of New Zealand Te Tatau o te Whare Kahu continues to keep under review, its approach to CTG (cardiotocography) training, including intrapartum fetal surveillance monitoring training, and continue to actively consider whether such training will be a mandatory competency requirement for re-certification for all midwives including self-employed midwives.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken by Police and entered into evidence that show Nico, in the interests of decency and personal privacy.

Miss X [2021] NZCorC 39 (19 March 2021)

CIRCUMSTANCES

Miss X, 19 months, of Hawke's Bay died on 24 September 2018 at Hawke's Bay of accidental asphyxiation from a roman blind cord.

At around 6:30pm on 24 September 2018, Miss X was put to bed by her mother. At around 9:30pm, Miss X's mother checked on her and found Miss X on the other side of her bedroom with her head against the wall, suspended about 10cm above the floor. Miss X's head was caught in the cord of a roman blind and she was deceased.

It was unknown how Miss X came to have her head tangled in the cord. Police considered that possibly she approached the window to watch her father arrive home and may have tripped and been unable to regain her footing. Police noted that Miss X's head was stuck in the inner cords on the unseen reverse of the roman blind.

The blind itself was 200cm high x 85cm wide, and the foot of the blind was 33cm from the bedroom floor. It had been custom made for the window, and was not supplied with any safety warning information. It was provided with attachments to affix to the wall, and it was installed by Miss X's father.

The Coroner noted that while there are a number of compulsory product regulations relating to corded internal window coverings internationally, no such regulations exist in New Zealand. Advice as to implementing regulations for corded internal window coverings was sought from the Ministry of Business, Innovation and Employment (MBIE), who reported that in order to do so the Minister of Commerce and Consumer Affairs (the Minister) needed to declare regulations. MBIE stated that there were no plans to develop mandatory regulations in relation to corded internal window coverings.

COMMENTS OF CORONER BORROWDALE

I. It is a recognised purpose of the Coroner's jurisdiction to make comments or recommendations with a view to reducing the chances of further deaths occurring in similar circumstances.

II. I therefore make the following comments pursuant to section 57A of the Coroners Act 2006:

    a. This case is one of six within a period of nine years in which a New Zealand infant has been strangled by the cord on a domestic window blind. The fatality rate from this source is therefore 0.67 deaths per annum. Five of those were deaths caused by roman blind cords.

    b. The family tragically affected by this death were unaware of the hazard posed by inner blind cords, located at the reverse of the blind. Their custom-made blind was supplied with no safety information.

c. New Zealand differs from comparable major jurisdictions in having no product regulations designed to ensure the safe supply and use of corded blinds.

d. Efforts to educate the New Zealand public on mitigating the hazard of blind cords have focussed to date on the installation of cleats or cord-tidies out of the reach of children, and on ensuring that beds and other furniture are not located near to corded blinds.

e. Those efforts, while laudable, are alone not sufficient to protect young New Zealanders from the risks of corded blinds. The ACCC [Australian Competition and Consumer Commission] stated[3] before mandating its stricter 2014 regulations that "… *the ACCC does not believe that parental education alone sufficiently mitigates the hazard.*" I record here also the comments of Dr Gary Smith, co-author of the Ohio study of US window cord fatalities:[4]

> … messaging is not enough. Designing the problem out of existence, in this case by manufacturing only cordless blinds, is the most effective strategy.

f. In particular, the focus on long looped cords and the use of cord-tidies overlooks the hazard caused by long, accessible, but less visible cords that can become wrapped around a child's neck or from which a child could become suspended.

g. The incidence of window cord fatalities in this country, and the availability of preventative devices, to my mind readily make the case for mandatory regulation to address the risks from corded window coverings.

h. Developments in blind enhancements now mean that there is a safety solution for virtually all corded blind hazards.

i. I cannot accept the suggestion made by MBIE to this inquiry that already installed blinds "*present a long term risk that can only be mitigated by information that encourages the occupant to take the necessary action…*"

j. My researches have established that retro-fit safety devices, and schemes to help consumers install those devices, are available overseas. Education is not the only available mitigation.

k. It is regrettable that New Zealand has not followed its closest international partners to impose any form of regulation. It is additionally regrettable that MBIE has taken no steps to develop product regulation.

l. The fact that there is already a risk to consumers by way of installed corded blinds should not in my view dissuade MBIE from promulgating regulations. It is possible to both mitigate that existing risk, and to regulate future sales and installations so that the risk is not magnified.

[3] ACCC Consultation Paper: Proposed Services Standard for Corded Internal Window Coverings August 2013 https://www.productsafety.gov.au/news/consultation-paper-proposed-services-standard-for-corded-internal-window-coverings.
[4] NPR "Window blind cords still pose a deadly risk to children" 11 December 2017 https://www.npr.org/sections/health-shots/2017/12/11/569463027/window-blind-cords-still-pose-a-deadly-risk-to-children#:~:text=Window%20Blind%20Cords%20Still%20Pose,%3A%20Shots%20%2D%20Health%20News%20%3A%20NPR&text=Live%20Sessions-,Window%20Blind%20Cords%20Still%20Pose%20A%20Deadly%20Risk%20To%20Children,effort%20to%20reduce%20the%20toll.

III. I therefore make recommendations directed towards improving public safety, pursuant to section 57A of the Coroners Act, as follows.

RECOMMENDATIONS OF CORONER BORROWDALE

I. There is an abundance of information and evidence implicating window covering cords as a significant contributor to infant and toddler strangulations.

II. Measures can be taken to reduce mortality caused by window covering cords. Each death of this kind is an avoidable tragedy, when design modifications and technologies exist to protect against harm.

III. Reliance on general and principles-based law such as the Consumer Guarantees Act 1993 (the requirement for products to be "safe") is insufficient protection against unsafe blind cords, as the six New Zealand fatalities since 2009 make sadly clear.

IV. I do not share MBIE's confidence that providing industry participants with a 'signal' through a product safety policy statement is an appropriate level of response to this known risk.

V. I recommend that MBIE includes as a priority in its policy planning the goal that the Minister of Commerce and Consumer Affairs will declare prescriptive mandatory regulations or standards designed to protect young New Zealanders from the hazards of corded blinds in domestic settings. MBIE has advised me that no regulations would be made by the Minister without MBIE "*establishing a robust case for a mandatory standard*." It is to be hoped that this finding, and the studies and resources referred to within it, will give MBIE much of the robust case that it needs.

VI. It is not for me to design that regulation. International examples abundantly detail the ways in which regulation has been designed elsewhere. Some other safety problems present intractable design or implementation difficulties. That is unlikely to be the case here, where existing safety technologies are available, like fixings that snap under pressure/weight and cord shrouds. Solutions are readily available to this well-established problem.

VII. I would, however, recommend that any resulting regulation goes beyond mere product warnings and installation directions. For the reasons given [above], warnings and user guidance are important responses but are not on their own sufficient. Regulations should mandate design properties that prevent young children from accessing loose cords of whatever type.

Parental education

VIII. Providing parents and caregivers with educational information and resources based on statistical injury patterns should allow prevention efforts to be focussed on children who are at the greatest risk of severe injury.

IX. The children within that group of greatest risk include not only babies who might access long cords from within cots or bassinets, but also mobile toddlers and young children who might place themselves in the way of hazardous cords when moving about a dwelling. There is good evidence to suggest that the risks are especially acute to children aged under three years.[5]

[5] All six New Zealand window cord fatalities referenced here concerned children aged under three years. The JAMA study showed that 93% of US paediatric fatalities from window cords in the period 1981-1995 were aged below 3 years: at 1697.

X. Efforts towards educating consumers, parents and homeowners should extend beyond the recommendation to install cord cleats and to ensure that furniture is not proximate.

XI. Relevant educative messages should include the following:

a. Cordless and inaccessible window coverings are recommended for use in homes with young children, or in places regularly visited by them.

b. Corded blinds should never be used in the bedrooms or playrooms of young children; even the most attentive parent cannot watch their child 100% of the time, and most injuries occur in these places.

c. Cord hazards can be found on the front, side and even on the back of blinds, so occupiers should examine their blinds to ensure that there are no cord hazards in any of these places.

d. All cords of every type must be kept wholly outside the reach of a young child. This means that cords must be tidied safely out of reach, and that the child must be unable to reach any cord by standing on furniture, beds or other objects.

e. Occupiers should regularly check their blinds to ensure that cords remain out of reach of a young child and do not have or cannot form hazardous loops.

f. If loose blind cords are found by occupiers of dwellings where young children live or frequently visit, occupiers should consider replacing the blind or shade with another style that does not have exposed pull cords or inner cords.

XII. Education should promote, through the use of examples, or something like a safety-tick approval system, ways for householders to select blinds that have safe design features for use around young children.[6]

XIII. Education efforts should draw attention to the risks of corded blinds in ways that parents are likely to find compelling, such as that death or severe injury can occur silently and rapidly, and that corded blinds are 'as much a hazard to young children as standing bodies of water.'

Remediation recommendations

XIV. It is desirable for New Zealand blind manufacturers, importers and sellers to make it easy and low-cost (or costless) for occupants to replace or retro-fit safety enhancements to existing hazardous corded blinds. I recommend that participants in the supply of corded blinds to the public give consideration to introducing a scheme, potentially similar to that operated by the US WCSC [United States Window Covering Safety Council], to supply the information and equipment necessary for occupiers to make their blinds safe.

XV. I further recommend that such a scheme should be considered by MBIE as something with which it could usefully organise and assist. I have been unable to identify any extant industry organisation of New Zealand blind importers, manufacturers and sellers; but the industry might well organise itself in response to efforts by MBIE to initiate remediation of existing blinds in New Zealand dwellings.

[6] I note that the US Window Coverings Manufacturers Association (WCMA) launched in 2015 a "Best for Kids" programme to help householders easily identify those window coverings that are certified as suited for use in homes with young children: https://windowcoverings.org/window-covering-industry-launches-best-for-kids-program-new-safety-program-to-help-consumers-and-retailers-easily-identify-products-for-homes-with-young-children/.

XVI. Alternately, I note the statement to this inquiry by Window Treatments Wellington that Window Treatments NZ intends "to initiate a New Zealand wide awareness of issues with Cord and Chain Safety…". Commendable as that is – and I encourage Window Treatments NZ to liaise with the agencies listed here who are active in providing such guidance – I recommend that Window Treatments NZ may additionally work towards organising a New Zealand-wide remediation scheme for existing products in homes, similar to the US WCSC scheme.

Responses to consultation on recommendations

XVII. A draft set of my recommendations in this Finding was provided to each of MBIE, Safekids Aotearoa and Window Treatments NZ.

XVIII. MBIE responded that it would take full account of this finding, including in giving potential advice to the Minister of Commerce and Consumer Affairs. MBIE was unwilling to prejudge what position it may take.

XIX. MBIE also withdrew its earlier statement that it was not considering mandatory regulation of corded internal window coverings. I take encouragement from that retraction and will await developments from MBIE on this issue.

XX. Safekids Aotearoa stated that it fully supported and endorsed the above recommendations.

XXI. Window Treatments NZ stated that it still intends to initiate an awareness campaign of issues with cords and chain safety. The company also restated its commitment to ensuring that cord tidies and cleats are used on all blinds, to prevent the formation of hazardous loops. This position is commendable, but does not fully respond to the risks of internal exposed cords such as those on roman blinds.

Receipt of recommendations

XXII. These recommendations are directed to:

a. Trading Standards at MBIE: recommendations at [69]-[83].

b. Window Treatments NZ: at [82]-[84].

c. Plunket and Safe Kids Aotearoa: at [76]-[81].

Recipients of findings

XXIII. In an effort to promote public awareness and enhance public safety I direct that this Finding be sent to the following and further disseminated as appropriate:

a. New Zealand media outlets;

b. Trading Standards at MBIE;

c. Safekids Aotearoa;

d. Plunket;

e. Window Treatments NZ; and

f. The Child & Youth Mortality Review Committee, Health Quality and Safety Commission NZ.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of the deceased, and making public the names of, and any particulars likely to lead to identification of, the deceased and each of her parents in the interests of personal privacy and decency.

Drowning

Renata [2021] NZCorC 37 (18 March 2021)

CIRCUMSTANCES

Wairongoa Clarence Renata, aged 54, of Palmerston North, drowned on 2 January 2018 at Cable Bay, Northland.

Cable Bay is around 1km long, and rocky outcrops are located along the beach. Surf Lifesaving New Zealand, describes it as a popular recreational area for activities, including swimming, bodyboarding, kayaking, paddle boarding, fishing and walking, especially during school holiday periods. There was (and remains) no surf lifesaving service at Cable Bay to provide hazard surveillance, advice and rescue.

At around 4pm on 2 January 2018, Mr Renata was on the Cable Bay beach, watching his three children swimming in the water at the west-end of the beach, near a rocky outcrop about 100m from shore. Shortly afterwards, the children became distressed in the water. Mr Renata quickly entered the water in an attempt to help them. Other members of the public also entered the water, and emergency services were called.

Police arrived and assisted with the rescue effort of the children. However, Mr Renata himself encountered difficulties; he was seen towards the north end of the bay, about 75m from shore. A member of the public swam to Mr Renata. As he approached Mr Renata, he could see him going under the water and taking longer and longer to resurface. When he reached Mr Renata, he was under the water, unresponsive and foaming at the mouth. Others came to assist and transported Mr Renata to shore, where a waiting ambulance unsuccessfully tried to resuscitate him.

Nick Mulcahy, Aquatic Risk Manager of Surf Lifesaving New Zealand, advised that the natural hazards to swimmers at Cable Bay cannot be mitigated. However, Mr Mulcahy proposed a range of safety interventions to reduce the risk of further fatal incidents at Cable Bay, which are set out below (in the order of priority ascribed to them by Mr Mulcahy):

	Risk management strategy	Safety intervention	Description
1	Increase awareness and understanding	**Water safety signage**	Water safety signage should be installed at all access tracks leading to Cable Bay. The signage should comply with the current standard, AS/ NZS 2416:2010 (Standards NZ, 2010).
2		**Site information**	Information on site hazards and ways to avoid them, as well as water safety information, should be

			integrated in any resources attracting visitors to Cable Bay, Taipa Bay, Coopers Beach and elsewhere in Doubtless Bay.
3	Enable and equip	**Water competence**	Individuals should take responsibility for increasing their water competence and therefore their resilience to hazards. However, the development of these skills is a personal choice.
4	Increase supervision and surveillance	**Community Rangers and Community Responders**	Members of the community could be trained as Community Rangers and/ or Community Responders to provide surveillance over the peak summer period, educate water users, and advise water users of hazards. Community Responders could also be trained to enter the water to perform a rescue.
5		**Informal supervision and surveillance**	Family, friends, and members of the public should continue to provide informal supervision and surveillance of one another at Cable Bay.
6	Increase efficiency and effectiveness of response	**Public rescue equipment**	Public rescue equipment should be implemented at Cable Bay. A range of devices should first be trialled for their effectiveness in likely incidents, and evaluated for their ease of use by trained and untrained personnel.
7		**Community Responders**	Community Responders could provide surveillance over the peak summer period, educate water users, and respond to incidents as required. Those who reside close to the site could also be on-call to provide water-based response.
8		**Emergency response plan**	An emergency response plan should be developed for the response to water-based emergencies at Cable Bay, Taipa Bay, Coopers Beach, and other beaches in Doubtless Bay. The emergency response plan should include both formal emergency services and informal personnel.

The Far North District Council advised that signs, warning of the rip tide dangers, had been installed but were removed some years ago for reasons unknown. Furthermore, public information published on the internet by Doubtless Bay Promotion Inc., designed to inform and attract people to the Doubtless Bay area, did not contain any messaging or warnings about the risks present at Doubtless Bay and Cable Bay.

Following Mr Renata's death, and in response to public advice regarding the need for flotation devices, a local Northland resident instigated a program named Operation Flotation, now a charitable trust, which has installed five flotation devices in Doubtless Bay: two at Cable Bay, one at Taipa Beach and two at Coopers Beach. The trust has raised the funds for the devices; sourced and installed them; had signs made advertising their availability; and organised a base of community volunteers to check, clean and maintain the devices.

COMMENTS 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.

II. The beach hazards that claimed Mr Renata's life are, sad to say, a continuing feature of Cable Bay Beach. Surf Lifesaving New Zealand summarised these as: sudden changes in water depth close to the shore, dumping waves at times, rips and currents. It described the beach morphology as highly dynamic, such that the location and severity of hazards such as rip currents, varies over time.

III. The trustees at water safety group Operation Flotation, its enthusiasts and volunteers, are to be commended for their prompt, innovative and focussed action to improve water safety in the Far North region (and now also in other regions, by way of their assistance to other community groups.) The speed with which Operation Flotation was established (within two months of Mr Renata's death), and the significant improvements it has made in the time since, shows what can be achieved with focus and determination, notwithstanding few financial resources.

IV. Equally, I am dissatisfied with the complacent approach taken by the Far North District Council to ensuring the mitigation of beach hazards in this region:

    a. In the first instance, the Council has not installed any safety devices itself. It has been content to rely on the work done by Operation Flotation.

    b. Secondly, the Council has not installed any signage at Cable Bay advising of the known beach hazards. It is to my mind wholly unsatisfactory that there remain no water safety warning signs at the approaches to Cable Bay beach (proposal 1 by Surf Lifesaving New Zealand). It is apparent from the evidence that this beach is deceptively safe-looking, but in fact contains life-threatening hazards that are hard for people to detect.

    c. Thirdly, given that the internet is a primary resource for travellers who seek outdoor activities, it is unacceptable that the internet resources pertaining to this popular beach region contain no water safety warnings for Cable Bay, and no safety advice to beach users (proposal 2 above). Ideally, such warning information should also be available in printed leaflets and other material; but I am less concerned about this, given that the internet is now so heavily used for travel and outdoors information.

V. Proposal 3 (swimmer competency), as above needs no comment.

VI. Proposal 6 (flotation devices at beach) has, as above, been implemented. See below my additional comments on the principles that should be applied when installing public rescue equipment.

VII. While I can see obvious merit to proposals 4, 5 and 7 (Community Rangers/ Responders and informal beach surveillance), I can also see other alternatives for beach supervision – including the installation of a trained lifesaving service at each beach. Accordingly, I make no recommendation adopting these proposals. Instead, I consider that Surf Lifesaving New Zealand is well placed to weigh these options and to liaise with other interested organisations and community groups as to how best to provide beach surveillance, and I hope that it does so.

VIII. Proposal 8 (development of an emergency response plan by formal emergency services and informal personnel) has obvious merit. I recommend its development below.

IX. Surf Lifesaving New Zealand helpfully advised my enquiry that a Public Rescue Equipment Working Group[7] has identified three key principles that should be considered when installing public rescue equipment for aquatic hazards:

a. Principle 1: Public rescue equipment should be:

i. Easy to use with minimal hesitation.

ii. Supported by internationally recognised signage standards and easy-to-follow instructions.

iii. Supported by an education programme that teaches emergency services personnel and members of the public (especially appropriately aged children) how to use the equipment before it is required in an emergency.

b. Principle 2: Public rescue equipment should not be installed in places that encourage in-water rescue by untrained emergency services personnel or bystanders.

c. Principle 3: Public rescue equipment should not place the rescuer at unnecessary risk.

X. These key principles have obvious appeal and are a useful guide and contribution to water safety. I have some reservations that Principle 2 might – if applied – prevent bystander rescue where that could prove lifesaving but suggest that Operation Floatation works through its practical application directly with Surf Lifesaving New Zealand.[8]

XI. Surf Lifesaving New Zealand also advised me that there are internationally recognised uniform standards for water safety signage,[9] and that it recommends that all beach hazard signage complies with the specifics in that standard. This seems entirely appropriate.

RECOMMENDATIONS OF CORONER BORROWDALE

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

a. That the Far North District Council should erect prominent and informative water safety signage at all approaches to the Cable Bay Beach, which meet the requirements of the Australian/ New Zealand standard.

[7] The recently established Public Rescue Equipment Working Group includes representatives from: Ambulance New Zealand, Coastguard New Zealand, Fire and Emergency New Zealand, LandSAR New Zealand, NZ Police, NZSAR Secretariat, Surf Life Saving New Zealand and Water Safety New Zealand.
[8] I note that Principle 2 is motivated by evidence showing the dangers of altruism, where untrained bystanders and personnel have been drowned while rescuing others. Surf Lifesaving New Zealand advised me that between 1980 and 2019 there were 102 preventable drowning deaths by persons who were rescuing others.
[9] The Australian/ New Zealand standard is AS/NZS 2416 Water safety signs and beach safety flags standards (the **Australian/ New Zealand standard**).

b. That the Far North District Council should extend this water safety signage to other beach areas also, where similar hazards have been identified by Surf Lifesaving New Zealand, namely Taipa Bay, Coopers Beach and elsewhere in Doubtless Bay (proposal 2 above).

c. That Doubtless Bay Promotion Inc. should amend its website, containing travel and outdoors information for Cable Bay and other Doubtless Bay beaches, to include prominent warning of the regional beach hazards and advice for their avoidance.

d. That the Far North District Council should expand the "Visiting the Far North" section of its website www.fndc.govt.nz to incorporate water safety warnings and information for Cable Bay Beach and any other areas of known hazards (see those listed in proposal 2 above).

e. That water safety agencies, the local authority, emergency services and local residents (including the Operation Flotation Charitable Trust) should work together to develop an emergency response plan, considering the Surf Lifesaving New Zealand proposals that are recorded [in the table] above, with a view to developing enhanced risk prevention and emergency response at Cable Bay.

f. That agencies and community groups should consult with Surf Lifesaving New Zealand before placing flotation devices at beach areas, so that Surf Lifesaving can recommend appropriate rescue equipment for different rescuer groups that complies with the key principles above.

II. These recommendations are directed to the Operation Floatation Charitable Trust (e-f), Far North District Council (a-e), Doubtless Bay Promotions Inc. (c) and Surf Lifesaving New Zealand (e-f).

Rationale

III. The purpose of these recommendations is to increase public awareness of the water hazards at Cable Bay; and to improve emergency responses when beachgoers encounter difficulties in the water.

IV. This death may have been prevented if the Renata family had apprehended the hazards present that day at Cable Bay beach, in which case they may have decided not to swim, to stay close to shore or to take a flotation device with them.

Recipients of findings

V. In an effort to promote public awareness and enhance safe practices in swimming and water-based activities at Cable Bay, I direct this Finding be sent to the following and further disseminated as appropriate:

a. New Zealand media outlets;

b. The Far North District Council;

c. Surf Lifesaving New Zealand;

d. Operation Flotation Charitable Trust; and

e. Water Safety New Zealand.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Mr Renata entered into evidence during this inquiry, on the grounds of personal privacy and decency.

Rawhiti [2021] NZCorC 20 (10 February 2021)

CIRCUMSTANCES

Kupa James Rawhiti, aged 50, died between 7 and 8 September 2017 at Otangawhiti (Sandy Bay) on 7 September 2017 of drowning.

On 7 September 2017 Mr Rawhiti was on a diving trip with friends at Otangawhiti (Sandy Bay). He was free diving with a friend, Thomas Dunn, for kina and paua. On their last dive Mr Dunn noted that swell was coming in and the water was rapidly rising and falling.

At the end of their dive, Mr Rawhiti and Mr Dunn wanted to return to their car but in order to do so they had to cross a channel in the water. Mr Rawhiti entered the water first and started swimming across the channel but had trouble due to waves. Mr Dunn and Mr Rawhiti then discussed how they would cross the channel. Mr Dunn was not confident he could swim across so decided to walk around the rocks. On reaching the other side of the channel he gave a thumbs up to Mr Rawhiti who then re-entered the water and started to swim across.

Halfway across Mr Rawhiti got into trouble. Mr Dunn threw him a buoy, which Mr Rawhiti was able to use to reach the rocks that Mr Dunn had traversed. As Mr Rawhiti was trying to get his backpack off, a wave came in and washed him off the rocks. Mr Rawhiti appeared exhausted and worried and Mr Dunn saw him disappear under water. He did not resurface. Mr Rawhiti's body was recovered the next day.

COMMENTS OF CORONER TETITAHA

I. I make the following comments pursuant to section 57A of the Coroners Act 2006:

II. The area where this death occurred is very remote and inaccessible. There is no cellphone coverage. There is limited water safety information.

III. One avenue for conveying information about weather, tides and currents is beachside signage. A sign regarding currents may have prevented this and other deaths in this area.

IV. Any signage should only be done in conjunction with the local Iwi given the significance of the area. Signage could also be used to communicate culturally appropriate information such as when rahui may be imposed if required by Iwi.

V. These comments are directed to the Department of Conservation. I also directed a copy to be provided to Te Hiku Development Trust for their consideration. Attempts to contact local Iwi to seek their views were unsuccessful in that they did not reply to requests for information.

RECOMMENDATIONS OF CORONER TETITAHA

I. I make the following recommendations pursuant to section 57A of the Coroners Act 2006:

II. That the Department of Conservation consult local Iwi regarding erecting signage in Otangawhiti and any other beachside area regarding currents and water safety generally as well as any culturally appropriate information.

III. The Department of Conservation have replied as follows:

> I have read the findings of Coroner TG Tetitaha report that was attached to your email and I can confirm that on behalf of DOC I will work with local Iwi to work towards achieving recommendation item 55 listed in the report – "That the Department of Conservation consult local Iwi regarding erecting signage in Otangawhiti and any other beachside area regarding currents and water safety generally as well as any culturally appropriate information."
>
> Ka pouri te ngakau, ka mihi aroha ki te whanau Rawhiti, na reira,
>
> Meirene Hardy-Birch
>
> Operations Manager

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Mr Rawhiti during the inquiry (being photographs of a deceased person) in the interests of decency and public interest.

Tuitalau [2021] NZCorC 26 (1 March 2021)

CIRCUMSTANCES

Solomone Ofa Mei Amelike Tuitalau, aged 23, died on 25 January 2020 at Hokitika Gorge of drowning.

At about midday on 25 January 2020 Mr Tuitalau, his partner, Tamika Brand, and a large family group arrived at the Hokitika Gorge. Hokitika Gorge is located on Department of Conservation land. The Hokitika River passes through the gorge with steep rock faces and contains multiple eddies that push up and under rock faces. These characteristics make swimming dangerous.

Mr Tuitalau's group walked over the bridge and followed the path down to the beach to have a look around. After seeing others jump off the rocks successfully, Mr Tuitalau wanted to find a rock to jump from. At about 12:30pm he walked down to the river's edge to see how deep it was. Mr Tuitalau then jumped from a rock into the water. When asked how the water was Mr Tuitalau advised that it was very cold and added that he had hurt his back on a rock but was going to find a bigger rock to jump from.

Mr Tuitalau climbed a larger rock before checking the water for rocks. He jumped and landed in the water, went completely under for a short time and emerged further downstream. Mr Tuitalau was then observed trying to grab a rock as he drifted downstream. He appeared to be struggling to breathe and was spitting out water. He again went under for three or four seconds before emerging and again trying to grab hold of the rocks. He then disappeared from sight. Emergency services were notified. At 12:53pm a helicopter searched the river and riverbank area but was not able to locate Mr Tuitalau.

Extensive search efforts followed which involved a local white water kayaker, Kotuku Surf Rescue, and Hokitika Land Search and Rescue.

The Police National Dive Squad arrived on 26 January 2020 and located Mr Tuitalau's body in the middle of the Hokitika River, approximately 20 metres downstream from the Hokitika Swing Bridge.

RECOMMENDATIONS OF CORONER ROBINSON

I. Water Safety New Zealand provide information on its website regarding safe swimming in rivers. Its website states:[10]

> More people drown in rivers than in any other New Zealand water environment.
>
> Rivers are changeable and unpredictable and can contain hidden dangers.
>
> Look before you leap. Check for hidden objects and swimming holes can change depth summer to summer and currents can move objects underwater.
>
> There are strong currents and suction effects, and deep water especially near dams.
>
> The pressure of moving water is constant and can be powerful even if the river looks slow moving and calm.
>
> Swimming in a river is different from swimming in a pool or in the sea. Swimmers often underestimate the power of a river or overestimate their abilities.

II. Given the constantly changing nature of rivers, those intending to swim should always check the depth of the water to ensure that they are not swimming beyond their comfort zone or capabilities.

III. It is unclear from the evidence before me whether there are any signs warning swimmers about the dangers posed by the multiple eddies in the Hokitika River near the Hokitika Gorge. In the event that no such signage is present, the Department of Conservation should give consideration to the same.

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

Drugs

Ellett [2021] NZCorC 31 (11 March 2021)

CIRCUMSTANCES

Karen Siale Ellett, aged 43, of Auckland died on 15 April 2018 at Bastion Point, Auckland of MDMA toxicity.

On the evening of 14 April 2018, Ms Ellett attended a 'rave' (organised dance party) in gun emplacement bunkers at Bastion Point. Ms Ellett was there with her flatmates. A witness who saw Ms Ellett described that she appeared "high on something" and was very "out of it".

[10] Water Safety New Zealand: https://watersafety.org.nz/Community-Resources/How%20to%20Stay%20Safe%20around%20Rivers.

At around 5:00am on 15 April 2018, Ms Ellett who was seen stumbling around and being unsteady on her feet, fell to the ground unconscious. Despite CPR efforts, Ms Ellett could not be revived and was pronounced deceased by attending paramedics.

Subsequent toxicological analysis confirmed methylenedioxymethamphetamine (MDMA) at a level of 2 milligrams per millilitre in Ms Ellett's blood. It was noted that an MDMA blood concentration higher than 1 milligram per millilitre can potentially be lethal.

COMMENTS OF CORONER GREIG

I. The New Zealand Drug Foundation reports that after cannabis, MDMA is the second most used illegal drug in New Zealand.[11]

II. As Dr Stables has recorded, MDMA can cause confusion, agitation, anxiety and psychosis. It may also cause increased heart rate, increased blood pressure, hyperthermia and shortness of breath. Importantly it may also cause seizures, abnormal heart rhythms, coma and death.

III. Ms Ellett's death is a tragic illustration that this drug, although reportedly widely used in New Zealand, is not without risk as Dr Stables has explained and Ms Ellett's death sadly illustrates. MDMA is generally made in illegal laboratories, which means the person taking it has no idea if the dose will be strong or weak, or even if it will contain any MDMA at all. It is possible for pills sold as MDMA to include a range of undisclosed chemicals that can cause serious health issues.

IV. The NZ Drug Foundation provides the following advice on its website:

> When to get help
>
> Large doses or a strong batch of MDMA may result in overdose resulting in symptoms such as: irregular or racing heartbeat, high body temperature, high blood pressure, convulsions, difficulty breathing, passing out, symptoms of heart attack and stroke.
>
> If things have gone wrong for you or for someone you know because of MDMA use (or any other drug) call for an ambulance immediately (dial 111).[12]

V. Another important safety message is set out by the Victorian State Government Department of Health: If taking MDMA, plan what you would do in an emergency and don't delay seeking help because you think you would get into trouble. A quick response can save someone's life. Stay with the person until the ambulance arrives. Tell the ambulance officers as much as you can about what drugs were taken, when they were taken and whether the person has a medical condition.[13]

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

[11] https://www.drugfoundation.org.nz/matters-of-substance/august-2012/about-a-drug-mdma/.
[12] https://www.drugfoundation.org.nz/info/drug-index/mdma/.
[13] https://www.betterhealth.vic.gov.au/health/healthyliving/ecstasy.

Hotter-Matehe [2021] NZCorC 18 (5 February 2021)

CIRCUMSTANCES

Dylan Alan James Hotter-Matehe, aged 25, died between 7 and 8 March 2018 at 23 Basingstoke Street, Christchurch of synthetic cannabinoid toxicity.

Sometime during the evening of 7 March 2018 Mr Hotter-Matehe smoked synthetic cannabis with others at the Basingstoke Street address. One witness recalled that, about a minute after finishing the bong, Mr Hotter-Matehe was sitting falling asleep, “zoning out”, “buzzing out” and was “sort of leaning forwards”. When the witness left to go upstairs, he recalled that Mr Hotter-Matehe was “all good”, sitting in a chair looking at the ground and an acquaintance was on the other couch.

At around midnight two other people in the house woke up and found Mr Hotter-Matehe on the floor. One of them thought he was asleep. The other person saw that Mr Hotter-Matehe’s face was purple and there was froth coming out of his mouth. CPR was performed until emergency personnel arrived. Resuscitation attempts were unsuccessful and Mr Hotter-Matehe was pronounced dead.

RECOMMENDATIONS OF DEPUTY CHIEF CORONER TUTTON

I. Mr Hotter-Matehe died as a direct result of using synthetic cannabinoids. AMB-FUBINACA, 5F-ADB acid and 5F-ADB were all present in samples taken from his body.

II. AMB-FUBINACA and 5F-ADB, have been, and continue to be, the cause or contributing factor in a number of deaths in both New Zealand[14] and overseas.[15]

III. The dangers of consuming synthetic cannabis 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 manufacturers/distributors in New Zealand.

   d. The quantity and strength of AMB-FUBINACA and 5F-ADB is an unknown gamble which can have fatal consequences.

[14] McAllister, CSU-2017-HAM-000336, Taoho, CSU-2017-ROT-000345.
[15] Adams AJ, Banister SD, Irizarry L, Trecki J, Schwartz M and Gerona R. " "Zombie" Outbreak Caused by the Synthetic Cannabinoid AMB-FUBINACA in New York" New England Medical Journal 376 (2017) 235-242. Hasegawa K, Wurita A, Minakata K, Gonmori K, Yamagishi I, Nozawa H, Watanabe K and Suzuki O. "Identification and quantitation of 5-fluoro-ADB, one of the most dangerous synthetic cannabinoids, in stomach contents and solid tissues of a human cadaver and in some herbal products" Forensic Toxicology 33 (2015) 112-121.

e. The manufacturing process of the drug can result in inconsistency of potency, with *"… hot pockets where even in a single joint single areas can have variation as much as 5x (or more) the dose and with such a potent agent that means a single puff can suddenly be an overdose."*[16]

f. Individuals who fall unconscious after consumption of synthetic drugs can die if they do not receive timely and appropriate medical assistance; dying from a 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.

IV. Due to the circumstances and cause of this death, I repeat and adopt the recommendations made by Coroner Matenga in reliance on the expert evidence of Dr Quigley in the coronial inquiry into the death of McAllister, CSU-2017-HAM-000336. Dr Quigley is a vocational specialist in Emergency Medicine who 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. Coroner Matenga wrote:

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. *I agree with Dr Quigley, however I am unable to make any recommendations in this regard, as I have not heard any evidence. I am aware however, that Coroner McDowell*[17] *is conducting a joint inquiry into deaths from synthetic cannabis which occurred in Auckland. I will refer this suggestion to Coroner McDowell to consider in the course of her joint inquiry. No recommendations will be made by me.*

c. *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.*

d. *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.*

VI. I endorse Dr Quigley's advice and reiterate the dangers of synthetic cannabis use and the need to get help immediately if a synthetic cannabis user collapses or becomes unresponsive.

VII. These findings will be distributed to the media for publication.

[16] *Finding of Coroner Matenga in McAllister, CSU-2017-HAM-000336*, at paragraph 16.
[17] The joint inquest referred to will now be conducted by Coroner Mills.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Hotter-Matehe taken during the investigation into his death in the interests of decency and personal privacy; it also prohibits the publication of the names and any particulars likely to lead to the identification of witnesses present at the Basingstoke Street address that night, in particular, details likely to identify the children present at the address, in the interests of personal privacy.

Kidwell [2021] NZCorC 3 (6 January 2021)

CIRCUMSTANCES

Erin Patrick Kidwell aged 40 years of Auckland died on 8 November 2017 at Manurewa, Auckland of synthetic cannabinoid toxicity (AMB-FUBINACA). Other conditions contributing to death but not relating to the disease or condition causing it are multifactorial cardiomyopathy and renal failure.

Mr Kidwell had periods of homelessness and received assistance from the Auckland City Mission. He also suffered poor health and had periods of hospitalisation. He had never been employed.

On 7 November 2020, Mr Kidwell was socialising and drinking at home with several friends and his ex-partner. Around 2:00am on 8 November 2017, Mr Kidwell left the address. Around 3:00am, he was heard speaking to his partner in the kitchen. He was rolling a cigarette while wheezing and coughing and struggling to breathe. A friend said he had been like that for a few days.

Mr Kidwell coughed and fell onto the floor after it was believed he smoked synthetic cannabis. This was an expected pattern of behaviour for him – he would smoke synthetic cannabis then collapse on the floor before regaining consciousness. It appears it was expected he would get up afterwards.

Around 7:00am, someone at the address saw Mr Kidwell on the floor. He was face down in his own vomit. Two people left the address believing he was asleep and would eventually wake up. However, when they returned at 7:30am, he was in the same place. Mr Kidwell could not be woken, and emergency services were called. Mr Kidwell was pronounced dead.

COMMENTS OF CORONER TETITAHA

I. I make the following comments for the purposes of publicising and (hopefully) preventing further deaths such as Mr Kidwell's.

II. From an analysis of 84 coronial cases (both open and closed) involving synthetic cannabis related deaths there are distinctive trends.[18] The most at-risk group are male (94% of deaths), Māori (62%), aged 40 or older (55%), being treated for mental health illnesses[19] (60%) and medical conditions[20] (73%) usually including a heart related illness (54%) as well as homelessness[21] (42%). All of those factors apply in Mr Kidwell's case.

[18] Deaths identified by Coronial Services in which synthetic cannabis was consumed at or around time of death including those where death was then recorded as another cause and those cases in which death is yet to be legally determined by the inquiring Coroner.
[19] Defined as those on medications for mental illness, suffering from traumatic brain injury or under the care of mental health services.
[20] Defined as having received care for chronic medical conditions or that medical conditions were identified by a pathologist at post-mortem.
[21] Defined as having no fixed abode, in emergency accommodation, dossing down, squatting, or living for short periods of time (less than 3 months) at any given address.

III. In 2017 the United Nations Office on Drugs and Crime (UNODC) noted the low cost and high potency of synthetic cannabinoids make them attractive to vulnerable groups with low disposable income including the homeless.[22] In some countries these substances were being actively sold to, and by, homeless persons.[23] Severe adverse health events such as fatalities, hospitalisations and a number of toxic effects similar to Mr Kidwell's were reported by synthetic cannabinoid users including (but not limited to) seizures, loss of consciousness and vomiting.[24]

IV. Users of synthetic cannabis should be made aware of the high toxicity and consequently the risks they take when using this product of severe health effects including fatalities associated with this product.

V. I am dumbstruck by the lack of action taken to assist Mr Kidwell by others when first found on the floor. Synthetic cannabis users such as Mr Kidwell should not be left unaided if found unconscious and/or vomiting on the floor. Hospitalisation could have prevented this death.

VI. I have no information on the reasons for Mr Kidwell's homelessness. This is often a complex issue. This decision and these comments do not address those reasons other than to note an apparent link between homelessness with synthetic cannabis deaths. This may prompt further research into this topic to prevent further deaths such as Mr Kidwell's.

VII. A recent study by Waikato University confirmed premature and amenable death associated with homelessness at the average age of 45 years.[25] Social isolation and disconnection from the health system, combined with chronic psychological distress and unstable life conditions, negatively affect the health-seeking behaviours of homeless people.

VIII. I endorse the authors' comments about the pressing need for improving the accessibility for homeless persons to adequate health care and the development of health policy to enable early identification of homeless patients at high risk of premature mortality. This requires enhancing access to care, as well as providing the continuity and quality of care for homeless people with life limiting conditions.

IX. For Mr Kidwell, homelessness resulted in an inability to store and therefore comply with his medication requirements and a worsening of his medical conditions. Issues such as storage and dispensation of medication by homeless people who often experience multiple health issues can and should be addressed.

X. Mr Kidwell as well as many of the synthetic cannabis deaths before the coroners indicate dual diagnoses of both substance abuse and mental and physical health issues combined with intermittent homelessness. The combination of these factors in synthetic cannabis deaths cannot be ignored. A more holistic approach targeting the challenges faced by the affected group is required.

[22] United Nations Office on Drugs and Crime (UNODC) World Drug Report 2017 Part 4: Market analysis of synthetic drugs Amphetamine-type stimulants, new psychoactive substances. United Nations publication.
[23] United Nations Office on Drugs and Crime (UNODC) World Drug Report 2017 Part 4: Market analysis of synthetic drugs Amphetamine-type stimulants, new psychoactive substances at 34. United Nations publication.
[24] United Nations Office on Drugs and Crime (UNODC) World Drug Report 2017 Part 4: Market analysis of synthetic drugs Amphetamine-type stimulants, new psychoactive substances at 42. United Nations publication.
[25] Charvin-Fabre, S "Amenable mortality within the New Zealand homeless population: we can do better!" New Zealand Medical Journal Article 133 No. 1572: 18 December 2020 https://www.nzma.org.nz/journal-articles/amenable-mortality-within-the-new-zealand-homeless-population-we-can-do-better.

XI. Lastly, I also support the comments in evidence in an inquiry before Coroner Matenga regarding the need to develop an all-encompassing harm reduction approach which reduces demand, supply and increases easy access to treatment for those seeking assistance.[26]

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Mr Kidwell taken during this inquiry (being photographs of a deceased person) in the interests of decency.

Larsen [2021] NZCorC 41 (15 March 2021)

CIRCUMSTANCES

Judith Anne Larsen, aged 59, of Napier died on 21 February 2020 at Napier due to the effects of drug toxicity in accidental circumstances.

Ms Larsen lived alone in Napier. On 21 February 2021, Ms Larsen's sister (who lived in Porirua) drove to Napier to check on Ms Larsen after not hearing from her for four days. She found Ms Larsen in her home deceased.

Toxicological analysis confirmed the presence of codeine and tramadol in Ms Larsen's system. The level of codeine was consistent with normal use but also at a level associated with codeine related fatalities. The level of tramadol was excessive, and within a range associated with tramadol related deaths.

There was no evidence that Ms Larsen deliberately took an overdose of these drugs. Rather, it was noted that Ms Larsen had been suffering from pain in her ankle. In addition, there was no record of Ms Larsen being prescribed codeine (which until recently could be purchased over the counter), but Ms Larsen was prescribed tramadol in 2016 and 2017.

COMMENTS OF CORONER RYAN

I. I note advice from the Ministry of Health warning of the dangers of using medication that has passed its expiry date and that your GP is unaware of:[27]

> **Tips for safe use of medicine**
>
> Regularly clean out your medicine cabinet and dispose of any medicine that is past its expiry date or that you no longer use. These medicines can be returned to your local pharmacy for disposal.
>
> Make sure everyone involved in your health care knows about every medicine you take, including non-prescription and complementary medicines such as vitamins and herbal supplements. Mixing medicines can cause side effects.

[26] CSU 2017-HAM-000336 at paragraphs [16] and following.
[27] Found at: https://www.health.govt.nz/your-health/conditions-and-treatments/treatments-and-surgery/medications/medicine-safety.

Shakespeare [2021] NZCorC 46 (29 March 2021)

CIRCUMSTANCES

Thomas William Shakespeare was 48 years of age when he died at his address in Auckland sometime between 12 and 18 October 2020 of polydrug toxicity (dihydrocodeine, codeine, diazepam, alcohol).

Mr Shakespeare was found deceased on his bed on 18 October 2020 by two friends undertaking a welfare check as he had not been seen or heard from for six days. He had been complaining to his friends about being in pain in early October 2020 and was at the time of his death prescribed several different types of pain relief medication to address his symptoms. He also suffered from mild anxiety and depression for which he was prescribed medication.

The medical evidence established that Mr Shakespeare had continued medicating himself with his pain medication at more than the recommended dosages. The medication can act synergistically to cause respiratory depression and death. Furthermore, he had atherosclerotic heart disease and obesity which may have made him more vulnerable to the combined effects of the medication.

RECOMMENDATIONS OF CORONER HESKETH

I. I recommend that people on prescription medications should comply with the instructions given to them by their Medical Practitioner concerning dosage and frequency.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Mr Shakespeare entered into evidence, on the grounds that it is in the interests of personal privacy and decency.

Tunupopo [2021] NZCorC 30 (10 March 2021)

CIRCUMSTANCES

Tae-Zepharn Tunupopo (Tae), aged 16, of Otara, Auckland died on 23 March 2019 at Middlemore Hospital from burn injuries sustained on 18 December 2018.

At the time of his death Tae was subject to a Child, Youth and Family service (now Oranga Tamariki) custody order and a youth justice plan. Tae and his partner, Kiana, had been provided with temporary accommodation as they had been living on the streets.

On the night of 17 December 2019 Tae and Kiana were at their flat. All the windows and doors were closed, and they were “huffing” on aerosol deodorant cans. Kiana estimated that they had huffed about 24 cans that day. Huffing” is a common term used to describe Volatile Substance Abuse (VSA). It is the intentional inhalation of chemical vapours to attain a mental high or euphoric effect.

At around 3am on 18 December 2019 Tae lit a cigarette which caused an explosion resulting in him sustaining severe burns to approximately 70% of his body. He was admitted to Middlemore Hospital and remained in intensive care until he passed away from unresolved, irreversible septic shock secondary to multiple resistant organism secondary to the major burns he sustained in the explosion.

RECOMMENDATIONS OF CORONER MILLS

I. Having given due consideration to all the circumstances of this death, I make the following comments pursuant to section 57A of the Coroners Act 2006.

II. As the statistics provided by FENZ indicate, death and serious harm as a direct or indirect result of huffing/VSA are not new. Between 1 January 2014 and 20 May 2019 there were 36 reports of huffing related fires and injuries. In at least 13 of those cases, a person or persons were either seriously injured or died.

III. VSA abuse has been a problem in New Zealand for many years now. In addition to the risk of fire, VSA abuse can cause sudden death. VSA like any drug use, involves a complex range of factors and issues.

IV. In 2012 The Chief Coroner's Recommendations Recap No. 2 included a case study report on deaths in New Zealand which related to VSA, specifically butane, between 2000 and 2012 (the Case Study).[28] The Case Study found that 63 people had died as a result of intentionally inhaling butane in that time period, of which 87% were under 24, and 77% were male. 30 of these 63 people were Māori.

V. As a young man, aged 16 with Māori and/or Pacifica whakapapa, Tae was therefore among those identified in the Case Study as being most at risk of VSA. Tae was particularly vulnerable given his history of whānau dysfunction, homelessness and state care.

VI. The case study noted that:

> VSA is extremely complex in nature due to the substances involved, the availability of the products and the culture surrounding abuse. Due to this complexity, the need for an inter-agency approach has been advocated. Multiple areas of intervention and prevention have been identified including regulation, education, research, support of vulnerable young people, individual and community health and family and socio-economic issues.
>
> Coroners have made a number of recommendations and comments relating to butane-deaths over the past decade. Several coroners have expressed concerns regarding the availability of abused substances from retailers and have commented on the need for regulation and strategies to address this problem. Other recommendations have discussed the need for a national education campaign and increased publicity to improve knowledge about the risks of VSA and to help curb this dangerous practice.

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

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

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

IX. In a finding from 2016, Coroner McDowell referred to earlier recommendations and comments which have sought to highlight the risks associated with butane inhalation. She also referred to the 2013 Child Youth Mortality Review Committee Special Report: Unintentional deaths from poisoning in young people and its recommendations. These recommendations included supporting vulnerable young people, a cross-government focus on youth injury prevention, improving education, inter-agency collaboration and communication (both across government and also wider organisations) and reducing access to substances. Coroner McDowell noted that she had been advised that the Ministry of Health has already taken a number of actions in response to the recommendations made in the CYRMC report.

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

XI. Sadly, VSA abuse has continued to cause harm and death to young people in Aotearoa/New Zealand and deaths from VSA have continued, despite the numerous recommendations and comments that Coroners have made in an attempt to prevent further harm.

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

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Tae during the inquiry (being photographs of a deceased person) in the interests of decency and public interest.

Fall

Mr Z [2021] NZCorC 14 (27 January 2021)

CIRCUMSTANCES

Mr Z, aged 47, died on 13 May 2018 at Christchurch Hospital due to an acute subdural haemorrhage and hypoxic brain injury after a low distance fall.

On the evening of 10 March 2018, Mr Z was drinking with friends at the Carlton Bar and Restaurant from around 5pm. Over the course of the evening, he became significantly intoxicated. At about 9.40pm, Mr Z was standing at an outdoor bar leaner when he fell backwards, hitting his head and briefly losing consciousness. Mr Z was helped up by his friends, who considered calling an ambulance. However, after observing that Mr Z was speaking coherently (although drunkenly) and did not appear to be visibly injured, they decided that no medical attention was necessary.

Mr Z was able to walk unaided to an Uber, which he took home accompanied by a friend. When they arrived at Mr Z's home around six minutes later, Mr Z appeared to have fallen asleep. He was helped to exit the vehicle and walk towards

the house. Mr Z's wife, Ms Y, came outside and saw Mr Z on his back in their driveway. The friend told her that Mr Z was "not so good", but did not advise her about the fall or that Mr Z had lost consciousness. Ms Y tried but was unable to wake Mr Z, who was snoring loudly. Ms Y said this was not unusual when he was intoxicated. As he was too heavy for her to move, Ms Y was forced to leave Mr Z outside to recover.

Ms Y checked on Mr Z regularly over the next few hours, eventually calling friends who lived nearby for assistance. After rolling Mr Z into a duvet and moving him several metres towards the house, they noticed that Mr Z appeared to have stopped breathing. He also had vomit dribbling from his mouth and fluid containing blood coming from his nose.

Emergency services were called and Mr Z was transported to Christchurch Hospital, arriving at 1.43am. A CT scan identified an acute subdural haematoma and subarachnoid haemorrhage as well as skull fractures. In ICU, Mr Z's injuries were deemed unsurvivable. His condition subsequently deteriorated and he died on the evening of 13 March 2018.

COMMENTS OF CORONER ELLIOTT

I. I make the following comments pursuant to sections 57A and 58 of the Coroners Act 2006:

On the evening of 10 May 2018, Mr Z was drinking alcohol with friends at the Carlton Bar and Restaurant. During this time, he consumed 7 pints of beer and the equivalent of approximately 2 bottles of wine.

While standing at an outdoor bar leaner, Mr Z fell backwards, hitting his head. He sustained head injuries which resulted in his death.

Mr Z's death warrants comment in three respects:

Mr Z's alcohol consumption

Analysis of samples of Mr Z's blood identified the presence of alcohol at levels of 264 and 300 milligrams per 100 millilitres. At the time he fell, he was significantly intoxicated. This contributed to the fall and his death.

The Health Promotion Agency advises, '*reduce your risk of injury on a single occasion of drinking by drinking no more than*:

- *four standard drinks for women on any single occasion*
- *five standard drinks for men on any single occasion.'*

Mr Z's death illustrates the potential consequences of excessive consumption of alcohol.

Supply of alcohol to Mr Z

Proceedings were taken in the New Zealand Alcohol Regulatory and Licensing Authority against Papanui Road Limited and the Duty Manager at the time. Both accepted that there had been breaches of sections 248(1), 249(1) and 252(1) of the Sale and Supply of Alcohol Act 2012.

The Authority accepted that the signs of intoxication were not apparent throughout most of the night. They were, however, apparent in the last 45 minutes or so that Mr Z was on the premises. The Authority

concluded that forty-five minutes ought to have been more than enough time for Mr Z's intoxication levels to have been noticed with greater diligence and improved systems.

Medical treatment for head injuries

Mr Z died due to the head injury he sustained when he fell. The evidence shows that he briefly lost consciousness at the time.

None of those present sought medical assistance for Mr Z. This was because Mr Z was coherent after the fall and did not appear to have suffered any significant injury. None of those who were present was medically qualified. In addition, any symptoms displayed by Mr Z following his fall may have been identified as being due to intoxication rather than a head injury.

Mr Z did not receive any medical treatment between 9.42pm (the time of his fall) and 1.43am the next morning (when he arrived in hospital after his wife called an ambulance). Earlier medical treatment would have improved Mr Z's chances of survival.

The Ministry of Health advises:

> *If you or a family member suffers a head injury, there may be no immediate symptoms – no loss of consciousness and no signs of injury on your head or face.*
>
> *However, it's very important to carefully monitor a person who has had a head injury, as symptoms may develop later.*
>
> *If the person is unconscious or is unable to move all or some of their limbs, or is complaining of neck pain:*
>
> - *Call 111 immediately*
> - *Do not move the person (unless it's dangerous to leave them where they are).*
>
> ***When to see a doctor***
>
> *Take the person to a doctor as soon as possible if they lose consciousness (even for a moment) or have symptoms of concussion.*
>
> *Remember that these symptoms may develop some time after the injury 'Take the person to a doctor as soon as possible if they lose consciousness (even for a moment) or have symptoms of concussion.'*

Mr Z's death illustrates the importance of this advice.

Note: Orders under section 74 of the Coroners Act 2006 prohibit publication of the following in the interests of personal privacy and decency, and on the grounds of little public interest in publication: the name of the deceased, any photographs of the deceased entered into evidence, and the name of the deceased's wife and any details which may lead to her identification.

Fire

Smith [2021] NZCorC 40 (19 March 2021)

CIRCUMSTANCES

Bruce William Smith, of Piha, Auckland, died on 4 January 2018, at Middlemore Hospital from severe septic shock caused by either a bacterial or fungal infection.

Mr Smith was admitted to Middlemore Hospital on 6 December 2017 following a house fire at his home in which he sustained severe burns to over 90% of his body. The fire began in the outside deck area of the property. Mr Smith was alerted to the fire by his wife, who had woken to the sounding smoke detector. She alerted the other occupants of the house who were able to successfully exit the house unharmed, except for Mr Smith, who ran further into the house.

Fire and Emergency New Zealand suggested that as Mr Smith approached the fire, it may have flashed over, or a backdraught may have occurred, if Mr Smith opened a door from the house to the fire.

COMMENTS OF CORONER GREIG

I. Mr Smith's death is a stark reminder of the important safety message that if there is a fire in your house you must leave immediately and once you are out of the house, stay out. Never go back inside.[29]

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Mr Smith entered into evidence during this inquiry, on the grounds of personal privacy and decency.

Leisure Activities

Chand and Smith [2021] NZCorC 2 (30 October 2020)[30]

CIRCUMSTANCES

Sarwan Philip Chand, aged 27, and Conor Jon Neil Smith, aged 23, died on 22 April 2017 at the foot of Marian Peak, Darran Mountains, Fiordland of multiple traumatic injuries sustained in a fall from height while climbing.

At the time of their deaths, Messrs Chand and Smith were members of the New Zealand Alpine Team (the Team).

The Maid Marian climb (which was not the Team activity) was described as having been Mr Smith's project for the summer, a climb that he had been training specifically for, including undertaking ascents in Fiordland. The south face of Mount Marian is known as "Maid Marian". The climb involves an ascent in excess of 750 vertical sections separated by a ledge.

[29] https://fireandemergency.nz/in-the-event-of-fire/what-to-do-in-a-house-fire/.
[30] While this finding was issued in August 2020, it could not be published until final non-publication orders had been made.

There were no fixed protection points (that is, bolts inserted into the face of which carabiners could be attached and the climbing rope passed), therefore protection had to be placed by the lead climber at regular intervals throughout the pitch. “Protection” involves the use of devices such as “cams” (a device that when placed in parallel cracks expand to fill out a crack) and “chocks (a tapered wedge shape attached to wire rope that can be placed in gaps in rock).

The placing of protection ensures that, in the event of a fall, the lead climber could fall no further than twice the length of the rope above the highest point of protection. Accordingly, protection would be placed every few metres to mitigate the risk of a catastrophic fall.

Common practice is for the lead climber to place the first running belay protection shortly after starting a pitch (that is, within one or two metres) to reduce any impact force on the belayer.

In preparation for the climb Messrs Smith and Chand discussed the matter with Team members Daniel Joll and Ben Dare and covered matters such as the route to the location (a topographical map was provided), the suggested route up the faces, likely timings, recommended equipment, the suggested location for the bivvy (and the equipment necessary for that) and weather. They were told that there could be sections where there was “long runouts between gear”, that is, parts of the climb where it was not possible to place protection with the regularity that the prudent climber might otherwise wish.

The plan was to undertake the climb over two days, which was regarded as a “conservative approach”, giving them significantly more time to work out any technical issues that arose during the course of the climb. To the Coroner, that evidenced a careful approach by the climbers. It was intended that Mr Smith be the lead climber throughout, with Mr Chand adopting the belay position, reflecting the climbers playing to their respective strengths.

There was a loose arrangement for the Team’s captain, Stephen Fortune, to accompany Messrs Smith and Chand on the Maid Marian ascent. However, he had a work commitment on 22 April 2017. Mr Joll would also have accompanied them on the climb but could not due to a sprained ankle.

Messrs Chand and Smith arrived at the Homer Hut at about 11:00pm on 21 April 2017. The following morning, they likely left before 5:00am. Hut volunteer, Bill Lendrum, noted that neither Mr Chand nor Mr Smith wrote their intentions in the “intentions book”. Messrs Chand and Smith were well equipped to undertake the climb with the appropriate range of ropes, chocks, cams and slings.

Mr Fortune was aware of Mr Chand and Mr Smith’s intentions and arrived at the Homer Hut in the evening of 23 April 2017. The following morning Mr Fortune followed their intended route and saw no sign of them. He called out but there was no reply and he saw no sign of their gear. He returned to the hut sometime after 4:00pm. From that point, concerns were held for the safety of Messrs Chand and Smith, and the appropriate authorities were notified. A helicopter flew to the area, and sometime after 6:00pm on 25 April 2017, their bodies were sighted at the foot of the Maid Marian face. Messrs Chand and Smith were recovered by rescue personnel the following day.

A photograph from a camera recovered at the scene allowed for the conclusion that Messrs Chand and Smith were on the third pitch at the time of the fall.

The climbing ropes, harnesses and equipment were recovered from the scene which, following examination, allowed conclusions to be made as to the climbers’ setup:

a. They were climbing using a running belay system;

b. Mr Smith was the lead climber while Mr Chand was the belayer;

c. There was 17 metres of rope between Mr Chand's belay and Mr Smith's harness, indicating that Mr Smith was climbing at a distance from Mr Chand;

d. There was no evidence of fall protection having been placed between Mr Chand as belayer and Mr Smith as lead climber;

e. Two anchors had been placed at the belayer's position, a Cam .75 (as the "primary" anchor) and a CamX4 size .2 micro-cam (as a "secondary anchor");

f. The anchor and rope set up did not place Mr Chand (as belayer) between the anchors and the lead climber; and

g. While the primary and secondary anchors were connected by way of a 7mm anchor cord, the climbing rope ran through a carabiner attached to the primary anchor, meaning that in the event of a fall the resultant force would be applied to that anchor first.

The plan was for them to establish a bivvy after the fifth pitch. Given the evidence that they were on the third pitch at the time of the fall, the Coroner concluded that the fall occurred on 22 April 2017. Their location would have placed the time of the fall sometime mid to late afternoon of that day.

Mr Smith suffered a fall, which due to the environment was effectively a free fall. He fell up to 34 metres vertically (that is, twice the length of the played-out rope (of 17 metres)).

The absence of protection might have reflected the absence of any suitable placement for the same. Alternatively, it could have reflected judgement that there was no particular need for the placement of protection as the terrain was considered easy. In the context of this terrain and the Coroner's impression of Messrs Chand and Smith being careful and risk averse climbers the second scenario was inherently unlikely.

The resultant force of Mr Smith's fall went on to the .75 cam dislodging the same. An examination of the cam revealed that the wire was bent (indicative of shock loading), but the cam itself still functioned. The cam was suitable for use as a primary anchor and design capacity had not been exceeded, rather the load applied was such that either the cam could not maintain contact with the rock, or the rock on which it was placed failed.

The force then went on to Mr Chand's belay, his body, and then on to the secondary anchor (the micro-cam) which also failed (in the sense of either not being able to maintain contact with the rock, or the rock in which it was placed failing). The cam itself was still functional, indicating that its design capacity had not been exceeded.

A court appointed expert, Geoff Wayatt, gave evidence about the suitability of the micro-cam being that its use was restricted to a very specialised circumstance, usually in the context of there being no other device that could be used. Mr Wayatt considered that there was a significant difference in the "holding power" of the .75 cam compared to the micro-cam, and he considered that the micro-cam failed more easily.

The anchor and rope setup did not place Mr Chand (as belayer) between the anchors and Mr Smith (as lead climber). While not reflecting best practice, it was not, in the Coroner's view causative. The primary and secondary anchors were connected by way of a 7mm anchor cord. Ordinarily, this would mean that the anchors were "equalised" (that is, configured so that any shock loading was applied to both cams). In this instance however the climbing rope had been clipped through the carabiner of the primary anchor with the consequence of the anchors not being equalised. In the event of a fall the force transmitted through the climbing rope was applied to the primary anchor first or had the effect of applying a disproportionate force to the primary anchor when compared to the secondary anchor. The reasons for that configuration are not clear but could have been for reasons of "rope management", such as to prevent rope dragging. Ultimately, given the forces involved from Mr Smith's lead fall, the failure of the anchors would not have been prevented by them being properly equalised.

The other matter of note was that the anchor and rope setup did not place Mr Chand between the anchors and Mr Smith. The evidence was that had Mr Chand been so placed, the initial force of Mr Smith's fall would have been transmitted through Mr Chand before coming onto the anchors. That would have had some effect of attenuating or dissipating the force. Such a configuration reflects best practice. Again, however, in the context of the forces involved here it seems unlikely that this setup would have been effective in preventing this tragedy.

The resulting force pulled Mr Chand from the face. Both he and Mr Smith suffered a fall of approximately 100 vertical metres (from about a third of the way up the lower face) which was not survivable.

RECOMMENDATIONS OF CORONER ROBINSON

I. Before addressing specific matters that arose in relation to recommendations, I need to comment on my jurisdiction to make the same. Section 57A relevantly provides:

II. Recommendations or comments may be made only for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred.

III. Recommendations or comments must—

    a. be clearly linked to the factors that contributed to the death to which the inquiry relates; and

    b. be based on evidence considered during the inquiry; and

    c. be accompanied by an explanation of how the recommendation or comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

IV. In the absence of a direct link between the subject matter of the recommendation and the cause or circumstances of death, the statute precludes me from making a recommendation.

V. Mr Lendrum noted that neither Mr Chand nor Mr Smith wrote their intentions in the "intentions book". Apart from knowing that they were heading into the Marian Valley, Mr Lendrum did not have further detail of the planned climb until Mr Fortune arrived at the hut late on Sunday night (23 April 2017). It was not until Mr Fortune returned that a search was commenced.

VI. Mr Lendrum noted, and I think fairly so, that “the boys should have put their intentions in the Homer Hut intentions book in the common room and we would have probably been looking to start a formal search from the Monday morning.”

VII. In terms of section 57A (above), as the absence of an earlier search did not contribute to death, I cannot make what would otherwise be a sensible recommendation as to recording one’s intentions.

VIII. The Chand family sought the following recommendations:

a. NZAT need to keep parents in the loop. We as parents never knew of Sarwan’s attempt to climb the South Face. And this trip was recommended by NZAT mentor(s);

b. NZAT needs to have a timetable of times when particular challenges are not recommended. Of course, someone outside of the NZAT could attend those challenges and NZAT could as well. But the guidelines are there and advise from the mentors if so desired;

c. NZAT mentor or another member who has already accomplished the route to accompany members on new and unconquered routes.

IX. I have sympathy for Mr and Mrs Chand’s stance in relation to recommendations. I need to recognise, however, that their son was 27-years old when he died. Mandating such contact does not reflect his independence, nor does it bear sufficient connection to the circumstances of this death for me to be able to make a recommendation even if I thought it appropriate.

X. I acknowledge the concern as to the time of year. The expert evidence did not preclude the climb being undertaken when it was. The information sought by the family in terms of a recommendation is readily available through sources such as climbing guides.

XI. Finally, as to a mentor or another person who had completed the route accompanying mentees, I accept the evidence that this is not practical. The evidence satisfies me that Mr Chand (and Mr Smith) was capable of undertaking this climb. Mr Fortune would have accompanied them had he been available, as would Mr Joll. I do not consider the recommendation warranted given the evidence I heard as to the abilities of Messrs Smith and Chand.

XII. I make the following recommendations:

a. Anchor setups must be “failsafe” and established in a manner that any resultant shock load is equalised across all anchors. Clipping the climbing rope through one arm of the anchor should be avoided.

b. In alpine climbing the belayer’s body and rope control should be placed between the anchor set up and the lead climber to absorb energy before any falling climber load is applied to the anchor system.

c. Lead climbers must ensure that, where possible, they place sufficient and robust protection to prevent serious lead climber falls.

XIII. The Mountain Safety Council has also provided useful commentary. I set out (and endorse) their recommendations below:

Anchor setup

- For trad anchors, at least three pieces should be used. Two pieces is only suitable if using bolts or if slinging solid items such as trees or boulders.
- Anchors should be equalised and built for purpose so that they perform as intended when loaded in the expected direction.
- On multipitch routes, remember that additional gear may need to be placed to prevent an upwards or outwards loading before the next pitch begins.

Lead Trad Climbing

- The dangers of a factor two fall on multipitch routes should never be underestimated. Protecting against this possibility should always occur as early as possible by placing your first pieces of gear as soon as one can after leaving the belay. Ideally this should be two pieces, or a well-placed Cam, set for both outwards and downwards loading (the expected directions of loading from a fall).
- Clipping into one of the anchor points as the first piece of lead protection often does not achieve this desired result on trad as it may do in sport climbing. Doing so may compromise the integrity of the anchor and also adds rope drag for the lead climber as they ascend the face.
- The anchor (where the belayer is attached) and the climber should ideally be independent besides the indirect connection through the belayer. Once the lead climber is on belay, the anchor should solely be for the safety of the belayer.

Placing Runners

- Consider the direction of pull if you (the leader) are to fall. Incorrect orientation of carabiner gates could result in the gate being opened by the rope in a fall.
- Ensure there are no twists in slings that could cause it to rotate when loaded as this can cause gear to pop out of place, or for carabiner gates to change their orientation.

Practise

- All of the above should be practiced to the point that they are second nature and decisions can be made quickly and efficiently.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of the name of one of the submitters to the report prepared at the request of the New Zealand Alpine Team in the interests of privacy. It also prohibits making public any photographs of Messrs Chand and Smith entered into evidence, on the grounds of personal privacy and decency.

Deutschbein [2021] NZCorC 7 (18 January 2021)

CIRCUMSTANCES

Nathan Deutschbein, aged 40, of Australia died on 29 November 2018 when he was caught in an avalanche and became buried while descending the Eugenie Glacier in the Aoraki-Mount Cook National Park.

On 25 November 2018, after six months of planning, Mr Deutschbein travelled from Australia to Christchurch with his friends, Ion Mihaila and Conor Quinn. They had travelled to New Zealand together on several occasions before and had climbed Mount Aspiring, Nuns Veil, Hoschstetter Dome and Mount Aylmer.

After arriving in Christchurch, the group travelled to Mount Cook Village with the intention of climbing mountains in Aoraki – Mount Cook National Park. Their original plan was to fly in to Kelman Hut at the head of the Tasman Glacier and then climb Mount Elie De Beaumont, which would have taken around four or five days. They were prepared for poor weather and had allowed ten days at Mt Cook Village.

The weather reports were not good when they arrived causing them to remain in the village for several days. The group spent that time checking the weather and chatting to Department of Conservation (DOC) Visitor Centre staff. They also spent time discussing their climbing options.

On 27 November 2018, the weather forecast predicted spells of fine weather on 29 November 2018 and the group decided they would walk up to Sefton Bivvy the next day and then climb The Footstool the following day. Given the short window of opportunity, this alternate plan meant they would be able to walk in and not have to rely on flights.

On 28 November 2018 the group rented avalanche transceivers and probes. At approximately midday, they set off on foot from the Hooker Valley car park, arriving at the Sefton Bivvy hut just before 4:00pm. They spent the next few hours reading guidebooks, talking to others at the hut and walking out 150 – 200 metres from the hut to see the safest route and plan their approach for the following day. While doing so they saw evidence of old avalanches.

At 7:00pm DOC advised via radio that the weather forecast was for fine spells the following day. The group advised DOC staff of their intention to climb The Footstool. Mr Quinn also checked Met Service which forecast “sunny periods with possible showers in the afternoon.” They retired to bed at about 8:30pm.

On 29 November 2018 the group woke at 3:30am. It was raining so they decided to wait before starting their climb. They woke again at 5:30am and thought the weather looked good as they could see the mountain. They set off just after 6:00am. Mr Quinn noted that they were up to their ankles in snow as there was no freeze overnight. Mr Quinn felt unwell, and by 6:30am he decided to turn back.

Mr Deutschbein and Mr Mihaila continued, reaching the saddle at the top of Eugenie Glacier on the Main Divide, at 12:00pm. They could not see The Footstool due to the cloud cover as the weather was getting worse and it was starting to rain. They could see snow sliding down the mountain a couple of hundred metres away from them. They had lunch on the saddle and decided to head back down to Sefton Bivvy at around 12:15pm.

They descended back the way they climbed up, staying roped together. At about 1:00pm, when they were halfway down Eugenie Glacier, they were hit by a naturally occurring loose wet avalanche. They were carried about 250 vertical metres.

Mr Mihaila was relatively unscathed having stayed on the surface of the avalanche and was able to unclip himself from his pack and untangle from the rope. He started looking for Mr Deutschbein and found him about five metres away. Mr Deutschbein's legs were exposed on the surface with his upper body trapped under the snow. Mr Mihaila used gloves and a shovel to dig down to Mr Deutschbein's face, which was about half a metre below the surface. His nose and mouth were full of snow. Mr Mihaila tried to clear the snow and shook him, but Mr Deutschbein did not respond. He was purple, and Mr Mihaila said he knew he was gone.

The Coroner commissioned an independent review of the circumstances of Mr Deutschbein's death from the New Zealand Mountain Safety Council (MSC). The MSC identified a number of causative factors in this incident, including the weather and snow conditions. It noted that even when the Eugenie Glacier route is in a good condition for climbing, the morning sun impacts the snow surface quickly and can significantly alter the stability. As a result, the group was exposed to heightened avalanche risk on their chosen route. The group's incorrect interpretation of the avalanche dangers was another causative factor in this incident. Mr Quinn understood the avalanche risk as being "low", but the forecast clearly indicated "moderate" at all elevations above 1,400 metres, with specific reference to loose wet avalanches in the heat of the day and on all aspects in case of rain.

The MSC reported that The Footstool would be considered an appropriate choice for the group's skill level. However, the group failed to recognise the heightened avalanche risk. It also failed to turn back earlier, given that the ascent of this route would take about eight to ten hours from Sefton Bivvy. Typically, mountaineers would aim to be back at the bivvy by midday but Mr Deutschbein and Mr Mihaila did not turn around as expected. It took them six hours to reach the saddle, which was less than half the total distance they had intended to climb that morning, indicating poor travel conditions.

The MSC also considered whether Mr Mihaila should have performed CPR on Mr Deutschbein. While the MSC did not consider this failure a contributing factor to the incident, it wanted to discuss it as it was relevant to its recommendations on what the MSC would expect of any trained person with duty to respond to an avalanche victim, as well as any person undertaking a recreational activity in an area with avalanche risk. Noting the MSC's position on this, the Coroner concluded that it would be speculative to offer a view on whether CPR might have altered the outcome in this case.

RECOMMENDATIONS OF CORONER ROBINSON

I. The MSC made a number of recommendations to mountaineers which I consider appropriate and endorse below.

II. The MSC encourages all mountaineers to:

   i. Attend an official avalanche training course which also includes avalanche rescue techniques. Courses can be found here: http://www.avalanche.net.nz/education.

   ii. Always thoroughly read, discuss and make sure you understand the official avalanche advisory for your area. If you are not sufficiently experienced or competent to understand the advisory, or have questions about the details, you should seek advice from a suitable source.

   iii. Whilst it is important to understand and apply the information in the avalanche advisories, it is also critically important to take into consideration locally observed conditions in a specific area. For example, at Sefton Bivvy, in this situation, there were multiple warning signs: rainfall, no overnight

freeze, evidence of avalanches in the immediate area, direct sun on the snowpack from early morning and soft snow underfoot when travelling.

iv. Ensure that your climbing objective is in alignment with the current conditions. Always remain vigilant to changes in your environment and always be prepared to assess those conditions and turn around.

v. Always establish a “turn around time” for any return trip, especially in the mountains where snow melt can cause significant risks as the day progresses.

vi. In line with International Commission for Alpine Research recommendations, always administer CPR with ventilations for avalanche victims if they are not showing signs of life and not showing any signs of obvious death, after removing as much snow as possible from mouth and nose. The only exception to this rule is if they patient has been buried for over one hour and their mouth and nose is totally blocked with snow and ice and there are other patients who also need to be rescued. A person is not dead until they are warm and dead, and verified by an appropriate medical professional.

III. I encourage the MSC, and other applicable interest groups, to continue to give publicity to these recommendations, and to adopt them in their educational programmes.

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

Rogers [2021] NZCorC 12 (25 January 2021)

CIRCUMSTANCES

Te Hei Kakurangi Rogers, aged 44, died on 4 January 2019 while diving near Black Rocks off Moturoa Island, Bay of Islands, as a result of drowning.

On the morning of 4 January 2019, Mr Rogers arranged to go to Black Rocks with his daughter and two of his cousins, Vincent Joyce and Haare Simon-Anderson. The group set off in Mr Rogers’ boat at about 7am to an area near Moturoa Island. Mr Rogers entered the water wearing his usual diving equipment, which included a dive cylinder, a buoyancy compensator device (BCD), dive regulators, fins, a weight belt with five weights attached, a dive mask, a wetsuit, a pair of dive boots and gloves. He also had a catch bag with a float attached.

The rest of the group saw Mr Rogers’ float line move from the outside of the island to a large rock pool inside the island. A short time later, Mr Simon-Anderson heard Mr Rogers call out for help and entered the water fully clothed to assist him. While waves surged, Mr Simon-Anderson held Mr Rogers up against the edge of the rock pool and unclipped the top strap of his BCD. It fell away along with the attached cylinder and regulators. Another wave surged in, causing Mr Simon-Anderson to lose his grip on Mr Rogers. Mr Rogers sunk below the surface into the rock pool, and the group were unable to locate him after this point.

Police and other boats responded to calls for assistance, including two commercial divers who were experienced at diving in the area. They commenced a search for Mr Rogers, but quickly determined that the conditions were too dangerous to continue. Another experienced diver arrived later and managed to locate Mr Rogers underwater.

The Police National Dive Squad (PNDS) attended that evening and recovered Mr Rogers' body. He was found at a depth of 8.5 metres, underneath a large boulder at the end of a series of short caves and crevices. His weight belt was still attached to his body.

PNDS provided a report which found that the following factors contributed to Mr Rogers' death:

- Mr Rogers' dive cylinder was assembled incorrectly, with the cylinder valve facing away from him. When tested, a PNDS member was unable to turn their head to the left as the regulator would be pulled from their mouth. PNDS advised that this is a basic diver error which indicated that Mr Rogers was either rushed and did not check his dive equipment prior to diving, or was inexperienced and lacked formal training.
- Mr Rogers did not remove his weight belt when he got into difficulty, despite this being a recommended practice in diving emergencies. It could indicate that a sudden event overcame him, that he panicked, or he lacked sufficient experience to recognise the situation he was in. It was also noted that his weight belt had a single tongue rather than a quick release system.
- There was a strong wave surge around the rockpools and throughout the pools themselves, making the conditions inside the rockpools dangerous for diving that day.
- Mr Rogers had not completed a pre-dive medical check, nor had he completed any formal training for scuba diving.
- Although he used a float on the surface which allowed his whānau to identify his location, Mr Rogers dived alone, which is an unsafe diving practice.

The Coroner accepted the PNDS' conclusion that whilst the above factors contributing to Mr Rogers' death may not have been fatal individually, the combination of these factors had led to fatal consequences.

RECOMMENDATIONS ENDORSED BY CORONER BELL

I. PNDS provided the following recommendations in its report:

   a. Ensure dive equipment operates correctly and is regularly serviced, at least annually;

   b. Divers should abandon their weights when in difficulty;

   c. Ensure persons are medically fit to dive. Dive medicals must be done on a regular basis and redone if there are any changes in health;

   d. Proper dive training must be completed;

   e. Dive with a buddy for the duration of the dive;

   f. Monitor the conditions and abandon the dive when unsafe or outside your experience;

   g. Divers must wear a watch or dive computer or timing piece to monitor their time under water.

II. These recommendations are similar to those available on the Water Safety NZ website.

III. I endorse these recommendations pursuant to s 57(3) of the Coroners Act 2006 and direct that these findings be provided to Water Safety New Zealand and to the editors of the Dive New Zealand magazine for dissemination as appropriate.

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

Tornmarck [2021] NZCorC 52 (30 March 2021)

CIRCUMSTANCES

Hans Christian Tornmarck, aged 28, of Sweden, died in the Regina Creek area, Karangarua Valley between 13 and 22 May 2017. The direct cause of Mr Tornmarck's death is unknown. His death occurred in the context of a mishap in an alpine environment.

Mr Tornmarck arrived in New Zealand on 1 March 2017 for his third visit. On 12 May 2017, Mr Tornmarck sent a text message to his friend, Denis Moloney, saying he was off to do a "solo-mission up Regina now". Mr Tornmarck advised that he "should be back Tuesday or Wednesday". It appears he then drove to the Karangarua River Bridge on Stage Highway 6, where he parked his car in a layby adjacent to the river.

Another walker on the Karangarua River track told Police that between 3:00pm and 4:30pm she had seen a person believed to be Mr Tornmarck. She also reported that in this time period a creek had risen noticeably with a lot more white water. Police noted that that was potentially dangerous, especially if it continued to rise before Mr Tornmarck's arrival.

A hunter and his two companions stayed in the Cassel Flat Hut on the night of 12 May 2017 where they encountered Mr Tornmarck. They discussed Mr Tornmarck's intention to go up the Regina Creek and suggested the Horace Walker trail instead because they had been up there that evening and had seen a bull tahr on the top of the ridge. They thought it might be a better option because going to the head of Regina Creek is very difficult, as the trail stops after the wire bridge. Mr Tornmarck explained that he had been up the creek the year before with his brother and was planning on hunting at the head of the creek again. Mr Tornmarck was aware that it was a tough hike.

The hunter told Police he was surprised Mr Tornmarck was going up Regina Creek by himself as he and his partner had had a "hard time" in the area and it was very slow going, even without going all the way to the head of the creek. Knowing this, he had assumed Mr Tornmarck was a fairly experienced hunter/hiker to be going back in by himself. However, he said that Mr Tornmarck was well prepared, although he did not ask him whether or not he had a rescue beacon.

At 10:45am on 17 May 2017, Mr Moloney contacted Police and reported that Mr Tornmarck had failed to return, with his latest expected time out being the evening of 17 May 2017. An extensive search was initiated. A campsite appearing to be that of Mr Tornmarck was discovered at Regina Creek but Mr Tornmarck was not there. The campsite was situated high up the valley near the head of the creek in an extremely hazardous area, under a large, near-vertical rock which went for 200 metres directly upwards. Searchers noted the rocks could have easily come down the rock and into the campsite, indicating Mr Tornmarck's inexperience, as did the fact he did not have a locator beacon. The search was suspended on 24 May 2017.

The Search and Rescue Coordinator reported that the search terrain was amongst the toughest terrain he had searched during his career, with multiple hazards and an infinite number of places where Mr Tornmarck could be hidden from view, either under or between boulders of under scrub or bush. It was also possible Mr Tornmarck was covered by snowfall.

A second search was undertaken in 2020. The Incident Controller reported that it would have greatly assisted if Mr Tornmarck had gone into the area with someone else, and that his inexperience showed itself in the placement of his campsite under a big rock fall. In addition, Mr Tornmarck did not have a personal locator beacon or in-reach device and did not fill in the intentions book at the Cassel Flat Hut.

Police confirmed that there was no evidence to suggest that Mr Tornmarck was alive. Mr Tornmarck's family have had no communication from him and all of his bank accounts have remained untouched.

The New Zealand Mountain Safety Council (MSC) provided a report to the Coroner identifying likely contributing factors and recommendations. MSC wrote that it was reasonable to assume that Mr Tornmarck was out hunting at the time of his incident. Much of the desirable hunting areas are extremely steep bluffs on the creek's true left, with hundreds of metres of exposure. Given the nature of the terrain, what is known about alpine hunting fatalities over the previous decade, and the type of hunting required to successfully locate and shoot a tahr, it is reasonable to assume that Mr Tornmarck experienced a fatal fall at some point while hunting. With no hunting partner or regular way to communicate his daily intentions, there was little chance of recovery or aid in this area as it is very remote.

Given that over the past ten years the most common cause of fatalities for alpine hunters has been falls resulting in severe trauma, MSC recommended to all alpine hunters that they take a cautious approach to route finding and to always consider the fall line for any animal they intend to shoot, so they are not exposed to high consequence terrain when recovering the animal. The MSC also recommended that alpine hunters always hunt in pairs, a common practice in the mountaineering community due to the hazards which exist in alpine areas. In addition, the MSC recommended that alpine and backcountry hunters always carry two-way communication devices with them so they can communicate with their hunting partner, keep trusted contacts informed if their plans change, or alert rescue services if help is needed.

DOC publishes a brochure containing information for hunters hunting in conservation areas, which contains a basic gear list for those planning a hunting trip. That list includes a personal locator beacon (PLB), and notes that the use of a PLB that is GPS equipped reduces the time it takes for the user to be found. The brochure records that PLBs can be hired or purchased. It also recommends the use of the Mountain Radio Service ("MRS") lightweight radios, which are available for hire and provide a reliable form of two-way communication in the back country.

The MSC website also provides comprehensive information for those planning hunting (and other) trips. The gear list provided includes a phone and emergency communications device.

The website records that a mobile phone may not be sufficient in areas with unreliable coverage or where the user is unsure about the extent of coverage. It provides information about different types of communication devices and includes the following:

> *Why take a communication device?*
>
> *There are a number of reasons you'll need to be able to communicate to others. You might:*
>
> - *Get lost and need rescuing*

- *Change your route and need to alert a friend*
- *Be running late and need to stay an extra night*
- *Want to get updates on the weather along the way*
- *Get injured or be in an emergency situation and require rescue.*

RECOMMENDATIONS OF DEPUTY CHIEF CORONER TUTTON

I. In the course of producing this Finding, I considered making a recommendation that the DOC website alert users to the dangers of areas that are particularly hazardous, such as the Regina Creek area, to emphasise that they should only be accessed by those with appropriate skills, knowledge and experience, or with a guide.

II. I advised DOC of the possible recommendation and Andy Roberts, Visitor Safety Manager, responded on its behalf.

III. Mr Roberts wrote that DOC understands that its website users search appropriate activities to undertake, and are not looking for safety information per se. He stated that "Hunter safety on the DOC website attracts a very small proportion of page visits" and that website usage suggests that most hunters prefer to get location specific information rather than review general hunting safety information.

IV. Mr Roberts acknowledged the importance of getting information on hazards and risks in front of users early on in their decision making process and said it is unknown whether there is enough of the right information to support users to make sound decisions about their trip. He noted that information highlighted in relation to the relevant area of South Westland displays a consistent theme of "difficulty of terrain, expert skill levels needed, highly skilled user etc".

V. Mr Roberts stated that DOC supplies a large amount of information about hazards and risks to visitors and that decision making rests with visitors. He wrote that it is considered that some international visitors may underestimate hazards, risks and the skills required and over-estimate their own skills and capabilities. He referred to three fatalities of hunters from Europe in South Westland between 2016 and 2019 but noted that the problem is also evident among New Zealand users of conservation lands.

VI. Mr Roberts opined that DOC could improve the information about hazards and risks it provides to visitors. He stated that DOC proposes to:

a. Review information for users of remote, challenging and difficult conservation land (such as the whole Karangarua catchment) to ensure that the messages are consistent between the various DOC channels noting the current messages, while not inconsistent, do have different phrasing.

b. Establish more standardised wording for hazard warnings activities in remote difficult areas to provide a more robust picture of the hazards and the skill level required “e.g. *"Hunting/climbing/tramping/kayaking in X area has difficult challenges for the visitor to overcome. The terrain is steep,* access *is difficult and the skills required are at the highest level" - or something like that*".

c. Review history of fatalities and/or SAR events on conservation lands over the last five years to consider where standardised high-level warning might need to be applied.

d. Link the high-level hazard warnings to the specific webpages for the sites identified above.

e. Investigate any new approaches to web page and other channels to try and alert international hunters to the hazards of hunting in particularly difficult and remote areas.

f. Work with others in the sector (Game Animal Council, NZSAR, NZDA, Police and MSC) on these topics to ensure consistency of approach.

VII. In conclusion, I endorse and repeat the recommendations made by MSC:

a. That all alpine hunters take a cautious approach to route finding and always consider the fall line for any animal they intend to shoot, so they are not exposed to high consequence terrain when recovering the animal;

b. that alpine hunters should always hunt in pairs; and

c. that alpine and backcountry hunters should always carry two-way communications devices with them so they can communicate with their hunting partner, keep trusted contacts informed of the plans change, or alert rescue services if help is needed.

VIII. Tragically, it appears that Mr Tornmarck, who had limited experience in the New Zealand West Coast alpine environment, died as a result of his failure to follow many of the basic safety rules of hunting or tramping in the New Zealand alpine environment.

IX. Mr Tornmarck went alone into an alpine environment described by experienced members of the search team as among the most hazardous and challenging in New Zealand. He failed to fill in the intentions book at the hut in which he stayed the night before setting out and did not take a personal locator beacon with him.

X. Information relating to the basic safety rules is freely available. It is not known whether Mr Tornmarck was unaware of those rules or was aware of them but elected to disregard them.

Medical Care

Laing [2021] NZCorC 17 (4 February 2021)

CIRCUMSTANCES

Tonette Avis Laing, aged 64 years, of Tairua died on 22 August 2018 at Waikato Hospital of multi-organ failure antecedent to sepsis.

Mrs Laing's first admission into hospital was on 5 June 2018. She was suspected of having pancreatic cancer without this being confirmed on tissue biopsy. Investigations identified narrowing of her bile duct. As a result, a stent was inserted which allowed the flow of bile. During this admission there were indications of infection and a possible septic episode, which is something that can occur as a result of a stent procedure. Mrs Laing subsequently showed signs of improvement without antimicrobial therapy.

By 1 July 2018 there was a further suspected septic episode leading to antibiotics being administered until 3 July 2018 when they were stopped in light of a palliative approach being undertaken at that time. However, Mrs Laing rallied on 4 July 2018. On 11 July 2018 she was discharged to hospice care before being discharged home in mid-July. There were no definitive indications of infection through that latter period and no indication of an antibiotic regime being in place at that time.

The potential for Mrs Laing to be suffering from pancreatic cancer remained, with some of the testing during that admission being consistent with cancer. There were, however, indications that she was suffering from inflammation. By 21 July 2018, Mrs Laing developed sepsis and was admitted into hospital again. Blood cultures were taken and in due course grew identified bacteria. Mrs Laing's operative diagnosis was still pancreatic cancer.

On 27 July 2017 the clinical notes record a plan for continuing intravenous antibiotics and for contact to be made to the infectious diseases in respect of an oral alternative. There is reference to an email being sent to the infectious diseases team, but the contents of that email and any response do not form part of the clinical notes and there is no other documentation available.

On 1 August 2018 a house surgeon reviewed Mrs Laing's chest x-ray leading to a diagnosis of hospital-acquired pneumonia and started intravenous co-amoxiclav (augmentin). She was treated with ceftriaxone and metronidazole until 11 August 2018.

Chest x-rays on 9 August 2018 and 13 August 2018 identified new large left pleural effusion and likely dense left base consolidation. An ultrasound liver biopsy had been scheduled for 10 August 2018 but did not occur as no discernible lesion was found on ultrasound and Mrs Laing's risk of bleeding was such that it was not safe to perform a biopsy. The biopsy ultimately occurred on 16 August 2018 and resulted in no evidence of malignancy and no evidence of abscess formation.

By 17 August 2018 Mrs Laing's deterioration was clear. There were no viable treatment options. She was transitioned to comfort cares and died on 22 August 2018. The post-mortem showed that Mrs Laing died due to sepsis, related to portal vein thrombosis and secondary hepatic abscesses. What caused the obstructive jaundice and portal vein thrombosis initially is unknown.

Dr Metcalf provided an expert opinion about Mrs Laing's care and raised three broad concerns: in respect of the direct contact and input from the consultant surgeon; in respect of delays in pleurocentesis and testing due to bleeding risks; and in antibiotic management.

The Coroner determined there was no evidential basis to conclude that the first concern was a cause or contributing factor in respect of Mrs Laing's death. He also accepted that the bleeding risk was appropriately considered in the decisions that were made and thought it inappropriate to make any further comment or recommendations on that matter

in the overall circumstances. As Mrs Laing's death was ultimately the consequence of sepsis, the Coroner considered that the antibiotic treatment regime was an issue to consider.

Dr Metcalf highlighted that there was no documented response to the positive blood cultures and reported antibacterial sensitivities. Any input or request for input from the Clinical Microbiology or Infectious Diseases was not documented.

The relevance of this was that the blood cultures taken on the day that Mrs Laing was readmitted into hospital (21 July 2018), as earlier noted, subsequently resulted in identification and isolation of klebsiella pneumoniae (which Dr Metcalf advised was sensitive to cefuroxime, ceftriaxone, ciprofloxacin and gentamicin), morganella morganii (which Dr Metcalf advised was sensitive to gentamicin and ciprofloxacin), and enterococcus faecium (which Dr Metcalf advised was sensitive to vancomycin). Dr Metcalf advised that the appropriate response would have been to alter the antimicrobials to treat all bacterial isolates in the blood culture. She advised that the morganella and enterococcus were resistant to the antibacterials that had been prescribed.

Dr Welsh of Waikato District Health Board (the DHB) responded to Dr Metcalf's opinion, including on when and where the blood cultures were sent, when they were available and when antibiotics were commenced. Dr Welsh also provided an explanation from the DHB guidelines for treatment of mild-to-moderate hospital-acquired pneumonia for patients who did not have complex clinical regimes/antibiotic prescriptions. That guideline directs the first line antibiotic should be co-amoxiclav, which was what had been prescribed.

Dr Welsh went on to explain that although Mrs Laing had been prescribed cefuroxime and metronidazole that would not have been evaluated to be a 'complex antibiotic regime' in a surgical ward. He further noted that on the morning of prescribing augmentin, Mrs Laing was recorded as doing well, and thus would not have been viewed as suffering from severe hospital-acquired pneumonia at that time. According to Dr Welsh, the augmentin was therefore prescribed in accordance with the Waikato DHB guidelines for Mrs Laing's perceived clinical presentation.

Dr Metcalf advised that there was appropriate recognition of sepsis at the time of the second admission and that appropriate investigations were undertaken. However, she advised that it would have been preferable for two sets of blood cultures to be drawn down rather than just the one with a second blood culture and sputum culture having been undertaken on 1 August 2018 when the chest x-ray led to a diagnosis of pneumonia. She advised that an agent such as intravenous piperacillin+tazobactam should have been considered at that time. Dr Welsh agreed with this suggestion as being a better choice of antibiotic for Mrs Laing to account for the possibility of resistant gram-negative bacteria but noted that this was not what was actually written in the Waikato DHB protocol for mild-to-moderate hospital-acquired pneumonia (as outlined above). Dr Welsh advised that a doctor without specialist training in infectious disease reading the protocol would have been guided to prescribe augmentin.

Dr Metcalf was clear in her advice that the initial choice of augmentin was not optimal given Mrs Laing's recent hospital stay and antibacterial treatment but acknowledged that this prescribing was quickly changed to ceftriaxone and metronidazole which was more appropriate. However, there was no change of antibacterial treatment in response to the blood culture results nor recognition that the anti-bacterials that Mrs Laing was receiving were not active against two of the bacterial species cultured. She advised that Clinical Microbiology should have provided unsolicited expert advice regarding treatment for this infection or directed the treatment team to seek advice from Infectious Diseases.

Despite this she explained that there was nonetheless an improvement in laboratory sepsis parameters for Mrs Laing, as well as clinical observation parameters. She acknowledged that the surgical team would have considered Mrs Laing's

sepsis appropriately managed, in the absence of that external advice. She also advised that the CRP (a protein made by the liver the presence of which in the bloodstream is a response to inflammation or infection) failed to fall to within the normal range despite ongoing antibacterial treatment. She advised that ideally this should have prompted concern as to whether the spectrum of antibacterial activity was adequate, particularly with the CT report demonstrating micro-abscesses in the liver.

Dr Welsh agreed with the suggestion that there may have been a better choice of antibiotic for Mrs Laing to account for the possibility of resistant gram-negative bacteria, however a doctor without specialist training and infectious disease reading the Waikato DHB antimicrobial guide would have been guided to prescribe augmentin.

Dr Welsh acknowledged that ideally there should have been engagement by the clinical team looking after Mrs Laing with the Clinical Microbiology or Infectious Disease team regarding antimicrobial therapy. He noted the gap in information in respect of the email correspondence between the house surgeon and infectious disease.

RECOMMENDATIONS OF CORONER ROBB

I. The documentation of to whom and when the results of the blood cultures were received is not clear within the clinical records. The steps taken to consult with the Infectious Disease team is also not documented in the clinical records, nor what advice, if any, was received. Blood culture results can have an impact on diagnosis and treatment decisions.

II. One difficulty in there being no documentation of who reviewed the blood culture results and what advice was sought and received, is that any internal Serious Event Review by the DHB, any other expert review, or any subsequent coronial investigation, is limited in what can be learnt from the treatment decisions because those decisions are inadequately documented.

III. However, of greater significance is in respect of the ongoing care of a patient. The recording of information in the clinical notes must assist members of the treating team to be in the best position for treatment decisions during treatment. Allowing team members to know that blood culture results had been reviewed and evaluated, advice had been sought, and what advice had been received. Documenting also ensures that any transfer between teams is made with a full record of care decisions, and advice sought and received from any specialist team. In this instance, advice on the blood culture results from infectious diseases, may, and as Dr Metcalf would argue should, have led to advice being received to prescribe something such as Tazocin.

IV. With a view to reducing the risk of death in similar circumstances I make the following recommendations:

   a. A process/practice be developed to ensure blood culture results are provided to the treating team and are documented as having been provided, received, and evaluated by the team.

   b. Where multiple bacteria have been cultured advice is sought from the appropriate clinical microbiology or infectious disease team, to ensure prescribing of antibiotics that are active for all bacterial species that have been cultured.

   c. The advice sought, any advice received, and any consequent treatment decisions are documented in the clinical records.

V. Pursuant to section 57B the Coroners Act, the making of recommendations comes with a requirement that any affected party must be provided with an opportunity to consider and respond to the proposed recommendation. That opportunity was accordingly provided to the DHB. The response received from the Waikato DHB Associate Chief Medical Officer includes the following:

> At Waikato DHB there is a regular twice weekly meeting between members of the I.D. (Infectious Disease Team) and Clinical Microbiology to review blood culture lab results of concern. These cases are usually those that ID have clinical involvement with. There is an opportunity for Clinical Microbiology to provide unsolicited expert advice regarding positive blood culture results. However, they cannot comment on antibiotic choices if they are unaware of what has already been prescribed.
>
> Further detail on the relevant systems and processes currently in place at Waikato DHB are provided below. We will certainly use this opportunity to review our Policies and ensure that we are continually improving in this area.
>
> Waikato DHB has a system in place to alert teams to positive blood cultures in general. This is outlined in the document "Waikato DHB Protocol: Limits for Phoning Laboratory Results". In addition, the Laboratory also has an Escalation Process for when difficulties are encountered in contacting the responsible clinical service.
>
> The MicroGuide app which is the electronic Waikato DHB reference for antimicrobial prescribing and management has a section outlining the "Infectious Disease Service Consultation Policy 2018". This gives advice on when and how to contact the ID Service and includes the need to document this in the clinical notes. There is also a section on Blood Cultures under "Principles of Antimicrobial Prescribing", which includes procedures to follow after notification of positive blood culture results and management of patients.
>
> The latest Waikato DHB Policy on Antimicrobial Prescribing was published in June 2020 and emphasises the need to review and document management with "Review and changes made to a patient's antimicrobial therapy must be clearly documented in the clinical notes" highlighted. It advises when to seek advice from an Infectious Diseases Specialist.
>
> There are clear Waikato DHB guidelines on Standards for Clinical Documentation, setting out the expectations for all staff.
>
> Finally, on behalf of Waikato DHB I would like to extend our condolences to Mrs Laing's family for their loss. If it would assist the family to discuss Mrs Laing's care further with me I would be happy to do so.

VI. I gratefully received the above additional report and acknowledge the scrutiny the Waikato DHB have undertaken in respect of their processes and expectations of staff brought about by Mrs Laing's death. I also acknowledge their ongoing intention to continue to seek to improve.

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

Mausii [2021] NZCorC 1 (3 August 2020)[31]

CIRCUMSTANCES

Hineihana Sosefina Mausii, aged two years and 10 months, of Dunedin, died on 29 September 2013 at Dunedin Public Hospital of cerebellar tonsillar herniation (coning) secondary to overwhelming streptococcal infection, with underlying acute myeloid leukaemia (AML).

On 22 September 2013, Hineihana was noted to be slightly unwell by her mother, Tracey Elvins. She attended preschool on 25 September 2013 but had a disturbed sleep that night. Ms Elvins kept her home from preschool the following day. She treated Hineihana with paracetamol and prospan cough syrup.

Shortly after midnight on 27 September 2013, Hineihana was obviously unwell with a mild fever. Ms Elvins administered paracetamol and drove her to the Emergency Department (ED) of Dunedin Public Hospital.

Hineihana was admitted at 12:55am and observed to be alert and settled but with a temperature of 38.5°C. She was triaged as category three which required her to be seen by ED medical staff within 30 minutes. She was reviewed by a registered nurse at 1:30am and given paracetamol and an iceblock. At 1:55am, Hineihana was reviewed by a house officer whose impression was that her symptoms were consistent with an upper respiratory tract infection. Ms Elvins was advised to give Hineihana paracetamol four hourly with cooling measures to reduce her temperature.

Hineihana was assessed by a supervising registrar and it was noted that her temperature had not reduced, despite earlier paracetamol. The registrar prescribed an oral dose of ibuprofen. On review 30 minutes later, Hineihana's temperature had reduced to 37.4°C and there were no other changes on examination. The registrar established with Ms Elvins that they lived nearby and that Ms Elvins felt comfortable taking Hineihana home. She was discharged at 3:55am.

Hineihana did settle when she returned home but managed only short periods of sleep. She was drinking water but was off her food. Around 10:30am on 27 September 2013, her temperature was 38.9°C. Ms Elvins was treating her in accordance with the clinicians' treatment advice from the day prior.

The following morning, 28 September 2013, after further scheduled doses of medication, Ms Elvins thought Hineihana's temperature was normal. However, that afternoon, Hineihana confirmed to her mother that she was having trouble breathing. Ms Elvins administered a dose of a Ventolin inhaler and resolved to return to ED.

At 9:14pm on 28 September 2013, Ms Elvins returned to the ED with Hineihana. She was immediately reviewed and triaged as category two. This required her to be assessed within 10 minutes and required the triage nurse to call a triage code over the ED intercom and notify the Paediatric Registrar. There is no evidence that either of these notifications in fact occurred on this occasion.

Hineihana was reviewed by a registered nurse and a record from 9:30pm shows her presenting complaints as "irritable, lethargy, cough, grunting, not eating and diarrhoea x 2". Her temperature was 37.3°C, heart rate 175, respiration rate 44 and oxygen saturation 97 per cent. Dr A, a house officer,[32] commenced an examination and took a history from Ms

[31] While this finding was issued in August 2020, it could not be published until final non-publication orders had been made.
[32] Doctors in their first and second postgraduate year from medical school are known as House Officers (or House Surgeons, the terms are interchangeable). Typically, from a doctor's third postgraduate year (or for some it may be in their fourth or fifth year) they enter a specialty training programme with a College and hold a training job within that speciality in the hospital environment. These doctors are known as Registrars or sometimes

Elvins about Hineihana's presentation less than 48 hours earlier. The registered nurse alerted Dr A to the observations that she had just taken.

Dr A took the notes and nursing documents and discussed Hineihana's case with his supervising ED locum consultant, Dr Hussain. There were differing accounts between the doctors as to exactly what was relayed and discussed but a diagnosis of viral upper respiratory tract infection was reconfirmed and it was decided that further investigation was not warranted. Clinicians reassured Hineihana's parents that she could be safely discharged home.

Around 7:00am on 29 September 2013, Ms Elvins found Hineihana's temperature to be around 40.3°C so she called ED for advice. She spoke to a receptionist who transferred her to the Healthline telehealth service for assessment and advice.[33] This was in accordance with Southern District Health Board (SDHB) policy at the time that only "exceptional cases" of calls were referred to a Triage Nurse, Acting Charge Nurse Manager or Nurse in Charge on night duty.

RN W answered the call which lasted 3 minutes 12 seconds, a significant amount of which was taken up in obtaining Hineihana's personal information. They discussed her recent presentations to ED and her breathing which, at that time was quick and shallow. Hineihana became distressed and could not be settled so Ms Elvins ended the call saying she was "just going to go."

Around 1:00pm, Hineihana stopped breathing and became unresponsive. Her parents commenced CPR and called emergency services. Hineihana was transported to hospital in active resuscitation. This continued on arrival at ED but despite extensive efforts, she was unable to be revived.

Hineihana's post-mortem examination revealed underlying AML which made her more susceptible to sepsis. A medical opinion provided was that her AML led to immune suppression which meant Hineihana was unable to suppress and control the infection.

Hineihana's death was subject to a Serious and Adverse Event Review (SAE) by SDHB. Ms Elvins made a complaint to the Health and Disability Commissioner (HDC) about the services provided to Hineihana by SDHB and Healthline prior to her death. HDC undertook an investigation.

The SAE review and the HDC investigation found that at the time of Hineihana's ED presentation on the evening of 28 September 2013 the ED medical and nursing team as a whole was in possession of sufficient information to indicate that Hineihana was a very unwell child and to have provided her with appropriate care. The failure to do so was, in the HDC's assessment, a result of "a series of judgment and communication failures".

The Coroner found that Dr A's relative inexperience with paediatric presentations, coupled with inadequate supervision by his locum consultant, Dr Hussain, within the wider context of a lack of interdisciplinary approach to Hineihana's care, and a culture where staff were not encouraged to question or challenge decisions of senior doctors, meant there was a critical failure to identify 'red flags' in Hineihana's clinical presentation and to initiate a senior doctor review and examination. The decision to discharge Hineihana home barely an hour later, rather than have her remain in the ED for a

Senior Registrars and remain in that role for between five and seven years depending on their specialty. House Officers/House Surgeons, and Registrars/Senior Registrars are collectively known as Resident Medical Officers (RMOs) or junior doctors. Once Registrars pass their final exams they can hold a position as a specialist Consultant. Consultants are Senior Medical Officers (SMOs).

[33] At the time of Hineihana's death, Medibank Health Solutions NZ Limited (Medibank) provided the Healthline service through a contract to the Ministry of Health (MoH). Since June 2015, this service has been provided by Homecare Medical Ltd through a contract with MoH. Medibank no longer operates a telehealth service so no recommendations or comments were made in relation to that service.

further period of observation and monitoring, and the lack of clear discharge advice to Hineihana's parents on what to monitor for and when to return to ED, or seek further medical advice, cemented this critical failure. RN W's failure to recognise in a timely manner the seriousness and acuity of Hineihana's clinical situation was a lost opportunity to engage urgent medical intervention, albeit Hineihana may well have already been in an irrecoverable state at that point.

SDHB advised that, in response to the SAE review, it instituted the requirement that "all children re-presenting to ED in relation to the same illness should be assessed by a senior registrar or consultant". The HDC Report referred to a memorandum dated 16 July 2014 (2014 ED Memorandum) which sets out a low threshold for paediatric re-presentations to be referred and is distributed regularly.[34]

HDC recommendations included that SDHB commission an independent review of the senior/junior rostering to establish if sufficient levels of supervision were available in ED. SDHB did so and the independent review made the following recommendations:

- review of the RMO orientation handbook to include information about expectations for SHOs with respect to supervision in ED;
- consideration of a note in the handbook about paediatric patients and in particular children who return to ED requiring an SMO review if seen by a SHO;
- an SMO portfolio is created specifically for HO orientation and supervision;
- review of staffing levels in particular the cover that the RMO office provides for weekends. Whilst the weekdays are usually well covered the weekends rely heavily on additional duties by RMOs and SMOs. This is likely to be unsustainable and result in reduced staffing over the weekend making it difficult to supervise.

SDHB advised that there had been a subsequent increase in ED medical staffing numbers for a variety of reasons. As part of those changes, there is now an increase from 12 to 16 FTEs rostered registrars in ED.

The HDC report noted that SDHB made the following changes, among others, in response to the SAE review:

- it made optimisation of on-the-job clinical training of junior staff an ongoing agenda item at SMO meetings; and
- all house surgeons have a nominated supervisor and comply with regular meetings and updates with the ED supervisor.

HDC also recommended that SDHB include information in its training and induction that asking questions and reporting concerns is expected and accepted from all members of the multidisciplinary team. SDHB responded by having "listening sessions", establishing a set of common values and a "Speak Up!" programme.[35]

[34] This is distributed to all clinical staff in the ED three-monthly (at the start of each new RMO run) and included in the RMO Handbook (see below footnote).
[35] Described as an in-depth formal programme where training and guidance is given to people about how they can speak up, identifying what the barriers are, and putting people into roles who can facilitate the speaking up process.

The HDC reported in correspondence dated 29 March 2017 that it received a number of documents relevant to recommendations being met. However, the RMO Handbook was not updated. SDHB stated this was because a wider education programme was implemented.

In April 2017, a document titled “ED SMO Roles” was developed by SDHB explaining respective roles.

At the time of Hineihana’s death, there was a Memorandum of Understanding (MoU) in place between ED and the Child Health Service at Dunedin Hospital to identify the need for, and to facilitate, appropriate and timely referral for senior doctor review of paediatric presentations to the ED. Actions that should have been triggered by Hineihana’s second presentation did not occur. An updated MoU has been developed but this still relies on the appropriate exercise of clinical judgement to ensure a paediatric review.

Auditing requirements were also implemented in response to an HDC recommendation.

In response to SAE recommendations, the SDHB developed a pamphlet for parents and caregivers of children presenting at the ED. The pamphlet details the process for triaging patients and also includes a space for “Discharge Advice” to be recorded, including diagnosis, medications, and further tailored discharge instructions. The purpose is essentially to give parents and caregivers information on where to find further information.

RECOMMENDATIONS OF CORONER WINDLEY

I. My inquiry has had the benefit of the previous reviews undertaken by the SAE clinicians and the HDC, including the recommendations to address the identified root causes of the shortcomings in the care and treatment provided to Hineihana. My inquiry has gone further, greatly aided by the expertise of Professor Dalziel, to carefully assess the extent to which the identified shortcomings contributed to Hineihana's death, and whether there were in fact opportunities to have prevented that tragic outcome.

II. Although these findings come, regrettably, some years after her death this has meant there has been an opportunity to more fully consider the extent of implementation of those recommendations and whether additional recommendations are required.

III. I acknowledge the SDHB has done much to implement the recommendations set out in the SAE Report and the HDC Report. Ultimately, this inquiry has shown that the critical failure lay in the lack of a robust review by a senior doctor at the time of Hineihana's second presentation, and the associated decision to discharge her home. At inquest Dr Millar was 'close to certain' that a child who presented in the circumstances Hineihana did at the time of her second presentation, would not now be discharged home. The SDHB has since instituted a blanket requirement that all paediatric re-presentations to the ED must be reviewed by a senior doctor. To give genuine effect to the preventative potential of that requirement, such a "review" must be more than a prescribed tick-box exercise. In practice the level of review undertaken by the senior doctor will necessarily be informed by a range of considerations, including the fact of an unplanned re-presentation, the triage category, the nursing assessment, the history presented by the junior doctor, and the known level of experience and ability of the junior doctor.

IV. I remain unclear as to whether this requirement has the standing of clinical policy, protocol or guideline, and why the expectations incumbent upon both RMOs and SMOs in relation to this requirement are not featured in the RMO Handbook or readily accessible information accessed via the ED Sharepoint page.[36] In the absence of further audits having been undertaken I have no way of knowing whether the RMO orientation programme, the regular distribution of the 2014 ED Memorandum,[37] and the operation of the "ED SMO Roles" has meant existing and newly on-boarded RMOs and SMOs (including locums) are both familiar with the requirement, and that there is in fact sustained compliance with the requirement in the clinical practice delivered to paediatric patients in the ED.

V. There is no evidence before my inquiry that the recommendations by Drs Rubython and Collins in relation to reviewing, rationalising and streamlining the large number of documents, MOUs and guidelines pertaining to the review of paediatric presentations to the ED, into coherent and usable documents has been progressed in any significant way. Similarly, it is difficult to understand the justification offered for the decision not to update the RMO Handbook as Dr Thornton recommended.

VI. In relation to the adequacy of the discharge information provided by the SDHB to parents and caregivers of children who present to the ED, the evidence before my inquiry gives me little confidence that the pamphlet is in regular use and that tailored discharge instructions are appropriately recorded in writing, either on the pamphlet or in some other form.

VII. In light of Professor Dalziel's evidence, I regard the provision of written discharge information to the parents or caregivers of a child who presents to the ED as representing best clinical practice. In fact, I consider all patients who attend ED, not just paediatric patients, should be provided with written discharge information. However, in formulating the following recommendations in relation to written discharge information I am mindful of the parameters imposed by s 57A(3), and have therefore focused the recommendations on paediatric ED patients.

VIII. I therefore recommend that the **SDHB**:

a. Clarify the status of the requirement for senior doctor review of (re)presenting paediatric patients (i.e. does it have the standing of clinical policy, protocol or guideline?) and ensure links to expressions of this requirement are included in the ED Sharepoint page;

b. Undertake a programme of work to review, rationalise and streamline the large number of documents, MOUs and guidelines (including the RMO Handbook content) pertaining to the review of paediatric presentations to the ED, into coherent and usable documents which clearly and consistently reinforce expectations of senior doctor review for re-presenting paediatric patients, and expectations of SMO's in relation to effective supervision of RMOs for all paediatric ED patients;

[36] An ED RMO Handbook (RMO Handbook) is provided to each RMO as part of their ED rotation orientation with the expressed intention of assisting the RMO in orienting to the speciality of Emergency Medicine and to the Dunedin Hospital ED. It makes clear that the guidelines therein are to be used in conjunction with reference texts, journals, electronic resources and SDHB policies, procedures and guidelines available on the intranet and in specific manuals located in the ED resource room.
[37] A memorandum dated 16 July 2014 that SDHB to ensure that staff are aware of the requirements that patients re-presenting with ongoing symptoms related to the same illness should be thoroughly assessed by a senior registrar or Consultant and there should be a low threshold for paediatric (or other specialist) referral for re-presenters.

c. Review (and implement if required) SDHB policy in relation to the provision of written discharge information to parents or caregivers of children who present to the ED, including written provision of the diagnosis, medications prescribed (if appropriate), follow-up requested or arranged (if appropriate), and specific reasons to return to the ED or to seek alternative medical care for the child;

d. Rewrite the ED paediatric pamphlet to include an explanation of the ED process, available community resources (including after-hours pharmacies and after-hours primary care), where to get further advice, and expressly encouraging/empowering parents to "Speak Up!" if they feel concerned about the care provided, or communication of information in relation to their unwell child;

e. Undertake regular audits of written paediatric discharge advice to ensure compliance;

f. Undertake a further audit of re-presenting children to the ED to assess whether there is sustained compliance with the requirement of senior doctor review. If possible, the audit should seek to differentiate the level of review by the senior doctor, i.e. whether the review involved only a discussion with a senior doctor, or whether there was a discussion and the senior doctor also reviewed the patient in person;

g. With the consent and input of Hineihana's family, develop an educational resource that promotes Hineihana's experience, including the perspectives of her clinicians, as a significant learning opportunity for staff involved in the delivery of care and treatment to children in ED settings.

IX. The SDHB has accepted these recommendations.

X. The myriad of learnings from Hineihana's ED experience are not confined to the SDHB, or to the doctors and staff involved in her care and treatment. In light of the critical failure identified by the SAE review, the HDC, and Professor Dalziel, I consider that every DHB in New Zealand should reflect on the adequacy of their own ED practices for senior doctor review of paediatric patients. As Professor Dalziel identified, the care that gets delivered to paediatric patients who present with common conditions should be the same regardless of whether they present to the tertiary paediatric ED at Starship or to smaller provincial EDs.

XI. I therefore recommend that:

a. **the Director General of Health**, in promoting the effective care of paediatric patients who present to EDs with reference to the Ministry of Health Operational Policy Framework 2020/2021 principles and standards, require each DHB to have a robust ED process in place which makes clear the threshold for engagement, and facilitates in a practical way, appropriate senior doctor review of paediatric patients; and

b. **the Australasian College for Emergency Medicine, The Royal Australasian College of Physicians - Paediatrics and Child Health Division, and Otago University and The University of Auckland Medical Schools**, look to utilise any educational resource that is developed in furtherance of SDHB recommendation (g) above, to promote learning opportunities with relevant health practitioners.

Note: A permanent order under section 74 of the Coroners Act 2006 prohibits the publication of the names and identifying particulars of Dr A and RN W in the interests of justice.

Seagar [2021] NZCorC 28 (8 March 2021)

CIRCUMSTANCES

Ellen Mary Seagar, aged 88, of Auckland died on 19 July 2019 at Middlemore Hospital, Auckland of bilateral subdural haematomas caused by her falling and hitting her head on the ground on 16 July 2019.

Ms Seagar lived in supported accommodation at Acacia Cove Retirement Village in Wattle Downs, Auckland. On 10 July 2019, Ms Seagar suffered a fall and cut the right side of her eye and required medical attention as a result. In the early hours of 11 July 2019, Ms Seagar had another fall and hit her head. The nurse who attended Ms Seagar called an ambulance and arranged for her to be admitted to Middlemore Hospital because this was the second time that Ms Seagar had fallen and hit her head within a 24-hour period.

While in hospital, a watch was present with Ms Seagar. A watch is a person who provides one to one supervision of a patient to prevent behaviours which may lead to the patient absconding, or injuring themselves or others.

Ms Seagar had a further two falls on 16 July 2019. The first fall at 6:40am was relatively minor. A repeat falls risk assessment was completed and Ms Seagar's score was 105, which equates to a high risk of falling. Despite this high risk, a watch was not implemented after this fall and no post fall form was completed. Ms Seagar's second fall was more severe, as she landed on the back of her head. A watch was implemented following this fall.

A CT scan revealed the presence of a bilateral subdural haematomas. Ms Seagar's condition deteriorated. It was decided between hospital staff and Ms Seagar's family that active treatment would be withdrawn. Ms Seagar passed away on 19 July 2019.

Counties Manukau Health (CMH) investigated the events leading up to Ms Seagar's death. Dr Farid Shaba, a Medical Consultant at Middlemore Hospital, reported that Ms Seagar presented to hospital with several comorbid conditions. While ideally a watch would have been implemented given this, it is uncertain whether a watch would have made a difference to Ms Seagar's long-term prognosis. It was also noted that some documentation requirements were not fulfilled in respect of Ms Seagar's care.

RECOMMENDATIONS OF CORONER WOOLLEY

I. I accept Dr Shaba's opinion that given Ms Seagar's pre-existing comorbidities at the time of her admission to Middlemore Hospital, the implementation of a falls watch may not have altered her long-term prognosis. However, I also agree with Dr Shaba that it was ideal for a falls watch to be implemented given Ms Seagar's history and symptoms. I consider that a watch should have been in place, at the very least, following her fall at approximately 6:40am on 16 July 2019.

II. I acknowledge that CMH undertook its own review of the circumstances leading to Ms Seagar's falls while she was in Middlemore Hospital and, because of that review, took steps to increase staff awareness. It is reassuring that CMH took these steps shortly after Ms Seagar's death to address the shortcomings identified with its processes that contributed to her falling. In my view the steps that CMH took at the time should be carried out on an on-going and regular basis at Middlemore Hospital to reduce the likelihood of further deaths occurring in similar circumstances. This would ensure that:

a. staff are continually reminded of the importance of the fall assessment procedures;

b. new staff are made aware of the importance of the fall assessment procedures; and

c. improvements made to existing practices in the hospital are endorsed and remain in place.

III. Accordingly, I recommend to the Clinical Quality and Risk Manager, CMH that:

a. the Falls Champion and Nurse Educator conduct sessions with ward staff on a quarterly basis about the importance of following falls assessment procedures, and referring to practical examples such as the learnings from Ms Seagar's case as appropriate; and

b. the Falls Champion should conduct random audits of patient files bi-monthly, and the results of the audits should be discussed at ward quality meetings.

IV. In accordance with section 57B of the Coroner's Act, I notified CMH of the proposed recommendations as outlined above in paragraph [III]. The Chief Medical Officer at CMH, Dr Peter Watson, confirmed that CMH fully accepts and supports the recommendations. In addition, Dr Watson also outlined work that the Falls Prevention Group undertakes on an ongoing basis. For completeness, I set out the full response from Dr Watson below:

> *We would like to convey our condolences to the family and friends of Ms Seagar for their loss.*
>
> *We appreciate you giving us the opportunity to review and accept the recommendations of your provisional findings. We fully accept and support the recommendations that you have outlined.*
>
> *The Falls Prevention Group, comprising of allied health (physiotherapists and pharmacists) senior clinical nurses and quality, provides governance and leadership in falls prevention for inpatients under the direct care of Counties Manukau Health (CM Health). As a group, our responsibilities also endeavour to ensure that CM Health staff know the importance of falls assessment procedures and continuously undertake quality improvement regarding falls prevention activities.*
>
> *We would like to outline some of the Falls Prevention Group work to show that we are committed in continuously reminding and spreading awareness to CM Health staff on the importance of the falls assessment procedures. The majority of the adult inpatient wards are undertaking monthly falls audits. These audit results are displayed on each respective ward's Quality of Care Board for staff, patients and their whanau to view. The audit results are also reviewed by the respective division's Clinical Quality and Risk Manager, and the Falls Prevention Group.*

An intranet webpage dedicated to falls prevention is available for all CM Health staff to access. Within this falls prevention webpage, resources such as policy, guidelines, patient information leaflets, fall risk alert signage, safe use of bedrails information, safe patient handling, mobility, and post falls checklists are included.

Additionally, the Falls Prevention Group has included within its work plan, the development of a falls awareness day and a falls prevention e-learning module. The aim of the falls awareness day, planned for July 2021, is to increase the awareness of the risk of falls and to highlight the importance of falls assessment procedures.

V. I acknowledge, and endorse, the aforementioned work of the Falls Prevention Group, CMH.

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

Shaw [2021] NZCorC 25 (1 March 2021)

CIRCUMSTANCES

Robin Elissa Mary Shaw, aged 80, of Christchurch died on 27 July 2016 at Burwood Hospital. Mrs Shaw's direct cause of death was a traumatic brain injury with acute subdural haemorrhage complicated by Warfarin therapy and delayed administration of Prothrombinex (8 days). An antecedent cause of death was a fall from a shower stool in the context of having decreased mobility following a subarachnoid haemorrhage complicated by hydrocephalus requiring a ventricularperitoneal shunt (7 weeks) for which she was undergoing rehabilitation.

Mrs Shaw was admitted to Christchurch Hospital on 3 June 2016 with a headache and neck pain. A CT scan identified the presence of a subarachnoid haemorrhage with mild hydrocephalus. Mrs Shaw underwent surgery on 5 June 2016 to have an external ventricular drain inserted. On 17 June 2016, Mrs Shaw returned to theatre and had a ventricularperitoneal shunt inserted for hydrocephalus.

On 29 June 2016, Mrs Shaw was diagnosed with a pulmonary embolus and deep vein thrombosis. The treatment administered to Mrs Shaw included Warfarin, which is an anticoagulant and reduces the risk of blood clotting but increases the risk of bleeding.

Mrs Shaw was transferred to the B2 Ward at Burwood Hospital for rehabilitation on 8 July 2016. She had reduced mobility, ongoing delirium and a fluctuating Glasgow Coma Scale (GCS). Following a decline in her GCS on 9 July 2016, Mrs Shaw was transported back to Christchurch Hospital. She stayed there for three days and was then discharged back to Burwood Hospital.

On 13 July 2016, Mrs Shaw was sitting on the edge of her bed at Burwood Hospital when she fell. No injuries were found. On 19 July 2016, Mrs Shaw fell from a shower stool while being assisted to shower by an enrolled nurse and hit her head on the wall behind her.

A CT scan identified the presence of a subdural haematoma. Burwood Hospital had no Prothrombinex (used to reverse the effects of Warfarin) at the time, so 2mg of Vitamin K was administered instead even though the recommended dose is 5mg of Vitamin K. Later in the afternoon, Mrs Shaw was transferred to Christchurch Hospital where she was finally administered Prothrombinex. However, her conditions deteriorated and she died on 27 July 2016.

Mrs Shaw's death was reviewed by the CDHB Review Team. The Review Team found a number of factors that contributed to Mrs Shaw's fall and her death and made several recommendations.

RECOMMENDATIONS OF CORONER ELLIOTT

I. Before addressing [recommendations], I acknowledge Professor Geoffrey Shaw's work in preparing his detailed brief of evidence.

II. One of the primary issues Professor Shaw raised is the question of why certain things did or did not happen, for example, 'Why did no one anticipate in a population of elderly patients with a high falls risk and resultant injury the risks of not having Prothrombinex stocked?' He pointed out that the Root Cause Analysis Report in this case, and such reports generally, address the 'what' rather than the 'why.' He viewed this as a lost opportunity to identify the type of safety culture operating at Burwood Hospital and within CDHB.

III. In the Ruling [on the scope of the inquest], I referred to the practical and procedural difficulties in making findings about the culture of the whole organisation. The primary issues relating to Mrs Shaw's fall and death were the provision of a stool rather than a chair in the en suite and the unavailability of Prothrombinex at Burwood Hospital. The decision-making preceding those issues was addressed in evidence at the inquest.

IV. In relation to the first issue, Nurse Chudleigh said that the relevant meeting was not 'a safety meeting as such.' It seems that specific safety considerations were deferred for the Occupational Therapists to assess in relation to individual patients. This assessment had not yet taken place at the time Mrs Shaw fell.

V. In relation to the second issue, Dr Hurring said that it was not a deliberate omission and pointed out that Princess Margaret Hospital was a sub-acute hospital and that patients could be transferred to Christchurch Hospital. An assumption seems to have been made that existing systems could meet the needs which arose.

VI. There was no evidence that anyone involved in these decisions was not acting in good faith. However, in both cases, I have concluded that a Safety II approach would have resulted in a different outcome. I have therefore made a recommendation about Safety II below.

The use of chairs while showering

VII. The Review Team made a number of recommendations. These included:

> 3. The shower stool used on 19 July was inappropriate in the context of patient's clinical presentation and fall risk. It is an expectation that all inter-disciplinary team members assess the appropriateness of equipment to be used by patients during every episode of care, guided by the care plan and according to their current presentation.
>
> Noting that a stocktake of ensuite equipment was undertaken on 1 August and reviewed in accordance with the Burwood Hospital patient cohort, to ensure sufficient appropriate equipment is available to support safe patient care on each ward, it is also recommended that:
>
> • Guidance be developed to support assessment and decision making re ensuite equipment

- Bedside Patient Status at a Glance boards be reviewed and bathroom mobility and equipment needs added.

VIII. I endorse these recommendations. Counsel for CDHB confirmed that all of the Review Team's recommendations have been implemented.

IX. Counsel for the family also submitted that, unless an Occupational Therapist has carried out an assessment indicating otherwise, a chair rather than a stool should be used. Counsel said:

> What the family would submit would be an appropriate outcome so that the learnings from this case are applied throughout New Zealand is a recommendation that for the benefit of other facilities there should be consideration of standardised best practices throughout New Zealand.

X. Mrs Shaw's fall on 19 July 2016 illustrates the risks associated with the use of a stool when showering a patient who is at risk of falling. A chair is a safer option. The chances of deaths in similar circumstances would be reduced by the use of chairs, unless an Occupational Therapist has advised that a stool is appropriate.

XI. I therefore proposed a recommendation that the Ministry of Health gives consideration to facilitating a standard practice to this effect across the country.

XII. The Ministry was given an opportunity to comment and did not oppose this or any of the other proposed recommendations. However, counsel for the Ministry of Health invited me to seek comment from the HQSC and said:

> The Ministry supports the consistent implementation of HQSC recommendations and policies by using available planning and funding and regulatory frameworks to maximise consistent application of best practices that are recommended by the HQSC.

XIII. HQSC made the following comments in relation to this proposed recommendation:

> Reducing harm from falls was a national programme led by the Commission, working in partnership with a wide range of stakeholder organisations, from 2012 until 2018. The sustainability is monitored through District Health Board (DHB) quality safety marker reporting data on (a) the percentage of inpatients (same of patients aged 75+ or 55+ for Māori and Pacific peoples) who are assessed as being at risk of falling (b) those assessed at being at risk who have an identified care plan implemented. The Commission, in collaboration with ACC, provides tools to enable the assessment to occur and provides updated reducing harm from falls evidence reviews.
>
> Review of the falls evidence in 2019 highlighted the need to consider the relationship between falls and cognitive impairment, including delirium (https://www.hqsc.govt.nz/assets/Falls/PR/cognitive-impairment-interventions-2019-final.pdf page 12). The report recommended for individual risk assessments and care planning for patients in hospital with cognitive impairment and suggested a person-centred care with dignity approach including close observation and assistance in achieving the patient's goals.
>
> Therefore the Commission believes that a standard of practice regarding assessment and individualised plan of care should already be embedded in DHB inpatient services.

XIV. The responses from the Ministry of Health and HQSC indicate that neither opposes the proposed recommendation and that HQSC believes that a standard of practice should already be embedded in DHB inpatient services.

XV. I therefore recommend that, if it is not already incorporated into DHB inpatient services, the Ministry of Health gives consideration to facilitating a standard practice across the country that a chair is used when showering a patient who is at risk of falling, unless an Occupational Therapist has advised that a stool is appropriate.

Transfer of patients

XVI. The Review Team said:

> 9. This report has highlighted issues surrounding the transfer of patients between Christchurch Hospital and Burwood Hospital. It is recommended that the CDHB Transfer of Patients between Hospitals Policy be reviewed paying particular attention to:
>
> • Firmer guidelines around timing of non-acute/urgent patient transfers
>
> • Decision making processes of patients being escorted or not
>
> • How to transfer acutely unwell patients urgently

XVII. This recommendation has been implemented. No further recommendation is required.

The availability of Prothrombinex

XVIII. It was agreed that the delay in administering Prothrombinex to Mrs Shaw was a contributing factor in her death.

XIX. Dr Hurring accepted that there is a need for Prothrombinex at Burwood Hospital. She said that this 'seems really obvious now.' Prothrombinex is now readily available at Burwood Hospital. In these circumstances, it is regrettable that Prothrombinex was not readily available at Burwood Hospital on 19 July 2016.

XX. The Review Team said:

> 5. Due to numbers of patients taking anticoagulants at Burwood Hospital, it is recommended that:
>
> • Immediate reversal agents (Prothrombinex and Idarucizumab [reversal agents for Warfarin and dabigatran respectively]) be held at Burwood Hospital.
>
> • All medical staff are reminded of the CDHB protocol Hospital Health Pathways/Intracranial bleeding whilst on Warfarin.

XXI. This recommendation has been implemented.

XXII. I proposed a recommendation that the Ministry investigates whether reversal agents are readily available in those facilities where there are patients taking anticoagulants. HQSC said:

> The Commission is not a regulator but does facilitate a National Medication Safety Advisory Group that has key stakeholders across the medication continuum. At their meeting in March we can raise for discussion the consideration of a systems approach to enabling rapid access to anticoagulation reversal agents including the use of human factor considerations such as storage, administration skills etc.
>
> The Health and Disability Commission have raised concern regarding the safe use of anticoagulants across the health and disability sector. Therefore, we are also supporting a cross-sector working group to identify quality improvement activities to improve the use of anticoagulant and antiplatelet medicines in primary and secondary care. The findings from the working group will inform our quality focussed improvement activity for the 2021/2022 financial year. We will include your findings and recommendation with regards readily available reversal agents in facilities.

XXIII. Neither the Ministry of Health nor HQSC opposed the recommendation. I therefore confirm my recommendation that the Ministry investigates whether reversal agents are readily available in those facilities where there are patients taking anticoagulants.

Safety II

XXIV. Counsel for the family submitted:

> The DHB appears to take the position that recommendations in the Root Cause Analysis go far enough.
>
> It is the submission of the family that the recommendations while addressing what happened in this case do not address the thinking that allowed the circumstances to be created that lead to the death of Mrs Shaw. Hence it is their submission that as an element of a safety II approach there should be a recommendation that in all planning for health care there should be a specified item requiring that patient's safety is explicitly considered.
>
> It is submitted that this element of a safety II approach would be one effective outcome that could significantly enhance the likelihood of ensuring safety focused resourcing decisions, risk identification and prevention. This is one way to ensure that other patients do not die for want of the safest option of a shower chair, access to urgent transportation or making available an obviously needed medication.

XXV. Dr Nightingale [CDHB Chief Medical Officer] stated:

> [Safety II] is an ideal to aspire to but currently the RCA process is the process required of us by the Ministry of Health and the Health Quality and Safety Commission and I am unaware of any DHBs adopting the Safety II approach at this time.

XXVI. Dr Skinner gave detailed evidence about continuous improvement and quality improvement, the importance of patient safety and the ways in which this is addressed at CDHB. In relation to Safety II, Dr Skinner said:

> … a lot I think of what we do in terms of our quality improvement and continuous improvement and also the safety culture and clinical governance that we do, although we don't call it Safety II, it actually fits in with the Safety II culture.

XXVII. I have confined my consideration of Safety II to the decisions about whether to place chairs or stools in the en suites when equipping Ward 2B and whether to have Prothrombinex available at Burwood Hospital. In both cases, I have concluded that a Safety-II approach would have made a difference.

XXVIII. In the Ruling [on the scope of the inquest], I said that the findings I make about the cause and circumstances of Mrs Shaw's death would not provide a basis to recommend that every DHB in the country should fundamentally change the way they approach patient care.

XXIX. However, the findings do illustrate the value of a Safety-II approach in addressing patient safety. They therefore provide a basis to recommend that the Ministry of Health at least considers how this approach may be applied. The comment from CDHB's Chief Medical Officer that Safety II is an ideal to aspire to adds weight to this.

XXX. I therefore proposed a recommendation that the Ministry of Health considers how the adoption of a Safety II approach may benefit the health system.

XXXI. HQSC said:

> We are pleased to advise that since this review was completed by CDHB in 2016 there have been some key national changes. Following the review of the National Adverse Events Reporting Policy in 2017 health and disability providers are not restricted to root cause analysis methodology. The Commission now promotes a system learning review methodology that focuses on human factors and work-as-done versus work-as-imagined (Safety-II approach). We have modified our education programme to have this accessible through the Ministry of Health's Learn online learning platform.
>
> The Health and Disability sector are encouraged to share learnings ('adverse events shared learning tool') so others health providers can be proactive in preventing patient harm. This reflects the Shaw family outcome from the inquest (section [92]).
>
> We have been actively working with the Ministry of Health with the review of the health and disability standards and I am pleased to advise that the 2017 National Adverse Events Reporting Policy is now a criterion in the revised standards. This will support sector engagement in a quality adverse event review process.
>
> We are facilitating a human factors workshop for key stakeholders across the health and disability sector on 3 March 2021. Human factors in health care is important as it focuses on designing for human well-being and overall system function. On 4 March 2021 we are hosting the Aotearoa Resilient Healthcare open hui to further explore the emerging approach in patient safety on proactively making healthcare safer through understanding how people thrive rather than fail (safety-II). This approach reflects our honouring of Te Tiriti o Waitangi in our vision of Hauora kounga mō te katoa, quality health for all, partnering and working with others involving, informing, influencing and improving.

XXXII. Once again, there was no opposition to the proposed recommendation. I therefore recommend that the Ministry of Health considers how the adoption of a Safety II approach may benefit the health system.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of the name and any particulars likely to identify the enrolled nurse and a doctor, as well as paragraph 61 of the brief of evidence of Professor Shaw.

Miscellaneous

McKenzie and Daley [2021] NZCorC 36 (18 March 2021)

CIRCUMSTANCES

Ngaire Ellen McKenzie, aged 61, died at home in Waipukurau from ligature strangulation on 3 June 2017. Murray James Daley, aged 58 also died at Ms McKenzie's home on 3 June 2017 in circumstances amounting to suicide.

Ms McKenzie and Mr Daley had been in an on and off relationship since 2014. However, Mr Daley's aggressive, possessive and controlling behaviour caused the relationship to deteriorate quickly which was of concern to Ms McKenzie's daughters. Mr Daley also harboured jealous traits towards Ms McKenzie's dog. Nevertheless, they remained in contact and did see each other.

In the weeks immediately prior to their deaths, Ms McKenzie tried to end her relationship with Mr Daley, but Mr Daley struggled to accept the break-up and persistently tried to communicate with Ms McKenzie. Ms McKenzie's family and close friends were concerned for her, and eager to see her sever all ties with Mr Daley. Importantly, Ms McKenzie and her circle appear to have been unaware that Mr Daley had previously been violent towards women who were in close relationships with him.

On 2 June 2017, Mr Daley was staying with Ms McKenzie and was meant to depart at 8:00am on 3 June 2017. There were some text message exchanges up until 9:39am, after which no one was able to contact Ms McKenzie. Following concerns for her safety, a friend made a report to the Police that evening who promptly attended and discovered Ms McKenzie and Mr Daley deceased.

The evidence established to the standard required that Ms McKenzie died as a result of strangulation by Mr Daley who then took his own life.

COMMENTS OF CORONER BORROWDALE

I. The circumstances of this tragedy, which have caused such loss and grief to the families and friends of those who died, are not such that I am in a position to make recommendations that may prevent deaths in similar circumstances in future.

II. However, I do consider that there are comments that I can usefully make pursuant to section 57(3) of the Coroners Act 2006 for that purpose. These comments are made in order to raise public awareness of the wide range of 'red flags' that may indicate risk of serious family violence, and to protect the public from domestic coercive control.

Persons who were unable to prevent this tragedy

III. I am conscious that the women in Ms McKenzie's and Mr Daley's lives may be inclined to blame themselves for having been powerless to prevent what happened. I am particularly cognisant that Mr Daley, in his messages left at the scene, explicitly blamed Ms McKenzie's daughters for their mother's death.

IV. Mr Daley - and Mr Daley alone - bears responsibility for the tragic and premature end of Ms McKenzie's life.

V. To the extent that Mr Daley tried to avoid Ms McKenzie's daughters while he was alive, and to blame them for the deaths that he brought about, this was in my view because they were concerned for their mother when he was in her life. Mr Daley was aware that the daughters supported their mother ending her relationship with him.

VI. Her daughters lived independently and were not at the scene that evolved. I find that Mr Daley was angered because they had tried to thwart his relationship with their mother, as they were right to do, given the risks that he posed to her wellbeing and safety.

VII. Within Mr Daley's circle, his ex-partner and their daughter knew of his poorly controlled anger and its past expression in physical violence against women. Each of them had been the victim of violent attacks by Mr Daley.

VIII. However, I am not prepared to find that Mr Daley's ex-partner and daughter should have done more to alert Ms McKenzie to these risks. These women had only limited insight into the couple's relationship and Mr Daley's current domestic behaviour. And both women were themselves past victims of his physical attacks. Mr Daley sought to deter both of them from being frank with Ms McKenzie if she asked about his past. I am prepared to accept that both will have been concerned to placate and calm him, rather than incite and anger him, and given the hazard he represented they cannot fairly be criticised for this. As well, I am sure that both will have felt deep remorse at what occurred.

IX. I have found that it is likely that Ms McKenzie herself apprehended something, if not the full extent, of the threat presented by Mr Daley. When his ex-partner included in her text to Ms McKenzie the words "I could tell you a lot about Murray", Ms McKenzie correctly took the meaning that Mr Daley had a dangerous and dark side. She responded by describing Mr Daley as "unstable."

Domestic violence 'red flags'

X. There are publicly available resources describing the help available to people who fear physical violence from their partners. Common "red flags" of domestic violence risk are listed. These red flags include strangulation events and escalating violence. We do not know whether Ms McKenzie suffered from these behaviours before her death.

XI. But the listed red flags also include the kinds of less-obvious signs that did characterise Mr Daley's behaviour towards Ms McKenzie, and which many people may not immediately realise are serious danger signs that a person is at risk of being killed by their partner:

a. Controlling behaviour

b. Intimidation

c. Intense jealousy or possessiveness

d. Stalking

XII. Ms McKenzie's death is a singular example of what can happen when these behaviours are not seen for the danger signs that they are. Mr Daley was intensely needy; self-absorbed; repetitive and badgering; exacting and hectoring in his demands for response and reassurance; and jealous of Ms McKenzie's relationships with others, even including her pets. When Ms McKenzie did not respond fast enough or with the response Mr Daley wanted, he became enraged and threatening. His threats included coming to her house when he knew he was not welcome, and making her fight with him "face to face." He manufactured excuses to return to her house, and he ignored her repeated requests to be left alone.

XIII. The website www.areyouok.org.nz contains valuable information, resources and help for those affected by domestic violence. It is managed by the Social Campaigns Team within the Ministry of Social Development. The site includes essential guidance for the public to recognise and act on the signs of domestic violence,[38] and I reiterate that guidance here:

XIV. The danger signs should be taken very seriously. These are the signs that someone is in danger of being killed by their partner:

a. Controlling behaviour

b. Intimidation

c. Threats to kill

d. Strangulation and 'choking'

e. Worsening violence - more severe, more frequent

f. Intense jealousy or possessiveness

g. Stalking

XV. Each incident or episode may not seem serious on its own. A pattern of controlling behaviour will become obvious over time.

XVI. Never assume a victim is safe because she is planning to leave or has just left a violent relationship. Victims commonly underestimate the danger they are in, believing "*I can handle it*."

XVII. Around half of New Zealand homicides each year are family violence related. One woman is killed by her partner or ex-partner each month, on average. About half of those are killed during or following separation from their partner.

Criminal law awareness

XVIII. Ms McKenzie died at the hands of her former partner, in circumstances where he may not previously have been physically violent with her, but where he was controlling, threatening and isolating her. Until recently,

[38] http://www.areyouok.org.nz/family-violence/the-danger-signs/.

and at the time of Ms McKenzie's death, these were not behaviours for which the Police were empowered to intervene or assist victims.

XIX. Overdue change arrived in the form of the Family Violence Act 2018 (in force from July 2019), which empowers the Police and courts to take steps to prevent family violence, including psychological abuse. This includes abuse comprised of a pattern of behaviour that is coercive or controlling of the victim and which may cause them serious harm, even if a number of the acts may when viewed in isolation appear minor or trivial.[39]

XX. Importantly, when one considers Ms McKenzie's circumstances, psychological abuse is broadly defined and includes ill-treatment of pets.

XXI. Research has been undertaken by the New Zealand Institute for Security and Crime Science at the University of Waikato, into coercive control in intimate partner violence.[40] Studying reports to Police of intimate partner violence, the researchers found evidence of coercive controlling behaviours in 45% of domestic violence reports to Police. Researchers noted the importance of Police capturing in complaints any features of the five types of controlling behaviour: economic, threatening, intimidating, isolating and emotional control.

XXII. I encourage the Police, the Ministry of Women, and other agencies with responsibility for protecting the public against domestic coercive control, to clearly communicate to the public both how to spot such behaviour (the warning 'red flags') and the fact that such behaviour is now criminally enforceable.

Recipients of findings

XXIII. In an effort to promote public awareness of the warning signs of family violence, I direct that this Finding be sent to the following and further disseminated as appropriate:

a. New Zealand media outlets;

b. The Ministry for Women;

c. The Communications Team at the New Zealand Police; and

d. Te Kupenga Whakaoti Mahi Patunga/National Network of Family Violence Services.

Note: Orders under sections 71 and 74 of the Coroners Act 2006 (Coroners Act) apply. Accordingly, no person may, unless granted an exemption under section 71A of the Coroners Act, make public the method or suspected method of Mr Daley's death, or any details that suggest the method or suspected method of his death, and may not publish photographs taken of Ms McKenzie or Mr Daley entered into evidence during the inquiry, on the grounds of personal privacy and decency.

[39] Family Violence Act 2018, sections 9 and 10. Similar statutory protections have been enacted in the UK (Serious Crime Act 2015 section 76) and are before the New South Wales Parliament (Crimes (Domestic and Personal Violence) Amendment (Coercive Control – Preethi's Law) Bill 2020).
[40] See for example https://www.waikato.ac.nz/__data/assets/pdf_file/0006/508956/Sam-Poster-1.pdf.

Motor Vehicle

Bin Jeman, Binti Abd Hamid, Binti Adanan, Maisarah Binti Adanan [2021] NZCorC 10 (22 January 2021)

CIRCUMSTANCES

On 6 December 2019, Adanan Bin Jeman was driving a rental vehicle south along State Highway 1 near Hapuku, Kaikoura, with his wife and three young daughters as passengers. Mr Bin Jeman and Rumihati Binti Abd Hamid, both 48, along with their daughter Nur Aaleeyah Maisarah Binti Adanan, aged 13, died in a collision with another vehicle at the scene. Their oldest daughter, Nur Ifran Binti Adanan, aged 14, was transported to Christchurch Hospital where she died on 7 December 2019. Their youngest daughter, Nur Arifah Bahiyah Binti Adanan, aged 11, was the only surviving passenger.

The Malaysian family were holidaying in New Zealand, having arrived in Auckland three days prior. The family's busy travel itinerary meant that Mr Bin Jeman had had little meaningful sleep in the days leading up to the crash.

On the morning of 6 December 2019, the family travelled by ferry from Wellington to Picton, arriving at around midday. At approximately 3:10pm, their vehicle veered across the centre line on a straight section of road into the path of an oncoming truck and trailer unit. The truck's driver tried to take evasive action but was unable to avoid the collision. Mr Bin Jeman, Nur Aaleeyah and Nur Ifran died due to multiple blunt force injuries. Mrs Binti Abd Hamid was found to have died due to positional asphyxia, as a result of entrapment in the car.

Attending Police observed that Mr Bin Jeman was wearing his safety belt, while the three girls in the back seat were not. As there was conflicting evidence as to whether Mrs Binti Abd Hamid was wearing a safety belt, the Coroner made no finding on this.

Senior Constable Stephen Lamont, of Tasman District's Serious Crash Unit, investigated and reported on the crash. He commented that had Nur Aaleeyah and Nur Ifran been wearing their safety belts, their injuries would have been lessened which may have made the impact survivable for them.

The Coroner agreed with Senior Constable Lamont's conclusion that the crash was most likely due to Mr Bin Jeman suffering from severe fatigue. Several aspects of the crash supported this finding, such as the vehicle leaving the lane at a shallow angle with Mr Bin Jeman making no attempt at corrective steering. Additionally, Mr Bin Jeman did not respond to another motorist sounding their horn and applied the brake just before the collision occurred, indicating he had only become aware of the danger at the last moment.

COMMENTS OF CORONER ELLIOTT

Fatigue

I. Senior Constable Lamont suggested the following recommendation:

As a preventative recommendation, if not already done, information on driver fatigue could be added into rental car companies' safety documentation, which needs to be brought to the renter's attention as part of their safety initiation before they drive off commencing their journey.

II. According to the New Zealand Rental Vehicle Association's Rental Vehicle Operators Code of Practice for Informing Overseas Drivers, rental operators must provide pre-arrival information to visitors on New Zealand road rules and safe driving:

1.1. Operators will make information on NZ road rules and driving conditions available in a prominent position on their .nz homepage/landing page. The information will be visible and promote the DriveSafe logo. Minimum requirement is a direct link to www.DriveSafe.org.nz

Good Practice:

- Put the information on the organisation's home page
- Use the DriveSafe tile to link through to the website (tile available from TIA/RVA).
- Provide the information in the language of the hirer
- Encourage the hirer to consider if self-drive is an appropriate option for travel
- Provide direct links to videos on safe driving in New Zealand
- Provide direct links to the ten key road rules and NZTA's 'Driving in New Zealand' (http://www.nzta.govt.nz/resources/driving-in-nz/docs/driving-in-nz.pdf)

1.2. Operators will provide educational information to the hirer upon booking confirmation. Minimum requirement is a link to www.DriveSafe.org.nz. Operators must encourage visitors who are arriving on long-haul flights to stay overnight in that destination.[41]

III. Apex Car Rentals, from which Mr Bin Jeman had rented the Toyota vehicle, has a page on its website about 'Safe Driving in New Zealand.'[42] This includes the recommendations made by the New Zealand Rental Vehicle Association.

IV. The New Zealand Transport Agency/Waka Kotahi also provides information about safe driving in New Zealand. Its 'Driving in New Zealand' guide,[43] which is available in multiple languages, states:

FATIGUE

If you're tired you're much more likely to have a crash.

- Get enough quality sleep before you drive, especially if you've just arrived in New Zealand after a long flight.

[41] http://www.drivesafe.org.nz/assets/Uploads/9ff844daf0/Rental-Operators-Code-of-Practice-v1.3.2-Sept2018.pdf.
[42] https://www.apexrentals.co.nz/travel-tips/safe-driving-in-new-zealand.
[43] https://www.nzta.govt.nz/assets/resources/driving-in-nz/docs/driving-in-nz.pdf.

- Take a break from driving every two hours. If possible, share the driving with someone else.
- Avoid driving during the hours when you would normally be sleeping.
- Avoid large meals, which can make you tired, and drink plenty of water.
- If you begin to feel sleepy, stop at a safe place and try to have a short nap for 15-30 minutes. If you're feeling very tired, find a place to stay overnight.

Use of seatbelts

V. NZTA/Waka Kotahi states on its website:[44]

Safety belts support you in a crash or when the vehicle stops suddenly. Without a belt, front seat occupants can be thrown through the windscreen and onto the road. Back seat passengers can be thrown onto the front seats or the front seat passengers, or can hit the roof.

Wearing a safety belt reduces the risk of being killed or seriously injured in a road crash by about 40%. If everyone wore their safety belts an estimated 25 lives could be saved from road crashes each year.

Using safety belts

- All modern cars must be fitted with safety belts in the front and back seats.
- Safety belts must be worn in front and back seats if fitted.
- Remember that if you sit in a seat fitted with a safety belt, you must wear your safety belt.

Safety belts save lives. They support you if you're in a crash or when a vehicle stops suddenly. The force on safety belts can be as much as 20 times your weight – this is how hard you'd hit the inside of your vehicle without restraint. A lap/sash safety belt gives better protection than a lap belt and should always be used as a preference if available.

Requirements for wearing safety belts

All modern cars in New Zealand must be fitted with safety belts and older vehicles may require webbing clamps to improve the 'hold' of their belts.

Specifically, in New Zealand the requirements are that:

- Front and back seats in all modern cars must be fitted with safety belts
- If you sit in a seat with a safety belt you must wear the safety belt
- All children aged under seven must be secured in an approved child restraint when travelling in cars or vans

[44] https://nzta.govt.nz/safety/vehicle-safety/safety-belts-and-restraints/.

- Children aged seven must use a child restraint if available. If not available, they must use a safety belt. If a safety belt is not available they must travel in the back seat
- Children aged between eight and 14 must use safety belts if available (if not available, they must travel in the back seat)
- People aged over 14 must wear safety belts where they are available.

Recommendation or comment

VI. Given the matters set out above, I make no recommendations.

VII. I make the following comment pursuant to section 57A of the Coroners Act 2006 which, if drawn to public attention, may reduce the chances of deaths in similar circumstances:

> This crash illustrates the danger of driving while tired and the importance of ensuring that everyone in a car wears a safety belt.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs showing the deceased during the course of this inquiry in the interests of decency and personal privacy, and as there is little public interest in such photographs being published.

Blackburn [2021] NZCorC 6 (12 January 2021)

CIRCUMSTANCES

Graeme Joseph Blackburn, aged 33, of Christchurch died on 15 January 2018 when he lost control of his motorcycle and collided head on with an oncoming four-wheel-drive vehicle. He was a priest at Our Lady of Victories Parish, on Main South Road, Christchurch.

At approximately 5:15pm on 15 January 2018, Reverend Blackburn was riding his Ducati Monster 620 motorcycle north west on the Purau-Port Levy Road towards Purau, when he misjudged a left turning bend. His braking action forced his motorcycle to cross the centre line of the road and into the path of a four-wheel-drive, with which he collided. He died at the scene.

Speed and weather conditions were not factors in the crash. However, Reverend Blackburn was a relatively inexperienced motorcyclist and had a blood alcohol level considerably above the legal blood alcohol limit.

During the crash sequence Reverend Blackburn's motorcycle helmet came off his head causing him to sustain a blunt force head injury when his unprotected head likely came into contact with the road surface.

RECOMMENDATIONS OF DEPUTY CHIEF CORONER TUTTON

I. Senior Constable Isitt stated in his report:

> I have in the past noted to the coroner that in my experience, there is a high proportion of crash helmets that come off the riders' heads in a crash sequence. It appears that it is often the second impact with the road surface that causes the fatal head injuries.

II. As part of my inquiry into Reverend Blackburn's death, I sought a report pursuant to section 120 of the Coroners Act 2006 from Waka Kotahi New Zealand Transport Agency (the Agency). I specifically asked:

a. Whether there is any current statistical data or information that the Agency holds regarding motorcycle helmet failures during accidents;

b. Whether there is any current statistical data or information that the Agency holds on the numbers of motorcyclist deaths where helmets have come off and/or have failed in the crash; and

c. Whether the Agency has conducted any publicity campaign or produced information or guidelines regarding the safe wearing of motorcycle helmets.

III. The Agency reported that it operates New Zealand's Crash Analysis System (CAS), which was established to capture information on where, when and how road crashes occur. The Agency also advised that helmet failures are not captured in the CAS as they would not be a causative factor in a crash.

IV. The Agency also noted that helmet failures are not consistently recorded in the Traffic Crash Reports it receives from the New Zealand Police. The Police confirmed to the Agency that they do not hold any other information regarding motor cycle helmet failure statistics. The Agency was, therefore, unable to answer parts (a) and (c) of my request.

V. The Agency reported that it is responsible for producing the Official New Zealand Road Codes. Within this series of publications is the Motorcycle Road Code and information on wearing the right gear when motorcycling, along with the safety standards for motorcycle helmets. Specifically this information states:

> If you fall off your motorcycle, it's likely that your head will hit the road hard. This is why the law requires every rider and pillion passenger to wear an approved safety helmet securely fastened on the head. A good helmet can prevent serious injury.
>
> An approved safety helmet will have a sticker on it showing that it meets an approved safety standard. Don't buy or wear any helmet that isn't approved.
>
> Your helmet should also:
>
> - fit snugly - it shouldn't be too tight or too loose (a loose helmet is almost as bad as no helmet at all)
> - be securely fastened when riding
> - be a bright colour, such as white, orange, yellow or red
> - have red reflective material on the back and sides.

> You will need to replace your helmet if it is cracked, has loose padding, frayed straps or exposed metal, or is damaged in any way, as it may not be safe. Dropping it onto a hard surface can cause damage that can't always be seen. For this reason, never buy a second-hand helmet.
>
> Soap and water is the best way to clean a helmet. Never use petrol, methylated spirits or any other solvent to clean a helmet, as they can weaken the shell or the shock-absorbent lining. For the same reason, you should never use paints or stickers with unsuitable glues on a helmet.

VI. The Agency advised that it launched a motorcycling campaign "Respect every ride" in early 2020 as part of the national road safety advertising programme. The campaign aims to highlight the vulnerability of motorcyclists on the road and reminds individuals not to be complacent when riding. General safety information relating to motorcycling can also be found on the Agency's website.

VII. I endorse the safety information the Agency has published on its website.

VIII. It is unfortunate that statistics regarding the incidence, prevalence and aetiology of helmet failures in road crashes and their association with fatalities on New Zealand roads cannot be obtained. While a helmet failure may not be the cause of an accident, it can certainly be the cause of death in a crash sequence when a rider's unprotected head makes contact with a hard surface.

IX. Without appropriate data I am unable to make specific comments or recommendations for the purpose of reducing the chances of future deaths occurring in similar circumstances.

X. I recommend, however, that this finding is sent to the Ministry of Transport (Te Manatū Waka), Waka Kotahi New Zealand Transport Agency, and the Motorcycle Association of New Zealand, for their consideration of further research and data gathering with regard to the incidence, prevalence and aetiology of motorcycle helmet failures in the aftermath of crashes.

XI. Reverend Blackburn's death is also a tragic reminder of the obvious dangers of riding or driving after drinking. Those dangers are well known and widely publicised.

XII. Given that existing publicity in relation to the dangers, I do not consider there are any recommendations I can usefully make in relation to that issue.

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

Brenssell and Waitokia [2021] NZCorC 32 (15 March 2021)

CIRCUMSTANCES

Wayne Brenssell died near 1487 Waikaka Valley–Tapanui Highway, Tapanui, on 6 December 2013. The cause of death was massive traumatic injuries including a fractured neck, sustained in a motor vehicle crash.

Toby Tiema Waitokia died near 1487 Waikaka Valley–Tapanui Highway, Tapanui, on 6 December 2013.

The cause of death was massive traumatic injuries including severe chest trauma, sustained in a motor vehicle crash.

On 6 December 2013, Mr Brenssell was driving a truck and low-loader semi-trailer travelling south on State Highway 90 from Tapanui towards Gore when it rolled over on a bend. Mr Waitokia was travelling in the truck with Mr Brenssell. Both Mr Brenssell and Mr Waitokia suffered fatal injuries as a result of the crash.

The truck was carrying five pre-cast concrete panels, supported by a steel A-frame structure. The load was secured to the trailer by chains draped over the tops of the concrete panels and attached to the trailer by steel J-hooks. A number of webbing straps were also used. The total weight of the load was estimated to be 23.43 tonnes, which exceeded the maximum permitted weight over a quad axle group of 20 tonnes.

The Coroner consulted a panel of experts to assist in determining the cause of the crash. While no single factor could be identified, it is likely that the crash was the result of the combination of four identified factors:

a compromised structural integrity of the steel A-frames, allowing the centre of mass to shift on the trailer when the following three factors came into play;

b the effect on the truck and trailer combination of the undulating road surface;

c aggravation of this effect due to the air suspension system on the trailer not dealing well with the high centre of mass of the load and the modest overload; and

d a single braking application by the driver part-way through the bend, most likely due to sudden movement of the trailer under dynamic inputs from the road undulations.

RECOMMENDATIONS OF CORONER RYAN

I. The experts have provided me with a proposed recommendation covering the design and manufacture of A-frames used for carrying heavy and tall loads. It is considered that the proposed recommendation may help reduce the chances of further deaths occurring in similar circumstances, as the condition of the A-frames was identified as a contributing factor to this crash.

II. I have considered the proposed recommendation, and I am of the view that the following recommendation should be made pursuant to section 57A of the Act, for the purposes set out in section 4:

a. I recommend that the design and manufacture of all A-frames used for carrying heavy and tall loads on trucks or trailers should require to be certified, and that this should become part of the New Zealand Truck Loading Code.

b. This recommendation is addressed to New Zealand Transport Agency and to the Ministry of Transport, together with any other relevant regulatory agency.

c. Based on the recommendation provided by the experts, I also make the comment that the design and manufacture of A-frames, together with other risks related to dynamic loading, should be addressed through a consultative process involving all interested parties. It seems to me that the particular interested parties would include (but not be limited to) New Zealand Transport Agency, the Ministry of Transport and the New Zealand Heavy Haulage Association.

Response from Waka Kotahi/New Zealand Transport Agency

III. After receiving a copy of the proposed recommendations in this matter, a response was received from Waka Kotahi. The response records that the Agency is generally supportive of the recommendations, but considers it may be more appropriate to include them in the Land Transport Rule: Heavy Vehicles 2004 rather than the truck loading code.

IV. I am grateful for the suggestion provided by the Agency, and leave it to the Agency to decide where this recommendation should best lie. I note that the Agency states that it will work with the Ministry of transport, WorkSafe New Zealand and other relevant agencies to ensure positive changes take place in this area.

V. The Agency also suggested that WorkSafe may benefit from receiving a copy of the Finding with the recommendations. A copy of this Finding will be provided to WorkSafe.

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

Craig [2021] NZCorC 29 (9 March 2021)

CIRCUMSTANCES

Peter Thomas Craig died at Wellington Hospital on 1 October 2019. The cause of death was traumatic brain injury as a result of a motor vehicle crash (truck).

On 25 September 2019, Mr Craig was driving a logging truck and trailer unit on Kereru Road, Napier. While driving along a straight section of the highway, Mr Craig lost control of the truck and trailer. Mr Craig's attempt to regain control of the truck and trailer unit caused it to cross the centreline and roll onto the driver's side. Mr Craig suffered serious injuries and was taken to Wellington Hospital, where he passed away on 1 October 2019.

A Crash Analysis Report identified the state of the roadway as a contributing factor in Mr Craig's crash. The edges of the road had deteriorated and at irregular intervals along the road, the edge of the road was at the fog-line. There was no roadway outside the fog-line along these areas.

The width of the lane where the crash occurred ranges from approximately 2.6 to 2.7 metres. The width of the truck and trailer is 2.55 metres. The narrow width of the lanes in comparison to heavy motor vehicles leaves no room for error while travelling along the road.

COMMENTS OF CORONER FITZGIBBON

I. The Crash Analysis Report identifies the environment as a contributing factor in the crash. It states that the road would benefit from widening so there is a shoulder outside the fog line, allowing vehicles to remain on the sealed roadway if they drift outside the fog line. This will allow actual lanes on the road to be widened to accommodate larger vehicles.

II. Hastings District Council had scheduled widening the road to 6.5 metres and cut a new drainage channel approximately 3 metres further away from the existing channel. These works were to be conducted in

November 2019 but were re-scheduled to February/March 2020. The HDC has confirmed this work has now been completed.

III. In light of the widening of the road being completed, no further recommendations are required.

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

Dahl [2021] NZCorC 13 (26 January 2021)

CIRCUMSTANCES

Emily Rose Dahl, aged 17, died on 2 November 2018 at Kokopu Road, Poroti, Whangārei. The cause of death was a severe traumatic head injury sustained in a motor vehicle collision.

At 9:15pm on 2 November 2018, Ms Dahl was one of three passengers in a BMW motor vehicle driven by a young man. She was seated in the rear of the vehicle. All of the passengers and the driver were wearing seat belts.

The vehicle was travelling westbound on Kokopu Road towards Mangakahia Road on a 1.5 km straight. The area was dark, with no street lighting. About 500 metres from the turnoff to Mangakahia Road, the driver approached a small downhill slope travelling at a speed estimated at over 150 km/hr. As the vehicle crested the hill it became airborne. It swerved off to the left-hand side of the road, crashing through road signs and vegetation. It then left the road and hit a culvert, causing the vehicle to tumble and roll before coming to rest in a nearby paddock.

Ms Dahl died at the scene from her injuries. The driver suffered multiple injuries, including a serious traumatic brain injury. Another passenger also suffered multiple injuries of a moderate to severe nature.

The Police Serious Crash Unit investigation found that the driver exceeded the speed limit prior to the crash and lost control of the vehicle. He had been in breach of his restricted licence by carrying passengers unsupervised. The vehicle was also found to have faults on the steering, suspension and tyres, and had recently failed a warrant of fitness. These faults may have affected the handling and directional stability of the vehicle, thereby contributing to the crash.

The driver was charged in respect of Ms Dahl's death and the other passenger's injuries, but due to his traumatic brain injury was found unfit to plead or to stand trial.

COMMENTS OF CORONER TETITAHA

I. I make the following comments pursuant to section 57A of the Coroners Act 2006. I have consulted the New Zealand Transport Agency, ACC, and the Whangārei District Council regarding these comments. All three support the making of these comments and the below recommendations.

II. The above facts indicate the youth of the driver and speed largely contributed to this death. I note it occurred on a rural road in an area where there was a 100 km/hr speed limit.

III. In 2017 NZTA statistics showed there were 95 fatal crashes, 643 serious injury crashes and 3232 minor injury crashes involving young drivers (drivers aged 15 to 24 years old). In the same year young drivers had

primary responsibility for 85 fatal crashes, 543 serious injury crashes and 2644 minor injury crashes. In these crashes 97 people died, 727 people were seriously injured and 3595 people suffered minor injuries.[45]

IV. In 2018 there were 103 fatal crashes, 409 serious injury crashes and 1502 minor injury crashes where speeding (travelling too fast for conditions) was a contributing factor. In these crashes 120 people died, 551 people were seriously injured and 2167 people suffered minor injuries.[46] These figures were an increase on 2017. There were 9 road deaths with speed as a contributing factor in Northland.[47]

V. Research into reducing the road death statistics due to speeding was undertaken by ACC in 2000.[48] The research concluded that:

> **Fewer New Zealanders would be killed and injured if we all slowed down**
>
> The speed we drive on our roads is a major public safety and health issue in New Zealand. … If we reduced average speed on New Zealand's roads by just 4 km/h - that is, from 102 to 98 km/h – it is estimated that 52 fatalities, 133 serious injuries, and 257 minor injuries would be saved.
>
> **New Zealand's rural roads aren't generally built for speeds over 100 km/h**
>
> A significant part of New Zealand's rural road network was constructed under an 80 km/h open road speed limit regime. Where roads have been rebuilt, these design speeds have generally been increased to 100 km/h. Similar road networks and other developed countries often have speeds of 80 or 90 km/h.
>
> The roading system in New Zealand is not built to safely sustain vehicle speeds over 100 km/h. We are consistently driving too fast on our rural roads.
>
> …
>
> **The roading environment can be altered to slow us down**
>
> How drivers perceive the road is a critical factor in speed reduction. Roadside development tends to slow traffic down, so drivers will tend to travel faster on open rural roads and slower on built up urban roads. Speed humps, road narrowing and chicanes as well as road markings can help reduce speed. To be effective, speed limits should be consistent with the design speed of the road and be backed up by enforcement.

VI. I sought the views of the Whangārei District Council on recommendations that they review and consider whether speed restrictions below 100 km/h and speed markers, signage and/or equipment are required on Kokopu Road where this occurred. This is because these actions may have prevented this and other similar deaths.

[45] NZTA "Safety – Annual Statistics – Young Drivers" https://www.transport.govt.nz/statistics-and-insights/safety-annual-statistics/sheet/young-drivers.
[46] NZTA "Safety – Annual Statistics – Speed" https://www.transport.govt.nz/statistics-and-insights/safety-annual-statistics-speed/.
[47] See above https://www.transport.govt.nz/statistics-and-insights/safety-annual-statistics/sheet/speed#element-1052.
[48] Accident Compensation Corporation "Down with speed: a review of the literature, and the impact of speed on New Zealanders." Online publication https://www.transport.govt.nz//assets/Uploads/Report/ACC672-Down-with-speed.pdf.

VII. I have now been advised by the Whangārei District Council that they are currently in the process of undertaking a speed management review of local roads (excluding state highways) including Kokopu Road, and this assessment will consider appropriate speed limits, signage and the introduction of appropriate speed control devices on all these roads.

VIII. I endorse and thank the Whangārei District Council for taking this action. In the circumstances there is no need to make any further recommendations.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Ms Dahl during the course of this inquiry in the interests of decency and that there is no legitimate public interest or benefit in the publication of these images.

Grigg [2021] NZCorC 9 (20 January 2021)

CIRCUMSTANCES

Brooklyn Andrew Grigg, aged five, died on 20 August 2016 at his family's property in Kumeu, Auckland. The cause of death was drowning in the context of a quad bike crash.

Brooklyn had a passion for motorised vehicles. At about 2:30pm on 20 August 2016, he started riding a child's Suzuki LT80 quad bike around the back of the rural property. He had ridden the bike many times before and, as always, was wearing a motorcycle helmet and protective gear.

Brooklyn's father was working in the garage area, from where he could keep a general eye on Brooklyn and hear the quad bike's engine. At about 3:30pm, Mr Grigg realised that he could not hear the quad bike or see Brooklyn anywhere. After checking that Brooklyn was not inside, Mr Grigg went to search for him. Shortly afterwards, the bike was spotted upside down in a stream at the back of the property. When the bike was lifted up, Brooklyn was found fully submerged in the water and unresponsive. CPR was started immediately and emergency services were called. Tragically, Brooklyn was unable to be resuscitated and was pronounced dead at the scene at 4.05pm.

A Police Serious Crash investigator noted that tyre marks from the quad bike led down a slight hill and stopped at the edge of the stream. The nature of the marks indicated that Brooklyn had not braked at any stage before entering the stream. Police concluded that the cause of the crash was operator error, as no faults with the quad bike were found and it appeared to have been operating in a normal manner prior to the crash.

The Suzuki LT80 is a youth model suitable for children aged 12 and over. Notwithstanding the experience Brooklyn had, it was not suitable for a child his age to be riding. However, other than a provision in the Land Transport Act 1988 making it illegal for children under 16 to ride adult quad bikes on public roads, there is no legal or regulatory framework in relation to children's use of quad bikes in New Zealand. As such, it was not unlawful for Brooklyn to be riding the quad bike. The Coroner considered that Brooklyn's parents did not appreciate the inherent dangers associated with him riding the quad bike without active supervision. Had they done so, they would have monitored him more closely.

A Child and Youth Mortality Review Committee (CYMRC) report in 2014 highlighted that quad bike and other off-road vehicle accidents are the second largest cause of child recreational deaths in New Zealand. The CYMRC's view was that no child under the age of six should ever be in control of an off-road vehicle.

RECOMMENDATIONS OF CORONER GREIG

I. As Brooklyn's tragic death highlights, child sized quad bikes are not toys. They are serious pieces of machinery and extreme caution must be exercised in where and how they are used. Careful adult supervision is always required. It is vital that parents and caregivers recognise that the risks arise because in addition to inexperience, children have inadequate physical size and strength and their brains are not sufficiently well developed to have the perceptual abilities or judgment required to use these vehicles safely.

II. I have considered what recommendations it is appropriate for me to make that may reduce the chances of further deaths occurring in similar circumstances in the future – including recommending legislative reform. I have formed the view that suggesting legislative reform (such as children under sixteen years not being permitted to ride quad bikes or regulation of child quad bikes) is not appropriate on the basis of this case alone. Such recommendations need to be made based on accurate data about deaths in New Zealand, as well as abroad. As CYMRC has highlighted, in New Zealand there is lack of data on deaths occurring in the context of child quad bike use.

III. However, as a result of this inquiry, MBIE has undertaken to investigate the children's recreational quad bike market in order to better understand the size of the market, the rate of compliance with applicable standards and the relationship between compliance with the standards and injuries with the aim that the information gathered will support the future consideration of mandating of standards. This is an encouraging start.

IV. Additionally, these findings will be circulated to relevant organisations involved in considering issues relating to the safe use of child quad bikes (including the possibility of regulation) and to organisations involved in researching, promoting and advocating for child safety. The facts and circumstances of Brooklyn's death will form an important part of the data required to provide for evidence based decisions.

V. Further and importantly, strong safety messages arise from these findings, which if appreciated by parents and caregivers may help to prevent deaths in similar circumstances in the future. I agree with MBIE's assessment that education and information for parents and caregivers can help build awareness of both the risks associated with quad bikes and what considerations should be taken into account to manage the risks and encourage good safety outcomes.

- *Recommendation*

VI. Accordingly, I am referring these findings to the Chief Executives of Safekids Aotearoa, the Accident Compensation Corporation, REAP Aotearoa and MBIE with the **recommendation** that these organisations (and any other organisations they consider relevant) work together to identify key safety messages in relation to quad bike use by children (including age limitations and use of child quad bikes) and how best to promulgate these messages so that they are available and accessible for parents and caregivers.

VII. In response to consultation on this recommendation, the Accident Compensation Corporation (ACC) has advised that it welcomes the recommendation. It advised that ACC is currently involved in a number of investments in the agriculture sector as well as partnering with WorkSafe, focusing on quad bikes. In terms

of general quad bike safety, it provided information on a subsidy it offers for farming businesses to purchase crush protection devices for installation on their quad bikes.

VIII. ACC suggested that REAP Aotearoa may be a good organisation to add to the recommendation as it is a rurally oriented organisation that provides a channel to rural communities, specifically children, and could complement the important work that Safekids Aotearoa does. REAP Aotearoa has responded that it would be pleased to be included.

IX. Safekids Aotearoa agreed that education and information can help build awareness of the risks associated with quad bikes and what considerations can or should be taken to manage the risks and encourage good safety outcomes. It cautioned however that to deliver tangible and sustained reduction in deaths, interventions should be multifaceted with collective responsibility from manufacturers and users and consideration of matters such as engineering (for example use of crush protection systems) and legislative changes. While some of the matters it raises are outside the scope of this inquiry, it is to be hoped that the details of Brooklyn's death will assist to inform consideration of future steps that may be taken to ensure that other children do not die in circumstances similar to those in which Brooklyn died.

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

Healey [2021] NZCorC 44 (26 March 2021)

CIRCUMSTANCES

Naomi Francis Healey, aged 64, died at Waikato Hospital on 27 March 2020 from complications of severe head trauma and associated injuries sustained in a motor vehicle collision.

At 3pm on 19 March 2020, Ms Healey was driving south on State Highway One, East Taupō Arterial, Taupō. She crossed the centreline into the opposite lane and into the path of an oncoming truck. The two vehicles collided and Naomi suffered serious injuries. She was taken to Waikato Hospital, where she passed away.

An investigation into the collision concluded that it was possible that Ms Healey was fatigued to the point of falling asleep or having a microsleep.

RECOMMENDATIONS OF CORONER ROBB

I. The dangers of driving while fatigued are evidenced by Naomi's death. It is recommended that drivers watch for signs of fatigue - even if they have only recently taken over driving duties.

II. When fatigued, stopping for a rest or a mini break or sleep is necessary, regardless of how long driving has been undertaken. This can be particularly so when:

   a. driving while other passengers are sleeping,

   b. driving during the middle of the afternoon,

c. travelling on roads where there are few intersections or other essential interactions for the driver resulting in a risk of being ‘under-stimulated’.

The NZTA identifies the following warning signs of fatigue:

i. having trouble focusing, keeping your eyes open or holding your head up;

ii. daydreaming, wandering or disconnected thoughts, loss of memory;

iii. yawning or rubbing your eyes repeatedly;

iv. drifting from your lane, tailgating and missing signs or exits; and

v. feeling restless and irritable.

III. The East Taupō Arterial was completed in 2010. Between 2010 and 2017, three people have died and six people have been seriously injured on this stretch of road. On 4 March 2020, Waka Kotahi, the New Zealand Transport Agency, announced a series of safety improvements to the East Taupō Arterial as part of their Safe Network Programme. One of the improvements is the installation of a flexible median barrier to prevent head-on collisions.

IV. In light of Waka Kotahi’s planned safety improvements, I do not consider it necessary to make any additional comments or recommendations pursuant to s 57(3) of the Coroners Act 2006, in respect of the East Taupō Arterial route.

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

Hull [2021] NZCorC 8 (18 January 2021)

CIRCUMSTANCES

Jason Walter Joseph Hull, aged 52, died on 8 October 2019 at the Neudorf Road Saddle, Tasman of blunt force head injury in the context of a motorcyclist in a single vehicle collision with fixed terrain.

Mr Hull and three others left his house just before 3:00pm on 8 October 2019 to go for a motorcycle ride. The group stopped twice, once for fuel and then at the Tapawera Tavern for a handle of beer. They travelled along Motueka Valley before ending up on Neudorf Road heading east back towards Tasman. The group continued for approximately three kilometres along Neudorf Road. Mr Hull and Clinton Brough were about 200 metres ahead as they headed towards the Neudorf Road Saddle. At one point, Mr Hull spontaneously overtook Mr Brough doing around 130km/h according to Mr Brough’s estimate. It was out of character for Mr Hull to overtake before corners and Mr Brough was particularly surprised as they were approaching a bump in the road in the left-hand curve near the top of the Neudorf Road Saddle.

When Mr Hull returned to his lane after completing the overtaking manoeuvre he was approximately 40 metres away from the start of the left-hand curve. He began to lose control of his motorcycle and Mr Brough described seeing the back wheel of Mr Hull’s motorcycle snake as he hit the bump. This caused Mr Hull to go across the centreline. Mr Hull’s

motorcycle eventually slid over on the left-hand side of the road and Mr Hull was thrown from the motorcycle, while his motorcycle crashed into the fence on the opposite side of the road. Emergency services arrived but resuscitation attempts were unsuccessful and Mr Hull was confirmed as deceased.

A Serious Crash Unit investigation identified two wheel track depressions on the road, which had been made over a long period of time, presumably by heavy motor vehicles. The start of the depressions is the point where Mr Hull finished his overtaking manoeuvre and where he began to cross back into the left-hand lane. The unit's report concluded that the wheel tracking depressions posed a real risk, especially to motorcycle riders when they crossed between the left-hand and right-hand wheel track depressions. The risk is further heightened due to the fact that motorcycle riders follow the road's curvature around the left-hand curve for approximately 50 metres. The wheel track depressions were a contributing factor to the crash. The Serious Crash Unit recommended that a copy of the report be provided to the local road authority, the Tasman District Council (TDC), to consider repairing the approximate 90 metres section of wheel tracking depressions.

RECOMMENDATIONS OF CORONER ROBINSON

I. Given the recommendations in the Serious Crash Unit report, I sought a response from the TDC.

II. Having reviewed the Serious Crash Unit report the TDC inspected the road environment both in the vicinity of the crash and along the remainder of Neudorf Road.

III. In correspondence dated 24 June 2020 TDC's Transportation Manager, Jamie McPherson, advised that the undulations referred to in the Serious Crash Unit report are called ruts, which are very common and are on most roads. Mr McPherson reported that ruts can cause problems when they get very deep and hold water which can possibly lead to "aquaplaning". Mr McPherson noted that, given the prevalence of ruts, it is not economically feasible to repair them.

IV. An analysis of TDC's rut data on Neudorf Road showed that the condition of the section where Mr Hull crashed is very typical of the condition of the entire road, meaning that Mr Hull had traversed several kilometres of road that was in similar or worse condition than where the crash occurred.

V. The TDC has rutting data for approximately 40 per cent of the total sealed road in the region. When compared with the TDC's overall sealed road network, it was found that the rutting condition of Neudorf Road is in slightly better condition. The mean rut depth is slightly lower, and the percentage of the road with ruts deeper than 20 millimetres is lower than the overall sealed network.

VI. Mr McPherson stated that the level of service the TDC provides in terms of rutting and unevenness on its sealed roads is considered appropriate and particularly bad defects are repaired. Mr McPherson reported that, in this case, there was nothing to suggest that the section of Neudorf Road where Mr Hull ran into difficulties is particularly bad or in need of repair.

VII. There is no specific detail of the depth of the rut at the point where Mr Hull "hit the bump" so I cannot comment on whether a localised repair is necessary.

VIII. The current speed limit on Neudorf Road is 100 km/h. Mr McPherson advised that the TDC would like to implement a proposal to change the speed limit change to 80 km/h, however, there was insufficient support for this.

IX. Given the information from the TDC, I would support the lowering of the speed limit along Neudorf Road be lowered reflecting the nature of the road.

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

Ledger [2021] NZCorC 24 (23 February 2021)

CIRCUMSTANCES

Christopher John Ledger, aged 80, of Collingwood, died on 20 November 2018 on State Highway One near Wharanui due to injuries sustained in a motor vehicle crash.

On the morning of 20 November 2018, Mr Ledger left his home at around 9am to drive to Christchurch. As planned, he stopped in Picton to have lunch with friends at around 1pm. Mr Ledger had several glasses of water during the meal. He stayed visiting his friends for an hour and a half, during which he appeared upbeat and his usual self. At around 4pm, Mr Ledger's car drifted to the side of the road off State Highway One near Wharanui, travelling onto the gravel verge and striking a large stone letterbox. Members of the public went to Mr Ledger's assistance, but he was unable to be revived and died at the scene.

An investigation by the Serious Crash Unit found no evidence that the vehicle had been braking as it left the road, or that any corrective action had been taken by Mr Ledger. Based on the information available, it was not possible to establish the cause of the crash. However, it was possible that Mr Ledger was experiencing extreme fatigue at the time.

RECOMMENDATIONS OF CORONER ANDERSON

I. I do not consider that any recommendations are required in relation to Mr Ledger's death. Very sensibly, Mr Ledger took a good long break during the drive and he had something to eat and drink during the stop.

II. Driver fatigue is a common cause of fatal and serious injury crashes in New Zealand. Waka Kotahi, the New Zealand Transport Agency, states that in 2019 fatigue was a factor in 17 fatal crashes and 85 serious injury crashes. There is helpful information available on the Waka Kotahi website that provides details about how to recognise fatigue, tips on avoiding fatigue and other useful resources to help prevent fatigue related motor vehicle crashes. This information can be found at https://www.nzta.govt.nz/safety/what-waka-kotahi-is-doing/education-initiatives/fatigue/.

III. A copy of these findings will be provided to Waka Kotahi to assist with its ongoing work and education in relation to fatigue and driving.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken by Police of Mr Ledger during the course of this inquiry in the interests of decency and personal privacy.

Love [2021] NZCorC 43 (24 March 2021)

CIRCUMSTANCES

Jeremy Love, aged 21, of Temuka, died on 6 January 2019 at 87 MacAulay Road, Milford as a consequence of being an unseated motorcyclist in collision with the fixed environment.

At approximately 5pm on 6 January 2019 Jeremy was riding a farm bike home on a quiet rural road, followed by his workmate. Jeremy was wearing an AgHat 2, which is a type of farm utility safety helmet designed for off-road use by ATV riders/drivers at speeds of less than 30km/h. His workmate estimated that they were travelling at approximately 80km/h. At one point Jeremy stood up and placed both his feet on the seat while continuing to hold the handlebars. This is something he would do on the way home and his workmate thought nothing of it. However, as he stood up, the motorcycle started to wobble and fishtail, and Jeremy fell over the handlebars onto the road. He landed on his head and rolled along the ground three or four times. He survived the crash but was deceased upon arrival at Timaru Hospital.

The Serious Crash Unit Analysis Report concluded that the severity of Jeremy's injuries might have been affected by him wearing the unsuitable AgHat. It was almost certain that him standing up on the seat was the cause of his loss of control and his fall.

RECOMMENDATIONS OF CORONER MCKENZIE

I. Section 57A of the Coroners Act 2006 permits me to make recommendations or comments. They may be made only for the purposes of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred. They must be clearly linked to the factors that contributed to the death, based on evidence considered during the inquiry, and be accompanied by an explanation of how, if drawn to the public attention, the recommendation or comment may reduce the chances of further deaths occurring in similar circumstances.

II. According to the eyewitness account of the accident, Jeremy was riding a farm bike on the open road at a speed of approximately 80km/h or just under, and was wearing an AgHat 2 designed for ATVs travelling off-road at speeds of up to 30km/h. Jeremy did not have a motorcycle licence and toxicology results were consistent with the use of cannabis. In this setting, I have considered whether any comments or recommendations are appropriate pursuant to s 57A of the Act in relation to safe riding and wearing an appropriate helmet.

III. I first set out the relevant law. The LTR 2004 is the starting point. For the purposes of the LTR 2004 and this section of my findings more generally, Jeremy was riding a "motorcycle"[49] on a "road."

IV. A person riding a motorcycle on a road must wear a helmet of an approved standard. Rule 7.12 relevantly provides:

> 7.12 Safety helmets for all terrain vehicles, motorcycles, and mopeds

[49] A "motorcycle" is relevantly defined as "a motor vehicle running on 2 wheels." A motor vehicle relevantly is a "a vehicle drawn or propelled by mechanical power." MacAulay Road is a "road" for the purposes of the LTR 2004 for reasons including that it is a place to which the public have access.

(1) A person must not drive or ride on an all terrain vehicle, on a motorcycle, in a sidecar, or on a moped on a road unless the person is wearing a safety helmet of an approved standard that is securely fastened.

….

V. The approved standards are (emphasis added):

7.12 Safety helmets for all terrain vehicles, motorcycles, and mopeds

….

(2) The approved standards for safety helmets are -

(a) UN/ECE Regulation No 22, Uniform provisions concerning the approval of protective helmets and their visors for drivers and passengers of Motor Cycles and Mopeds (E/ECE324–E/ECE/TRANS/505/Rev.1/Add.21):

(b) **Australian Standard AS 1698, Protective helmets for vehicle users:**

(c) **New Zealand Standard NZ 5430, Protective helmets for vehicle users:**

(d) Snell Memorial Foundation, Helmet Standard for use in motorcycling:

(e) Federal Motor Vehicle Safety Standard No 218, Motor-cycle helmets:

(f) British Standard BS 6658, Specification for protective helmets for vehicle users (for type A helmets only):

(g) Japan Industrial Standard T8133.

VI. The sticker on the AgHat 2 Jeremy was wearing records it as “Standard: NZS8600, AS/NZS 1801; Type 1.”

VII. There are exceptions to this rule, including when riding at 30km/h or slower and when moving from one part of farm to another part of it or to an adjoining farm owned or occupied by the same person:

7.13 Exceptions from requirement to wear motorcycle safety helmet

(1) Clause 7.12 does not apply to the driver or rider of an all terrain vehicle, a motorcycle, or a moped while it is being used at a speed not exceeding 30 km per hour to travel from one part of a farm to another part of the same farm or from one farm to another adjoining farm which is owned or occupied by the same person.

(2) For the purposes of subclause (1), farms must be regarded as adjoining even though they may be separated by a road, a railway, or a watercourse.

….

VIII. However, on the evidence before me Jeremy was riding at a significantly greater speed than 30km/h and so the helmet exemption did not apply.[50]

[50] I do not understand Jeremy to otherwise have been exempt as provided for in the LTR 2004.

IX. I now turn to consideration of any recommendations or comments. I have focussed on recommendations regarding:

a. Safe motorcycle riding and

b. Use of the appropriate helmet.

X. With respect to safe riding, I am satisfied that there are already significant public campaigns addressing this. In these circumstances I do not make any recommendations relating to safe riding.

XI. I now turn to use of the appropriate helmet and, more specifically, the limitations of use of an AgHat. I consider it is reasonable to observe that AgHats, designed as they are for off-road use on ATVs at speeds of under 30km/h, should not be worn on the open road at much higher speeds. A motorcyclist should wear the appropriately rated safety helmet for the particular riding at hand.

XII. I sought the views of Police, Waka Kotahi NZ Transport Agency, WorkSafe, and Forbes & Davies Ltd.[51] I consulted these parties on the following recommendation:

> I recommend that Police, WorkSafe, and Waka Kotahi NZ Transport Agency undertake a joint safety campaign regarding the appropriate use of Aghats and, in particular, include their limitations in terms of use on open roads and at speeds greater than 30km/h.

XIII. Waka Kotahi NZ Transport Agency supports the recommendation. It advised that it has worked with WorkSafe and Police in the past on public safety campaigns, including specifically targeted at correct helmet usage. It stated that it will continue to work with both agencies on this and other ATV related safety matters.

XIV. I thank Police for their continued assistance and in particular provision of information regarding various aspects of the use of AgHats.

XV. There were no objections or suggested amendments to the proposed recommendation.

XVI. Accordingly, I make the following recommendation:

> I recommend that Police, WorkSafe, and Waka Kotahi NZ Transport Agency undertake a joint safety campaign regarding the appropriate use of AgHats and, in particular, include their limitations in terms of use on open roads and at speeds greater than 30km/h.

XVII. I consider that such a safety campaign may reduce the chances of further deaths occurring in circumstances similar to those in which Jeremy's death occurred. I note that I do not have evidence of whether an approved motorcycle helmet would have made a difference following a fall of this nature. Also, on the material before me the fall was not caused by the type of helmet Jeremy was wearing. However, in my view it is reasonable to infer that wearing a helmet of the approved standard for the specific riding at hand – or, not wearing an incorrect helmet type for the specific riding at hand – may have made a material

[51] Forbes & Davies Ltd is an importer, wholesaler, and distributor of motorcycle and ATV tyres and accessories, including AgHats.

difference to Jeremy's outcome. Hence it may help reduce the chances of further deaths occurring in similar circumstances.

XVIII. In my view, the recommendation is clearly linked to the factors that contributed to Jeremy's death – a high energy impact injury to the head and brain. It is based on evidence I have considered, including materials relating to AgHats and their intended use off-road by ATV riders at low speeds not exceeding 30km/h. In my view, drawing the issue to the public attention via a safety campaign may reduce the chances of further deaths occurring in similar circumstances.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Jeremy taken by Police or any other party in the interests of decency, personal privacy and justice.

McKitterick [2021] NZCorC 51 (30 March 2021)

CIRCUMSTANCES

Kyle John McKitterick, aged 48, of Christchurch died on 10 November 2018 at Dyers Pass Road, Governors Bay due to high energy impact to his shoulder and chest with major vascular injury.

On 10 November 2018, at around 2:00pm, Mr McKitterick was riding his motorcycle on Dyers Pass Road, Governors Bay towards Christchurch. While Mr McKitterick was riding, a stationary van in the opposing lane of traffic turned in front of Mr McKitterick and collided with him. Mr McKitterick was transported to Christchurch Hospital but died later in the day. No charges were laid against the driver of the van.

Canterbury District's Serious Crash Unit investigated the cause of the collision. It was calculated that Mr McKitterick was travelling at a minimum speed of between 89 – 95km/h prior to the collision. It was noted that the speed limit for Dyers Pass Road was 60km/h. Excessive speed on the part of Mr McKitterick was identified as a factor in the collision, and it was concluded Mr McKitterick was unable to stop before connecting with the van.

COMMENTS OF CORONER ELLIOTT

I. The Road Code provides advice about speeding:

> **Speed limits**
>
> Excessive speed is one of the biggest killers on our roads. On average, 130 people die every year in New Zealand in speed-related crashes.
>
> Remember, the faster you go, the more likely you are to be killed or seriously injured if you crash.
>
> **Compulsory speed signs**
>
> A speed limit is the maximum legal speed that you can travel on the road under good conditions.
>
> Signs showing the speed limit are displayed beside the road. These signs usually have a red border, which means that the sign is compulsory.

II. Given that this advice is incorporated into the Road Code, it is not necessary to make any recommendations. However, in order to reduce the chances of deaths in similar circumstances, I make the following comments pursuant to section 57A of the Coroners Act 2006:

> This crash illustrates that, as the Road Code states, 'Turning can be dangerous, because it usually means you have to cross the path of other vehicles.' It also illustrates the danger associated with driving in excess of the speed limit.

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

Murupaenga [2021] NZCorC 38 (19 March 2021)

CIRCUMSTANCES

James Henare Murupaenga, aged 62, of Ahipara died on 8 October 2018 at State Highway 1, Umawera, Northland. Cause of death was asphyxiation due to a significant surgical emphysema involving head, neck and chest and a significant pneumomediastinum.

At around 2:30am on 8 October 2018, Mr Murupaenga was discovered on the side of the road by a passing motorist on an isolated area of State Highway 1, between Mangamuka and Umawera. He was sitting in his vehicle which had crashed. Mr Murupaenga reported to the passing motorist that he was fine and explained that he had crashed while trying to avoid an opossum on the road.

Soon after, Mr Murupaenga's condition deteriorated. Emergency services were called. Fire and Emergency Services arrived at 3:02am, with ambulance staff arriving at 3:33am. It was confirmed by Fire and Emergency Services (including a registered nurse) that Mr Murupaenga had trouble breathing. A request for a helicopter was made at 3:31am, and this was assigned at 3:34am. Despite medical assistance, Mr Murupaenga continued to deteriorate and went into cardiac arrest at 4:20am. At 4:31am the helicopter arrived with an intensive care paramedic, who tried to place an endo-tracheal tube but was unable to do so as Mr Murupaenga's tongue was swollen. Further treatment was unsuccessful and Mr Murupaenga was declared deceased at 4:44am.

A subsequent investigation of the crash by the Northland Police Serious Crash Unit concluded that Mr Murupaenga losing control of his vehicle to avoid an opossum was the probable cause of the crash, but fatigue could not be ruled out either. WSP Opus investigated the crash and prepared a report for NZTA which noted that there were no audio-tactile profiled (ATP) markings on the stretch of road where Mr Murupaenga crashed. These are primarily used to prevent fatigue related crashes from occurring. WSP Opus recommended the following:

a Promote a Low Cost Low Risk Safety Project to implement ATP markings on the edge and centre line for the entire length of Reference Station 149; and

b Investigate and, if practical, submit a Low Cost Low Risk Safety Project to provide a roadside barrier along the embarkment section.

Dr Tony Smith, St John's Clinical Director and an Intensive Care Physician, reviewed Mr Murupaenga's treatment. He found, in line with the post mortem, that a significant contributor to Mr Murupaenga's death appeared to be his neck

injury, which resulted in a very severe swelling of his neck and tongue, causing airway occlusion. Dr Smith advised that this is a very rare, but life-threatening injury that requires early intervention from an intensive care paramedic or a specialist doctor. Dr Smith also identified small delays, which were partially preventable and collectively amounted to 40 minutes, and which contributed to delay in an intensive care paramedic reaching the scene.

COMMENTS OF CORONER GREIG

I. Mr Murupaenga's crash occurred on a remote rural road in the Far North in the early hours of the morning. Although appearing well when he was first found, he deteriorated soon after, with a rare but life-threatening injury that requires early specialised intervention. When and where the crash occurred affected how quickly he received the needed specialised emergency medical assistance.

II. Although I have found that it is possible, but by no means certain, that Mr Murupaenga's life could have been saved if an intensive care paramedic had been able to provide Mr Murupaenga with specialised emergency care sooner, and that there were some delays in the emergency medical response, I make no criticism of the emergency responders involved. The findings referred to are made with the benefit of hindsight. Nor do I consider recommendations are necessary.

III. St John has already reviewed the emergency medical response to this incident and Dr Smith has advised that it is conducting a further review of what occurred, with a view to identifying what it can learn and what it can do differently in future.

IV. St John's initial review has identified two areas for improvement (reducing the time spent in identifying the exact location of the crash and the ambulance dispatcher seeking input from a clinical support officer about escalating the level of response on the basis of the information provided by non St John first responders). There have also been changes made to ensure the local emergency helicopter night time response is not slowed by 'on call' staff having to respond from home at night.

V. The recommendations contained in the WSP Opus report, as detailed above, are helpful general road safety improvement recommendations for the area of the crash - particularly in relation to mitigating the effects of fatigue. However, because fatigue was not established as a factor in Mr Murupaenga's crash, endorsing the recommendations to the New Zealand Transport Agency (within whose purview State Highway 1 falls) is outside my jurisdiction. However, I note that the WPS Opus report was instigated by the New Zealand Transport Agency and accordingly they have WPS Opus recommendation (and the reason for it) available to it.

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

Qiu [2021] NZCorC 35 (17 March 2021)

CIRCUMSTANCES

Gouchin Qiu, aged 30, of Goodwood Heights, Auckland, died on 12 May 2018 at Te Irirangi Drive, Auckland.

At approximately 5pm on 12 May 2018 Mr Qiu attended a work barbecue where he consumed alcohol. He left at approximately 9:40pm. At 10:55pm CCTV footage showed a vehicle, similar to the one Mr Qiu was driving at the time, stopped at a red light waiting to turn right to travel south on Te Irirangi Drive. It also showed that he was not wearing a seat belt.

When Mr Qiu turned at the intersection he crossed the centre medium strip into the northbound lanes. Mr Qiu travelled on the wrong side of Te Irirangi Drive for approximately 900m and into the path of an oncoming vehicle. The northbound vehicle was unable to avoid the crash and the two vehicles collided head-on. As a result of the injuries received in the crash, Mr Qiu died at the scene.

The Serious Crash Unit Report (the SCU Report) concluded that speed and alcohol were factors in the crash. It was estimated the Mr Qiu was driving between 133 and 117km/h on an 80km/h road at the time of the crash. Mr Qiu was also found to have had a level of 269 milligrams of alcohol per 100 millilitres of blood. The ESR noted for comparison purposes, that the legal blood-alcohol limit for a driver aged 20 years or over is 50 milligrams of alcohol per 100 millilitres of blood.

The SCU Report noted that there was a lack of road markings for drivers turning right at the intersection of Smales Road and Te Irirangi Drive and inferred that clearer road markings may have prevented Mr Qiu's death.

COMMENTS OF CORONER TETITAHA

I. I make the following comments pursuant to section 57A of the Coroners Act 2006:

II. There is merit in clearer definition of road markings at the intersection where the crash occurred. The intersection is very busy and there is room for confusion regarding the correct entry lane from Smales Road into Te Irirangi Drive.

III. I have provided these comments to Auckland Transport.

RECOMMENDATIONS OF CORONER TETITAHA

I. Given the above comments, I also made the following recommendation pursuant to section 57A of the Coroners Act 2006:

> To consider adding painted guidelines to indicate to drivers turning right from Smales road into Te Irirangi drive, where the turn needs to be made.

II. Andrew Garrett, Team Leader Road Safety Engineering, Auckland Transport has provided the following reply:

> From the initial assessment it appeared that two large vehicles following road markings when turning right at the same time and in opposite directions are likely to collide. However, following a further investigation and a slight redesign of the road markings, … road markings can be installed without two large vehicles colliding when turning right from the opposite direction. I have, for your information, attached the latest tracking plan.

I will arrange for the road markings to be installed and I anticipate that this should be completed before the end of July 2021.

III. It appears the recommendation has been accepted and shall be implemented by July 2021. A copy of my decision shall be forwarded to Auckland Transport with thanks.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Mr Qiu during this inquiry (being photographs of a deceased person) in the interests of decency and public interest.

Richards [2021] NZCorC 4 (6 January 2021)

CIRCUMSTANCES

Michael John Richards, aged 53, of Auckland died on 26 November 2017 at Apirana Avenue, Glen Innes, Auckland of multiple injuries sustained in a motorcycle incident.

Mr Richards attended a rugby league match at Mount Smart Stadium on 25 November 2017 with a group of friends and consumed a significant amount of alcohol over the course of the night. He left his motorbike at a pub prior to the game and returned there afterwards. Mr Richards consumed beer there then rode his motorbike to dinner in Ellerslie. A member of the group asked him if he was okay to drive and he said that he was fine.

Mr Richards consumed more beer at a nearby bar. Around 1:00am on 26 November 2017, when the bar closed, the group decided to go home. The same member of the group advised Mr Richards not to ride his motorcycle home, but he was anxious not to leave his motorbike behind.

Around 1:30am, Mr Richards was riding his motorbike in a northerly direction on Apirana Avenue, a short distance away from his home. He was wearing a helmet. As Mr Richards approached the intersection with Eastview Road, he failed to make an easy left-hand bend in the road and lost control of his motorbike. The motorbike crossed the centreline of the road, entering the southbound land before striking the concrete kerb on the road shoulder. The motorbike mounted the road shoulder before striking a large tree. Mr Richards died at the scene from injuries he sustained.

Toxicology testing by Environmental Science and Research Ltd (ESR) established that Mr Richards had a blood-alcohol level of 271mg alcohol per 100ml of blood. By way of comparison, the legal blood alcohol limit for a New Zealand driver aged over 20 years is 50mg/100ml. In other words, Mr Richards was more than five times over the legal limit for alcohol. The Coroner noted that at a blood-alcohol level of 100mg/100ml – which falls well short of Mr Richards' level of 271mg – a driver of Mr Richards' age is 61 times more likely to crash than a driver who has not been drinking. Mr Richards' blood also tested positive for cannabis, and its constituent element tetrahydrocannabinol (THC).

COMMENTS OF CORONER BORROWDALE

I. Having given due consideration to all of the circumstances of this death, I consider that there are comments that can usefully be made pursuant to section 57(3) of the Coroners Act 2006. The purpose of these comments is to reduce the chances of further deaths occurring in similar circumstances to those in which Mr Richards died.

II. Coroners have for decades made findings in which they warned against the practice of drinking and driving. More recently, Coroners have had ample opportunity – which they have taken – to caution against consuming cannabis when driving; and against using both substances in combination when driving.[52]

III. I will here add my voice to that chorus of caution. This crash, like so many others, points to the very real potential for tragedy when drivers use alcohol, and even more so when drivers combine the consumption of alcohol with cannabis.

Relationship between alcohol and road fatalities

IV. It is unsafe to consume alcohol when driving. Even low quantities of alcohol greatly magnify the risk of causing a fatal vehicle accident. A driver of Mr Richards' age who had a blood-alcohol level of 100mg/100ml was 61 times more likely to be involved in a fatality than a sober driver.[53] Mr Richards' own blood alcohol level was almost three times higher than that level, and his risk was exponentially greater.

V. Moreover, contrary to common belief, drinkers do not have the ability to accurately assess whether they are "okay to drive" after having consumed alcohol.

VI. The apparent effects on a driver from having consumed alcohol depend on many factors, including gender, age weight, health and demography. Even at alcohol levels far in excess of the legal blood-alcohol level, the drinker may not appear to observers to be intoxicated. But the appearance of sobriety does not translate into the safe operation of a motor vehicle.[54]

VII. Drinkers and their associates should not assume that they can accurately gauge whether a person who has been drinking alcohol is safe to drive. They can reliably make no such assessment.

VIII. For that reason, I repeat here the advice of Coroners over the years: do not drink and drive. Drinkers cannot dependably estimate their ability to safely drive a vehicle. Even when the drinker seems coherent and functioning, their motor skills and reactions may be dangerously dulled to the point where they risk grave injury to themselves and other road users.

IX. Ultimately, however, road safety comes down to individuals making prudent decisions. Mr Richards need not have died, had he exercised greater caution and ensured that he left his motorcycle at home or en route at the point when he started drinking. Alternately, Mr Richards could have ensured that he consumed no alcohol since he was driving. Either way, this tragedy was avoidable.

Relationship between cannabis and road fatalities

X. The clear connections between cannabis use and road accidents are also well-understood – scientifically, if not yet publicly - and of growing concern. In September 2020 a Ministry of Transport media release expressed the issue as follows:[55]

[52] Coroner Borrowdale particularly recommends the findings of Coroner D P Robinson in An Inquiry into the Death of George Bernard Holland (CSU-2017-CCH-000553) dated 21 November 2018.
[53] See [circumstances] above.
[54] Sullivan JB, Hauptman M and Bronstein AC "Lack of Observable Intoxication in Humans with High Plasma Alcoholic Concentrations" (1987) J Forensic Sci 32 at 1660-1665.
[55] Media release "Drug Driving Bill referred to Select Committee" Ministry of Transport 23/09/20 https://www.transport.govt.nz/multi-modal/keystrategiesandplans/road-safety-strategy/drug-driving/.

> Addressing drug impaired driving is an important objective to make our roads safer. Between 2013 and 2019, the annual number of road deaths in New Zealand increased by nearly 50 percent. Drug driving is making an increasing contribution to this statistic.

XI. That media release related to consultation on a proposed roadside drug testing regime,[56] contained in the Land Transport (Drug Driving) Amendment Bill which is currently before Select Committee.

XII. The policy documents that supported that Bill (which are found at the same online link) record a wealth of evidence about the extent to which recreational and prescription drugs have the potential to impair driving ability. For example, a World Health Organisation 2015 review of 66 studies found that drug-use while driving was associated with an increase in both crash involvement and the fatality (i.e. severity) of crashes. Specifically referring to cannabis, the Cabinet Paper on the Bill states:[57]

> The negative effects of high doses of cannabis on driving performance are well-documented and cannabis use is associated with increased risk of being killed or injured.

XIII. In addition, the Cabinet Paper evidences the prevalence in New Zealand of persons driving while under the influence of drugs. In a 2017 University of Waikato study around 13% of drivers admitted to using cannabis within three hours prior to driving.[58]

XIV. ESR's analysis of the blood samples of 787 New Zealand drivers who were killed in crashes between 2014 and 2018 found that 27% of deceased drivers had consumed cannabis.

XV. ESR also analysed the blood samples of over 1,600 drivers who were hospitalised in non-fatal crashes in the same period; 37% of these drivers had used cannabis.

XVI. In August 2020 the New Zealand Transport Agency (NZTA) launched a new drug driving advertising campaign. In its media release announcing the campaign,[59] the NZTA stated that its own national poll showed that 32% of respondents believed it was safe to use cannabis and then drive. According to the New Zealand Drug Foundation, 56% of cannabis drivers think that using cannabis makes no difference to their driving ability.[60]

XVII. These statistics speak to the inaccurate self-belief of cannabis-using drivers. In part, this type of error is exacerbated because – unlike with alcohol – there is no bright-line limit set on how much cannabis can be safely consumed before driving, or the duration of time that should pass between cannabis consumption and driving.[61] The Cabinet Paper describes this complicating factor:[62]

[56] Including a compulsory random roadside oral fluid testing scheme, and limits for the presence of drugs in blood to be prescribed in legislation.
[57] September 2018 Cabinet Paper: An Enhanced Drug Driver Testing Regime at [14]. https://www.transport.govt.nz/assets/Import/Uploads/Research/Documents/Cabinet-Papers/603785bd81/FINAL-Drug-Driving-Cabinet-paper-An-Enhanced-Drug-Driver-Testing-Regime-September-18.pdf.
[58] Cabinet Paper at [19]; Starkey and Charlton "The Prevalence and Impairment Effects of Drugged Driving in New Zealand," NZ Transport Agency Research Report 597 June 2017 https://www.nzta.govt.nz/assets/resources/research/reports/597/597-The-prevalence-and-impairment-effects-of-drugged-driving-in-NZ.pdf.
[59] NZTA media release "Drug affected driving new advertising campaign (Aug 13)" 13/8/20 https://www.nzta.govt.nz/assets/site-resources/content/about/docs/Drugged-Driving-O-n-A.pdf.
[60] NZ Drug Foundation media release "Survey reveals drug driving concern" 10/9/2009 https://www.drugfoundation.org.nz/news-media-and-events/survey-reveals-drug-driving-concern/.
[61] At present, a Police officer who has 'good cause' to suspect that a driver is impaired by drugs can require the driver to undergo a compulsory impairment test (CIT). The CIT is a behavioural test which comprises eye, walk and turn, and one-leg-stand assessments. If this test is failed, the driver can be required to undergo a blood test to determine the presence of a qualifying drug: Cabinet Paper at [29]-[31].
[62] Cabinet Paper at [27].

> We acknowledge that the presence of a particular drug or drugs in a driver's blood system does not necessarily equate to impaired driving. There is not a clear linear relationship between when drugs are taken and when impairment occurs, as is largely the case with alcohol. People respond to individual drugs, combinations of drugs and different dosages of drugs in different ways. Different drugs are metabolised at different rates, meaning that evidence of some drugs can be detected a considerable time after they have been ingested, while in other cases evidence dissipates very quickly. To a lesser extent, this is also the case with alcohol, except there is a clearer correlation between use and impairment that makes it possible to set limits at which any person can be considered to be impaired.

XVIII. Accordingly, cannabis-users cannot readily and reliably gauge their own degree of impairment. Nor can Police dependably and promptly establish driver impairment by cannabis:[63]

> The low number of CITs [compulsory impairment tests] completed limits the opportunity to achieve a general deterrence effect, meaning that the perceived and actual risk of detection is minimal.

XIX. The Bill that is before Select Committee has a deterrence focus.[64]

XX. It is beyond the scope of this finding to take matters much further at present than to note:

a. the commonality of cannabis use by New Zealand drivers;

b. its potential – especially when combined with alcohol – to produce tragic outcomes for the driver, their passenger and other road-users; and

c. the alarming fact that the bulk of cannabis drivers do not believe they are putting themselves and others at greater risk when doing so.

XXI. Ultimately, it is for community members to moderate their cannabis intake or avoid its consumption, in light of such laws regulating the use of cannabis as apply at the time. The same, of course, applies to alcohol use and the laws that apply to it.

XXII. As a Coroner, I can simply record that the death of Mr Richards was avoidable, had he not consumed cannabis and excess alcohol before the motor vehicle accident that claimed his life; and I set that single death in the context of a wide and expanding evidence-base demonstrating the strong connection between cannabis use and driving fatalities and injuries. Having done so, I note my real concern that the perils of mixing cannabis with driving (on its own and with alcohol) are poorly understood by members of the public. Such laws as we currently have are being poorly observed.

XXIII. I am encouraged by the quality of research that is being compiled, into the hazards of cannabis use when driving,[65] and will track with interest the public policy responses that are made to the problem.

[63] Cabinet Paper at [34].
[64] August 2020 Cabinet Paper: Introducing the Land Transport (Drug Driving) Amendment Bill at [2]. https://www.transport.govt.nz/assets/Import/Uploads/Research/Documents/Cabinet-Papers/Land-Transport-Drug-Driving-Amendment-Bill.pdf.
[65] Coroner Borrowdale derived particular assistance from the May 2020 NZTA Research Report 664: Risks of driving when affected by cannabis, MDMA (ecstasy) and methamphetamine and the deterrence of such behaviour: a literature review, WSP Research https://www.nzta.govt.nz/resources/research/reports/664/. The review found evidence that all three drugs have a negative impact on the driving of users,

XXIV. In the meantime, I urge the public to follow the cannabis awareness and driving safety advice that is promulgated by the Ministry of Transport, the NZTA, the NZ Drug Foundation and other agencies, and abstain from driving while under the influence of drugs and/ or alcohol.

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

Schuler [2021] NZCorC 27 (4 March 2021)

CIRCUMSTANCES

Patricia Ann Schuler, aged 47, of Whangarei died on 22 February 2017 at Auckland City Hospital as a result of injuries sustained in a motor vehicle collision.

At around 8:45am on 21 February 2017, Ms Schuler was driving her two daughters to school. While they were travelling on State Highway 1, Ms Schuler's vehicle suddenly swerved into the path of a truck and trailer travelling in the opposing lane of traffic. The two vehicles collided head on.

Ms Schuler was extracted from her vehicle and airlifted to Northland Hospital where she underwent x-rays and CT scans, which showed that she had suffered serious injuries. She was subsequently airlifted to Auckland City Hospital. Ms Schuler's condition deteriorated, and she died the following day. Her children suffered only moderate injuries.

It was unknown why the crash occurred. However, a fatal crash report completed by Fulton Hogan identified two similar head-on crashes (but non-fatal) at around the same site between 2012 and 2016. The report recommended that NZTA investigate installing a median barrier or alternative centreline treatment. The Police Serious Crash Unit (SCU) noted a median barrier would have prevented the crash from occurring. As part of the Coroner's inquiry, NZTA were asked whether it had installed a median barrier. NZTA advised that they had not due to the low amount of fatal crashes occurring at this site, further safety interventions being investigated on this stretch of road (Whangarei to Kawakawa roading corridor) and the need to balance ongoing safety projects with available funding.

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. In particular, I accept that the NZTA has competing roading demands to address and must properly devote priority to those highways that frequently give rise to serious crashes.

III. However, I accept the advice of the SCU that a median barrier in this area would have prevented this fatality, and that of Fulton Hogan to the NZTA encouraging consideration of providing a median barrier or alternative centreline treatment. I encourage the NZTA to keep these possible safety interventions in mind as the agency decides upon improvements to the Whangarei to Kawakawa roading corridor.

which may be an acute impact due to recent ingestion or a more long-term impact from being a regular user. All three drugs also form more dangerous combinations when used with alcohol and other drugs, than on their own.

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

Thompson [2021] NZCorC 22 (16 February 2021)

CIRCUMSTANCES

Sharon Tewhaiora Thompson, aged 57, died at Thornton Road, Matata, Whakatane on 1 August 2019, from transection of her cervical spinal cord as a result of blunt force trauma sustained in a motor vehicle accident.

On 1 August 2019, Mrs Thompson was driving east on Thornton Road, near Matata. She failed to navigate a right-hand bend. The vehicle she was driving moved left onto the grass verge. As Mrs Thompson steered right to correct this, she crossed the centreline and collided with an oncoming vehicle. As a result of the collision, Mrs Thompson suffered fatal injuries and passed away at the scene.

Serious Crash Unit considered that inattention or distraction may have been factors in the collision. There are no Audible Tactile Profiles (ATP), also known as rumble strips, through the centreline or fog lines of this section of Thornton Road. ATP serve to alert a distracted or fatigued driver that they are deviating from their lane of travel. ATP may have alerted Mrs Thompson to the fact her vehicle had crossed the fog line.

COMMENTS OF CORONER BATES

I. Given the circumstances of Mrs Thompson's death, pursuant to s 57(3) of the Coroners Act 2006, I make the following recommendation to Waka Kotahi New Zealand Transport Agency (Waka Kotahi):

    a. That Waka Kotahi consider installation of Audible Tactile Profiles on the centreline and fog lines on this section of Thornton Road.

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

Wafer [2021] NZCorC 48 (29 March 2021)

CIRCUMSTANCES

Shade Manepo Tapsell Wafer, aged 21, died at Te Puke Highway, Te Puke on 2 April 2019, due to a severed brainstem, the result of a motor vehicle accident.

On 2 April 2019, Mr Wafer was driving east in a Toyota Vista (the Toyota) on Te Puke Highway, Te Puke when he started overtaking vehicles at high speed. At one point, he lost control of the vehicle while overtaking another vehicle, and collided with a car travelling in the opposite direction.

RECOMMENDATIONS OF CORONER BATES

I. If a centre wire barrier had been present along the stretch of road where some of the passing manoeuvres by the Toyota and the collision eventually occurred, this crash may have been avoided. This road experiences high traffic volumes due to it being the non-toll alternative to the new State Highway and large volumes of traffic travelling in and around Te Puke township.

II. Given the circumstances of Mr Wafer's death, pursuant to s 57(3) of the Coroners Act 2006, I make the following recommendation to Waka Kotahi New Zealand Transport Agency (Waka Kotahi):

    a. That Waka Kotahi consider installing a centre wire barrier through the corridor of Te Puke Highway from the intersection with Pah Road to the AFFCO Rangiuru Freezing Works entry.

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

Self-Inflicted

Miss A [2021] NZCorC 15 (2 February 2021)

CIRCUMSTANCES

Miss A, aged 15, died on 22 October 2015. Her death was self-inflicted.

A number of agencies cared for Miss A prior to her death.

RECOMMENDATIONS OF CORONER ROBINSON

I. Overall, I accept Dr Fortune's description of the care provided to [the deceased] as being "poorly coordinated and very linear in its approach" with there being "little evidence of robust assessment feeding into a biopsychosocial formulation which could then inform a coherent treatment plan.

II. The ready sharing of information and greater overlap between services was highlighted by [the DHB psychiatrist] as a key component of the ideal model of care:

    A. …where we had increased overlap between different services and more communication-shared information so that people couldn't move easily in and out through the different levels of care in an integrated ways from the step-care model; that would be seen as they wouldn't even necessarily notice that that was happening.

    …

    A. … I think the sharing of information is really important and we have learnt this recently through some of the post-vention work because the more you know about a young person the more accurate your decision-making process is, and we don't routinely get together and talk about young people, and that includes organisations like the Police and more recently we've got a vulnerable list where everybody knows who's on it – everybody – well, agencies –

having access to know which key agency is involved, maybe having access to action plans and those kinds of things for the other agencies if they come in contact, particularly after hours, they can access that and know, have a better idea of what to do next.

III. As I hope my findings above demonstrate, the sharing of information and more "joined up" services are the keys to effective care.

IV. A high degree of collaboration between agencies is apparent in relation to suicide postvention work. The evidence at inquest establishes that effective information sharing and collaboration between agencies is necessary to support prevention work in relation to those known to be vulnerable and at risk of self-harm or suicide.

V. The other matter that stood out as a universal theme was that of resourcing. Significant constraints were evident across all agencies involved in [the deceased's] care.

VI. The recommendations stated below are my final recommendations. Below each recommendation I provide commentary on submissions made, and detail any amendments made to draft recommendations, or instances where, following submissions, I have elected not to make a recommendation.

Ministry of Health

VII. I recommend that the Ministry of Health:

a. Lead the development of a model of care for children and young persons that are at significant risk of self-harm or suicide that:

i. draws together information from a wide variety of sources (including but not limited to the person's GP, specialist mental health services; Oranga Tamariki; school, allied health and NGO providers);

ii. allows for robust assessment of the child or young person and the development of a biopsychosocial formulation and coherent treatment plan;

iii. facilitates and oversees the implementation of the treatment plan (across different agencies where necessary);

iv. provides for effective transfer of care between providers where appropriate; and

v. provides for periodic review of the child or young person, their circumstances, and the appropriateness and the coordination of the services provided.

[The GP] / [The GP Practice]

VIII. I recommend to [the GP] / [the GP Practice] that:

a. On receipt of notifications from the Child and Family Safety Service (or other child welfare agency) concerning a young patient:

i. the notification should be brought by the administration staff to the specific attention of that patient's GP;

ii. GPs should inquire with the agency as to whether any further action is necessary by the GP; and

iii. the notification should be recorded on the "long-term classifications" or "alerts" section of the patient's medical notes in order that any GP reviewing the notes will be aware of the background to the extent that it is relevant to any particular presentation; and

IX. Requests for BIC referral of young persons via the practice should be brought to the attention of the young person's GP.

<u>Oranga Tamariki / [Agency 1]</u>

X. I recommend to Oranga Tamariki / [Agency 1] that:

a. Oranga Tamariki and [Agency 1] (and more generally the agencies to which Oranga Tamariki refers matters that do not require a statutory response) should review the terms under which referrals are made to confirm:

i. The roles and responsibilities of the referrer and provider;

ii. The specific services to be provided and the latitude the provider has to offer services beyond those specified (and to persons other than those described in the referral);

iii. The extent to which the referrer will be overseeing the services to be provided under the referral;

iv. Provider reporting requirements;

v. The process for notifying the referrer of matters of significance where there is a risk of harm or suicidal ideation (including from persons who are not the agency's primary client), and for determining which agency is to respond to the issue; and

vi. The process for closure of the referral including:

1. Any necessary review of the effectiveness of the referral;

2. Assessment of any unmet needs;

3. Written confirmation from the referee that no further services will be provided under the referral;

4. A report similar to a discharge summary being sent to the person who is the subject of the referral (which in the case of a health-related service should be copied to the person's GP and the Ministry).

b. Oranga Tamariki and [Agency 1] should clarify and agree their roles in relation to the lodging of ACC sensitive claims; and

c. [Agency 1] should review its policies as to when it ought to make direct referrals to other agencies (such as [the DHB rural mental health team]) as opposed to leaving it to the client to effect the same.

XI. The recommendation relating to processes for notifying the referrer of matters of significance where there is a risk of harm or suicidal ideation has been modified slightly from the original form to be specific to a risk of harm or suicidal ideation, reflecting comment from [Agency 1].

XII. Oranga Tamariki made no comment in relation to the wording of this recommendation, except as to 4 which is now extended to include the Ministry.

To [the PHO] / [PHO]

XIII. I recommend to [the PHO] / [PHO] that:

a. In conjunction with GPs within the PHO District, a policy should be developed whereby BIC referrals for young persons are brought to the attention of their GP.

b. The policy requiring notification to the referrer of discharge from Brief Intervention Counselling (including a summary of the presentation and services provided and specific advice of any patient discharged without being seen) should be confirmed to all BIC staff.

XIV. The PHO agreed with the recommendations and noted that (b) reflected its standard practise. As to (a), I am advised that currently all mental health referrals come from general practice. Any arrangement requiring an external agency to make a referral to a GP on behalf of the Youth BIC will require a policy document between the PHO and the external agency.

[The Youth Mentor] / [Agency 1] / [Community Trust]

XV. I recommend to the [Youth Mentor] / [Agency 1] / [Community Trust] that:

a. Persons engaged in Youth Mentor roles should undertake suicide prevention training. Such training should be updated annually. The HEADSSS tool, described in evidence as being a tool that can be used by youth workers may be of assistance;

b. Youth Mentors should maintain notes of their contact with young persons to both assist with recognition of developing concerns and to facilitate effective supervision; and

c. The young person's GP should be notified of referrals to other healthcare providers made or facilitated by a Youth Mentor.

XVI. In response to the draft recommendations, the [Community Trust] noted that the current youth mentor has undertaken suicide prevention training, and that the Trust would look into using the HEADSSS tool. The current mentor maintains good notes. The Trust queried whether notifying the GP of referrals to other healthcare providers might encroach on the young person's privacy.

XVII. I recommend to [the deceased's school] / [the Youth Mentor] / [Agency 1] / [the Community Trust] that:

a. The Memorandum of Understanding between [the school] and the Trust should be reviewed and amended to clarify:

i. Guidance Counsellors (or other school staff member) oversight of Youth Mentor's work with school pupils;

ii. Formalisation of communication / liaison between Guidance Counsellor and Youth Mentor;

iii. Demarcation of the Youth Mentor / Guidance Counsellor roles, particularly in relation to matters of mental health;

iv. Information sharing between Youth Mentor and Guidance Counsellor (and other school staff) including specific types of information to be shared or escalated, and the Youth Mentor's responsibilities regarding information about school students gained from work outside the school environment;

v. The circumstances in which the Youth Mentor can hold him/herself out as a person authorised to receive information relating to students supported by the Youth Mentor on behalf of the school.

XVIII. The [Community Trust] responded that (i) to (iv) were all achievable, and that the Trust was updating the Memorandum of Understanding to cover those points. I made recommendation (v) after the submissions from the Trust. No comment was made on that proposed recommendation subsequently.

[District Health Board]

XIX. I recommend to the [District Health Board] that:

a. Correspondence from the Child and Family Safety Service to a GP should be specific as to the action or response required of the GP;

b. DHB staff should adopt a low threshold for assessing persons presenting to specialist mental health services with a background of sexual assault for Post-Traumatic Stress Disorder;

c. [DHB] should develop and implement a policy for facilitating the making of a sensitive claim to ACC by persons presenting to specialist mental health services with a background of sexual assault;

d. When disclosing information to a Youth Mentor or similar person intended to be conveyed to a school or other agency, specific inquiry should be made as to that person's authority to act as a conduit for such information; and

e. [DHB] as a partner in the [online health records] platform should explore the expansion of that platform to include records from other providers including NGOs with a view to it being a single health record. Such a single record could mitigate against the potential siloing of health information and allow for more informed care decisions.

XX. For completeness I note this submission from [the PHO manager] of the PHO supporting a shared care record involving all NGOs in the care of the patient, describing that as “invaluable”.

XXI. No specific response was received from the [DHB] to these recommendations.

Oranga Tamariki

XXII. I recommend to Oranga Tamariki that:

a. First and foremost, offices must be adequately staffed, resourced and supervised as the majority of the issues identified in relation to CYF in this case reflected the extreme pressures on the individual staff members concerned and issues around supervision;

b. Training should be reviewed to ensure that all frontline staff engaged with children and young persons:

i. develop holistic psychosocial formulations of their clients;

ii. can recognise symptoms of distress or depression in children and young persons;

iii. undertake suicide prevention training. Such training should be updated annually; and

iv. are aware of how to access support via the Towards Wellbeing programme.

v. A system enabling “self-harm” flags to be applied to CYRAS records should be developed, given the evidence of the significance of self-harm as a risk indicator; and

vi. Oranga Tamariki should consider an information programme to inform general practitioners of the scope of its services for young people in distress.

XXIII. Oranga Tamariki agrees with the recommendation as to resources and, and I am advised that it continues to recruit additional social workers to achieve a reduction of average caseload from 31 (when Oranga Tamariki started in 2017) to a current average of 21. I note the challenges it faces in recruiting trained staff, and attracting such staff to small and rural centres.

XXIV. Oranga Tamariki supports my recommendation as to training at (b) above, and Mr Lewis helpfully provided an overview of training and initiatives that will have led to enhanced practice since 2015.

XXV. I had made a draft recommendation:

(c) “Suicide risk” alerts should be applied to all files where there is a known history of self-harm, suicide attempts or suicidal ideation to prompt a formal risk assessment where appropriate;

XXVI. Mr Lewis noted the existing CYRAS alert for suicide risk, and the current processes to be followed in the event of an identified risk of suicide. The real issue in this case was that the risk was not identified, and the flag was not applied. In that context, and in light of Mr Lewis’ submissions, I do not consider it necessary to made recommendation (c).

XXVII. I think there is value in a “self-harm” flag. Such harm, falling short of suicidal behaviour is a useful indicator of risk.

XXVIII. Finally, he noted that Oranga Tamariki would consult with the Ministry of Health on whether additional information could be provided by the Ministry of Health to general practitioners. He also noted the "Hear Me See Me" campaign that Oranga Tamariki has developed in collaboration with a number of agencies, including the Health Promotion Agency will be launched this year intended to give young people facing significant difficulties the chance to be heard, understood and better supported. Such information will be available to general practitioners, and will highlight community organisations and support systems that can address issues faced by young people.

General Practitioner / [District Health Board] / Oranga Tamariki

XXIX. I recommend to the General Practitioner / [District Health Board] / Oranga Tamariki that:

a. GPs, DHBs and Oranga Tamariki should develop and implement a policy for ascertaining from Oranga Tamariki whether a patient presenting in relation to self-harm or suicidal ideation is a current client of Oranga Tamariki;

XXX. I originally made a draft recommendation that:

> Referrals of a child or a young person to hospital based mental health services in relation to self-harm or suicidal ideation, or hospital attendances subsequent to a suicide attempt should be referred to Oranga Tamariki.

XXXI. The draft recommendation was controversial and attracted responses from both DHB and Oranga Tamariki. It reflected the evidence (above at [493] and following) and acknowledgement by CYF witnesses that awareness of the 2014 suicide attempt could have been relevant to the way in which that agency responded to the Report of Concern, and that such a scheme already operated within the [District Health Board 2].

XXXII. On behalf of the [District Health Board], Mr Brogden noted that most youth seen by the [DHB] in relation to suicidal ideation or self-harm have had no prior contact with Oranga Tamariki. He expressed that the stigma associated with such a referral, even if not a formal Report of Concern, would be a barrier to engagement between youth, their families and health professionals. He acknowledged the negative connotations associated with Oranga Tamariki (by dint of its statutory care and protection role) and queried the value in referrals to Oranga Tamariki where there has been no prior contact between the young person and that agency. He supported a modification to the recommendation requiring referral only where the youth, or their family were identified as having had prior contact with Oranga Tamariki.

XXXIII. For completeness, Mr Brogden noted that the [District Health Board] did not have a mandate to agree on a recommendation if that proposed a significant change to current practice across New Zealand, and submitted that the recommendation require discussion at a national level by the Ministry of Health and General Mental Health and Addictions Directorate.

XXXIV. For CYF, Mr Lewis raised a number of issues with the recommendations, suggesting that it demonstrated "a concerning lack of practicality". As to that, coronial recommendations are generally broad concepts, the inquest process not generally dealing with the minutiae arising from implementation. That such a scheme appears to be successfully managed within the [District Health Board 2] area detracts from the submission.

XXXV. Mr Lewis noted the significant level of distrust, and reluctance on the part of the community to engage with state agencies, and expressed concern that even a low-level inquiry could create a reluctance to engage with mental health services for fear of a report to Oranga Tamariki, thus placing young people at greater risk.

XXXVI. He acknowledged that health practitioners should be encouraged to refer care and protection concerns to Oranga Tamariki, and to seek information in order to support a health response, but noted experience that referrals to Oranga Tamariki where no care and protection concerns existed increased the risk of distress to the child, young person, and their whānau.

XXXVII. The challenge, as I noted above, is to balance the value of information to both clinicians and social workers against the risk of information exchange being a factor that inhibits use of mental health services.

XXXVIII. While I had thought that the balance could be struck by reference to a threshold for reporting, I think that mandating reporting to Oranga Tamariki has the potential to be counter-productive, and be an obstacle to engagement with mental health services. For that reason, I have stepped back from recommending mandatory referral, and consider that recommendation (a), coupled with the recommendation below as to either a Code of Practice for Information Sharing or specific guidance to relevant agencies as to such disclosure should be sufficient in the majority of cases to ensure clinicians are aware of relevant information held by Oranga Tamariki (and vice versa). Certainly, such inquiries in this case would have revealed relevant information about [the deceased].

XXXIX. I had recommended that:

> (ii) Oranga Tamariki develop and implement a policy for ascertaining from the relevant DHB and GP whether the subjects of reports of concern have any history of self-harm or suicidal ideation;

XL. That seems superfluous in light of Mr Lewis's advice:

a. of practice standards introduced by the Ministry in 2017 specifically addressing the need to work closely with other professionals to ensure that the full range of the needs of the child or young person are identified and addressed in a coordinated way; and

b. that the Ministry has a system for ascertaining from the relevant DHB and GP whether the subject of reports of concern have any history of self-harm or suicidal ideation.

XLI. [The deceased's] case emphasises the need for such processes to be followed. Mr Lewis' advice gives confidence that the likelihood of relevant information being missed is reduced compared to when CYF was responding to reports of concern about [the deceased].

<u>New Zealand Police / Oranga Tamariki</u>

XLII. I recommend to New Zealand Police / Oranga Tamariki that:

a. New Zealand Police and Oranga Tamariki develop, implement and adhere to a clear policy for facilitating both the making of claims to ACC by young sexual assault victims and the counselling for victims following the filing of the claim.

XLIII. Oranga Tamariki and New Zealand Police referred me to the 2016 Child Protection Protocol (CPP) to which those agencies were a party. The protocol provided that:

> Accident Compensation Corporation (ACC) should be the point of first contact for accessing support services for child victims. There is ACC funded support for victims and their whānau following sexual abuse or physical assault. Whānau should be supported to make an ACC claim…

XLIV. Police advised that it would work with Oranga Tamariki to develop a clear policy for facilitating both the making of ACC sensitive claims and follow-up counselling, to be included in an updated CPP, which would specify which agency will be responsible for facilitating the making of sensitive claims, and for arranging counselling for victims following the filing of a sense of claim.

XLV. Oranga Tamariki advised that it would consult with Police on whether additional guidance can be inserted into the CPP document which could then be further elaborated on in guidance to staff at both organisations.

[The School]

XLVI. I recommend to [the deceased's school] that:

a. [The school] should review its truancy procedure to ensure that emerging truancy issues are identified early and escalated appropriately;

b. Recognising that truancy can be a symptom of distress, situations involving sustained truancy should be referred to the guidance counsellor for exploration of underlying concerns;

c. [The school] should develop and implement a policy as to the types of information about a student's wellbeing that should be held by the school, and the levels within the staff hierarchy that such information should be known; and

d. The circumstances in which a Youth Mentor associated with the school can hold him/herself out as a person authorised to receive information relating to students supported by the Youth Mentor on behalf of the school.

XLVII. No specific response was received to the draft recommendations.

Oranga Tamariki, Ministry of Health, Ministry of Education, Children's Commissioner and Privacy Commissioner

XLVIII. I recommend that Oranga Tamariki, Ministry of Health, Ministry of Education, Children's Commissioner and Privacy Commissioner:

a. Develop either rules (as part of the Code of Practice for Information Sharing contemplated by ss 66L – 66N Oranga Tamariki Act 1989) or guidance as to the sharing of information between GP, DHB, Oranga Tamariki, school and any social agency or kaupapa Māori agency engaged with the child or young person relevant to the assessment or management of the child or young person's risk of self-harm.

XLIX. My draft recommendation was:

(i) To develop, as part of the Code of Practice for Information Sharing contemplated by ss 66L – 66N Oranga Tamariki Act 1989 binding rules as to the sharing of information between GP, DHB, Oranga Tamariki, school and any social agency or kaupapa Māori engaged with the child or young person relevant to the assessment or management of the child or young person's risk of self-harm.

L. No specific response was received from the Ministry of Health.

LI. The Children's Commissioner was in favour of a Code and advised of his intention to raise the matter with the Minister, and relevant stakeholders.

LII. Oranga Tamariki noted the July 2019 amendment to the Oranga Tamariki Act 1989 which came into force to address issues that had previously led to a lack of consistent and proactive information sharing across the sector, and detailed its activities to inform relevant bodies of the legislative change. That included guidance to healthcare professionals. Oranga Tamariki did not oppose the recommendation as to the development of a Code of Practice, and helpfully noted that the effectiveness of the current voluntary regime would be the subject of a report to the Minister for Children this year. Any difficulties reported in relation to the flow of information around self-harm or suicide risk might inform the development of a Code.

LIII. The Privacy Commissioner did not consider a Code of Practice to be necessary, there being no indication that the deficiencies in information sharing resulted from the legal framework then applying, or individual's beliefs as to legal constraints.

LIV. He supported my intention to facilitate information sharing, but did not consider a Code of Practice necessary to achieve that, and recommended that further work be undertaken by the relevant agencies to ensure competence in utilising the information sharing mechanisms already in place. The Privacy Commissioner referred me to his submission to the Select Committee on the amendment which raised the potential consequences of information sharing provisions applying to non-governmental providers (as my recommendation contemplates), including undermining relationships between providers and those in need of care.

LV. My thinking had been that a Code of Practice would be preferable, given its purpose to provide guidance and direction as to the application of the new information sharing provisions in the Oranga Tamariki Act 1989, and in mandating information sharing in defined circumstances.

LVI. Overall, I am not wedded to the idea of there being a Code (as reflected in my modified recommendation), provided there is agreement between the relevant stakeholders as to the types of information that is relevant to mitigating self harm risk, to whom such information should be proactively disclosed, and the circumstances where such disclosure should occur.

[Agency 1]

LVII. I recommend to [Agency 1] (and similar community agencies) that:

a. Agencies providing health related services should develop a policy of providing discharge reports to the client's GP to ensure the GP is aware of the issues confronting their patient and the services that have been accessed.

b. In its response to the draft recommendation, [Agency 1] confirmed that all recommendations were achievable and would be implemented on the release of my final findings.

Report back

LVIII. On behalf of the family, [the family representative] asked that there be a process for the parties to report back to the whānau on the implementation of the recommendations. In making that request, she expressed concern that there would be no visibility to the whānau of changes made.

LIX. She submitted:

> we have hoped and continue to hope that from this process, others may in some way benefit, and knowing that the loss of our taonga was not in vain, that she has made a difference. Closure is something we as whānau may never have but knowing that she made a difference in some way will help us move towards that - therefore having visibility of such changes would provide us the knowledge to know that a difference was made.

LX. The Coroners Act 2006 was amended in 2016 following an extensive review. There was considerable debate as to the extent to which this should be a requirement to implement coroner's recommendations, or at least to respond to the same. Unfortunately, the Act was not amended in that respect. As a matter of practice, government departments tend to provide responses to Coroners' recommendations, but they are not bound to. Experience suggests that the private sector seldom provide responses to recommendations, or indeed details as to the implementation of the same. Mandatory responses are a feature of coronial legislation in other jurisdictions. It was something that was supported by the (then) Labour opposition when the 2016 Amendment was debated in the House.

LXI. The Coroners Act 2006 does not permit me to make the direction sought, though I am bound to observe that it would be consistent with the collaborative effort to the inquest taken by all parties for there to be feedback to the family on the implementation of recommendations. My office can forward such feedback to the family should individual parties wish to provide the same.

Note: Pursuant to section 71(2) of the Coroners Act 2006 (as it was pre-2016 amendment), the Coroner has authorised the partial publication of the circumstances of Miss A's death but only by reference to the anonymised form of the finding made available to the media. For the avoidance of doubt, the method of her death must not be published.

In addition, an order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Miss A entered into evidence; Miss A's name or any detail that might tend to identify her or her family, the area in which she resided; her school, the names of the agencies (with the exception of Oranga Tamariki and CYF) and their employees, which provided services to Miss A and her family, the names or details that might tend to identify any person who gave evidence at inquest, or whose evidence was contained in the bundle (with the exception of two witnesses), Miss A's peers, the relevant Police officers or their stations, the contents of any of the evidence (including the bundle) except to the extent that the same is recorded in the anonymised version of the finding in the interests of personal privacy and decency.

Hartshorne [2021] NZCorC 50 (30 March 2021)

CIRCUMSTANCES

Martin Dehar Hartshorne, aged 53, died near Mossop Road, Tokoroa, on 12 March 2019 in circumstances amounting to suicide.

For a number of years, including in the time leading up to his death, Mr Hartshorne had made threats of self-harm but not acted upon them.

COMMENTS OF CORONER ROBB

I. I do not make, nor intend to imply, any criticism of anyone who Martin had direct contact with and to whom Martin had made comments about suicide. As noted above, these were comments that were made often and over a long period, but not acted upon. However, he had accepted and responded to mental health care from professionals when acutely unwell in the past. His tragic death does provide an opportunity to reiterate and provide a reminder about the Ministry of Health advice for anyone who becomes aware of suicide threats being made.

II. The Ministry of Health website provides the following information:[66]

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

      i. Call your local mental health crisis assessment team or go with them to the emergency department (ED) at your nearest hospital.

      ii. If they are an immediate physical danger to themselves or others, call 111.

      iii. Remain with them and help them to stay safe until support arrives.

      iv. Try to stay calm and let them know you care.

      v. Keep them talking: listen and ask questions without judging.

   b. If you think someone is at risk

      i. Ask them – it could save their life

      ii. Asking about suicide will not put the thought in their head.

      iii. Ask them directly about their thoughts of suicide and what they are planning. If they have a specific plan, they need help right away.

      iv. Ask them if they would like to talk about what's going on for them with you or someone else. They might not want to open up straight away, but letting them know you are there for them is a big help.

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

v. Listen and don’t judge. Take them seriously and let them know you care.

c. Help them find support

i. Help them to find and access the support they need from people they trust: friends, family, spiritual, community or cultural leaders, or professionals.

ii. Don't leave them alone – make sure someone stays with them until they get help.

iii. Support them to access professional help, like a doctor or counsellor, as soon as possible. Offer to help them make an appointment, and go with them if you can.

iv. If they don't get the help they need the first time, keep trying. Ask them if they would like your help explaining what they need to a professional.

d. How to be supportive

i. Be gentle and compassionate with them. Don't judge them – even if you can't understand why they are feeling this way, accept that they are.

ii. Try to stay calm, positive and hopeful that things can get better.

iii. You don't need to have all the answers, or to offer advice. The best thing you can do is be there to really listen to them.

iv. Let them talk about their thoughts of suicide – avoiding the topic does not help. Ask them if they've felt this way before, and what they did to cope or get through it. They might already know what could help them.

v. Do not agree to keep secrets about their suicidal thoughts or plans. It's okay to tell someone else so that you can keep them safe.

vi. Don't pressure them to talk to you. They might not want to talk, or they might feel more comfortable talking to someone who is not as close to them.

vii. Don't try to handle the situation by yourself. Seek support from professionals, and from other people they trust including family, whānau or friends.

e. Services that offer more information and support

i. Listed on the history of health website. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated.

III. 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 Hartshorne taken by Police in the interests of decency and personal privacy.

Holland [2021] NZCorC 45 (29 March 2021)

CIRCUMSTANCES

Julie Holland, aged 48, died at her address in Kawerau on 21 April 2019 in circumstances amounting to suicide.

On 24 April 2019 (Julie's birthday), Julie's daughter tried telephoning Julie, who did not answer. This was out of character as Julie and her daughter spoke regularly. Because Julie had previously made comments about self-harm and was experiencing some personal stressors at that time, her daughter contacted Julie's friend who advised her to notify the Police, which she did.

The Police call-taker asked if there were any dogs at Julie's address and Julie's daughter confirmed there were. Police officers were then tasked to perform a welfare check and were advised that dogs were at the address. Police arrived at 11:10pm on 24 April 2019. On arrival, they did not enter the address because they saw a large free-running dog inside the fence, which they evaluated would require force to neutralise. Despite efforts to alert Julie of their presence outside, the Police officers could not complete the welfare check and notified Police Communications, tasking the welfare check to a later shift.

At 7:53am on 25 April 2019, Police returned to the address but were again unable to contact anyone inside the property because of the dog. Police spoke with a neighbour who advised they thought Julie had gone to Auckland. The officers then tasked the welfare check back for another shift to attempt.

At around 10:00am on 25 April 2019, Julie's friend arrived at her address but could not see inside the house. She spoke with a neighbour who confirmed that the Police had attended earlier that morning. The neighbour suggested Julie was in Auckland. Julie's friend knew she was not, so she forced entry where she discovered Julie's body.

The evidence established, on the balance of probabilities, that Julie died sometime in the evening of 21 April 2019. Consequently, she was already deceased when the Police were asked to carry out a welfare check. However, in considering the actions of the Police in conducting welfare checks, the Coroner noted that despite the Police being forewarned of dogs posing a risk to the safety of Police, that information was not used to enable the officers to determine how to manage dogs at the address, to ensure that the welfare task could still be successfully completed.

The Coroner observed that the presence of dogs may require steps to be taken, such as for example, the input of family to assist in managing dogs at a property and thereby allow the undertaking of a welfare check, or to utilise someone else (such as a friend or neighbour in the area who knows the person and the dogs), or assistance from local authority animal control could be requested to complete that task.

COMMENTS OF CORONER ROBB

I. I do not make, nor intend to imply, any criticism of anyone who Julie had direct contact with and to whom Julie had made comments about suicide. As noted above, these were comments that were made often and over a long period, but not acted upon. However, Julie's tragic death does provide an opportunity to reiterate and

provide a reminder about the Ministry of Health advice for anyone who becomes aware of suicide threats being made.

II. The Ministry of Health website provides the following information:[67]

If you're worried someone may be suicidal

If you are worried that someone is suicidal, ask them. It could save their life.

If they need urgent help

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

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

If you think someone is at risk

Ask them – it could save their life

Asking about suicide will not put the thought in their head.

Ask them directly about their thoughts of suicide and what they are planning. If they have a specific plan, they need help right away.

Ask them if they would like to talk about what's going on for them with you or someone else. They might not want to open up straight away, but letting them know you are there for them is a big help.

Listen and don't judge. Take them seriously and let them know you care.

Help them find support

Help them to find and access the support they need from people they trust: friends, family, spiritual, community or cultural leaders, or professionals.

Don't leave them alone – make sure someone stays with them until they get help.

Support them to access professional help, like a doctor or counsellor, as soon as possible. Offer to help them make an appointment, and go with them if you can.

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

If they don't get the help they need the first time, keep trying. Ask them if they would like your help explaining what they need to a professional.

How to be supportive

Be gentle and compassionate with them. Don't judge them – even if you can't understand why they are feeling this way, accept that they are.

Try to stay calm, positive and hopeful that things can get better.

You don't need to have all the answers, or to offer advice. The best thing you can do is be there to really listen to them.

Let them talk about their thoughts of suicide – avoiding the topic does not help. Ask them if they've felt this way before, and what they did to cope or get through it. They might already know what could help them.

Do not agree to keep secrets about their suicidal thoughts or plans. It's okay to tell someone else so that you can keep them safe.

Don't pressure them to talk to you. They might not want to talk, or they might feel more comfortable talking to someone who is not as close to them.

Don't try to handle the situation by yourself. Seek support from professionals, and from other people they trust including family, whānau or friends.

Services that offer more information and support

Listed on the history of health website. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated.

Note: Orders under sections 71 and 74 of the Coroners Act 2006 (Coroners Act) apply. Accordingly, no person may, unless granted an exemption under section 71A of the Coroners Act, make public the method or suspected method of this death, or any details that suggest the method or suspected method of the death, and may not publish photographs taken of Julie taken during the investigation into her death, on the grounds that it is in the interests of decency and personal privacy.

Lilly [2021] NZCorC 16 (3 February 2021)

CIRCUMSTANCES

Jeffrey James Lilly, aged 66, died on 11 June 2017 at Flat 3, 34 Eversleigh Street, St Alban's, Christchurch, in circumstances amounting to suicide.

Mr Lilly was divorced with two adult daughters. He and his ex-wife had maintained an amicable relationship, and she described him as a good man and a good father. However, she also said Mr Lilly had always been a heavy drinker, with his alcohol abuse worsening in recent years. Mr Lilly had lost his licence in 2015 due to multiple drink driving offences,

and was convicted of driving while disqualified in early 2016. In the year preceding his death, Mr Lilly's relationship with his daughters had become strained and Mrs Lilly recalled that Mr Lilly had threatened suicide during an argument with one of their daughters.

On the day of his death, Mr Lilly expressed an intention to take his own life in a text message to Mrs Lilly. Mrs Lilly contacted Police, who went to conduct a welfare check and found Mr Lilly deceased in his home. A list of contact names and phone numbers had been left, along with a note expressing Mr Lilly's love for his children.

COMMENTS OF CORONER HESKETH

I. From the evidence gathered in the inquiry it is apparent that Mr Lilly had voiced suicidal ideation in the past, albeit in the context of a family argument. He had a serious problem with alcohol which put him in a very negative frame of mind. He had informed his GP that he was depressed.

II. Help is available to anyone who is struggling and thinking of harming themselves. Help is also available to anyone who is concerned or aware that a friend, family member or anyone else is feeling that way.

III. Information about the ways a person can support someone who is thinking about harming themselves is available at:

    a The Ministry of Health website on suicide prevention, the signs to watch for and ways of supporting someone who is suicidal at: https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide

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

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

IV. Some options and the contact details of some agencies that can help are listed below. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated:

    a For Counselling and Support:

        - Need to Talk? Free call or text 1737 any time
        - Lifeline – 0800 543 354
        - Samaritans – 0800 726 666

b For Children and Young People:

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

Note: Pursuant to section 71 of the Coroners Act 2006, no person may make public the method of death, or any detail that suggests the method of death. The death may be described as a suicide. An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Mr Lilly entered into evidence in the interests of personal privacy and decency.

Maaka [2021] NZCorC 34 (17 March 2021)

CIRCUMSTANCES

Houston Georgia Lexington Cairo Letrel Maaka, aged 18, died in Manurewa, Auckland on 21 November 2017 in circumstances amounting to suicide.

Houston primarily used social media to communicate with her peers.

COMMENTS OF CORONER TETITAHA

I. I make the following comments pursuant to section 57A of the Coroners Act 2006:

II. The current Government's Suicide Prevention Action Plan 2019-2024 seeks to build a nationwide suicide prevention system including the establishment of the Suicide Prevention Office. It is hoped this plan may prevent deaths such as Houston's in future.

III. The focus of the plan appears to centre upon the provision of supports and services primarily through District Health Boards (DHB) and current investment in Māori and Pasifika DHB, NGO and community suicide prevention services and develop resources. This may limit the ability to identify at risk youth such as Houston. She had no discernible health issues including no history of mental illness or treatment or alcohol or drug addiction. It is unlikely these groups would have had contact with Houston or similar young adults.

IV. Most young people at risk such as Houston are active social media users. More often (as occurred here) social media messaging and posts about their distress precedes a suicide death. Any strategy targeting the reduction in youth suicide could seek to identify at risk youth through or involving the forums that they use.

V. It is possible for social media and the algorithms underpinning social platforms to identify and influence young users such as Houston who may be exhibiting distress and direct them to appropriate assistance. This type of intervention may have prevented this death.

VI. A specific social media strategy to identify at risk youth would be beneficial in preventing further deaths such as Houston's.

VII. These comments were directed to the Suicide Prevention Office and the Ministry of Health. I provided a copy of this decision to the Suicide Prevention Office. I received a detailed response summarised below:

    a. We have previously been involved in discussions about the potential use of algorithms in the context of managing responding to risky and unsafe communications of social media. Algorithms are an extremely expensive tool, and more difficult to utilise the way proposed than it might seem.

    b. There is an action item in the national suicide prevention action plan to "develop, implement and evaluate new suicide media guidelines, with an additional focus on social media and entertainment media, to encourage responsible reporting";

    c. Work is underway and the scope is reporting and depiction of suicide; in the context of social media is expected to include references to suicide.

    d. A critical aspect of driving change, responsibility and safety in this area is to educate everyone about the appropriate ways of responding to such messaging when they view it, which while a challenge is probably more achievable than using algorithms. This is also likely to have a greater impact on vulnerable populations, as such education would inform their responses to distress and talk with suicide in all contexts, not just social media.

    e. The coroner might consider making a comment or recommendation that the next suicide prevention action plan give due consideration to the way in which young people experiencing suicidal distress use social media and opportunities for prevention in that space.

RECCOMMENDATIONS OF CORONER TETITAHA

I. I have considered the suggested recommendations from the National Suicide Prevention Office. I have determined to make the following recommendation to the Ministry of Health and the National Suicide Prevention Office pursuant to section 57A of the Coroners Act 2006:

    a. That any future suicide prevention action plan includes consideration of the way in which young people experiencing suicidal distress use social media and opportunities for prevention in that space.

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 Ms Maaka taken by Police in the interests of decency and personal privacy.

Sutton [2021] NZCorC 47 (29 March 2021)

CIRCUMSTANCES

Phillip David Eric Sutton, aged 48, was found dead at his home in Hokitika on 3 October 2017 in circumstances that amounted to suicide.

Philip was struggling with the effects of persistent mental health diagnoses as well as with his work. In February 2017, he wrote to senior management voicing his concerns about the culture or his workplace. His employers believed that these issues were resolved at a subsequent meeting, but for Phillip, they remained a cause of concern over the following months.

In October 2017, Philip told a number of his friends and workmates that he was feeling very low and very unhappy. He also told a friend that he was very unhappy about the way he was being treated at work.

COMMENTS OF CORONER ANDERSON

I. He Ara Oranga, the 2018 Government Inquiry into Mental Health and Addiction, noted that around 1 in 5 New Zealanders experience mental distress or addiction challenges in any given year.[68] People who might benefit from professional support or treatment can find it hard to reach out to service providers and ask for help. It is not an easy step to take. Despite the encouragement and best efforts of friends, family members and workmates it can be difficult to persuade some people to seek the assistance that they need.

II. The Mental Health Foundation provides some useful information about how to support individuals who may be depressed or thinking about suicide. This material is available at https://www.mentalhealth.org.nz/get-help/a-z/resource/48/suicide-worried-about-someone.

III. There is also specific information available about how to promote wellbeing and support mental health in the workplace. This can be found at https://www.mentalhealth.org.nz/home/our-work/category/27/workplace-wellbeing.

IV. I do not intend to make any formal recommendations, as contemplated by the Coroners Act 2006, in relation to Philip's death. However, I highlight these existing resources and note the importance of educational material of this nature.

Note: Orders under sections 71 and 74 of the Coroners Act 2006 (Coroners Act) apply. Accordingly, no person may, unless granted an exemption under section 71A of the Coroners Act, make public the method or suspected method of this death, or any details that suggest the method or suspected method of the death, and may not publish photographs taken of Philip taken during the investigation into his death, on the grounds that it is in the interests of decency and personal privacy.

[68] He Ara Oranga, Government Inquiry into Mental Health and Addiction (2018) at paragraph 1.4.

Mr X [2021] NZCorC 11 (22 January 2021)

CIRCUMSTANCES

Mr X died in circumstances that amount to suicide.

Mr X was employed in a role that subjected him to high pressure and traumatic material. He had numerous personal stressors in his life. In the period leading up to his death, he was noted by colleagues to have elevated levels of stress and a tendency to become excessively agitated. This was reported to a senior person in the organisation.

Mr X sought counselling for relationship issues in the month prior to his death but did not take up the suggestion from colleagues to have counselling for matters occurring in his professional life.

The Coroner requested an expert opinion from Jacqui Maguire, a clinical psychologist and expert in organisational well-being, on particular issues, including "what can be put in place in high stress work environments to manage stress, identify highly stressed individuals and support those in need?" Ms Maguire provided the following recommendations about steps that could be taken to support individuals in Mr X's role to prevent similar deaths occurring in the future:

1. Consideration of mandatory professional supervision on a regular basis (minimum monthly). She notes there is growing international evidence that in some high stress professions there is a risk of experiencing heightened levels of psychological distress, anxiety, depression, secondary trauma, burnout, and alcohol dependence. She also notes that some roles create isolation and loneliness. There can be prolonged exposure to traumatic material, high workload, public scrutiny and emotional labour (the process of managing or suppressing feelings and expressions to fulfil the emotional requirements of the job). In her opinion, these factors were documented in Mr X's case.
2. Quarterly (minimum) review of [workload], especially if an individual employee is experiencing either personal or professional challenges.
3. Biannual (minimum) performance reviews.
4. Mental health awareness training for all staff including providing skills to enhance mental health and manage workplace challenges.
5. Well-being conversation training for those in leadership positions including how to spot signs of concern in others, how to raise and conduct well-being conversations and how to plan a support program.
6. Developing a culture of psychological safety within the organisation. Ms Maguire advises that psychological safety is a shared belief that the team a person works in is safe for interpersonal risk-taking. People should not be afraid of negative consequences such as being criticised, ignored, laughed at, punished for speaking candidly, sharing ideas or seeking support.
7. A review of the [workload] model.

COMMENTS OF CHIEF CORONER JUDGE MARSHALL

I. Part of a coroner's role under the Coroners Act 2006 is to make recommendations or comments that, in the coroner's opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.

II. Section 57A(3) of the Coroners Act provides that recommendations or comments must –

a. be clearly linked to the factors that contributed to the death to which the inquiry relates; and

b. be based on evidence considered during the inquiry; and

c. be accompanied by an explanation of how the recommendation or comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

III. I have considered whether there are any recommendations that could be made in this case however it is difficult to clearly link any of the specific recommendations made by Ms Maguire to the factors that contributed to Mr X's death. Mr X was receiving counselling (albeit relationship counselling as opposed to personal counselling) and was resistant to seeking other forms of professional help. Professional supervision was available to all in his profession at the time and he was aware of that. His mental health decline had been noted by colleagues and he was being supported by them. However, he was facing numerous and long-standing challenges in his private and professional life.

IV. While it is difficult to identify one or more actions that would have prevented Mr X's death, the recommendations made by Ms Maguire are valuable and should be considered by any organisation. Her suggestions are designed to improve the mental health and resilience of organisations as a whole and to provide skills for identifying and supporting those in need.

V. In August 2020, the Director of the Suicide Prevention Office, Carla Na Nagara, issued a media release. She stated in part.

> "Preventing suicide requires an all-of-society effort from everyone. We all impact one another's wellbeing – this includes friends, family members, employers, colleagues, sports clubs, social clubs, NGOs and Government departments, as well as health and mental health services. We all have a part to play in preventing people from becoming so distressed that they see suicide as their only option.
>
> No matter what the stress is - and I acknowledge there is significant pressure in many of our communities at this time – if our mental wellbeing is strong, we can cope better with problems and uncertainty in our lives.
>
> Every single one of us has a role to play in suicide prevention. It's up to all of us."

VI. I am aware that the organisation has, in 2020, introduced a wellness programme for the profession. This has been adopted by other factions in the profession. The programme actively encourages people to undertake regular psychological supervision. It plans to provide education to identify indicators of stress and create tools to deal with stress.

VII. The organisation has also introduced a mentoring programme.

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

An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr X taken by Police and the publication of a note addressed to his wife in the interests of decency and personal privacy.

Sudden Unexpected Death in Infancy (SUDI)

Sudden Unexpected death in Infancy (SUDI) is an ongoing issue in New Zealand and Coroners continue to endorse the advice of the Ministry of Health. SUDI findings are also referred to the agencies responsible for SUDI prevention strategies.

Clark [2021] NZCorC 42 (24 March 2021)

CIRCUMSTANCES

Mason Ua Clark was four months of age when he died at his home in Huntly, on 28 July 2019, from asphyxiation in the context of an unsafe sleeping environment.

Mason was the fourth child to his parents, who are both of Māori descent. In the evening of 27 July 2019, Mason's father cared for Mason and prepared a makeshift bed for them to sleep on in the lounge by pushing a single bed between a couch and an armchair. Mason's mother and two of his siblings stayed in a bedroom. Later that evening, one of his siblings joined Mason and his father in the lounge and fell asleep on the couch. Soon after, Mason and his father went to sleep on the single bed.

At around 1:15am on 28 July 2019, Mason's father woke and could not see Mason next to him. He then saw that Mason had fallen between the single bed and the couch. Mason was facing downwards and only his legs were visible. Unfortunately, Mason's sibling was partially resting on top of him. Help was sought and resuscitation attempted. Attending ambulance personnel were unable to resuscitate Mason.

COMMENTS OF CORONER ROBB

I. This is a tragic case where Mason, a well-cared for and loved baby, has passed away in an unsafe sleeping environment.

II. Considerable effort is 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 back, in their own sleeping space (a firm, flat and level service with no pillows), 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 be delivered in a way that is understood, and the importance of the message appreciated.

III. Ministry of Health guidelines were launched to reduce the sudden unexpected deaths of infants.[69] 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 whānau/family, in the home and in the waka/car) and unsafe bed sharing (i.e. co-sleeping in the bed with baby).

IV. For ease of reference I provide the guidelines in full:

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
- 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

[69] 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.

- 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).

V. In light of the messaging and information provided and widely circulated about safe sleeping practices, as well as coronial recommendations and comments that have been made on the issue of safe sleeping, further recommendations or comments are not called for.

VI. Nevertheless, 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 Mason following his death, on the grounds that it is in the interests of decency.

Langdale-Hunt [2021] NZCorC 23 (22 February 2021)

CIRCUMSTANCES

Annabelle Verlie Rose Langdale-Hunt, aged approximately two and a half months, of Christchurch died on 26 November 2018 of a sudden unexpected death in infancy (SUDI) on the background of SOTOS syndrome.

Annabelle was born at 38 weeks gestation and spent time in the Neonatal Intensive Care Unit (NICU) due to hypotonia, particularly in the trunk and neck muscle area. She had difficulty with feeding and initially required a feeding tube. She had a number of dysmorphic features (abnormal differences in body structure) that were suggestive of an underlying genetic diagnosis. She had poor self-control and ability to regulate sensory input to enable focusing on a task (such as feeding).

Annabelle slept in a bassinet at night. She had her own room and her parents had a monitor set up in the bassinet with an alarm system that would activate if Annabelle stopped breathing. In relation to her low muscle tone, her parents noticed that she was unable to lift her head as other two-month old babies might.

Annabelle's parents raised concerns regarding Annabelle's breathing. On occasion Annabelle would almost gasp for breath, but after gasping would breathe normally. Her parents were also concerned that she would sometimes hold her breath until she was red in the face. She would do this multiple times during the day and would make a grunting noise.

At 6:30am on 26 November 2018 Annabelle woke and was fed by her father. After the feed she slept until approximately 9:30-10am. Her mother gave her another feed over the course of an hour and then put Annabelle back down to sleep.

Annabelle woke again between 12:30 and 1:30pm for another feed. Her mother noted that Annabelle appeared warm so she removed a layer of clothing from her. Annabelle was crying so her mother swaddled her with a blanket and then lay down on the sofa, with Annabelle on her side so she could rub her back as this normally settled her. Anabelle started to settle and fall asleep but would wake every couple of minutes crying.

Anabelle's mother fell asleep for a period of time while they were both on the couch together. She remembered waking suddenly from a loud noise in the movie. Annabelle was still asleep so she got up and moved her into her safe sleep device known as a 'Moses basket'. When she lay Annabelle down in the basket she placed her onto her back with her face up and covered her with a blanket, up to her torso.

At around 3pm Annabelle's mother moved the Moses basket into Annabelle's bedroom and then placed the Moses basket in the cot. She would normally put the apnoea monitor on Annabelle but did not on this occasion as she did not want to undo the blanket which was wrapped around Annabelle and disturb her. Annabelle was placed on her back with her head to the side in the middle of the Moses basket.

At approximately 4:30pm Anabelle's mother went to check on her and immediately noticed that Annabelle looked pale. The wrap blanket was partially over one side of her face. She approached and tried to wake her and noted she felt "sloppy". She immediately commenced CPR and contacted emergency services; however, Annabelle could not be revived.

The post mortem determined the cause of death as SUDI on a background of a suspected, as yet undetermined, genetic abnormality. Subsequently, the Coroner received the genetic testing results which showed that Annabelle had a likely pathogenic variant in a gene called NSD1. Mutations in this gene cause SOTOS syndrome. The Coroner concluded that Anabelle's death could not have been prevented as complications caused by SOTOS may increase the risk of SUDI.

COMMENTS OF CORONER HESKETH

I. The loose blanket riding up over Annabelle's face is troubling and is a matter that requires further comment. Despite my finding in this case I take this opportunity to reinforce the safe sleep message. It is an ongoing challenge to ensure that the safe sleep message is not only explained to all parents and caregivers but is also understood.

II. In terms of formal comments pursuant to the Coroners Act 2006, I draw attention again to the safe sleeping practices which are recommended in the information published by the Ministry of Health on its website.[70] That reads:

> **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.

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

Make sure that your baby is safe

To keep your baby safe while sleeping, make sure:

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

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

Make sure that your baby's bed is safe

Baby's bed is safe when:

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

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

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

If you don't have a baby bed, talk to your nurse. If you are on a low income, you may be able to get a Special Needs Grant from Work and Income to buy a bed. See the Work and Income website or call 0800 599 099.

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

Workplace

Chambers [2021] NZCorC 49 (30 March 2021)

CIRCUMSTANCES

Gerald Brian Chambers, aged 76, of Aria died on 2 February 2019 at Aria of hypovolemic shock due to traumatic injuries sustained in a quad bike collision.

Mr Chambers owned and operated a farm. On the morning of 2 February 2019, he and two others went to fix a water pump. They travelled on a quad bike with a trailer attached. On the return journey, one of the three, a 16-year-old with limited quad bike experience, drove them back. Mr Chambers was on the back of the quad bike and the third person was standing in the trailer. Mr Chambers was not wearing a helmet.

The track terrain was difficult to navigate and the driver of the quad bike travelled slowly. As they rounded a left-hand corner, the driver attempted to manoeuvre another corner, but the quad bike did not turn as he wanted it to. Instead, it continued straight, off the track, before rolling down a steep hill into a gully. The trio were ejected and landed in various positions near the quad bike and trailer. Mr Chambers died at the scene.

RECOMMENDATIONS OF CORONER ROBB

I. Quad bike deaths have been the subject of numerous recommendations by coroners. I note the warnings previously made with a view to reducing the risk of death or serious injury occurring in the future.

II. I recognise that those who are experienced and regularly use quad bikes may well evaluate the risk of serious harm or injury as minimal. However, this can lead to complacency and Mr Chambers' tragic death serves as an example of how a small error can have a fatal outcome. Re-familiarisation with safe and conservative practice is consequently important. To state the obvious, accidents are unplanned events.

III. WorkSafe have prepared fact sheets (Using a Quad Bike to Tow and Carrying Passengers on Quad Bikes) and a good practice guide (Safe Use of Quad Bikes) provide good guidance. I reiterate the importance of:

   a. Wearing a helmet, with this logically reducing the risk of brain injury or death.

   b. Ensuring the rider is of an appropriate age and experience to operate the quad bike.

   c. Restrictions on carrying passengers be followed.

   d. Transporting of loads be undertaken by considering the terrain, the appropriate weight, and the distribution of the load. A conservative approach as opposed to risk-taking best reduces the chances of serious injury or death.

IV. A copy of this finding has been sent to the following entities, in the hope that they can pass the message on to those members of the community most likely to be using quad bikes on rural properties:

a. Ministry for Primary Industries

b. Federated Farmers

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

Goodwin [2021] NZCorC 33 (17 March 2021)

CIRCUMSTANCES

Levi Dylan Goodwin died at Pukehou Road, Bulls on 9 July 2018. The cause of death was multiple injuries sustained in a forestry incident.

On 9 July 2018, Boyd Contracting Limited (BCL) was carrying out ground-based logging for John Turkington Ltd (JTL) on a forestry block situated at Pukehou Road, Bulls. Mr Goodwin was working for BCL as part of a four-person logging crew.

Due to deteriorating weather conditions the decision was made to leave the site. Mr Goodwin was standing next to a vehicle about to leave the site, when a large tree toppled over and landed on him and the vehicle. Mr Goodwin died at the scene.

The tree that fell was being used as a pivot tree. The purpose of the pivot tree is to hold onto the extraction track trees that are being pulled by a skidder around a corner or on a slope, so that the trees being extracted do not swing out and damage nearby structures or places. The use of pivot trees is an approved forestry practice. Mr Basher, a forestry expert, gave an opinion to WorkSafe as to whether the pivot trees were hazardous. In his view, BCL did not need to use the pivot trees at all. From his assessment of the temporary skid site Mr Basher stated:

> The skidder had been moving on the inside of Tree A [the tree which failed] and the outside of Tree B [the tree next to Tree A], as shown by the tire marks in the mud. The track is straight, and the skidder did not need to use Tree A to keep the drag on the track. Tree A did not serve to keep the drags away from the fence and the laneway.

RECOMMENDATIONS OF CORONER FITZGIBBON

I. WorkSafe decided to take no further action in relation to this incident. In the report it does outline that it was practicable for [BCL] to have;

1. Conducted an adequate risk assessment of risks posed by standing trees at the temporary landing area, including consideration of:

i. The potential uses to which the temporary landing area may be put by workers and others, such as for parking, transit and forestry work.

ii. The proximity to and positioning of potentially hazardous trees in relation to the temporary landing area.

iii. The elevated risk of potentially hazardous trees falling over (failing) due to removal of supporting trees, heavy machinery traffic, sodden conditions and exposure to unpredictable wind forces.

iv. Whether controls chosen to manage the risks provided workers with the highest degree of protection reasonably practicable.

2. Adequately consulted with JTL as to the effective management of risks to workers at the O'Leary woodlot, including the risk of workers being struck by potentially hazardous trees at the temporary landing area.

II. I advised [BCL] and [JTL] that I would be considering the report from WorkSafe New Zealand and the identified issues raised by WorkSafe in their report. Both companies have had the opportunity to respond.

III. [BCL] state as follows:

> Boyd Contracting Limited (BCL) does not agree with the opinion of the Forestry Expert, Leon Basher in paragraph 17.
>
> BCL made the decision to leave the pivot tree standing to protect the farm infrastructure along a laneway race that was being used for an extraction track.
>
> This decision was made on the advice of skidder operator for machine stability and to minimise damage to laneway posts.
>
> Pivot tree A had not yet been used for its intended purpose as noted above which was why the tracks were going around the inside of Tree A.
>
> It should be noted that this was a sudden freak weather event. I attempted to manage the situation by making the call to stopping work for the day as the weather was changing. If I had ignored the changing weather situation the tree would have still blown over and maybe hit the parked vacant utility vehicle. The landing processing deck and safe area were clear of the falling tree.
>
> In light of this event BCL has become more vigilant in the management of trees left standing near landings and access roads.

IV. [JTL] state as follows:

> John Turkington Limited (JTL) does not agree with the opinion of the Forestry Expert, Leon Basher in paragraph 17. JTL supports the decision by Aaron Boyd of Boyd Contracting to leave the pivot tree standing to protect the farm infrastructure along a laneway race that was being used for an extraction track.
>
> It should be noted that this was a sudden freak weather event. Aaron attempted to manage the situation by stopping work for the day. If Aaron had ignored the changing weather situation the tree would have still blown over and maybe hit the parked vacant utility vehicle. The landing processing deck and safe area were clear of the falling tree.
>
> In light of this event JTL has become more vigilant in the management of trees left standing near landings and access roads.

V. Accordingly, I consider that appropriate steps have been taken by [BCL] and [JTL] to reduce the likelihood of deaths occurring in similar circumstances to which the death of Mr Goodwin occurred, and I do not propose to make any further recommendations.

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

Kaynes [2021] NZCorC 21 (16 February 2021)

CIRCUMSTANCES

Tracey Royston Kaynes, aged 60, died on 26 January 2020 at 314 Timaru Road, Waimate of traumatic asphyxia due to compression beneath tractor.

On 26 January 2020 Mr Kaynes went to his property at 314 Timaru Road to clear the land of felled trees. He owned a 1981 International 684 Tractor, which had a rollover protective structure attached. Sitting on his tractor Mr Kaynes attempted to lift a log approximately 9.22 metres long and 0.67 metres wide using baling forks attached to a boom. He tried to reverse but the log was too heavy and the tractor wheels spun in the dirt. When Mr Kaynes tried to lift the stump higher the weight shifted, causing the tractor to tip to the left. Mr Kaynes attempted to jump out of the tractor towards his wife who was standing on the right but was not able to. He was thrown to the ground on the left side of the tractor and the tractor rolled on top of him pinning him to the ground. Emergency services were notified. Mr Kaynes was confirmed as deceased.

The Police noted that, due to the tractor's age, no seatbelts were fitted (the fitting of seatbelts is mandatory in tractors purchased after 2001). Seatbelts on a tractor are designed to be used in conjunction with the rollover protective structure by keeping the operator within the confines of the rollover protective structure during a rollover, thereby reducing the chance of injury.

RECOMMENDATIONS OF CORONER ROBINSON

I. Police recommended that retrofitting older model tractors such as the one involved in the rollover with seatbelts as that could have prevented Mr Kaynes' death.

II. I endorse that recommendation. This case emphasises the importance of wearing a lap seat belt in a tractor unit fitted with a rollover protective structure. It also highlights the importance of being aware of gravity issues when operating a tractor or other farm vehicle, particularly on terrain that may compromise the balance or mobility of the tractor.

III. I made a draft recommendation to WorkSafe New Zealand that the Approved Code of Practice (above) be amended to require seatbelt systems to be fitted to all agricultural tractors with rollover protection devices (regardless of age), such systems to comply with AS 2664 or an equivalent that encompasses the same or more stringent criteria.

IV. Mr Parkes, the chief executive of WorkSafe New Zealand replied, recording his agreement that having seatbelts fitted to all tractors with rollover protective structures has the potential to save lives. He noted a legislative impediment to my draft recommendation.

> **19 Application of regulation 20**
> …
> (2) Regulation 20 does not apply to the following:
> …
> (j) any tractor used in agricultural work:
>
> **20 Self-propelled mobile mechanical plant**
> (1) Every employer must, so far as is reasonably practicable, ensure that every self-propelled mobile mechanical plant to which this regulation applies is fitted with a roll-over protective structure and a seat belt.
> …

V. He advised of proposed regulatory reform:

> At present WorkSafe cannot legally require seatbelt be retrofitted for all tractors - regardless of age - used for agricultural work. The Health and Safety in Employment Regulations 1995, which remain in effect, specifically exempt any tractor used in agricultural work from a requirement that mobile plant must be fitted with ROPS [rollover protective structures] and a seatbelt. Therefore, as the law stands, the ACOP cannot be amended in this way without cutting across the regulations.
>
> However, MBIE is leading a plant and structures regulatory reform process that proposes removing current exemptions. MBIE proposes that the new regulations require mobile plant to have a suitable combination of operator protective devices (OPDs), so far as is reasonably practicable.
>
> Although the new regulations - if approved by the government - wouldn't make specific OPDs like seatbelt mandatory, we would expect a risk assessment involving a tractor with ROPs fitted would identify a seatbelt is needed to manage the risk of being crushed in a rollover. We will develop guidance on our expectations about OPDs, and how to assess risk to identify what a suitable combination of OPDs looks like for individual circumstances. The guidance would be released as part of the new regulations' implementation, which is intended to begin in 2022

VI. I endorse the intent of the proposed reform and express my hope that it is given proper effect by government. Given that project is underway, I do not need to make formal recommendations.

VII. I direct that a copy of this finding be sent to Federated Farmers for that entity to give publicity to the circumstances of this death as a reminder of the need to retrofit older model tractors with seatbelts.

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

Lim [2021] NZCorC 53 (31 March 2021)

CIRCUMSTANCES

Calvin Lim, also known as Fung Chye Lim, aged 29, of Malaysia died between 3:00pm and 4:00pm on 21 December 2017 on Mount Somers of high energy impact injuries to head and limbs from a tumbling, sliding fall from a height in steep sub-alpine terrain.

Mr Lim was a Malaysian national who had lived in New Zealand since 2008. At the time of his death he was working for the Department of Conservation (DOC) as volunteer hut warden on the Mount Somers track in the Hakatere Conservation Park in mid Canterbury. The tramp to the summit of Mount Somers is classified by DOC as an advanced tramping track, requiring moderate to high levels of skills and experience.

On 21 December 2017 Mr Lim completed his hut warden duties and left Woolshed Creek Hut at 10:30am. He recorded in the hut wardens' daily diary record that he was "off to Pinnacles Hut and back, to drop supplies and maybe go up summit?" He was expected to be back by 5:00pm for his afternoon warden duties. At midday Mr Lim called his fiancée and told her about his plan. He also mentioned that it was very cold and windy.

Mr Lim arrived at Pinnacles Hut at 12:30pm via the saddle, and told another hut warden, Alice Foote, that he was going to return to the saddle and then go to the summit. Ms Foote recalled that Mr Lim seemed unsure about where he needed to turn towards the summit. When he left Pinnacles Hut at 1:00pm, he was happy and excited. Mr Lim reached the summit and completed an entry in the Mount Somers summit book: "Windy! Cold! Foggy! Can't see a think thank GOD I have my compass. Came up from Pinnacles Hut." Mr Lim did not record the time that he reached the summit.

At 10:30am on 22 December 2017 Ms Foote arrived at Woolshed Creek Hut. She noticed that all of Mr Lim's gear was still there except his pack, personal locator beacon, radio and EFT-POS machine. None of the hut warden tasks for that day had been completed. Ms Foote thought Mr Lim may have gone for a walk to complete the EFT-POS transactions so decided to wait until 12:30pm. She then radioed the DOC office in Geraldine to see if Mr Lim had called in and was informed that he had not. DOC's missing persons procedure was implemented.

A cell phone was found in the safe at Woolshed Creek Hut and later confirmed to be Mr Lim's second cell phone, indicating that he had not returned to the Woolshed Creek Hut. Acting on this information a helicopter, with members of the Land Search and Rescue team on board searched the area under the summit of Mount Somers. They located Mr Lim lying face up in a deep ravine in a creek on the north face of Mount Somers, below the summit. He was still wearing his pack. One of the searchers was able to leave the helicopter to check on Mr Lim and confirmed that he was deceased. Due to the fading light and weather conditions Mr Lim's body was recovered the following morning.

Following Mr Lim's death, DOC completed a full incident investigation as part of its health and safety requirement and concluded that with the southerly wind and poor visibility the more direct route from the summit back to the Woolshed Creek Hut would not have been easy. Thus, it seemed likely that Mr Lim went onto the northern side of Mount Somers where it should have been sheltered sooner than he should have, so he could go down to the saddle.

COMMENTS OF CORONER JOHNSON

I. Mr Lim was tramping alone on Mt Somers. When he arrived at the summit the weather was cold, windy and visibility was poor. He had not turned back when the weather changed. After summitting he attempted to go

back down to the saddle the way he came up but went over to the northern side sooner than he should have done, which led to his fall.

II. The New Zealand Mountain Safety Council has published data on tramping incidents including deaths between 2007 and June 2017. This publication, 'A walk in the park? A deep dive into tramping incidents in New Zealand'[71] shows that between 1 July 2007 and 31 June 2017 falling was the number one case of incidents to trampers. This includes slips, trips and falls. A few common causal factors were seen across all falls which resulted in a fatality. Specifically, a lack of competence was a contributing factor for many of the incidents. This includes causal factors covering skills, experience, ability and choices made by the tramper.

III. Causal factors of death by falling were found to be:

25% - overambitious choice of route

25% - goal focussed with a desire to get to their destination

25% - insufficient /inappropriate equipment

18% - searching for a short cut or alternative path

18% - ice /snow

IV. In addition, the data shows that a surprisingly high number of fatalities occurred while solo tramping and this was disproportionately higher among males, those that were tramping on a route rather than a track and those that died by falling. Causal factors for solo tramping fatalities show that 30% of them had inadequate or insufficient equipment and 30% had a strong desire to get to their destination and 52% were on steep terrain.

V. Social and psychological factors were also found to play a part in why a death occurred, including a misperception of risk/underestimated risk, where the deceased had completed a number of similar trips in the past, and this has led to them being complacent to the risks which were evident and not controlling these risks adequately.

VI. The New Zealand Mountain Safety Council has publications on its website that provide advice. For example, New Zealand's weather can be highly changeable. The advice given is that trampers should source the latest weather forecast for the area they are tramping in, consider the impact the forecasted weather will have on their trip and be prepared to alter their plans to the conditions. The New Zealand Mountain Safety Council notes that one of the best ways to consider the effects the weather will have on a tramping trip is to keep an eye on what is going on around you. If the weather changes it may be significant enough to consider altering the plans.

[71] https://issuu.com/nzmountainsafetycouncil/docs/180529.msc.com.insights-awalkinthep?e=2922887/62283383.

VII. Trampers should carry reliable navigation equipment. The New Zealand Mountain Safety Council recommend that maps are laminated and kept it in a dry, clear plastic bag. The map should be kept handy so that it can be referred to frequently, particularly when moving through unfamiliar or untracked areas.

VIII. I endorse the New Zealand Mountain Safety Council advice and it is readily available to those who may be planning a tramp.

IX. I do not consider I need to make any recommendations.

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

OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND