OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments made between **1 October** and **31 December 2022**

Office of the Chief Coroner | 2022 (4)

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 44 findings with recommendations and/or comments issued by Coroners between 1 October and 31 December 2022.

Contents

Recommendations and comments **4**

1 October to 31 December 2022 ..... **4**

Drowning 4

Broadbent [2022] NZCorC 170 (5 December 2022) 4

Carswell [2022] NZCorC 138 (19 October 2022) 5

Kaur Singh [2022] NZCorC 139 (20 October 2022) 7

Klein [2022] NZCorC 140 (21 October 2022) 13

Prasad [2022] NZCorC 145 (27 October 2022) 15

Drugs and Alcohol 18

Rangiwai-Tikitiki [2022] NZCorC 161 (24 November 2022) 18

Fire 20

Kahukiwa [2022] NZCorC 136 (12 October 2022) 20

Leisure Activities 21

Bridson [2022] NZCorC 141 (27 October 2022) 21

Kava [2022] NZCorC 151 (2 November 2022) 24

Paul [2022] NZCorC 169 (2 December 2022) 27

Planas [2022] NZCorC 137 (18 October 2022) 30

Thomas [2022] NZCorC 176 (13 December 2022) 31

Medical Care 32

Alexander [2022] NZCorC 172 (7 December 2022() 32

Barton [2022] NZCorC 162 (25 November 2022) 34

Gebre [2022] NZCorC 155 (9 November 2022) 38

Joe [2022] NZCorC 153 (3 November 2022) 42

John H [2022] NZCorC 160 (22 November 2022) 45

More [2022] NZCorC 157 (14 November 2022) 47

Riley [2022] NZCorC 167 (1 December 2022) 48

Yeung [2022] NZCorC 164 (25 November 2022) 50

Miscellaneous 51

Marlow [2022] NZCorC 152 (2 November 2022) 51
Sutherland [2022] NZCorC 165 (28 November 2022) 58
Taikato [2022] NZCorC 163 (25 November 2022) 59
Wilkes [2022] NZCorC 147 (27 October 2022) 61
Motor Vehicle 62
Derby [2022] NZCorC 148 (28 October 2022) 62
Hammell [2022] NZCorC 174 (9 December 2022) 63
Hayes [2022] NZCorC 173 (8 December 2022) 63
Heathcote [2022] NZCorC 175 (13 December 2022) 64
Leaf [2022] NZCorC 144 (27 October 2022) 65
McLennan [2022] NZCorC 177 (16 December 2022) 67
Monopoli [2022] NZCorC 149 (28 October 2022) 68
Murphy [2022] NZCorC 150 (1 November 2022) 69
Samuel [2022] NZCorC 135 (5 October 20222) 71
Tawhai [2022] NZCorC 159 (18 November 2022) 72
Terry [2022] NZCorC 146 (27 October 2022) 72
Self-Inflicted 73
Carlin [2022] NZCorC 142 (27 October 2022) 73
France [2022] NZCorC 156 (9 November 2022) 74
Gargiulo [2022] NZCorC 143 (27 October 2022] 75
Halkyard [2022] NZCorC 134 (4 October 2022) 78
Martin [2022] NZCorC 166 (1 December 2022) 80
Quin [2022] NZCorC 158 (18 November 2022) 84
Sionelua [2022] NZCorC 171 (5 December 2022) 86
Wii [2022] NZCorC 154 (6 November 2022) 86
Sudden Unexpected Death in Infancy (SUDI) 88
Tereapii-Pavai [2022] NZCorC 168 (1 December 2022) 88

Recommendations and comments

1 October to 31 December 2022

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

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

Drowning

Broadbent [2022] NZCorC 170 (5 December 2022)

CIRCUMSTANCES

Dawson Peter Broadbent, aged three, died on 18 March 2019 at Riverhead, Auckland of accidental drowning.

On the afternoon of 18 March 2019, Dawson was playing in the children's play area in the backyard of his home address with his siblings. Dawson's mother was inside the house and came outside periodically to check on the children. The backyard was fenced but contained an unfenced, free-standing swimming pool with a height of approximately 117 centimetres. Dawson did not know how to swim and had not had any swimming lessons.

At some point, Dawson entered the pool. Other children at the address alerted Dawson's mother to the fact that Dawson was in the swimming pool. Another child described seeing Dawson climb up using his hands and feet and fall into the pool. Emergency services attended and confirmed Dawson was deceased.

An occupant of the property said the pool was not used that summer as the pump was broken and none of the children had ever gone near it. At the time of Dawson's death, the pool contained between 62 and 76 centimetres of water due to the uneven ground surface. The pool ladder was found lying in the water, however there were several external pipes. Police believed it was most likely that Dawson used these pipes to climb up to the outside of the pool and has then either fallen or climbed into the pool.

Auckland Council were not aware of the pool on the property prior to Dawson's death. The Council advised that every filled or partly filled residential pool with a maximum depth of water of 400 millimetres or more must have physical barriers that restrict access to the pool by unsupervised children under the age of five. The means of preventing access to a residential pool requires a building consent from the Council. Given the pool at Dawson's home was deeper than 400 millimetres, a physical barrier with building consent from the Council was required for the swimming pool.

COMMENTS OF CORONER BELL

I. Dawson's death highlights how quickly tragedy can strike when young children who cannot swim have access to water and the need to be extremely vigilant when young children are at properties containing swimming pools. His death is a tragedy that may have been prevented if the pool, which was within the children's play area, had fencing which was compliant with the law. The fencing of the backyard only is not sufficient nor complies with the law.

II. Dawson's death also highlights the need for constant checking by pool owners to ensure even unused pools do not contain water and that there are no external mechanisms that could be used to gain entry to the pool. It also highlights the importance of compliance for residential pools and pool owners with the Building Act 2004 which sets out the minimum requirements for residential swimming pools.

III. Because the pool in question was unknown to Auckland Council no checks of the adequacy or compliance with the legal obligations relating to the pool had ever been undertaken by the Council.

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

Carswell [2022] NZCorC 138 (19 October 2022)

CIRCUMSTANCES

Frances Rose Carswell, aged 74, died on 4 January 2022 at Wenderholm Beach, Auckland from drowning.

On 4 January 2022 Frances and her wider family went to Wenderholm Beach. Approximately 900 metres long, it is constrained by the Puhoi River to the north and cliffs to the south. The beach is characterised by a low energy wave environment, typically receiving fetch-limited, short-period wind waves. It is a popular location for a range of water-based activities including wading, swimming, bodyboarding and ball sports, and attracts a range of visitors including families with young children and groups of teenagers and young adults. Access is available along the length of the beach through the adjoining grass reserve of Wenderholm Regional Park, although visitors typically access the beach from a track that leads from the main carpark area.

Wenderholm Beach was not patrolled on 4 January 2022. After lunch, Frances and her sister, Shirley, were swimming in the middle section of the Wenderholm Beach front. The sisters felt a rip current and turned to float onto their backs to swim closer to shore.

When she was a little closer, Shirley looked up to see Frances calling out to a man on a surfboard: "can you come and help me". Shirley said that Frances seemed slightly anxious but not particularly distressed. The surfer paddled closer to help Frances get on to the surfboard. Some other people in the water also moved in to help.

Frances was helped back to shore, reportedly going under water several times, and was unresponsive on reaching the beach. She was placed into the recovery position. Shirley said that Frances appeared to be breathing but then lost colour. CPR was commenced but Frances could not be revived. She was pronounced dead at the scene.

Dr Mick Kearney, the National Coastal Safety Manager for Surf Life Saving New Zealand, gave evidence that it was unlikely there would have been rip currents at Wenderholm Beach that day given the reported conditions. However, at the time Frances got into trouble the tide was mid-outgoing. Large volumes of tidal waters would have been exiting the Puhoi Estuary creating strong currents at the northern end of the beach. Dr Kearney considered that what Shirley described, and what Frances might have been caught in, was a strong tidal current rather than a rip current. The Coroner accepted this.

RECOMMENDATIONS OF CORONER HO

I. Pursuant to s 57A of the Act I have the ability to make recommendations or comments to reduce the chances of future deaths occurring in similar circumstances and which are clearly linked to the factors that contributed to Frances Carswell's death.

II. There is a well-defined and deep tidal channel where water enters and exits the Puhoi Estuary. The flow of water scours the channel, which creates a sudden change in water depth, and is directed outwards from the estuary mouth on an outgoing tide. Dr Kearney states that sudden changes in water depth and strong tidal currents therefore pose considerable risk to water users at the northern end of Wenderholm Beach where the estuary is located.

III. Auckland Council is responsible for managing Wenderholm Beach and the regional park in which it sits. There are nine water safety signs located by the Puhoi Estuary and its mouth, including on tracks leading to the headland. The signs adhere to the Australian/New Zealand standard 2416:2010 on water safety signs. They are labelled "Puhoi River Mouth" and warn of strong or swift tidal currents and recommend against swimming. There is also a noticeboard at the main carpark with a map of the park and which warns of strong currents at the headland, including a no swimming symbol at that location, but no signage at or near the beach (away from the estuary mouth) itself. There is no water safety signage at or along the public accessways to the beach.

IV. A casual beachgoer heading for the main beach would not encounter any of warning signage currently in place. The only opportunity they would have of learning about the danger at the estuary mouth is by stopping to look at the noticeboard in the main carpark. Consequently, there is a risk that people might well enter the water along the main beach and swim out towards the north (estuary) end of the beach ignorant of the danger that the tidal currents in that area present.

V. In light of the risk identified to swimmers at the estuary end of Wenderholm Beach, I recommend that AS/NZS compliant signage also be installed at the beach itself which warns of the risk of strong tidal currents at the north end of the beach.

VI. Auckland Council responded to my proposed recommendation on 17 October 2022. It stated that it is committed to working with subject matter experts from Surf Life Saving New Zealand to consider additional signage and safety information at Wenderholm Beach. Auckland Council also noted that it would, at the same time, seek advice on whether any other similar signage should be implemented at other sites with similar hazards in order to ensure consistency of aquatic risk information.

COMMENTS OF CORONER HO

I. Surf Life Saving New Zealand has helpfully provided recommended safety messaging to prevent another drowning in similar circumstances. They are well known. I do not consider it necessary to formalise them as recommendations under the Act but they are worth repeating:

- Choose a lifeguarded beach and swim between the flags.
- Do not overestimate your ability or your children's ability to cope in the conditions.
- Watch out for rip currents which can carry you away from shore. If caught in a rip current, RELAX and float, RAISE your hand to signal for help, RIDE the rip until it stops and you can swim safely back to shore. Remember – nobody is stronger than a rip.
- If in doubt, stay out.
- If you see someone in trouble, call 111 and ask for Police.

II. The above safety messages are important. They should be publicised and reiterated ahead of the upcoming beach season.

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

Kaur Singh [2022] NZCorC 139 (20 October 2022)

CIRCUMSTANCES

Simarpreet Kaur Singh, aged 17, died on 23 November 2021 at Karioitahi Beach of drowning.

On the afternoon of 23 November 2021, Simarpreet and her cousin went to Karioitahi Beach for a swim. Simarpreet frequently went to Karioitahi Beach and was a proficient, but not confident swimmer. Karioitahi Beach is a West Coast beach, exposed to high energy ocean swells from the Tasman Sea. It is not patrolled by surf lifesavers on weekdays.

The water safety signage at Karioitahi Beach on 23 November 2021 was inadequate in many respects and did not comply with the relevant Australian/New Zealand standard. On 10 March 2022, new signage was installed at Karioitahi Beach by Auckland Council which addressed these deficiencies. There is no education signage specifically related to rip currents or what to do if swimmers are caught in a rip.

When Simarpreet went swimming at Karioitahi Beach there was no, or extremely limited, cellphone coverage at the beach. A cellphone signal could only be obtained by walking up the adjoining hillside.

At the time of the incident the tide was mid-outgoing. Dr Mick Kearney, the National Coastal Safety Manager for Surf Life Saving New Zealand, advised that rip currents, likely strong, would have formed with the wave energy and mid stage of the outgoing tide.

Simarpreet and her cousin went swimming about 35 to 50 metres from shore when Simarpreet was pulled out towards deeper water by a rip current. She was seen by her cousin trying to swim back to shore, against the rip current. Emergency services were contacted, and surf lifesaving assistance was requested. Two inflatable rescue boats, two helicopters, and a lifeguard at the water edge searched for Simarpreet. One of the rescue boats found Simarpreet face down in one of the inshore holes north of the main beach accessway, approximately 100 metres out to sea. Simarpreet was taken back to the beach where CPR was commenced but she was unable to be revived and pronounced dead at the scene.

COMMENTS OF CORONER HO

I. Surf Life Saving New Zealand has helpfully provided recommended safety messaging to prevent another drowning in similar circumstances. They are well known. I do not consider it necessary to formalise them as recommendations under the Act but they are worth repeating:

   a. Choose a lifeguarded beach and swim between the flags.

   b. Do not overestimate your ability or your children's ability to cope in the conditions.

   c. Watch out for rip currents which can carry you away from shore. If caught in a rip current, RELAX and float, RAISE your hand to signal for help, RIDE the rip until it stops and you can swim safely back to shore. Remember – nobody is stronger than a rip.

   d. If in doubt, stay out.

   e. If you see someone in trouble, call 111 and ask for Police.

II. Dr Kearney also identified that strong rip currents were especially likely when the tide was mid-outgoing. Swimmers should always be alert to their surroundings and the water conditions, including the risk of rips. However, the fact that mid-outgoing tide is a time of particularly increased risk should form part of a general approach to educating the public about rip currents. This information may influence decisions about whether to get into the water, which may in turn reduce the risk of swimmers getting into difficulties.

III. The above safety messages are important. They should be publicised and reiterated ahead of the upcoming beach season.

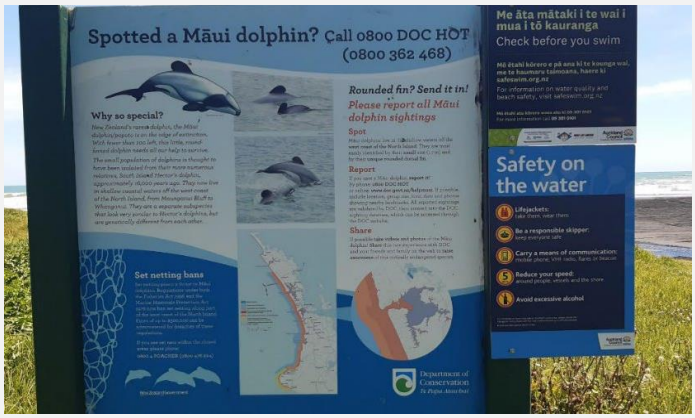
RECOMMENDATIONS OF CORONER HO

I. Pursuant to s 57A of the Act I may make recommendations or comments to reduce the chances of future deaths occurring in similar circumstances and which are clearly linked to the factors that contributed to Simarpreet's death.

II. In the last two years there have been five beach and coastal drowning deaths at Karioitahi Beach. The other four are subjects of separate coronial inquiries. It may be that once those coronial inquiries are completed, common factors are identified between those drownings and Simarpreet's. I confine my analysis to those issues which might have made a difference to Simarpreet or which have been raised by Simarpreet's family.

Signage

III. As at 23 November 2021 there were two small water safety signs mounted at Karioitahi Beach. They were bolted on to the side of a large Department of Conservation sign about Māui dolphins. The water safety signs were on a dark blue background. The first read “Check before you swim” and in smaller size type below, “For information on water quality and beach safety, visit safeswim.org.nz”. The second was headed “Safety on the water” and was directed at mariners rather than swimmers. A photograph of the two signs relative to the Māui dolphin sign is below.



IV. On 10 March 2022 Auckland Council installed three new water safety signs at the beach. The new signs warn visitors of the risk of strong currents/rips, large waves, deep holes and unstable cliffs at the beach, and include details about the presence of lifeguards. The signs are posted adjacent to every vehicular and pedestrian beach accessway. Auckland Council advised that it consulted with Surf Lifesaving Northern Region about the design, size and location of the signs.

V. The design template for the new signs is below.

VI. There is an Australian/New Zealand standard for water safety signs.[1] The standard provides that selection and use of signs should be determined following a risk assessment which takes into account, among other things, hazards and associated risks of the aquatic environment and users and their foreseeable behaviour.[2] The siting of water safety signs should allow hazards to be recognised and allow appropriate avoiding action to be taken. Among the factors which should be considered are the location of the hazards, location of access to the aquatic environment, location of any other signs, and the appropriateness of displaying information on multiple signs.[3] Specifically, the following principles should be considered when planning water safety signage:[4]

a. signs should be sited conspicuously within the normal field of vision;

b. signs should contrast to their surroundings;

c. signs should be visible from any place within the vicinity of the hazard;

d. signs should take precedence over all other signs;

e. care should be taken to avoid over-provision of safety signs at one location as this can confuse viewers and result in individual safety messages not being noticed or understood.

[1] AS/NZS 2416:1:2010.
[2] AS/NZS 2416:1:2010 part 3, section 4.1.
[3] AS/NZS 2416:1:2010 part 3, section 4.2.1.
[4] AS/NZS 2416:1:2010 part 3, section 5.1.1.

VII. The standard recommends the combination of red and yellow for signs as they are colours commonly associated with aquatic environments and lifeguards.[5]

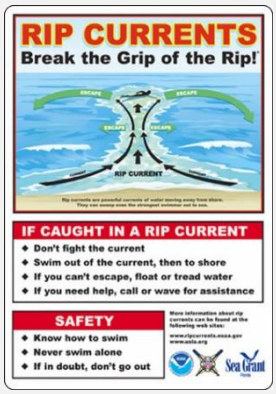
VIII. Water safety signs should conform to the relevant international standard which prescribes the graphical symbols for safety signs for the purposes of accident prevention and health hazard information. Supplementary text alongside symbols should explain their meaning and this text should clearly relate to the safety sign which it accompanies.[6]

IX. The sign mounted at the beach on the day of Simarpreet's death and purportedly directed at swimmers was inadequate in many respects. It did not comply with the relevant Australian/New Zealand standard. There was no clear indication of the hazard targeted by the sign. It said "check before you swim" but did not identify the specific hazards, such as rip currents or inshore holes, for which the reader ought to be checking. The text below that, referencing resources to check water quality, confused any safety messaging in that it suggested the reader ought to be alert to issues about water quality rather than dangerous sea conditions. The text was in varying sizes and the layout was cluttered because it attempted to present the same information in alternating languages (English and te reo Māori). The background colour choice of a dark blue was unlikely to draw the attention of beach users or provide a visual cue that the information on the sign was important. The sign was also bolted on to the side of a larger sign relating to Māui dolphins which meant it could have been easily overlooked in favour of the other information being presented in the same vicinity. Finally, the sign was installed at only one location despite there being multiple access points to the beach.

X. The new set of signage installed in March 2022 addresses these deficiencies. The quality and communication of the information on them is vastly superior to the signs they replaced. They also comply with internationally recognised design standards. This is important because it improves the chances of as many people as possible, from different backgrounds, recognising and understanding the importance of the information on them. Had these new signs not been commissioned I would have recommended, with the strongest possible force, that they should be. Auckland Council's proactivity means that this recommendation is now not necessary.

XI. I make one further recommendation. While I am conscious of the risk of overloading people with information, I consider that it would be beneficial if a separate sign was installed in the beach vicinity to remind swimmers of what to do if they are caught in a rip. Such signs are commonly installed at North American beaches:

[5] AS/NZS 2416:1:2010 part 3, section 7.2.4.
[6] AS/NZS 2416:1:2010 part 3, section 7.2.5.



XII. Simarpreet was seen trying to swim back to shore after being caught in the rip. This is contrary to the general advice not to fight the current and to ride the rip until it stops. Such a sign may educate or remind beachgoers about their best chances of survival if they are caught in a rip and make it more likely that information is prominent in their minds while in the water.

XIII. I notified Auckland Council of my intention to recommend that it consider installing rip education signs. Auckland Council responded on 13 October 2022 and advised that it was not opposed to installing such signs, but it wished first to consult with its usual subject matter experts[7] to understand why such signs had not been installed in the past, where such signs might be installed, and whether there were any other means of public education to complement such signs.

XIV. I formalise my recommendation. Auckland Council should consider, and consult with its experts about, installing rip education signs at beaches where there is a known risk of rip currents. Any signs should be in an AS/NZS and ISO compliant format.

Cellphone coverage

XV. At the time of Simarpreet's death there was no, or extremely limited, cellphone coverage at Karioitahi Beach. A cellphone signal could only be obtained by walking up the adjoining hillside. This could result in delays in notifying rescue services.

XVI. It is plainly desirable in cases of emergency for the alarm to be raised as soon as possible. However, given the rough sea conditions on 23 November, especially around the inshore hole where Simarpreet was ultimately found, and the fact that the closest rescue team was 15 minutes away, it is unlikely that any delay caused by having to obtain cellphone reception compromised Simarpreet's rescue effort. However, it is conceivable that delay may cause issues in future cases.

XVII. I advised Auckland Council of my intention to recommend that it make enquiries with the appropriate providers about improving cellphone infrastructure at Karioitahi Beach. In its response on 13 October, it advised that council officers have reported improved cellphone coverage this year and that cellphone coverage is now available in

[7] Surf Life Saving Northern Region, Surf Life Saving New Zealand and Drowning Prevention Auckland.

most areas of the beach. It further stated that where coverage is still an issue, it was supportive of advocating for and encouraging a joint approach to infrastructure providers with Surf Life Saving Northern Region, Drowning Prevention Auckland and possibly the New Zealand Police.

XVIII. I formalise my recommendation. Auckland Council, with other entities as appropriate, should explore with the appropriate providers about delivering consistent cellphone signal coverage at Karioitahi Beach, including the possibility of installing additional infrastructure.

Conduct of rescue operation

XIX. Simarpreet's family raised concerns about the conduct of the rescue operation. They suggested that surf lifesavers should have gotten everyone out of the water as this might have made it easier to locate Simarpreet.

XX. There is no evidence to substantiate this assertion. The rescue vessels in the water were supported by airborne searchers. Mr Coe, the life saver who eventually located Simarpreet, gave evidence about the search patterns he undertook. He does not say that he was hindered at any point by the presence of people in the water.

XXI. It is appropriate to defer to the experience of surf lifesavers and others who assist in beach rescues about the proper conduct of search operations. It may be that sometimes it is necessary to require water evacuation. I do not have any evidence that this was such a case.

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

Klein [2022] NZCorC 140 (21 October 2022)

CIRCUMSTANCES

Alwyn Keith Klein, aged 73, died by drowning as a result of a boating incident on 9 November 2019.

On the morning of 9 November 2019, Mr Klein and his wife (Mrs Klein) departed Whangamata Harbour in their boat, a 5 metre Marco aluminium trailer boat, for a fishing trip. The boat was powered by a modern outboard engine and was not fitted with a Marine VHF radio. Mr and Mrs Klein motored north to an area near Pokohino Beach and, once there, set a long line. Later that morning, Mr Klein attempted to retrieve the longline however it had become snagged on an anchor weight. Mr and Mrs Klein's subsequent efforts to retrieve the line resulted in the longline becoming tangled in the propeller of the boat's outboard engine. As Mr Klein continued to try and untangle the line, water began to enter the boat which then suddenly capsized and began to sink, forcing Mr and Mrs Klein to abandon the boat. Mrs Klein managed to swim to the beach. Mr Klein was later found deceased when his body washed up onto the beach

Maritime New Zealand (MNZ) investigated the incident and found as follows:

(a) At least two forms of communication should be carried when a person sets out in a boat or other watercraft. These may include Marine VHF radio, mobile phones, flares, or beacons such as Emergency Position Indicating Radio Beacons (EPIRB) or Personal Locator Beacons (PLB). Beacons such as EPIRB or PLB are more reliable

due to their use of satellites to receive the signal transmitted. In addition, Trip Reports (TR) are a valuable and effective tool to assist with boating safety. A responsible person should be informed of the details of the trip, including time and place of departure, the number of people on board, intended destination and /or areas of operation, and the expected time/place of return and/or time of next communication. This would also include an agreed overdue procedure if the boat does not return. No TR had been made by Mr and Mrs Klein.

(b) It was noted that Mr and Mrs Klein had fished in the area of the incident many times and were familiar with it. They generally kept to a reliable schedule. The weather and sea conditions on that day were not cause for concern. While the wind and waves had begun to build around the time of the incident and contributed to the likely cause of the capsize, had it not been for the longline entanglement the weather conditions were not unsafe.

(c) The most likely cause for the ingress of water and the sudden capsize was the longline becoming snagged on the bottom and fixed to the rear of the boat. The boat was suddenly swamped, quickly capsized and Mr and Mrs Klein had no choice but to immediately abandon it and thus unable to access communication equipment on the boat.

(d) Both Mr and Mrs Klein were wearing lifejackets, which had been activated and inflated properly soon after the couple entered the water. When Mr Klein's body was located on the beach, he had been separated from his lifejacket, indicating that his lifejacket had ultimately come off. The lifejackets worn by Mr and Mrs Klein had not been fitted with crotch straps. However, a correctly fitted crotch strap will prevent a lifejacket from riding up and should ensure that the lifejacket effectively holds the person's head above the surface.

RECOMMENDATIONS OF CORONER HESKETH

I. In light of the above evidence and from the comments contained in the MNZ report around recreational boating in New Zealand, I make the following recommendations under s57A of the [Coroners] Act:

a. When people are out on the water at least two forms of communication should be carried when they set out on a boat or other watercraft. One should be in the form of a Personal Locater Beacon (PLB).

b. Whenever possible a Trip Report (TR) should always be left with a responsible person ashore. The TR should inform the details of the trip, including the time and place of departure, the number of people on board, the intended destination and/or area of operation and the expected time and place of return and/or time of next communication.

c. Everyone on board should wear a properly fitted life jacket appropriate to the locations and conditions they are to be used.

d. Life jackets should have crotch straps fitted and adjusted to fit properly as they will prevent the lifejacket from riding up which will ensure the lifejacket effectively holds the person's head above the surface, and completely prevent the lifejacket coming off over the person's head, even if the person is unconscious.

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

Prasad [2022] NZCorC 145 (27 October 2022)

CIRCUMSTANCES

Sheetal Vasantika Prasad, aged 31, died on 28 October 2019 at Whites Beach, Anawhata, Waitakere, as a result of drowning with blunt force injuries of the head a contributing condition. Her death was accidental.

On 28 October 2019, Ms Prasad and her husband, Samuel Krishna, decided to go fishing at Te Waha Point, a small headland between North Piha and Whites Beach. They were familiar with the area and had fished there a number of times before.

Ms Prasad and Mr Krishna arrived at North Piha carpark at around 1:15pm, then walked approximately 3 kilometres along a track from the carpark to Te Waha Point. Mr Krishna noted that at around 4:00pm it began raining lightly and the sea became a little rougher, but the couple did not feel in danger. Neither were wearing life jackets.

At about 6:30pm, Ms Prasad was fishing while standing a on a rock ledge about half a metre from the water's edge. There was a 1.5 to 2 metre drop to the water. Mr Krishna was collecting bait about 20 metres away from his wife when he heard a loud splash and heard her calling for help. He ran over to where Ms Prasad had last been standing and saw her about 3 metres away from him in the water. Ms Prasad was still holding onto her fishing rod and extended it out in front of her with both hands. Mr Krishna climbed down the rock ledge into the water and tried to reach the fishing rod by stretching out one arm, while holding on to the rock ledge with his right hand. He was then hit by a large wave which dislocated his right shoulder and caused him to lose his hold on the ledge.

After floating in the sea for several minutes, Mr Krishna managed to climb back onto the rock ledge. He ran to get an "Angel Ring" flotation device located nearby and threw it into the water towards Ms Prasad, but a wave swept it away from her. Ms Prasad had been taken about 15 metres out to sea by this time, and Mr Krishna's efforts to hook her with his fishing line were also unsuccessful. He saw Ms Prasad sink and resurface several times and became very concerned for her, although she was able to swim. Ms Prasad was trying to take off her heavy jacket and he told her to float on her back.

As his cell phone was not working due to being waterlogged, Mr Krishna ran back over the track to North Piha and raised the alarm at a house bordering the carpark, where the occupier called emergency services. Several members of the public returned with Mr Krishna to Te Waha Point, but Ms Prasad could no longer be seen.

Police attended the scene, where the Piha Surf Lifesaving Club and the United North Piha Lifeguard Service search and rescue squads were tasked. The Police Eagle helicopter conducted a search of the area but was unable to locate Ms Prasad due to the inclement weather and fading light. It was considered too dangerous for inflatable rescue boats to search the area until the following morning. Shoreline searches continued but found no sign of Ms Prasad.

The following morning, Ms Prasad's body was located on the southern shoreline of Whites Beach and recovered by members of Land Search and Rescue. Police found no evidence to indicate foul play. The Coroner was satisfied that Ms Prasad fell or was swept into the sea by accident, and that she hit her head on the rocks in the course of doing so or at

some time after she fell into the water. The Coroner was also satisfied on the balance of probabilities that Ms Prasad died on the same day she entered the water.

Tragically, Ms Prasad's death may have been prevented had she been wearing a life jacket. The Coroner noted that there are several relevant safety signs between North Piha carpark and Whites Beach/Te Waha Point warning of strong rips and currents, large waves and submerged rocks, as well as specific signage relating to rock fishing that advise wearing a life jacket.

RECOMMENDATIONS OF CORONER GREIG

I. Rock-based fishing is a high risk activity. The West Coast Rock-based Fisher Safety Project 2020 report[8] prepared by Dr Kevin Moran, Faculty of Education, the University of Auckland, states that:

> Rock-based fishing (a form of land-based fishing) is one of the deadliest recreational pursuits in New Zealand. From 2015-2019, 23 fatal incidents were reported among land-based fishers. Of these, most were males (87%, n = 20) and three quarters (74%, n = 17) occurred at rocky foreshores (52%, n = 12), and surf beaches (22%, n = 5) (WSNZ Drownbase, 2020). Fishers of Asian ethnicity were the most frequent victims (39%, n = 9) followed by NZ Europeans (35%, n =6). Buoyancy aids were evident in only one fatal incident (4%) and alcohol consumption was also reported in the same incident (4%). The Auckland region accounted for 35% (n = 6) of incidents, 22% (n = 5) for the Waikato region, 33% (n = 7) for the South Island, and 17% (n = 4) for the rest of the North Island.

II. Mr Crewe of Auckland Council advised that a collaborative intervention by the Council, Drowning Prevention Auckland (DPA) (formerly Watersafe Auckland Inc) and Surf Life Saving Northern Region called the West Coast Rock-based Fisher Safety Project was initiated in 2006 and continues today. This intervention is aimed at reducing rock-based fishing fatalities and promoting a safety culture.

III. As part of the project the Council has installed angel rings (with signage) in high-use, high-risk rock fishing spots along the West Coast. There are eleven angel rings in the Piha area, and the duty ranger carries out routine checks to ensure they are in good condition. The angel ring at Te Waha Point/Whites Beach was installed in 2009 after the area was identified as high-risk for drowning fatalities.

IV. Mr Crewe advised that the West Coast Rock-based Fisher Safety Project is evaluated annually by Dr Moran who is a subject matter expert. He stated that the Council reviews and acts upon his reports and recommendations annually. Through the West Coast Rock-based Fisher Safety Project, the Council has over the last sixteen years been engaged in a number of safety activities related to promoting awareness of the dangers associated with rock fishing on the coastline in Auckland Council's purview and how it can be undertaken more safely.

V. In 2020-2021, in accordance with recommendations in the most recent West Coast Rock-based Fisher Safety Project report, safety initiatives undertaken have included:

- Hiring a Rock Fishing Advisor.

[8] https://www.dpanz.org.nz/wp-content/uploads/2020/09/2020-Rock-Fishing-report.pdf

- Preparing e-learning rock fishing resources on the Drowning Prevention Auckland website[9], with translations in Korean and Chinese.
- Publishing safety warnings on Auckland Council's websites, including a section with information on Hī ika – Fishing, with specific information on coastal fishing safety for both Anawhata and Piha, and links where the viewer can read more.
- Holding workshops at Muriwai beach with at-risk community groups.
- Holding a land-based fishing safety talk at Pakiri with at-risk community groups.
- Facilitating media coverage regarding rock fishing safety.
- Completing over 20 community presentations in relation to land-based fishing safety; and
- Maintaining angel rings and safety signage at high-risk sites.

VI. The 2021 annual West Coast Rock-based Fisher Safety Project report (which contains a survey of rock fishers) identified that never wearing a lifejacket when fishing from rocks continues to be a persistent high-risk behaviour amongst rock fishers. The importance of doing so is highlighted as a key message on the websites of organisations such as the Drowning Prevention Auckland and Water Safety New Zealand.

VII. Water Safety New Zealand's website contains key safety messages about Rock Fishing safety[10] which are relevant to this inquiry:

- Always wear a lifejacket.
- Pay particular attention to swell and tide information.
- Never fish in exposed areas during rough or large seas.
- Spend at least ten minutes observing the sea conditions before approaching the rock ledge.
- Never turn your back on the sea.
- Pay attention to warning signs.
- Never fish from wet rocks where waves and spray have obviously been sweeping over them.

VIII. I endorse these key messages. I particularly highlight the lifesaving importance of wearing a life jacket when rock fishing.

[9] https://www.dpanz.org.nz/courses/safer-rock-fishing/
[10] https://watersafety.org.nz/How%20to%20stay%20safe%20while%20fishing

IX. I also draw attention to the DPA's Safer Rock Fishing programme (https://www.dpanz.org.nz/courses/safer-rock-fishing/) an online freely available course that focuses on safety requirements to consider prior to going rock fishing, what equipment is necessary, what to do upon arrival at the fishing site, and what to do in the event of an emergency.

X. I acknowledge the sustained work of the West Coast Rock-based Fisher Safety Project which is continuing to do important work aimed at reducing rock-based fishing fatalities and promoting a safety culture.

XI. Ms Prasad's death, her husband's observations that he had never seen a rock fisher wearing a life jacket at Te Waha Point/Whites Beach, and his very sad reflections about having 'learned the hard way' the importance of wearing a lifejacket when rock fishing, highlight the importance of education and increasing safety awareness amongst those who wish to partake in rock fishing.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Ms Prasad taken by Police entered into evidence, upon the grounds of personal privacy and decency.

Drugs and Alcohol

Rangiwai-Tikitiki [2022] NZCorC 161 (24 November 2022)

CIRCUMSTANCES

Laura Rangiwai-Tikitiki, aged 44, died on 20 July 2017 at Auckland City Hospital of alcohol and AMB-Fubinaca toxicity with complications.

On the evening of 19 July 2017, Ms Rangiwai-Tikitiki, lost consciousness after smoking synthetic cannabis and consuming alcohol. She was transported to Auckland City Hospital by emergency services, where she died on 20 July 2017.

COMMENTS OF CORONER WOOLLEY

I. Although it is not possible to point to one direct cause of Laura's death, her death nonetheless occurred in the context of consumption of AMB-Fubinaca, a type of synthetic cannabis.

II. I note that the dangers of consuming synthetic drugs include:

a. It is promoted or sold as a form of synthetic cannabis, but that there is no cannabis in the product.

b. The synthetic drug can be made to look like cannabis by using dried plant or other material, but it is saturated in a synthetic drug not THC (tetrahydrocannabinol) the active ingredient in cannabis.

c. The pharmaceutical agents from which synthetic cannabis was developed were attempts to create new medications to treat spasms and epilepsy but were found to be unsuitable and were discarded. The

nature of the synthetic drug is unknown to the purchaser and unknown or poorly understood by the manufactures/distributors in New Zealand.

d. The synthetic drugs, AMB-Fubinaca and 5F-ADB, have been the cause or contributing factor in a number of deaths in both the Waikato/BOP,[11] elsewhere in New Zealand, and overseas.[12]

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

f. Individuals who fall unconscious after consumption of synthetic drugs can die if they do not receive timely and appropriate medical assistance; dying from cardiac event induced by consumption of the drug, or as a result of being comatose and asphyxiating on their own vomit, or they may suffer a hypoxic brain injury.

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

a. In order to prevent future deaths from synthetic cannabinoids, Dr Quigley suggested that an all-encompassing harm reduction approach which reduces demand, supply, and easy access to treatment for those seeking assistance should be developed. He cautioned that any recommendations on increasing enforcement, targets manufacture, trafficking and supply, while not overly penalising users as this can create a barrier to those seeking medical attention, even in cases of emergency.

b. Dr Quigley submitted that efforts should be made to inform users of synthetic cannabis, their families and associates, of the dangers of synthetic cannabinoids and the need to get help immediately if someone collapses. I agree.

c. Dr Quigley's advice for the families or associates of synthetic cannabis users was that if a person who has used synthetic cannabis collapses, that person should be immediately shaken to attempt to rouse that person. If the person rouses, that person should then be placed in the recovery position and a call for help should be made. If the person does not rouse, then call for help and commence chest compressions. The call taker who answers the emergency call for help will provide assistance. Do not delay.

IV. Dr Quigley is a vocational specialist in Emergency Medicine, he has completed additional studies in clinical toxicology and conducted research in forensic toxicology. He is a recognised expert in emergency management and treatment of drug and alcohol presentations.

[11] McAllister, CSU-2017-HAM-000336, Taoho, CSU-2017-ROT-000345.
[12] 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.

V. While I agree with, and endorse, Dr Quigley's advice, I am unable to make any recommendations in this regard, as I have not heard any evidence. I am aware however, that Coroner Mills is conducting a joint inquiry into deaths from synthetic cannabis which occurred in Auckland. I will refer this suggestion to Coroner Mills to consider in the course of her joint inquiry.

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.

Fire

Kahukiwa [2022] NZCorC 136 (12 October 2022)

CIRCUMSTANCES

Tania Roimata Kahukiwa, aged 31, died on 15 November 2019 at 8 Gosport Street of smoke inhalation due to a house fire.

Ms Kahukiwa lived with her partner and children in a two storey, three bedroom Kāinga Ora house.

At about 6:00pm on 14 November 2019 Ms Kahukiwa and her partner cooked dinner and had visitors who stayed until about midnight. After they left, Ms Kahukiwa went to the kitchen to eat the roast dinner she had cooked earlier. Her partner recalled that there were three pots on the stove that night; two contained food and the third contained cooking oil.

A short time later Ms Kahukiwa's partner was awakened by the fire alarm and their son's screams. He saw thick black smoke throughout the lounge and an orange glow of flames under the kitchen door, which was closed. The partner and the son exited the house via a smashed window. They did not know where Ms Kahukiwa was and she did not respond to their calls.

Fire crews arrived and extinguished the fire. They entered the house and found Ms Kahukiwa's body in the lounge near the main window. She appeared to be partially on a chair with her feet beside the window and her head resting on the floor. Ms Kahukiwa had sustained significant burns.

Fire and Emergency New Zealand carried out an investigation into the incident and provided a report to the Coroner. The report noted that smoke alarms were located throughout the building, in the lounge, the centre of the hallway and upstairs at the top of the stairs, hallway and in each bedroom. The fire started in a pot located on the left rear element of the stove. It appears to have overheated, caught fire and then spread.

RECOMMENDATIONS OF CORONER DUGGAL

I. I have considered whether any comments or recommendations would reduce the chances of further deaths occurring in similar circumstances. This issue is particularly relevant as Ms Kahukiwa and her whānau lived in a Kāinga Ora house. Two areas where recommendations may be of assistance is interconnected alarms and sprinklers. I have sought the input of Kāinga Ora on these two matters.

Interconnected alarms

II. While there were smoke alarms through both floors of the house, it appears that they were not interconnected. Interconnected alarms would have alerted residents or guests in the bedrooms upstairs earlier and thus increased their opportunity to escape the fire. While no one was in the upper rooms that night, that was a coincidence as normally the three older children would have been sleeping in those rooms.

III. Kāinga Ora have advised this inquiry that it had a smoke alarm policy which "goes above regulatory requirements for building and fire safety". The policy does not require interconnected alarms at a residence of the type at which Ms Kahukiwa and her whānau lived.

IV. The Ministry of Business, Innovation and Employment (MBIE) is responsible for setting regulatory requirements regarding smoke alarms in residential housing. MBIE is currently consulting on proposed changes to the regulations on the circumstances in which interconnected alarms are required.

V. I recommend that a copy of this finding and the Fire Emergency New Zealand report be provided to MBIE for consideration as part of its consultation process on interconnected alarms. I further recommend that Kāinga Ora install interconnected alarms in their properties in line with any new regulations.

Sprinkler system

VI. The house did not have a sprinkler system. Kāinga Ora advise that where the Building Code requires a sprinkler, it is installed and regularly tested. The property that Ms Kahukiwa and her whānau lived at was a single household unit and such houses do not require a sprinkler system under the Building Code.

VII. Kāinga Ora are currently running a pilot of sprinklers in 25 single household units. The results of the pilot will inform future decisions on sprinklers in such housing.

VIII. I recommend that this finding is shared with both MBIE and Kāinga Ora in order to inform both the current pilot and any future reviews on the issue of sprinklers in single household units.

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

Leisure Activities

Bridson [2022] NZCorC 141 (27 October 2022)

CIRCUMSTANCES

Jake Nelson Bridson, aged 23, died on 27 December 2020 at Owaka Heads, Owaka of drowning.

At about 11:00am on 27 December 2020 Mr Bridson went free diving for pāua at Owaka Heads with his grandfather Henry Thomson. Mr Bridson was wearing a weight belt, wetsuit, gloves, booties, snorkel, mask, and flippers. Mr Bridson and Mr Thomson were diving approximately 10 to 15 metres apart and within sight of each other. They were not using a surface buoy or dive flag.

At one point Mr Thomson saw Mr Bridson before he descended, but when he came up again, he could not see him. Mr Thomson swam around the general area looking for Mr Bridson for about 10 to 15 minutes. He then went ashore and sought assistance. Mr Bridson was located deceased lying on his back, face up, at a depth of approximately eight feet of water.

Mr Bridson was found wearing his full dive gear, including his weight belt. There were no faults identified with his dive gear. However, Mr Bridson had the excess from his weight belt tucked back into the belt. The swimmer who rescued Mr Bridson observed that he does not do this himself and lets the excess dangle so he can find it straight away if something happens.

The circumstances of why and precisely how Mr Bridson encountered difficulty in the water are not known. He was not observed to have been in any difficulty and his weight belt release mechanism was working when tested.

The Police National Dive Squad (PNDS) investigated the incident and provided a report. The PNDS calculated that Mr Bridson's weight belt would have made him negatively buoyant which increases the work effort of the diver to move through the water and to stay afloat. The PNDS considered that the following contributed to Mr Bridson's death: the amount of weight used causing him to be negatively buoyant, increasing his physical workload and exertion, and not abandoning his weight belt when in trouble.

The PNDS report also found that although Mr Bridson and Mr Thomson were diving at the same time, they were not actively watching each other and were therefore not diving together. Safe recommended practice and an industry standard is to dive with a dive buddy, employing the one up one down technique, this allows for immediate assistance if a diver is in difficulty. The PNDS report advised in combination the following factors might have had a domino effect even though on their own they may not necessarily have been fatal: the weight belt being too heavy and not abandoned, and not diving as buddies.

The PNDS report made the following recommendations for recreational divers:

- Check and adjust buoyancy weight to ensure diver is neutrally buoyant
- Dive with a buddy for the duration of the dive
- If diving in a remote area, ensure you have reliable forms of communication in case of an emergency.

COMMENTS OF CORONER MCKENZIE

I. Pursuant to s 57A of the Coroners Act 2006 I have considered whether any additional recommendations or comments are appropriate. Central to this consideration are the recommendations in the PNDS report and those made by other coroners following diving-related deaths.[13]

II. A coroner may make recommendations or comments in relation to a death for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred. 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. In considering whether any recommendations or comments are appropriate in this matter, I bear in mind the requirement that any recommendation must be clearly linked to the factors that contributed to death. This is where a challenge lies because I cannot determine why or how Mr Bridson encountered difficulty underwater and why he could not abandon his weight belt or otherwise return to the surface.

IV. The PNDS formed the view that Mr Bridson and Mr Thomson were diving at the same time but not diving together. On the evidence before me, Mr Thomson could see Mr Bridson coming up and down and he took action the first time he could not see Mr Bridson on the surface for a few moments. Mr Thomson had seen Mr Bridson before his last descent. That is, this is not a case where Mr Thomson was diving and was not looking for Mr Bridson, they were approximately 10 to 15m apart, even if not using the “one up one down” technique the PNDS report referred to. Mr Thomson relevantly told Police:

> ….
> The day was nice only a light breeze and the water was clear.
> The tide was still coming in but where we were there was no strong current.
> We were no further than 20 meters out.
> Jake was above a big rock and going up and down there.
> I went about another 10 or 15 meters out towards the pin.
> I saw Jake go down and come up a few times.
> I came up to the surface and I saw Jake was also on the surface and then I went down to get a few more paua for my bag.
> This time I came back up to the surface and Jake wasn’t there.
> I waited for a few moments for Jake to pop up and he didn’t.
> I yelled out and then started to worry something was wrong.
> I dropped my bag and went looking for him.
> ….

[13] See for example the recommendations of Coroner Woolley in Huang [2021] NZCorC 85. I note that this matter involved a scuba diving death.

V. Alongside this, and again bearing in mind the recommendations already made by the PNDS and other coroners, I have turned my mind to whether Mr Bridson might have been found quicker if he had been using a dive flag or surface buoy.

VI. In considering this, I have been mindful of the following important point: it cannot be known whether a surface buoy (or flag) would have enabled Mr Bridson to have been found and then retrieved quickly enough for a successful rescue. This is because I do not know what happened under the water, and why.

VII. I enquired about the use of a dive flag or surface buoy. The PNDS advised that it is best practice to have a dive flag displayed while diving, and to have a surface buoy marking a diver's location. I note that dive flags are generally used on boats where people are diving underneath. A surface buoy (or flag in some circumstances) generally attaches to a line that the diver holds and as such is a relatively good indication of a diver's location in real time.

VIII. In terms of knowing where Mr Bridson was in real time while diving, Mr Thomson was looking out for him and saw him on the surface before the last time he (Mr Thomson) descended and then ascended and lost sight of him. That is, Mr Thomson was actively mindful of where Mr Bridson was diving and, on the evidence before me, they remained within sight of one another even if not using the "one up one down" technique. Mr Thomson told Police that he swam in the general area looking for Mr Bridson for about 10 to 15mins before going ashore.

IX. In all of these circumstances, I make the comment that using a surface buoy or dive flag might assist in locating a diver in real time, should they not surface, quicker than without having the aid of such a visual device.

X. For completeness I record that I have not made any recommendations or comments in relation to the weight belt. This is on the basis that the release mechanism was functioning correctly when tested and, with respect to it being tucked back in, the PNDS noted that Mr Bridson might have been able to activate the quick release on the buckle without issue. It is unknown why Mr Bridson did not or could not release the belt.

XI. In terms of maintaining a neutral buoyancy, I am satisfied that there is already existing information about this principle both in the public domain and in terms of diver training, which Mr Bridson had done. I also do not know whether any buoyancy issues related to Mr Bridson encountering or recovering from difficulty.

XII. Accordingly, I have focussed my comment on the use of a surface buoy or dive flag in the specific factual circumstances of Mr Bridson's death. These factual circumstances include a number of significant unknowns. I have therefore stepped back from making a formal recommendation regarding this or any other matters.

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

Kava [2022] NZCorC 151 (2 November 2022)

CIRCUMSTANCES

Tevita Akapasi Kava, aged 29, died on 3 June 2017 in the waters of Auckland Harbour from drowning.

The Red Boats Limited ("Red Boats") is a fishing, cruising and charter company based in Auckland. On the evening of 3 June 2017, Mr Kava was part of a group of approximately 50 people that boarded the Reo Moana, a vessel operated by Red Boats, for a birthday celebration.

The boat departed from the Westhaven Marina. The cruise was licensed for sale of alcohol and a barbeque meal was provided. The barbeque was located at the rear of the vessel and fixed to the left side of the boat on a platform known as the duckboard. The duckboard extended from the stern of the vessel by approximately one metre and sat about 30 to 40 centimetres off the waterline. A hinged ramp, made of aluminium, was bolted to the duckboard. It could be raised and lowered so that passengers could easily step on and off the vessel. The ramp was secured in the upright position by a stainless-steel sliding bolt gate latch. At the opposite end of the bolt pin was a "U" shaped loop. The loop could either be locked in one of two positions or float freely. The ramp was also secured by a rope which was used by crew to lift and lower the ramp when the vehicle was moored.

Passengers were not allowed onto the duckboard during the Reo Moana harbour cruise. The exception to the rule was for passengers who were operating the barbeque, in which case one or two were allowed on the duckboard. The area could be blocked off from the main deck by a wooden partition that would slide into place. If that was not in place, a chain could be put across the opening.

Talanoa Finau, a passenger, was to cook the food that evening. At some point during the cruise, a crew member observed a group of six large individuals on the duckboard, in breach of the vessel's policy. The crew member went to the duckboard and reminded the passengers of the policy. He asked everyone but Mr Finau to leave.

Later in the evening, Mr Kava made his way on the duckboard. He leaned against the ramp which fell back resulting in Mr Kava falling into the water. Mr Kava could not swim. The crew were immediately alerted and commenced man overboard procedures. Emergency services were called to locate Mr Kava however all searches on the night failed to locate him. Mr Kava was found deceased the following day close to where he went overboard.

The District Court trial against the Red Boats did not identify why the ramp might have given way. After the trial and at the direction of the Coroner, Maritime New Zealand ("MNZ") and Red Boats arranged for expert testing of the ramp.

The Coroner found that the ramp was bolted and the "U" loop of the bolt secured by the catch plate when the vessel left its berth. The ramp was also secured by a rope and was securely affixed to the duckboard. There was some horizontal play, measured by Red Boats' expert engineer to be 1.12 millimetres, which allowed for the ramp to move horizontally relative to the base of the hinge. Passenger weight on the duckboard could cause the ramp to displace from the secured bolt and the extent of the displacement varied depending on the aggregate weight and location of the passengers on the duckboard.

The Coroner found that a group of six large individuals that congregated on the duckboard that evening likely caused the ramp to displace from the bolt to a position where the ramp would disengage completely if subsequent weight was applied to the duckboard by individuals congregating on it; and/or sufficient force was applied to the ramp. This is what happened later in the evening when Mr Kava leaned against the ramp. The force applied by Mr Kava's weight caused the rope tied between the ramp and the handrail to break; and the ramp to disengage completely from the bolt.

COMMENTS AND RECOMMENDATIONS OF CORONER HO

I. Following the accident, out of an abundance of caution, Red Boats removed the Reo Moana's ramp and relocated the barbeque to the upper deck. There is now no reason for any passenger to be on the duckboard while the vessel is in motion.

II. On the evening of the accident there were no specific instructions alerting passengers to the possible danger of the ramp falling open, either through the master's safety briefing or through visual cues such as signs in the cabin, duckboard or on the ramp itself. As a general principle, it is prudent not to lean against anything which might give way. The risk is particularly acute in relation to structures which are designed to open, such as a boarding ramp. This is not a criticism of Mr Kava; he was entitled to expect that the ramp would support his weight absent any indications to the contrary. However, sometimes things can go wrong – as they did that evening.

III. I have identified the following recommendations which I consider would prevent future deaths from occurring in circumstances similar to Mr Kava's.

Ramp security

IV. It would be prudent for stowed ramps, or other opening features, which form or have the appearance of forming part of the guardrail arrangement for what would otherwise be an exposed section of vessel, to be secured from falling open by at least two security mechanisms which operate in parallel rather than in series. This reduces the risk of failure by ensuring that, should one security mechanism become redundant, the other remains to prevent the ramp or feature from falling open.

V. Alternatively, or in addition, steps should be taken to minimise the risk of the ramp or feature inadvertently falling open beneath a person's weight:

a. affixing warning stickers to the top side of the ramp or opening feature cautioning persons from leaning against it or applying weight to it; or

b. screening the ramp or opening feature from passenger access by use of other mechanisms, such as a sliding gate which would have the effect of acting as the guardrail arrangement in place of the ramp or opening feature.

VI. I recommend that vessel operators consider introducing such measures and that Maritime New Zealand consider the above factors when assessing operators' Maritime Transport Operator Plans.

Restricted areas should be clearly identified by the vessel operator

VII. I have found that one factor in Mr Kava's accident was the disengagement of the ramp from a secured bolt, caused in part by the weight of passengers on the duckboard.

VIII. Red Boats' policy restricted passenger access to the duckboard because of the hazard of the operating barbeque rather than because of any concerns about weight on the duckboard.

IX. I recommend that areas of the vessel to which passenger access is available, but is for whatever reason restricted, should be clearly identified by the vessel operator through:

a. the verbal vessel safety briefing; and

b. signs in the passenger cabins, the access point to the restricted area, and in the restricted area itself.

X. There was a chain on the Reo Moana which controlled the access between the cabin and duckboard and which might reasonably have been thought to be sufficient to indicate to passengers that they should not cross it. This was not, however, the interpretation taken by some of the passengers on board the vessel that evening. A sign clipped to this chain, or posted elsewhere on the vessel, might have more clearly identified to passengers that the duckboard was not a general access area. This in turn may have reduced the number of individuals that congregated on the duckboard during the evening, thus reducing the extent of deflection of the ramp from the bolt that likely resulted.

XI. My recommendation is not a criticism of Red Boats' decision to use a chain to control access to the duckboard. Rather, it is directed at ensuring that lessons are learned, as best they can, from the events of 3 June 2017 and to minimise the risk of future deaths occurring in similar circumstances.

Responses by Red Boats and MNZ

XII. Red Boats and MNZ were advised of my intended recommendations and given an opportunity to comment on them.

XIII. Red Boats wished to record that there had been at least ten surveys of the Reo Moana since the ramp was installed. In 2016 Red Boats applied to MNZ for the vessel to be admitted into the Maritime Operator Safety System, which required MNZ to audit and review Red Boats' Maritime Transport Operator Plan, conduct a physical inspection of the vessel and discuss the plan with the operator. Red Boats stated that the physical set up of the vessel did not change between that inspection and the accident.

XIV. Maritime New Zealand advised that it would work to ensure that vessel operators were aware of the importance of ensuring the safety of passengers and crew around ramps. It will also consider whether to recommend to the Ministry of Transport that the appropriate maritime rule be amended to require that barriers work effectively and have sufficient strength for the loads they are expected to resist.

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

Paul [2022] NZCorC 169 (2 December 2022)

CIRCUMSTANCES

Jason Rangi Paul, aged 21, died on 16 May 2021 off the Mahia Peninsula, Hawkes Bay of undetermined causes, in circumstances consistent with drowning.

On 16 May 2021, Mr Paul went out with whānau to dive for food off the Mahia Peninsula, Hawkes Bay. At the time, Mr Paul was wearing a dive mask, snorkel, a thin wet suit, weight belt and flippers. Unfortunately, during the dive he got into difficulty and was found unresponsive before his body was washed away. His body was recovered the following day.

The Police National Dive Squad noted that:

(a) The conditions on the day of the dive were good (as reported by witnesses). It is therefore believed that the conditions were not a contributing factor.

(b) Mr Paul's buoyancy weight belt was too heavy and may have been twisted around his waist so that the buckle was the wrong place (on his back).

(c) Mr Paul did not abandon the weight belt when he got into difficulty. An examination of the belt used by Mr Paul shows there was no problem with the quick-release mechanism, although this was in the wrong place as set out above.

(d) It is unknown why Mr Paul did not abandon the weight belt, or why he found himself in difficulty.

(e) The evidence suggests that Mr Paul had not undertaken any diver training, although this is not required for free diving. During such training, the abandonment of weight is taught as a basic skill.

(f) The evidence indicates that Mr Paul was not a particularly experienced diver. Although the group started by diving in pairs, it seems that Mr Paul went off on his own and the group did not appear to be actively watching each other. This is known as unsafe diving practice and likely to have contributed to the death.

(g) Mr Paul was found without diving fins (used by divers to provide propulsion through the water). Witnesses say that Mr Paul was wearing fins at the start of the dive. It is unknown if the fins used by Mr Paul fitted properly. If too large, they could have slipped off during the dive. This could have also happened if Mr Paul experienced panic or stress. In either eventuality, if the fins came off, they would have reduced Mr Paul's ability to support himself in the water and therefore contributed to his death.

(h) Mr Paul had tested positive for cannabis, which is a drug known to impair judgement. This could have been a contributing factor.

RECOMMENDATIONS OF CORONER TELFORD

I. Sadly, it seems that Mr Paul's death could have been prevented by following well-publicised safe diving practices. Although I do not intend to make specific recommendations, I see merit in reproducing some of these key safety messages.

II. The Police National Dive Squad have made a range of recommendations in the context of this particular incident which I reproduce in summary form below:

a. Complete diving training before going out on a dive and be conscious of your experience level.

b. Check and adjust your buoyancy weight to ensure you are neutrally buoyant.

c. Make sure your buoyancy belt, fins and other gear fits properly and is in the right place throughout your dive.

d. Abandon your weight belt when in difficulty.

e. Always dive with a buddy for the duration of your dive and be aware of other divers in your group.

f. It is not safe to use alcohol or other drugs before diving.

g. If diving in a remote area, ensure you have reliable forms of communication in case of an emergency.

III. Water Safety New Zealand also publish basic guidelines for divers, using the acronym **DEEP**:[14]

D*on't drink alcohol or take drugs when you're thinking of going for a dive*

E*quipment always needs to be good and in good working order*

E*xercise and keep fit if you are going diving. Always have a health check to ensure you're fit for the task*

P*al, partner, or other person - never dive alone*

IV. The following basic advice is also given in terms of basic preparation before diving:[15]

a. Get professional training

b. Plan your dive and your dive plan

c. Check the forecast

d. Carry a signalling device

V. I wholeheartedly support and adopt all the above recommendations and strongly commend the Water Safe website to all New Zealanders who engage in water related sports. Even experienced divers need an occasional refresher on the safety guidelines and skills.

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

[14] (2022) How to Stay Safe when Diving. Water Safe New Zealand. https://watersafety.org.nz/how%20to%20stay%20safe%20when%20diving
[15] Ibid.

Planas [2022] NZCorC 137 (18 October 2022)

CIRCUMSTANCES

John Mark Baquial Planas, aged 33, died between 30 August 2020 and 2 September 2020 after falling from his kayak in the waters of the Tamaki Strait, Auckland. His cause of death was unascertained in the setting of cold-water immersion (accidental).

Mr Planas was fit and strong and would go out fishing on his kayak most Sundays, usually alone. He was regularly blown out to sea and occasionally turned out into the water from his kayak but was a strong swimmer and felt comfortable in the water.

On 30 August 2020, Mr Planas went fishing with two flatmates. At about 2pm, he set off alone on his kayak into the Tamaki Strait. Mr Planas' flatmate could see him until it got dark but then lost sight of him and eventually went home. When he awoke the next morning the flatmate realised that Mr Planas had not returned and reported this to Police. A Police search and rescue operation took place from 31 August 2020 till 14 October 2020 which recovered Mr Planas' kayak, lifejacket and other equipment. On 16 January 2021, Mr Planas' body washed up at Te Kawau Bay

Maritime New Zealand (MNZ) investigated the incident and noted that Mr Planas was operating a kayak in a situation of heightened risk due to low water temperature and lack of daylight. MNZ also noted that Mr Planas did not have the recommended two forms of waterproof communication and that it was unlikely his lifejacket would have become detached from his body if he had been wearing it properly.

COMMENTS OF CORONER GREIG

I. Thousands of New Zealanders go paddling along our coasts and on our lakes and rivers every year and fishing from a kayak is becoming increasingly popular.[16] However, although exhilarating, paddling is not without its risks. An average of two paddlers dies every year in New Zealand.[17]

II. To reduce the chances of future deaths occurring in circumstances similar to those in which Mr Planas' death occurred, it is vital that paddlers are properly prepared. The Paddle Craft Safety Guide[18] (a publication of the Safer Boating Forum) highlights that being prepared includes "knowing your stuff, checking your craft, taking the right gear and understanding what to do in an emergency."

III. The Kiwi Association of Sea Kayakers Inc.[19] contains the following safety advice on its website:

> The sea and lakes we paddle on are dynamic environments that can change quickly. If we are inadequately prepared, or don't have the correct equipment with us, we can easily and quickly get ourselves, and others,

[16] https://saferboating.org.nz/media/paddle-craft-guide.pdf
[17] https://saferboating.org.nz/media/paddle-craft-guide.pdf
[18] Ibid
[19] The Kiwi Association of Sea Kayakers (KASK) is a national association for sea kayaking in New Zealand – set up in part to promote and encourage the sport of sea kayaking and to promote safety standards. It is a founder member of the New Zealand Safer Boating Forum and a member of Water Safety NZ. It also maintains close liaison with Maritime New Zealand.

into trouble. If the conditions we find ourselves in are beyond our skill level then our fun day out can, at best, turn into a stressful experience or worse.

We can avoid getting ourselves into this kind of trouble if we take the time to think through our intended day of fun on the water and prepare properly. Think of things such as:

- Who we go with – going with a group of people with the right level of experience for the intended, and potential conditions.
- Shore contacts – who will know if we don't return as planned so they can notify a rescue if needed.
- Paddle within your ability – get training and practice skills.
- Environmental considerations – think about the weather, particularly the wind and how it may change through the day.
- How can I get help – carry appropriate communications equipment and know how to use it.
- Suitable Clothing – will I be warm enough if I end up in the water? Have I got suitable spare dry clothing for the end of the activity?
- Safety Equipment – have I got the kit I could need to deal with a capsize or to alert others if I need help etc.
- Personal ability – am I fit enough and skilled enough to undertake the intended activity with some left in reserve in case things start to go wrong.

IV. There are a number of resources available to kayakers in New Zealand to assist them to develop the technical skills and knowledge to paddle safely. I encourage every person who is contemplating kayaking to seek out the necessary information and training to ensure that they are able to undertake kayaking safely. The New Zealand Safer Boating Forum (a formal network representing a cross-section of government agencies, local body groups, organisations and the marine industry involved in promoting recreational boating safety in New Zealand) and a number of its constituent members (for example KASK)[20] and organisations such as New Zealand Fishing[21] provide relevant information and training resources.

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

Thomas [2022] NZCorC 176 (13 December 2022)

CIRCUMSTANCES

[20] https://www.maritimenz.govt.nz/content/about/people-we-work-with/safer-boating-forum/default.asp
[21] https://www.nzfishingworld.co.nz/search?query=kayak+fishing; https://www.fishing.net.nz/fishing-advice/how-to/kayak-fishing-the-basics/

Dean Adrian Mitchell Thomas, aged 57, died at sea near Katiki Straight, Shag Point, Palmerston on 19 November 2019 of drowning.

On 19 November 2019 Mr Thomas went diving for pāua north of Shag Point on Hampden-Palmerston Road in Palmerston, Southland. Mr Thomas was an experienced diver and was diving on his own, although his friends were onshore. He was out of his friends' sight for a short time, when they saw him face down in the water. They intervened, dragging him onto the beach, called emergency services and started cardiopulmonary resuscitation (CPR). Ambulance services attended and confirmed that Mr Thomas had died.

The Police National Dive Squad prepared a report and found, among other things, that Mr Thomas had not completed a pre-dive medical examination and had dived on his own.

RECOMMENDATIONS OF CORONER DUGGAL

I. Having given due consideration to the circumstances of Mr Thomas' death, I make the following recommendation based on the report provided by the National Police Dive Squad pursuant to s 57(3) of the Act:

    a. Where possible recreational divers dive with another person for the duration of the dive, using the "one up one down" method allowing for immediate assistance if a diver encounters any issue or difficulty.

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

Medical Care

Alexander [2022] NZCorC 172 (7 December 2022()

CIRCUMSTANCES

Isabella Rangimohia Alexander, aged 17, died on 10 September 2021 at Auckland City Hospital of pulmonary thromboembolism, caused by heterozygous Factor V Leiden mutation and exacerbated by recent commencement of the oral contraceptive pill.

On 9 September 2021, Isabella became short of breath and collapsed while out walking with her father. Her father ran the short distance to their home to get his phone and alert Isabella's mother. As they returned to assist Isabella, her father called emergency services as well as a nearby friend who had a defibrillator. They began CPR and attempted to revive Isabella while waiting for paramedics to arrive.

Isabella was transferred by helicopter to Auckland City Hospital. Upon arrival, she was deeply unconscious and found to have significant bilateral pulmonary emboli (clots in the blood vessels of her lungs). Staff suspected she had experienced an irreversible global hypoxic brain injury. Due to this, it was decided no resuscitation attempts would be made if she went into cardiac arrest. Isabella's condition continued to deteriorate, and she passed away early the next morning.

After her death, Isabella was found to have a rare blood mutation (heterozygous Factor V Leiden mutation). Dr McLintock, a specialist haematologist and obstetric physician, advised that both this condition and her recent use of the combined oral contraceptive pill would have contributed to the development of Isabella's fatal pulmonary embolism.

The Coroner noted that it is particularly important for people who take hormonal contraceptives, and other hormone-based medications, to know the warning signs and symptoms of thromboembolism and to have a low threshold for seeking medical advice. It is also essential for health providers to be vigilant for the risks and signs, which can be hard to identify. Isabella had seen her GP on 6 September 2021 with new onset respiratory symptoms, but her GP had not considered pulmonary embolism as an explanation. An independent review concluded that the GP's care was acceptable and that there were no indications pointing to this diagnosis at the time.

While noting the family's concerns that Isabella had recently received the Pfizer Covid-19 vaccine, the Coroner found no evidence to suggest that the vaccine played any role in causing her death.

RECOMMENDATIONS OF CORONER ANDERSON

I. Isabella's death is a reminder that widely used, and relatively safe, medications still have risks. These can include rare and serious side effects, and even death. It is important to be alert to these risks and the associated warning signs. Even healthy young people, who appear to have no obvious risk factors, can be affected. Those who have known risk factors need to be particularly vigilant.

II. While there is nothing that can be done to bring Isabella back, her tragic death highlights some important public health issues. In order to help reduce the chance of similar deaths occurring in future, I make the following recommendations under s 57B of the Act:

    a. All prescribers of the combined oral contraceptive pill, and other hormone related medications, should ensure that they take a comprehensive clinical history and must inform patients about the risks of venous thromboembolism (VTE), the seriousness of the condition, and the symptoms to look out for. In relation to deep vein thrombosis (DVT) these symptoms include:[22]

        i. Leg pain or tenderness in the thigh or calf

        ii. Leg swelling (oedema)

        iii. Skin that feels warm to the touch

        iv. Reddish discolouration and streaks

    b. Patients should also be advised that when a DVT breaks free from a vein wall and blocks some of the blood supply to the lungs, this can cause a pulmonary embolism which can be fatal. The symptoms include:

[22] https://www.heart.org/en/health-topics/venous-thromboembolism/symptoms-and-diagnosis-of-venous-thromboembolism-vte

i. Unexplained shortness of breath

ii. Rapid breathing

iii. Chest pain anywhere under the rib cage

iv. Fast heart rate

v. Light headedness and passing out.

c. People who take the combined oral contraceptive pill, or other hormone related medications, should be particularly alert to the risks of VTE and the signs and symptoms described above. Medical advice should be sought immediately in the event of any concerns.

d. All medical practitioners need to be vigilant about the possibility of a VTE, even in situations where a patient appears to have no, or few, risk factors.

III. Further, I note Dr McLintock's advice regarding recent studies which show emerging data of an association between vaping and the development of VTE, possibly due to activation of clotting cells called platelets or direct damage to lung blood vessels. Although Dr McLintock notes that data from large cohorts is not yet available, I strongly encourage medical practitioners, and people at increased risk of VTE, to be alert to these possible risks.

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

Barton [2022] NZCorC 162 (25 November 2022)

CIRCUMSTANCES

Norma Erica Barton, aged 96, died on 22 November 2018 at Hawke's Bay Hospital from sepsis complicating cellulitis post right lower leg injury.

On 21 October 2018, Mrs Barton lost her balance and fell at home. She had a large laceration with some bleeding to her right ankle and smaller lacerations to her right ankle and left shin. She was treated at Hawke's Bay Hospital and her wounds dressed. She was discharged home for follow up by the district nurse team. As the nurses worked on rotation, it was usually a different nurse who saw Mrs Barton each time.

On 11 November 2018, a district nurse noticed that Mrs Barton's wound smelled bad. A swab from the wound was sent for diagnostic testing on 12 November. The results of the swab showed a "heavy growth of streptococcus group A (pyogenes) and heavy growth of staphylococcus aureus" and were reported to Mrs Barton's GP. However, Mrs Barton's GP did not inspect the wound during a home visit on 13 November.

Different district nurses visited Mrs Barton on 15, 19, and 22 November to attend to her wound, which seemed to be improving. On 22 November, Mrs Barton's morning care worker found her in a state of distress. She was taken to hospital, where she passed away that day.

The Coroner sought expert advice from Dr Lynette Murdoch, an expert in GP related matters, and from nurse practitioner, Julie Betts, in relation to the level of care Mrs Barton received from her GP and the district nurses. The Coroner concluded that the diagnostic test on 12 November identified bacterial growth in a wound on Mrs Barton's right leg but neither the district nurses nor Mrs Barton's GP reviewed the test results. This was due to the following factors:

(a) The GP was not aware that a test had been ordered.

(b) The test result was reported to the GP, but the GP appears to have overlooked or not become aware of the notification.

(c) The GP had not been alert to a previous entry in Mrs Barton's clinical notes indicating concerns about her leg wound. In any event, the GP was of the view that the wound was being managed by the district nurses. The leg wound was consequently not discussed at a home visit by the GP on the day after the test was submitted.

(d) The district nurses were not immediately automatically notified of the test result becoming available. They generally received a paper copy of the result one to two weeks after the test. The result could be electronically accessed by district nurses but this required them to expressly access the system for this purpose.

(e) The district nurse who took the swab did not record in the clinical notes that a test had been ordered, thus limiting the knowledge of successive nurses that a test result was outstanding.

The manner in which the district nurses recorded the objective details about the leg wound differed between nurses. This compromised subsequent nurses' ability to track the progress of the wound and its recovery.

The Coroner also considered that the frequency of dressing changes between 15 and 19 November was inappropriate to manage Mrs Barton's leg wound.

RECOMMENDATIONS OF CORONER HO

I. A coronial inquiry is focused on fact finding and to identify opportunities to reduce the chances of future deaths in similar circumstances. It is not to determine civil, criminal or disciplinary liability. However, in such an inquiry, fault may sometimes be attributed to a party or witness. This is not fault in the legal sense, with legal consequences, but in the sense that it is the result of identifying the cause and circumstances of the death and making comments or recommendations so that lessons may be learnt.[23]

II. There were missed opportunities to more closely monitor and objectively track any developing infection in the wound and to ensure that the health professionals involved in Mrs Barton's care were apprised of relevant developments.

III. My inquiry also identified confusion, not only among the health professionals involved in Mrs Barton's care but also between the experts and organisations I consulted, about whether the district nursing team was solely

[23] Berryman v Solicitor-General [2008] 2 NZLR 722 (HC) at [2].

responsible, or had shared responsibility with the GP, for wound care and the times at which sole or shared responsibility applied.

IV. I formulated recommendations which I intended to make pursuant to s 57A of the Act. I notified Health New Zealand Te Whatu Ora Hawke's Bay, the Nursing Council of New Zealand and the New Zealand Nurses Organisation (NZNO) of my proposed recommendations. The recommendations below incorporate the feedback I received.

Recommendation 1 – consistent manner and content of information

V. I recommend that where a team of health professionals has ongoing care and management of a patient's wound, and the same professional does not attend on consecutive visits (such as a district nurse team), objective information about the wound should be recorded in a marked section of a standard document and in a consistent manner. This allows for easy progress tracking and observation of the characteristics of the wound over time; and reduces the risk of missing incremental changes.

Recommendation 2 – continuity of care by the same nurse or small group of nurses

VI. The NZNO advised that most district nursing services try to ensure continuity of patient care by arranging rosters so that the same district nurses care for the same patients during an episode of care. It invited me to consider recommending that all district nursing services have models of care that provide for consecutive visits by the same nurse or small group of nurses where possible. In making that proposal the NZNO acknowledged that district nurses in New Zealand practice relatively autonomously, some in isolation in rural services, and most in significantly under-resourced working environments.

VII. Mrs Barton was visited by five district nurses over seven visits. I consider that identification of any deterioration in her wound and trends in her care progression including her treatment and the response, would likely have improved with a single district nurse or smaller group in attendance. This reflects the proposition that personally acquired knowledge will usually result in more continuity and a better outcome.

VIII. I thank the NZNO for its suggestion. I recommend that, as best as possible and within the resourcing constraints that apply, district nursing teams adopt a model that provides for continuity of care for a single episode of care by rostering the same nurse or small group of nurses.

Recommendation 3 – communication and lines of responsibility

IX. There should be clear guidelines setting out the responsibility of district nurses submitting diagnostic lab tests on behalf of authorised providers.

X. The NZNO expressed the view that because it is outside a nurse's practice to direct treatment following an abnormal result, it was generally accepted that progressing treatment is the responsibility of the GP. I note that view conflicts with NP Betts' opinion that having ordered a test the district nurse had at least some responsibility to follow up the test result. It also illustrates the risks of the compartmentalised thinking that can develop on both

sides and which appears to have occurred in Mrs Barton's case, where the nurses see a diagnostic test result as the GP's responsibility, but the GP believed that ongoing wound care was the district nurses' responsibility.

XI. I recommend that Te Whatu Ora districts have clear policies, procedures and guidelines in place setting out the process for district nurses to follow when they submit a diagnostic test on behalf of an authorised provider. That process should cover the communication required to inform the authorised provider that a test has been submitted, set out the responsibility for checking results and amending the care plan if required, and emphasise the importance of communication between the district nurse and the authorised provider at all steps in the process. Such policies, procedures and guidelines should clearly identify, at each stage of the process, the points at which there needs to be a discussion about transfer of care from the district nurses to another authorised provider or where input should be sought by the district nurses from another authorised provider and the lines of responsibility which apply after that point depending on the decision that is made.

XII. This recommendation is particularly applicable in the cases of wound care, but in my view would also be relevant to all aspects of a district nurse's scope of practice into which GP input might be expected.

XIII. It is apparent from the evidence I received that there was significant confusion between the district nurse team and the GP about who was responsible for Mrs Barton's wound care and the points at which responsibility switched or needed to be jointly assumed. If this recommendation is implemented, I consider that it will significantly reduce the risk of such confusion, missed care and potential patient harm.

Recommendation 4 – electronic reporting of test results

XIV. I recommend that Health New Zealand districts should also consider implementing contemporaneous electronic notification of test results to recipients other than the authorised provider, such as district nurses. This would reduce the burden on those recipients to proactively remember to access the system to search for results and would likely improve communication between those involved in the patient's care, thus resulting in better clinical outcomes for patients.

Other matters not being recommendations

XV. NP Betts' opinion identified what she considered to be best practice issues about Mrs Barton's dressings, including the risks of using both antimicrobial and multiple absorbent dressings as an alternative to more frequent inspections and dressing changes. The NZNO noted that district nurses would be expected to follow their organisation's policies and guidelines for wound care and that prescriptive recommendations were not necessary. I agree.

XVI. Mrs Barton's death is also an important reminder to all health professionals to:

a. ensure all relevant events, such as diagnostic test orders, are documented in the clinical notes to ensure appropriate continuity of care; and

b. carefully review the clinical notes prior to any scheduled consultation to ensure that all health issues are identified and discussed at that consultation. The health professional should not rely solely on the patient to raise medical issues, particularly where the patient is of advanced age.

One common platform for patient records?

XVII. The NZNO raised additional concerns about difficulties in sharing patient care records between district nurses, most of whom work for Health New Zealand, and GP practices, most of which are privately owned. The NZNO invited me to consider making recommendations encouraging a nationally consistent electronic platform for clinical notes which would be available to both district nurses and GPs.

XVIII. The standard of Mrs Barton's care would no doubt have benefited if there had been one set of clinical notes easily accessible to both the district nurses and Dr Brits. Each would have been more aware of what the other was or was not doing. It would have also allowed each person involved in Mrs Barton's care to obtain a more holistic view of her health, which could only have resulted in a better clinical outcome.

XIX. I expect that there are likely significant obstacles to introducing a national, common use, electronic platform. It would require a commitment by a vast number of professionals, working in different environments, to adopt and integrate such technology. While the idea certainly has merit, and would no doubt enable consistent and reliable shared patient care, I am not convinced that it should be the subject of coronial recommendation. I nevertheless encourage Health New Zealand and other stakeholders to continue to work towards effective ways of ensuring that patient records are appropriately accessible and/or easily able to be shared among health professionals

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

Gebre [2022] NZCorC 155 (9 November 2022)

CIRCUMSTANCES

Dawit Solomon Gebre, aged 36, died between 19 and 26 December 2019 at Eden Park Lodge, Mount Eden, Auckland of dilated cardiomyopathy and obesity.

Mr Gebre was of Ethiopian African descent and arrived in New Zealand in 2004 as a refugee from Sudan. He was unemployed and resided at Eden Park Lodge.

Mr Gebre had diagnoses of schizophrenia (paranoid type) and nicotine dependence. He was subject to an indefinite community treatment order pursuant to section 29 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. Mr Gebre also had other medical conditions including obesity, dyslipidaemia, abnormal liver enzymes and was suspected to suffer obstructive sleep apnoea. He had been referred to a sleep clinic for consultation and sleep study but declined to attend.

On 25 December 2019, two community mental health nurses were asked to visit Mr Gebre to administer his injectable medication. He did not answer his door, so a card was left. The community mental health nurses returned on 26

December 2019 but the card was still in place and there was a noticeable odour coming from Mr Gebre's room. Upon obtaining the key to his room and opening the door, they found Mr Gebre lying on his bad. Emergency services were called and a pathologist later confirmed he was deceased.

COMMENTS OF CORONER TETITAHA

I. I make the following comments and recommendations to Te Whatu Ora pursuant to section 57A of the Coroners Act 2006.

II. There are several issues that arise out of Mr Gebre's care leading up to his death that require comment. The pathologist points to the well-known risks of sudden and unexpected death in persons with obstructive sleep apnoea and obesity. If Mr Gebre's obstructive sleep apnoea had been able to be properly diagnosed and managed, this may have prevented his death.

III. Mr Gebre's responsible clinician's report refers to possible language difficulties and lack of understanding of the treatment being offered. Offers of an Arabic interpreter were refused. He also expressed a lack of trust in "district inspectors, judges and the New Zealand government." Mr Gebre also continuously sought discharge from mental health services to the care of his GP whom he did not attend with any regularity. All of these factors indicate the complexity of his care.

IV. Refugees' access to health care in the resettlement country has unique difficulties. Academic writers have commented upon the challenges for refugees seeking to access health care as well as other services:[24]

> Refugees and asylum speakers have unique and complex needs relating to the experiences of forced displacement and resettlement. Cultural competence is widely recognised as important for the provision of effective and equitable services to refugee populations.

V. The World Health Organisation have provided technical guidance summarising research evidence and previous recommendations to assist policymakers in promoting mental health and providing good mental health care for refugees and migrants (WHO report).[25] The WHO report refers to the potential barriers for refugees establishing a positive therapeutic relationship with clinicians and engaging in treatment including:

   a. poor command of the language of the host country can prevent effective communication;

   b. cultural beliefs about mental health may hinder diagnosis and treatment provision for example supernatural explanations of physical presentations of psychological distress;

   c. cultural expectations can also impact care provision, for example concerns medical health professionals may report them to authorities or fail to keep conversations confidential.

[24] Lau & Rodgers "Cultural competence and refugee service settings: a scoping review" Health Equity 2021; 5 (1): 124-134 online publication https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7990563/
[25] WHO "Mental health promotion and mental health care on refugees and migrants: technical guidance" online publication https://www.euro.who.int/__data/assets/pdf_file/0004/386563/mental-health-eng.pdf.

VI. The WHO report refers to overcoming barriers to access the mental health care by refugees by, amongst other things:[26]

a. Provision of information on entitlements tailored to the characteristics of the groups and individuals to be reached including both written and verbal information;

b. Mapping specialised outreach services (or setting up new services if required) to establish trust and familiarity with health services, clarify healthcare entitlements and facilitate access to mainstream services.

VII. Mr Gebre's personal background as a refugee from Sudan is unknown. However, it is likely that he had more complex needs than an ordinary migrant that indicated he required more assistance with his health care.

VIII. Specialised outreach services (including mediators, health advocates and cultural navigators) could have established trust and familiarity with health services and facilitated access for Mr Gebre to medical treatment for sleep apnoea thereby preventing this death.

Reply and further comment

IX. I provided a copy of the draft comments and recommendations to Te Whatu Ora for comment. I have received a reply from Te Whatu Ora and express my thanks for their submissions.

X. Te Whatu Ora confirmed the Ministry of Health had commissioned an assessment of the refugee mental health pathway which was completed in September 2021. A copy of the draft document entitled "Refugee Mental Health Pathway" (RMHP document) has been provided.

XI. I have focused my further comments and recommendations on the parts of the RMHP document that relate to Mr Gebre's situation at the time of his death.

XII. The RMHP document focuses primarily on the services refugees should receive whilst at the Mangere Refugee Resettlement Centre (MRRC) located in Auckland during the five-week resettlement process. They are then relocated to one of 13 locations throughout Aotearoa.

XIII. From year two onwards, district health boards (DHB) and non-government organisations are tasked to provide support to refugees with mental health services akin to the general population.

XIV. Services refugees may receive beyond the resettlement process at the MRRC are not specified. There is reference to RAS (which I understand refers to Refugees As Survivors New Zealand) providing "ongoing refugee mental health support in the Auckland region" and playing "a national role teaching other agencies". The document appears to purport that RAS (Refugees as Survivors) and other services offered by DHBs should be sufficient to meet the needs of Mr Gebre but would benefit from re-organisation.

[26] See above.

XV. The RASNZ report for 2021[27] gives a different view of these matters. It states:

> Funding has played a key role in the determination of which professional groups could be employed, the number of hours that could be devoted to cross cultural community work and which services could be provided and for whom.
>
> …
>
> A significant restraint has been the fact that Cross-Cultural Facilitators have only been employed for a few hours each week, which impacted their ability to earn a viable income. An increase in the diversity of the quota over time has not been matched by increased funding to employ culturally and linguistically appropriate cross-cultural workers. Similarly, the ability to update community group programmes to meet the changing needs of communities has been limited.

XVI. An Australian study of culturally and linguistically diverse populations (CALD) found:[28]

> Health systems and services need to focus on treating multimorbidity through culturally appropriate health interventions that can effectively prevent and control diseases. Existing health services can be strengthened by ensuring multilingual health resources and onsite interpreters. Addressing structural challenges needs a holistic policy intervention such as improving social determinants of health (e.g., improving living and working conditions and reducing socioeconomic disparities) of CALD populations, which requires a high level political commitment.

XVII. I accept the RMHP document is a general mental health framework for all refugees and does not target vulnerable ones such as Mr Gebre. According to the RMHP document, treatment of refugees with pre-existing mental health conditions is limited to safety and support rather than commencing a clinical assessment and treatment program. This appears to be left to the DHB to manage in conjunction with RAS.

XVIII. I understand Refugees as Survivors New Zealand (RASNZ) offers culturally sensitive, trauma informed mental health assistance to people from refugee backgrounds living in Aotearoa. However, at one stage their website[29] indicated they were not accepting new referrals “due to high demand”.

XIX. I sought comment from RASNZ who have provided a reply which is summarised below.

> Earlier this year and on one other occasion in 2021 due to Covid -19 and other recruitment challenges the RASNZ mobile community service was temporarily unable to take referrals. This was due to unprecedented circumstances and is no longer applicable.
>
> RASNZ does not work with clients who are registered under the mental health act. We would not be able to manage the complexity of a client registered under the DHB Te Whatu Ora. CCFs do not have the level of skill to manage a client with complex mental health issues. RASNZ would never recommend them in a case such as this.

[27] RASNZ “25 years RASNZ”
[28] Khatri, RB & Anor “Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges” BMC Public Health https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9063872/
[29] RASNZ website https://rasnz.co.nz/

XX. Mr Gebre had a pre-existing diagnosis of paranoid schizophrenia that resulted in multiple admissions as a mental health services inpatient. There were concerns raised by his clinician about his understanding of the medical advice and services received and offered. The evidence suggests he did not understand the medical treatment he was being offered. From the evidence it did not appear as though Mr Gebre had had any access to a cross-cultural facilitator during this time.

XXI. There is little doubt refuges would benefit generally from targeted information about health care in their own languages. Vulnerable persons such as Mr Gebre also required a cross-cultural facilitator to explain the benefits of the health services being offered and to advocate on his behalf to health professionals and others. There are indications his concerns about the compulsory treatment orders may also have been ignored.

RECOMMENDATIONS OF CORONER TETITAHA

I. After considering the above replies, I have modified my draft recommendations. I now make the following recommendations pursuant to section 57A of the Coroners Act 2006:

II. Te Whatu Ora consider the following changes to refugee mental health pathway:

a. Provision of written and oral information on medical services entitlements in the languages of the refugee groups and individuals;

b. In addition to existing funding for cross-cultural facilitators, providing additional funding to RASNZ or a similar organisation to provide cross-cultural facilitators for vulnerable refugees subject to a compulsory treatment orders due to mental unwellness.

An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Gebre taken during this inquiry, in the interests of decency.

Joe [2022] NZCorC 153 (3 November 2022)

CIRCUMSTANCES

Joseph Junior Joe, aged 49, died on 5 April 2018 at Auckland City Hospital due to right haemothorax (accumulation of blood within the pleural cavity) following the complications of acute on chronic aortic dissection (type B). A significant underlying condition contributing to the death was hypertension.

Mr Joe had ongoing health problems with his aorta. On 28 March 2018, he presented to Middlemore Hospital with an acute type B dissection and an expanding aortic arch. He was transferred to Auckland City Hospital later that day and underwent an emergency endovascular stenting of his aortic arch and descending aorta. Following the surgery, Mr Joe was transferred to the intensive care unit where he spent five days in recovery. During this period, he experienced abdominal pain which was treated with oxycodone and paracetamol.

At around midday on 4 April 2018, Mr Joe complained of severe chest pain. His oxygen saturation had dropped and there was also mild tenderness in the abdomen. Mr Joe was provided analgesia which was noted to have a positive

impact on his pain. At this point the on-call registrar, after discussion with the house officer, decided that Mr Joe was experiencing post-operative pain, and it was felt that further investigations were unnecessary. As a result, information was not escalated to the consultant.

Mr Joe slept for most of the evening and was observed at around 5:00am on 5 April 2018 to be mobilising independently. Approximately an hour later he was found unresponsive in his bed. Resuscitation was attempted however Mr Joe could not be revived and was declared deceased at the scene.

A post-mortem computer tomography scan of Mr Joe's chest revealed that his aorta had ruptured into his right chest. An expert witness Dr Adam El Gamel explained that the surgery Mr Joe had is minimally invasive but "there is a small but significant risk of aneurysm rupture with endovascular stent grafting" which is "slightly higher than that of open chest aortic aneurysm repair." Dr El Gamel also advised that it was possible to discover the rupture on 4 April 2018 when Mr Joe started complaining of pain. However, an emergency thoracotomy and open repair of the dissection and rupture would have still been a high-risk procedure with an unpredictable outcome.

COMMENTS OF CORONER TETITAHA

I. After considering the evidence relating to this file, I make the following comments pursuant to section 57A of the Coroners Act 2006. These comments are directed to the Auckland District Health Board.

II. Pacific Island peoples experience poorer health outcomes than other New Zealanders across a number of health and disability indicators. In short Pacific people die younger and have higher rates of chronic diseases, which are recognised as leading causes of premature mortality and disability. Cardiovascular disease is the principal cause of death Pacific peoples in cardiovascular mortality rates are consistently and significantly higher than for the general population.[30]

III. Two out of five Pacific deaths are from heart disease and aged between 35 to 65 years old. One in three Pacific men who died in 2016, died from cardiovascular disease. Cardiovascular disease is the leading cause of death for Pacific people.[31]

IV. Aortic dissection is a cardiovascular condition.[32] Acute type A aortic dissections often require emergency high-risk surgical intervention and multidisciplinary critical care. The need for definitive surgery is underscored by a mortality rate of 1–2% per hour after onset of symptoms and that 40% of acute type A aortic dissection patients die immediately, 35–70% within 24–48 hours, 94% within 1 week and 100% within 5 weeks.[33]

[30] Ministry of health website https://www.health.govt.nz/our-work/populations/pacific-health/pacific-peoples-health
[31] Heart Foundation Website Pacific Heart Health statistics https://www.heartfoundation.org.nz/your-heart/pacific-heartbeat/pacific-heart-health-statistics
[32] Heart Foundation Website Aortic Dissection https://www.heartfoundation.org.nz/your-heart/heart-conditions/aortic-dissection
[33] AK Gupta, P Subramaniam, K Hulme, T Vasudevan The sharp end of cardiovascular disease in New Zealand: A review of acute type A aortic dissections of the Waikato NZMJ 7 August 2015, Vol 128 No. 1419 at 22.

V. The most common symptoms of haemothorax include sudden severe chest or upper back pain, severe abdominal pain, and breathlessness. Mr Joe's medical records show he was experiencing abdominal pain in the days leading up to severe chest pain on 4 April since the operation.

VI. Given the Pathologist's findings, his medical history, and his ongoing abdominal pain since the operation, I have concerns about the care he received leading up to his death.

VII. This may indicate the need for a reference of this matter to the Health and Disability Commissioner for further investigation.

VIII. These comments are directed to the Auckland District Health Board and the Auckland City Hospital.

IX. Dr Parma Nand has provided a reply on behalf of Te Whatu Ora. I have summarised the reply below.

X. In reference to [IV] above, it sets out the details of the transfer of Mr Joe from Middlemore Hospital to Auckland Hospital on 28 March 2018. These details are set out [above]. The reply then sets out the complexity and risks associated with the operation he underwent and his medical conditions that made him "an extremely high-risk surgical candidate". The reply listed the risks of the procedure explained to Mr Joe including mortality and has attached a copy of the informed consent form he signed prior to surgery.

XI. The possibility of a stent problem was known by 4 April 2018 when his chest pain was increasing. The reply attaches clinical notes from 4 April 2018 which sets out the concerns of the medical practitioners and the decision not to take any further investigation due to health risks.

XII. The notes do not record whether this decision had been discussed with Mr Joe at the time. It does not appear that he had any whānau or other support with him at the time. A witness statement from his younger brother indicates they were unaware of the complexity of his health conditions.

XIII. Given the critical nature of the decision made on 4 April by medical professionals not to investigate the stent problem, Mr Joe should have been fully informed and given a choice about whether further investigation should occur.

Health and Disability Commissioner

XIV. The Health and Disability Commissioner (HDC) is empowered to enforce the Code of Health and Disability Services Consumers Rights (the Code). These rights include the right to effective communication, to be fully informed and to make an informed choice.

XV. I consider that a reference to the Health and Disability Commissioner pursuant to section 119 of the Coroners Act 2006 is warranted. There is a public interest in having this death investigated by the Health and Disability Commissioner and performance of its functions. This death occurred in a public hospital. There are concerns raised about the care Mr Joe received in hospital including whether it met the standards set out in the Code.

XVI. Accordingly, I refer this death to the Health and Disability Commissioner pursuant to section 119 of the Coroners Act 2006.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photos taken of Mr Joe during this inquiry, on the grounds of decency.

John H [2022] NZCorC 160 (22 November 2022)

CIRCUMSTANCES

John H, aged 61, died of septic shock. The proximate cause of death was primary graft dysfunction (PGD) occurring during an intra-cardiac transplant procedure impacted by post-transplant myocardial injury and toxoplasma myocarditis in a heart with cardiomegaly and left ventricular hypertrophy.

After being diagnosed with chronic dilated ischaemic cardiomyopathy, Mr H underwent heart transplant surgery. During the retrieval procedure, the donor heart was dropped on the operating room floor. The primary implanting surgeon noted that the left ventricle of the heart appeared moderately hypertrophied, but no obvious abnormalities were detected. The post-operative period was complicated by poor cardiac function, which was not considered to be due to rejection. Despite maximum supportive therapies, Mr H died several weeks later.

As an investigation by the Health and Disability Commissioner found that the dropping of the heart did not directly contribute to Mr H's death, the Coroner determined that it was not an issue for her inquiry. Expert witness Professor McGiffin considered that Mr H's PGD was due to a prolonged ischaemic time (five hours) compounded by a degree of left ventricular hypertrophy. He noted both the immediate and prolonged conduction abnormalities together with ongoing poor myocardial function clinically indicated profound myocardial injury.

The post-mortem examination of the heart revealed findings which were not apparent clinically, including severe and widespread toxoplasma myocarditis. It was determined that Mr H had developed toxoplasma myocarditis at some point after the transplant. The donor's serology results were not sent to the cardiac transplant service until 21 days after the transplant (the day Mr H died). These results indicated a positive result for previous toxoplasma exposure, while Mr H had not previously been infected and therefore lacked immunity. The District Health Board (DHB) advised that while co-trimoxazole is usually commenced several days following a transplant to help prevent infection (including toxoplasmosis), Mr H was not given co-trimoxazole due to his impaired renal function. Had the transplant team been aware of the serology results earlier, their risk/benefit calculus would have been altered and Mr H would have been started on co-trimoxazole. Professor McGiffin provided examples of other countries where the serology results are back within 48 hours. While the role of toxoplasma myocarditis could only be speculated upon, he considered that it very likely contributed to the persistence of poor cardiac reserves in the final days of Mr H's life.

The Coroner noted that at the time of Mr H's death, there was no agreed timeframe with any of the transplant services for the communication of serology results. The DHB reviewed this following Mr H's death and stipulated a five-day period. The medication protocol was revised to state that "co-trimoxazole should not be withheld unless there are extraordinary circumstances".

The Coroner initially recommended that serology results taken from the donor and recipient blood samples be communicated to the transplanting team within 24 hours, and that if results are not known at 48-72 hours, the recipient be treated as if they were toxoplasma gondii positive. She also recommended that the medication protocol define

"extraordinary circumstances", and that it should be updated to provide guidance on safe dosages of co-trimoxazole and alternative prophylactic medications for use to prevent toxoplasma gondii in patients with renal impairment.

These recommendations were forwarded to the DHB and the New Zealand Blood Service (NZBOS) for their comment. The response was that it was not feasible or appropriate to enforce a 24-hour requirement for the communication of serology results, and that the recommendation should be amended to a 48-hour timeframe. It was noted that this timeframe would be dependent on various factors, such as the timing of the donor surgery, lab resources, and the time that results are available to Organ Donation New Zealand, who remove the donor's identifying details.

The DHB considered the need to define "extraordinary circumstances" was no longer necessary due to an update to the medication protocol in July 2022. It also proposed that a dosing algorithm for co-trimoxazole be added to Appendix 1 of the protocol and referenced in the guidance relating to safe dosages in the event of renal impairment. NZBOS considered that clinical treatment decisions and the drafting of medication protocols were primarily matters for transplant teams to address.

RECOMMENDATIONS OF CORONER BELL

I. I have considered the comments relating to my initial recommendations. My final recommendations are:

    a. serology results

        i. taken from the recipient blood samples be communicated to the transplanting team prior to or at the time of transplantation and

        ii. taken from the donor blood samples be communicated to the transplanting team within 48 hours of transplantation. I acknowledge the submissions made but on balance rely on the expert opinion of Professor McGiffin and do not consider this recommendation imposes overly onerous obligations compared to the potential harm being mitigated.

II. I recommend that the *Perioperative Medication Therapy in an Adult Transplant Recipient* protocol be updated, with a dosing algorithm for co-trimoxazole added to Appendix 1 (Dosing in renal dysfunction), so that if the patient has renal impairment the co-trimoxazole dose should be reduced appropriately with reference to Appendix 1. If clinical judgment in a particular case determines to override the medication protocol the reasons should be clearly documented.

Note: An order under section 74 of the Coroners Act 2006 prohibits the making public of the date (including the year) of the organ donor's death; the circumstances of the organ donor's death; the date (including the year) of the heart transplant; the date (including the year) of John H's death; the name of the hospital where the organ retrieval took place and the city in which that hospital is located; John H's full name; and any photographs of John H entered into evidence, in the interests of personal privacy and decency.

More [2022] NZCorC 157 (14 November 2022)

CIRCUMSTANCES

James David More, aged 89, died on 23 November 2019 at 50 Triangle Road, Massey, Auckland of stroke complicated by blunt force head injuries with an underlying condition of pneumonia.

Mr More was diagnosed with dementia in 2015 and moved into a rest home in 2017. He had been living in the dementia unit of the Edmonton Meadows rest home until 16 November 2019. The doors of the dementia unit of the rest home led to an outside area where residents could walk around. They were usually locked around 6pm.

Mr More had been susceptible to falls and his family had concerns about him being allowed to go on walks unsupervised. A registered nurse from the rest home confirmed Mr More was mobile and could walk around by himself. He would often not listen to rest home staff and would become agitated. When that happened, staff would let him do what he wanted, including go outside for a walk. He would go outside at least three times a day, sometimes more often. However, staff needed to check on him every 15 minutes.

At approximately 6:30pm on 16 November 2019, Mr More was found by caregivers and two members of the public lying face down outside the rest home. The caregivers stated they had checked on Mr More five minutes prior to the incident.

Emergency services were called and Mr More was transported to Waitakere Hospital. He remained in hospital until being discharged to a family member's home for end-of-life care.

COMMENTS OF CORONER TETITAHA

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

II. The cause of death is stroke complicated by blunt force head injuries. This gives the possibility that 'but for' the blunt force head injuries Mr More may not have died. There are questions that arise on this evidence about the care Mr More received to prevent injury by falls.

III. I am aware the family are unhappy with the level of supervision he received whilst walking outside.

IV. There were references to previous unwitnessed falls. His medical notes contain references to falls including one on 7 November 2019 that resulted in injury. The Police refer to information about a fall that occurred on 10 October 2019. His care plan also referred to two falls in the six months prior to 15 April 2019.

V. The care plan noted falls risk assessed as "medium" and mobility as "independent but need supervision". His care plan referred to having a staff member available "within arm's length" when taken for a walk.

VI. However, the rest home confirmed the supervision he received was 15 minute checks. I assume this requires a caregiver to be able to sight Mr More at 15 minute intervals. No record has been provided of these checks occurring. Whether there was an adequate falls risk assessment requires further investigation.

VII. The evidence also suggests the rest home's doors to the outside should have been locked by 6pm. Mr Moore was found outside at 6:30pm. There is no explanation how he was able to leave the building unsupervised.

VIII. The above concerns are best investigated by a specialist agency such as the Health and Disability Commissioner (HDC) including in particular by the Aged Care Commissioner. I have determined to make reference to the HDC below.

IX. These comments are directed to Henderson Healthcare Ltd trading as Edmonton Meadows rest home and the Health and Disability Commissioner.

X. I have determined to make no recommendations because of the below reference to the Health and Disability Commissioner.

Reference to Health and Disability Commissioner

XI. There is public interest in ensuring there have been no breaches of the Code of Health and Disability Services Consumers Rights by the care Mr More received. I am satisfied the public interest would be served by referring Mr More's death to the Health and Disability Commissioner pursuant to section 119 of the Coroners Act 2006 for further investigation.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Mr More during this inquiry, in the interests of decency.

Riley [2022] NZCorC 167 (1 December 2022)

CIRCUMSTANCES

Debbie Joy Riley, aged 54, died on 15 October 2019 at Nelson Hospital due to aspiration pneumonia and septicaemia following hypoxia caused by choking in the context of progressive multiple sclerosis.

Ms Riley suffered from progressive multiple sclerosis and was wheelchair bound. As a result, Ms Riley was at risk of choking while eating. From 6 October 2019, Ms Riley was in the care of Jack Inglis Friendship Hospital (JIFH) while her husband was out of town. Before he left, her husband gave detailed notes to JIFH staff about Ms Riley's care, including care during meals. On the evening of 13 October 2019, Ms Riley was being assisted by a caregiver while eating dinner. At one point, the caregiver had to attend to another patient and briefly left Ms Riley alone. At that point Ms Riley started choking. The JIFH caregiver raised the alarm and other staff came to help and tried to clear Ms Riley's airways. Paramedics were also called and, on arrival, cleared Ms Riley's airways. However, Ms Riley was deprived of oxygen and suffered hypoxia. On admission to Nelson Hospital, she was in a comatose state and placed on a ventilator. She subsequently developed septicaemia and aspiration pneumonia and died on 15 October 2019.

Ms Riley's husband raised concerns about the care provided to Ms Riley by JIFH. He complained to the Health Disability Commissioner who subsequently found that the standard of Ms Riley's care and level of staffing were appropriate, and that the choking episode was handled correctly.

COMMENTS OF CORONER ELLIOTT

I. At the meeting in court, it was explained to me that the process at JIFH was that each resident was to be fed each course until they finished that course, at which point the caregiver would move on to the next resident.

II. The caregiver was following this process with Ms Riley. She fed Ms Riley the soup and bread slowly and communicated with her during this time. She moved away because there were other residents to assist. At that time, she believed that Ms Riley had completely swallowed her food.

III. However, at the time the caregiver moved away, Ms Riley had not completely swallowed all of the bread. Ms Riley choked when the caregiver was attending to another resident.

IV. It should be noted that, given the nature of her condition, Ms Riley could have choked on the bread even if the caregiver was watching her at the time she was trying to swallow it.

V. However, if the caregiver had been present with Ms Riley until she had completely swallowed all of the bread, the risk of her choking would have been reduced because she would have been able to apply the type of strategies which are suggested by the Multiple Sclerosis Society.

VI. Ms Riley's death illustrates the importance of ensuring that a person who is at risk of choking has completely finished eating before moving on to assist another resident. The chances of deaths in similar circumstances may be reduced if rest homes ensure that this happens.

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

> Ms Riley choked at Jack Inglis Friendship Hospital on 13 October 2019.
>
> A caregiver had been assisting Ms Riley with her evening meal. At the time the caregiver moved away from Ms Riley, she believed that she had completely swallowed all of the food. However, this cannot have been the case. Ms Riley started to choke when the caregiver was assisting another resident.
>
> Ms Riley's death illustrates the importance that those who are assisting at-risk residents with their food in a rest home or hospital ensure that the resident has completely finished swallowing their food before moving away.

VIII. I proposed to make the following recommendation to JIFH:

> I recommend that JIFH ensures that those who are engaged in assisting at-risk residents with their food are aware of the importance of checking that a resident has completely finished eating (and swallowing) all of their food before moving away

IX. JIFH was given an opportunity to comment on this and provided the following response:

> JIFH recognises the Coroner's sound motivation in relation to the draft recommendation. However, JIFH would like to set out that:
>
> (a) At the time of Mrs Riley's death, JIFH did have specific training in place for caregivers in relation to feeding at risk patients as follows:

i. Included in the general orientation for all caregivers is feeding residents who are dependant. In addition, staff carry out the practical training with senior members of staff. This includes correct positioning, ensuring protectors in place, fluids given via an appropriate cup, correct diet being provided, sitting one on one, feeding slowly and waiting for each mouthful to be swallowed. Caregivers are observed doing this until competent.

ii. Within the Level 2 NZQA learning guide for Caregivers, there is a module on how to support a person to eat and drink. All caregivers at JIFH are encouraged and supported to complete the Level 2 qualifications within 3 months of commencing employment with us.

iii. As part of the work towards achieving Level 2, caregivers were required to read a Learning Guide...which includes material on safe swallowing and preventing asphyxiation.

(b) Immediately after Mrs Riley's death, JIFH further strengthened its ongoing training regarding procedures for providing food and water to at risk residents. The further steps which were implemented included all current caregivers are being asked to re-read the Learning Guide "Support a person to eat and drink". Reading this guideline and demonstration of feeding at risk residents also became a key part of the general orientation for all caregivers.

JIFH wishes to extend its condolences to Mrs Riley's family and loved ones. JIFH can well understand that Mrs Riley's loss is keenly felt. Staff very much enjoyed Mrs Riley's warm and bubbly personality; she was truly a delight to care for.

X. Given the steps taken by JIFH, I make no recommendation.

XI. A copy of these findings will be sent to the New Zealand Aged Care Association.

Yeung [2022] NZCorC 164 (25 November 2022)

CIRCUMSTANCES

Fei Tao Yeung, aged 81, died on 1 May 2019 at North Shore Hospital, Auckland, from a blunt force head injury received in a fall.

Mr Yeung lived in a secure dementia unit at Greenvalley, a rest home owned by Oceania Healthcare. On 28 April 2019, Mr Yeung was in the lounge with another resident, when an altercation occurred, which resulted in Mr Yeung falling and hitting his head. Although a staff member was supposed to be present in the lounge at all times, at the time of the altercation, the lounge was unsupervised.

Mr Yeung was admitted to hospital, where he passed away on 1 May 2019.

COMMENTS OF CORONER GREIG

I. I recommend that Oceania Healthcare Ltd assesses staff working at Greenvalley and all other dementia units that fall under the auspices of Oceania Healthcare to establish:

a. their familiarity and understanding of policies related to the supervision of residents;

b. compliance with such policies;

and:

c. if any gaps in knowledge, understanding and/or compliance are identified, undertake the appropriate steps to rectify this.

Response from Oceania

II. A copy of my provisional findings were sent to Oceania together with my draft recommendations. Dr Frances Hughes, Group General Manager, Clinical & Care Services/Clinical Director for Oceania Healthcare responded as follows:

> *Oceania accepts the provisional findings and recommendations.*
>
> *Oceania sincerely regrets the events that transpired at Greenvalley Lodge and the passing of Mr Yeung under these troubling circumstances. Oceania is committed to providing a safe and appropriate level of care for their residents. Therefore, in response to these findings, Oceania will be undertaking a thorough review of the processes which were put in place following Mr Yeung's passing and evaluate their efficacy. This includes the current guidelines and the education delivered to clinical staff working within dementia wings across all Oceania sites. This review will be undertaken by the Corporate Clinical Team at Oceania.*
>
> *Following this review, staff will receive further training surrounding the expectations of care for dementia residents. This will be delivered through the Clinical Quality Forum, which is attended by all clinical leaders and facility managers at Oceania. The Clinical Governance Committee and the Oceania Board have oversight of all coronial investigations, to ensure there is accountability and effective strategies to address any adverse findings.*
>
> *Furthermore, there has been a recent change in leadership at Greenvalley Lodge which has markedly strengthened the relationship between management and clinical staff. The new Clinical Manager and Business & Care Manager are well-versed in Oceania policies and have significant experience within Aged Residential Care. The services are also overseen by the Regional Clinical Manager who is committed to improving the quality of care at Greenvalley Lodge. We are confident that Greenvalley Lodge will embrace any new learnings from this event and continue to improve their practice.*

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

Miscellaneous

Marlow [2022] NZCorC 152 (2 November 2022)

CIRCUMSTANCES

Kaelah Emily Marlow, aged 19, died on 7 January 2021 at Waihi Beach, Bowentown from cardiovascular shock due to massive blood loss antecedent to a massive shark bite to the posterior compartment of her right thigh.

On 7 January 2021, Kaelah travelled to Waihi Beach with her friends to swim in the surf. At around 4:30pm, Kaelah and two of her friends went for a swim together in the ocean at the southern Bowentown end of Waihi Beach. They swam where the beach was patrolled by lifeguards and entered between the flags.

The sea was relatively rough and choppy with strong currents moving south along the beach. The group swam to a depth where they were no longer able to touch the ground, some 100 metres offshore. After swimming for 30 minutes, Kaelah's friends decided the current was too strong and headed back. When they reached the beach, they saw that Kaelah was still out in the water, moving further away from the shore.

Lifeguards had been watching Kaelah and her friends and made a decision to launch an inflatable rescue boat (IRB) to check on Kaelah. At this time, she did not appear to be in any distress or obvious difficulty. By the time the IRB was launched Kaelah was approximately 400 metres away from the shore.

Prior to the IRB reaching her, Kaelah was bitten by a shark. The lifeguards reached Kaelah while she was conscious and calling for help, yelling "shark". The lifeguards lifted her into the boat and quickly transported her to shore and signalled for help. Kaelah had suffered significant blood loss in a very short period of time. Onshore medical assistance was immediately provided by lifeguards and a doctor who had been swimming nearby. Emergency services had already been called and paramedics attended. Despite all resuscitation efforts, Kaelah was unable to be revived.

As part of the inquiry into Kaelah's death, expert opinion was sought from forensic odontologist, Dr James Goodrich; Technical Advisor, Marine Species Team, Department of Conservation, Clinton Anthony John Duffy; and marine biologist Dr Riley Elliott.

An analysis of Kaelah's bite injuries indicated that she was almost certainly bitten by a juvenile great white shark.

Relying on the experts, the Coroner noted that research indicates a recent increase in the population of great white sharks in the Bay of Plenty and potentially the North Island. The exact population increase in Bay of Plenty and why it occurred is yet to be researched. However, media attention, public concern and multiple accounts of sighting and interactions with great white sharks within the waters of the Bay of Plenty have culminated in a research project being announced.

The Coroner also noted that recent papers on juvenile white shark behaviour in Australia provide limited information about their movements and behaviours. One paper considered tagging a population of sharks on the New South Wales coast. Studies from Australia have also shown that elevation in viewing position and operating a drone in the vicinity of a flagged swimming area significantly increases the opportunity of observing a shark compared to the opportunity afforded to a lifeguard standing on the sandbanks above the flags.

COMMENTS OF CORONER ROBB

I. The expert evidence highlights the fact that great white sharks have always been in New Zealand waters. The evidence provided to me establishes an increase in the number of great white sharks in the area of the Bay of Plenty with significantly increased interactions and observations from the summer of 2020/21 onwards.

II. To what extent there has been an increase in abundance in the Bay of Plenty, over what period and for what reason is yet to be determined by research. In the North Island of New Zealand, and specifically in the Bay of

Plenty there is very limited research on the great white population, their numbers, the age of the population, their movements and feeding behaviours. Consequently, identifying the ongoing level of risk is difficult. Only comprehensive research will provide the answers.

III. The expert evidence highlights the rarity of great white shark attacks despite the ongoing presence of sharks with this being true internationally even in areas where there is an abundance of great white sharks.

IV. Despite the rarity of attacks, as the historical records in New Zealand and the international experience reveals, attacks can occur and when they occur, particularly in respect of swimmers, they are likely to be fatal.

RECOMMENDATIONS OF CORONER ROBB

I. A copy of my draft finding, and recommendations were provided to parties affected by the recommendations, and pursuant to section 57B of the Coroners Act 2006 those parties were provided with an opportunity to comment on the recommendations. I received comments from Surf Lifesaving New Zealand (SLSNZ), paraphrased below. No response was received by the Western Bay District Council Community Board responsible for signage. Additionally, I received further clarification and advice from Clinton Duffy which has been incorporated into this finding, and an update on research from Dr Elliott as detailed below.

Research recommendation

II. Recommendation one: That research, including tagging and satellite monitoring of great white sharks in the North Island of New Zealand be undertaken, to identify great white population, age, location, movements, feeding habits and any other matter likely to better inform understanding of risk and risk prevention to better determine the level and circumstances of risk of shark attack in the Bay of Plenty area. Adequate research is dependent on adequate provision of funding to allow for this to occur quickly and effectively.

III. Earlier in this finding I referred to research proposed to be undertaken. The update provided by Dr Elliott details the research project that he and others are directly involved in. This is described in the Sustainable Oceans Society website and has been given the name “Project Great White” with a start date scheduled for 1 December 2022.[34] Dr Elliott has explained to me:

> Research is the key to preventing or at least reducing the risk of a similar death or injury occurring… I have received a research permit to tag and track the Great Whites in this area.
>
> This is expensive research, which I have done around the world, but in NZ funding is rare for mega fauna research, as most marine research is funded by fisheries for fisheries interests.
>
> The Great White shark is a protected species, and comes under DOCs jurisdiction to protect. It is the Government's objective through the National Plan of Action for sharks, to improve research and data collection. However neither of these entities have provided funding for research into the recent increase of Great Whites in this region. At present I am about to issue a press release for the tagging project to advertise to the public, a

[34] Project Great White, Sustainable Ocean Society http://www.sustainableoceansociety.co.nz/

'Sponsor a Shark' program, which funds the $4000 per satellite tag to track these animals. They can follow the animals' movements live on a website, and learn more about their distribution relative to their own recreation. This is how, in places like California, Cape Cod and East Australia, the risk of adverse shark interactions has been reduced. This is my intention in the location of Kaelah's incident, but it will also span along the great NE North Island's coastline, being our summer holiday hotspots.

Overall, what I suggest is required to avoid or reduce the risk of such an accident occurring again, is funding support for this shark tagging program. As an example of how well it can work, East Australia funded over $100 million into their program. By no means is this even a reality in our less populous country, and where shark attacks have been far rarer, but it reflects the value of such a program.

With this population of Great Whites growing and persisting in these holiday hotspots for New Zealanders, it is my professional opinion that other adverse interactions with these animals is more a matter of time rather than a potential possibility. The risk of such an incident can only be reduced by gathering information on the habitat use and behaviour of the sharks in relation to our own.

IV. Funding is referred to by Dr Elliott with the opportunity for public involvement by sponsoring a shark as detailed in the Sustainable Oceans Society website. I understand that there will be opportunities for members of the public to help support this research financially by contributing more modest sums as well as the opportunity to sponsor a shark. The sponsoring of a shark is proposed to come with the opportunity for members of the public be involved in a process of naming a given tagged shark and to be able to live-access their GPS data. I anticipate (and hope) that considerable public interest will be generated when Dr Elliott, and the researchers that he is working with, formally announce the research project set to begin on 1 December 2022, and the opportunity for members of the public to play a role in the tracking of great white sharks. I understand that internationally the ability for members of the public to be able to view the GPS tracking in real-time has generated both interest and funding.

V. Research will provide the platform of knowledge to best understand the population size, movements, and behaviours of great white sharks in the waters around New Zealand and how best to limit the interactions between those utilising the coastal waters and those sharks.

VI. However, despite that research and its results not yet being known, based on what has been established about the circumstances of Kaelah’s tragic death, I am obligated to make additional recommendations to reduce the risk of death occurring in similar circumstances in the future.

VII. At ocean beaches where there is a known risk of the presence of great white sharks, and where surf lifesaving is in operation at those beaches, I make the recommendations detailed below.

SLSNZ role and beach signage recommendations

VIII. Recommendation two: The establishment of surf lifeguard towers to provide an elevated position to assist lifeguards to monitor flagged areas, the people swimming within those areas, and the waters in close proximity for the presence of sharks. Where necessary Council support, and/or introduction or amendment of bylaws, and coastal planning restrictions to allow for tall permanent surf lifeguard towers.

IX. Surf Life Saving New Zealand Responded:

SLSNZ agrees with the Coroner. SLSNZ actively promotes lifeguard towers at all patrol locations. Two types of lifeguard towers are available, permanent and mobile. However, the provision of permanent and mobile lifeguard towers is dependent on the ability to obtain sufficient funding.

Permanent towers

Due to their size, permanent towers provide the best elevation for lifeguards to monitor flagged areas and the wider coastal expanse. However, the placement of permanent towers is often not feasible due to a combination of factors. These include, but are not limited to:

1) Installation and maintenance costs;

2) Legislation and resource consenting may prohibit construction in the marine coastal area;

3) Council by-laws and coastal planning documents may prohibit construction in the marine coastal area;

4) The dynamic and unstable nature of the marine coastal area may prohibit construction;

5) Community support may not be forthcoming.

Mobile towers

Where patrol locations have no permanent towers, mobile towers are recommended to provide elevation for lifeguards to monitor flagged areas. Mobile towers do not allow for the elevation afforded permanent towers, however, this is often the only option available.

As a result of this tragic incident, two mobile beach patrol trailers were purchased for use at the Island View and Bowentown patrol locations and have been in use since November 2021 (photograph provided). They provide elevation for lifeguards to monitor the flagged areas. It is important to note these mobile patrol trailers were donated by Kaelah's family. Sourcing funding for permanent and mobile patrol towers/trailers remains an ongoing challenge for SLSNZ.

Clearly funding/resourcing is a significant and ongoing issue. I acknowledge the efforts made by SLSNZ, and in particular the personal donation by Kaelah's family. As the photographs provided to me reveal, the mobile towers provide an improved level of elevation for lifeguards to position them above the level of the sand dunes. The mobile towers provide some elevation with five steps to the trailer height of the mobile tower, and the benefit of additional height from the lookout position on one side of the mobile tower.

The cost of a taller permanent tower, such as those commonly utilised on Australian beaches, provides one practical limitation to what could readily be implemented at Waihi Beach. The benefit of the size of the Australian population, and their surf lifesaving funding, means that lifesaving towers in Australia can often provide additional elevation extending to 3–5 metres. The greater the elevation the better the opportunity for viewing in and around a flagged area.

X. Recommendation three: Drones be utilised by or for the benefit of surf lifeguards, where possible, to assist in the monitoring of ocean waters in and around flagged areas. Funding of equipment and personnel resource to allow for this to occur.

Surf Life Saving New Zealand responded:

> SLSNZ agrees with the Coroner. SLSNZ will undertake work to investigate the application and success of Surf Life Saving New South Wales (Australia) shark surveillance program and where applicable, introduce measures that have proven to be successful. However, this work will be dependent on the ability to obtain sufficient funding.

XI. SLSNZ identified their Shark Sighting National Standard Operating Procedure (Sighting Procedure) employed by lifeguards when there had been a confirmed shark sighting. The Sighting Procedure requires an assessment of the legitimacy of the sighting and severity of risk, a request that swimmers leave the water if the sighting is legitimate if the shark is within 500 m of patrol, closure of the flagged area with appropriate shark signage, scanning of the water from an elevated position, providing information to neighbouring clubs beaches, evaluation of when it is safe to reopen the flagged area. The difficulty in sighting sharks in murky water and/or where a shark was not swimming at the surface was recognised, and I acknowledge this. However, utilisation of drones in appropriate weather conditions extends the possibility of early detection.

XII. Recommendation four: Signage warnings be put in place to warn members of the public that while great white shark attacks are very rare, great white sharks are known to frequent the coastline, that swimming alone and beyond the breakers increases the risk of attack, swimming with others and within flagged areas is recommended. The Surf Life Saving New Zealand response was the following: “SLSNZ agrees with the Coroner.”

XIII. No response was received from the local council responsible for signage.

XIV. I had anticipated that there might be some understandable resistance to signage by some entities or individuals with this presenting an unpleasant message to those heading into the ocean for a swim. However, while attack by a great white is rare, the consistent expert advice is that there remains a risk. Members of the public have a right to know of the risk and of any matter that elevates or alleviates the risk.

XV. Recommendation five: this proposed recommendation sought to have lifeguards provide direction to swimmers who had made their way beyond the breakers. SLSNZ advised that they would undertake work to investigate the application and success of Surf Life Saving New South Wales shark surveillance program and introduce measures that have proven successful. However, while SLSNZ could provide advice, they had no statutory authority to direct members of the public.

Additional issues

XVI. In the report that Mr Duffy provided to my coronial inquiry he suggested the carrying of tourniquet in IRBs to provide the best opportunity to prevent massive blood loss following a shark attack. However, in the tragedy that unfolded for Kaelah I have formed the view that the shark attack was carried out with massive force and speed, it was, on the expert advice provided to me, intended to fatally incapacitate. The expert advice from the pathologist is that Kaelah’s blood loss was so fast that by the time she was placed in the IRB she had effectively stopped bleeding. Whether a tourniquet was available at the time or not, her injury was fatal, and there was nothing that the lifeguards could have done either in the IRB or immediately after onshore to have prevented Kaelah’s death.

Accordingly, in terms of the jurisdictional limitations of the Coroners Act I cannot formally make that a recommendation of this finding.[35]

XVII. I am further advised by SLSNZ that the focus of lifeguard training is on the removal of the patient from the water as quickly as possible for first aid where necessary. The specialist training necessary for drivers and crew persons of an IRB to successfully apply a tourniquet in the course of a rescue was viewed as not feasible from an operational, and financial, perspective by the SLSNZ. However, the SLSNZ are committed to working with subject matter experts in those organisations with expertise in the management of trauma induced life-threatening external bleeding. SLSNZ will investigate bleeding control methods which are best applied during normal lifeguarding operations.

XVIII. Additionally, Mr Duffy raised concerns and potential legislative difficulties that are presented to lifeguards in managing and clearing beaches when a shark attack has occurred. There does not appear to be a statutory provision that authorises lifeguards to require members of the public to leave the beach, nor to close a beach for any given period for the safety of the public. I agree with Mr Duffy that this is a matter that would best serve public safety and if there is no such legislation or clear understanding of the powers of a lifeguard then I agree this is a matter that requires addressing. However, again my jurisdiction as a coroner under the Coroners Act 2006 only extends to making recommendations about matters that may have caused, contributed to, or may have prevented the death which is the subject of the coronial inquiry. In other words, while the suggestion warrants consideration, I do not have the power to formally recommend any such legislative provision or clarification of lifeguard powers as these matters did not cause or contribute to Kaelah's tragic death.

Surf Life Saving New Zealand responded:

> SLSNZ agrees with the Coroner. Although a very small number of District Councils do have by-laws that require the public to swim between the red & yellow patrol flags and for craft to stay outside the flags, there is no statutory provision that authorises lifeguards to require members of the public to leave the beach, nor to close a beach for any given period for the safety of the public. Following this incident, SLSNZ has been working with NZSAR to address the issue of public and lifeguard safety in similar events. This work has resulted in the development of a national guideline that can be used regionally to develop a multi-agency response for marine animal threats. While any response will not be based on a legislative approach, it will enable at-risk areas to prepare their response in a collaborative manner. That being said, SLSNZ does agrees with Mr Duffy that there is no clear understanding of the legislation or powers of a lifeguard and is a matter that would best serve public safety and so is a matter that requires addressing. SLSNZ is currently engaging with the Ministry of Transport who are presently conducting a review into Search & Rescue and Recreational Safety. Whilst the review is not looking specifically at legislative provisions for lifeguarding, we do hope that it will lead to some level of clarification on the necessary legislative framework under which SLSNZ does it's best to provide New Zealand with a National Beach Lifeguard Service.

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

[35] S57A(3) Coroners Act 2006

Sutherland [2022] NZCorC 165 (28 November 2022)

CIRCUMSTANCES

Jeanette Anne Sutherland, aged 80, died on 5 September 2020 in the spa pool at her home due to sudden cardiac death in the context of warm water immersion.

Ms Sutherland lived alone. She had a long medical history of raised blood pressure. On the morning of 5 September 2020, a family member found her face-down in her outdoor spa pool. The spa was still operating, having been set to 41.5 degrees.

Toxicological analysis found alcohol in Ms Sutherland's blood at a concentration of 153mg/100ml. The pathologist who conducted a post mortem examination, Dr Michael Myskow, noted that sudden cardiac death while in a spa pool is a well-described phenomenon and that a past medical history of raised blood pressure, as well as consumption of alcohol before immersion in a spa pool are risk factors.

COMMENTS OF CORONER ELLIOTT

I. Section 57A of the Coroners Act 2006 states:

> **57A Recommendations or comments by coroners**
>
> (1) A responsible coroner may make recommendations or comments in the course of, or as part of the findings of, an inquiry into a death.
>
> (2) 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.
>
> (3) 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.

II. Based on Dr Myskow's evidence, I have concluded that Ms Sutherland's raised blood pressure, recent alcohol consumption and the temperature of the water in the spa contributed to the sudden cardiac event which caused her death.

III. As Dr Myskow said, sudden cardiac death while in a spa pool is a well described phenomenon. It is thought to be a consequence of 'a functional cardiovascular collapse as a result of profound peripheral vasodilatation.'

IV. In Ms Sutherland's case, there were two additional risk factors which rendered her susceptible to a cardiac event when using the spa, namely a medical history of raised blood pressure and recent alcohol consumption to a level of 153 mg/100mL.

V. The chances of a person dying in similar circumstances may be reduced if it is brought to public attention that raised blood pressure and alcohol consumption can increase the risk of a cardiac event in a spa pool.

VI. I therefore make the following comment pursuant to s 57A of the Coroners Act 2006:

A woman died on 4 or 5 September 2020 while at her home in a spa pool which was operating at a temperature of 41.5 degrees Celsius. She had consumed alcohol to a level of 153 mg/100mL. Her medical history included raised blood pressure.

The woman died due to a sudden cardiac event which was caused by her raised blood pressure, recent alcohol consumption and the temperature of the water in the spa. Her death illustrates that people who have raised blood pressure are at risk of sudden cardiac death when using a spa, particularly after consuming alcohol.

Taikato [2022] NZCorC 163 (25 November 2022)

CIRCUMSTANCES

James Whare Taikato, aged 51, died on 19 November 2020 at Cameron's Laughing Gas Pool, Hatupatu Drive, Sulphur Point, Rotorua due to hydrogen sulphide poisoning, in accidental circumstances.

Mr Taikato, known as Jim, was unemployed and lived alone in Rotorua at the time of his death. On the morning of 19 November 2020, Jim was seen leaving his property at about 8:00am. Police were unable to establish his movements throughout the rest of the morning and early afternoon. At approximately 2:00pm, a member of the public was walking past Cameron's Laughing Gas Pool, on the corner of Hatupatu Drive and Queens Drive. He saw the back of a person's head and shoulders floating in the pool and contacted emergency services.

Attending Police found a man, later identified as Jim, unresponsive and floating face down in a shallow part of the pool. His body was recovered with the assistance of the fire rescue service and it was confirmed that Jim was deceased. Police were later informed that Jim had been visiting the hot pool every day for several months leading up to his death, on each visit sitting closer and closer to the pool.

The pathologist who conducted the post-mortem examination confirmed that despite the presence of various medications and cannabis in Jim's system which may have slowed his reactions, the cause of his death was hydrogen sulphide poisoning rather than drowning.

A sign posted on the boardwalk in front of the hot pool at the time advised that hydrogen sulphide and carbon dioxide can cause fainting, which made bathing in the pool dangerous. However, the sign was lengthy and predominantly aimed at providing a light-hearted history of the pool. Another sign posted nearby appeared to portray the danger of walking in the area due to it being a thermal area. The Coroner concluded that neither of these signs, either separately or together, adequately warned the public of the potential dangers of high inhalation of hydrogen sulphide, which can cause rapid unconsciousness and ultimately death.

RECOMMENDATIONS OF CORONER DUNN

I. Pursuant to section 57A of the Coroners Act 2006 a Coroner may make a recommendation as part of the inquiry if the recommendation may reduce the chance of further deaths occurring in circumstances similar to those which occurred here. I intend to make a recommendation here relating to signage at the hot pool area.

II. The signs currently erected in front of the hot pool area in my view are vague and unhelpful. I refer to these signs at paragraphs 52 and 53 of my finding. The signs fail to adequately give an appropriate warning to members of the public regarding the risk of inhalation of hydrogen sulphide in the hot pools.

III. This area is freely and readily accessible to both tourists and members of the public as demonstrated by Jim's regular bathing in the pools prior to his death.

IV. I consider that it is appropriate to make a recommendation that the area is provided with additional signage to notify members of the public of the dangers of the high inhalation of hydrogen sulphide if bathing in the hot pools. These dangers should include the danger of bathing alone and that high levels of hydrogen sulphide inhalation can cause fatigue, dizziness, delirium, nausea, loss of consciousness and death. Signage should be clear and succinct to ensure members of the public are made aware of the potential danger.

V. It is difficult to know whether Jim was aware of the dangers or whether additional signage would have deterred him. However there have previously been deaths in Rotorua caused by members of the public bathing in the hot pools and dying from hydrogen sulphide poisoning. It is hoped that this recommendation will make the public aware of the possible dangers of bathing in hot pools.

Response from Rotorua Lakes Council following recommendations

VI. A copy of my draft finding was provided to Rotorua Lakes Council for their comments pursuant to section 57B of the Coroners Act 2006. Mr Pitkethley from the Council has responded to my recommendations advising that following Jim's death the Council actioned an improvement to the signage to warn of the dangers of geothermal gases. Attached to this finding and marked appendix 1 is a photograph of the sign.

VII. Mr Pitkethley advises that following the receipt of my draft finding a further and modified sign has been erected to expand on the effects of hydrogen sulphide poisoning. The new signage is to be erected to key entry points to the geothermal areas and along the walking areas in front of the hot pools as a priority. Attached to this finding and marked appendix 2 is a photograph of the modified sign referred too.

VIII. Mr Pitkethley is of the view that the new modified signage will provide much more detail to the public on geothermal hazards and give clear and succinct warnings in regard to the potential dangers of hydrogen sulphide.

IX. Mr Pitkethley also advises that the old signage (present when Jim died) has been removed.

X. I am grateful to the Rotorua Lakes Council for their prompt and helpful response to my recommendation and hope that such signage will ensure that the public are properly advised of the dangers of bathing in the hot pools and reduce the chance of any further deaths occurring in circumstances similar to Jim's death.

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

Wilkes [2022] NZCorC 147 (27 October 2022)

CIRCUMSTANCES

John Eric Wilkes died on 30 June 2020 at Waikato Hospital in circumstances not amounting to suicide.

John had a long history of involvement with mental health services dating back to 1979. He had been diagnosed with a psychiatric illness and had also suffered multiple head injuries since 2001. From October 2017 he was an inpatient at the Henry Rongomau Bennett Centre, where he was subject to a compulsory treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1992. On 24 March 2020, he was discharged to the care of Braeburn House in Matamata. During his time at Braeburn House, John appeared reasonably settled but was still suffering from psychosis.

On 16 June 2020, John appeared to be behaving as usual. However, at some time after 8:00pm, Braeburn House staff realised that he was not in his bedroom. A search of the premises and the local area failed to locate John. John was found injured later that evening, approximately 2km away from Braeburn House, and was transported to Waikato Hospital where he died on 30 June 2020.

The Coroner concluded that it was “entirely possible” that John was in the throes of a psychotic episode when he left Braeburn House, without the cognitive capability to form a genuine intention to end his life.

After his death, John’s family raised concerns about the care and support he had received, which they considered had been negatively impacted by ACC funding issues in respect of his brain injury. ACC advised that a claim had been made and was accepted. The same was true of other head injuries which had occurred from 1993 through until 2011. There was no evidence of any rejected ACC claims. There was also no evidence that John’s discharge to Braeburn House was driven by ACC decisions to refuse funding requests.

COMMENTS OF CORONER ROBB

I. John presented as likely having underlying mental health concerns potentially aggravated by subsequent brain injury. In that context there may have been some potential treatment and support gains from the combined expertise of a specialist in brain injury and rehabilitation, coupled with specialist mental health care. The benefit of combined specialist expertise, and the recognition that brain injury can cause mental health issues or exacerbate underlying mental health issues requiring a combined expertise approach was recognised in recent inquest evidence.[36] Working to understand and manage the consequence of rehabilitation and brain injury expertise in combination with mental health expertise requires significant resourcing where there is likely continued limited expertise readily available to DHBs across New Zealand.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken during the investigation into this death, in the interests of decency and personal privacy.

[36] *Inquiry into the death of B* CSU-2015-WGN-0000 74

Motor Vehicle

Derby [2022] NZCorC 148 (28 October 2022)

CIRCUMSTANCES

Owen William Derby, aged 51, died on 15 December 2020 at Waikato Hospital from non-survivable injuries to head and brain after he lost control of a motorcycle he was riding.

Owen was an avid motorcycle rider and rode a 2019 Harley Davidson Softtail. On the morning of 13 December 2020, a group of approximately 40 motorcycle riders met in Auckland with a plan to ride to Raglan in four groups. Owen was part of group 2.

At approximately 11:52am, Owen was traveling south on Ohautira Road, Waikato, when he failed to negotiate a moderate left bend in the road causing him to cross the centreline and ride off the sealed surface on the outer edge of the bend. This then caused him to ride into a shallow ditch, travelling a short distance before colliding with a gabion wire rock retaining wall. Emergency services were contacted and Owen was transferred to Waikato Hospital but passed away in the ICU ward on 15 December 2020.

The Police Serious Crash Unit (SCU) determined that Owen's failure to negotiate a moderate left bend on a downhill section was what caused the collision, but the precise reason for this could not be identified through the evidence on the scene. It appears Owen rode an incorrect line in exiting the corner immediately prior to the corner where the collision occurred. The fact Owen was riding a Harley-Davidson, a larger, heavier, and less manoeuvrable motorcycle than the motorcycles that others in his group were riding at the time may have increased the likelihood of an error occurring.

The curve where the crash occurred does not carry an advisory speed and is subject to an open road speed limit of 100 km/h. However, the SCU report noted the area contains a number of tight curves, requiring a reduced speed. While Owen's speed was not excessive, the SCU considered it to be a potential contributing factor in the crash.

RECOMMENDATIONS OF CORONER ROBB

I. The SCU suggested that there was a need for continued education and enforcement on safe motorcycle riding and education programs such as "Ride Forever" programme supported by the NZTA.

II. Ride Forever is an ACC initiative, aimed at giving riders sound information and access to training so that they can make better choices. With the SCU report in mind, I direct a copy of this Finding to be sent to them for their consideration of whether any kind of education would be appropriate.

III. I note that the SCU has advised that the area of Ohautira contains a number of tight curves that require a reduced speed. Waka Kotahi NZ Transport Agency is identifying roads, where safer speed limits can make a big difference in saving lives, and where communities are calling for change. However, I am informed that the Waikato District Council is a fact responsible for the management of Ohautira Road including its speed limits.

IV. I recommend that this Finding is also sent to the Ministry of Transport (Te Manatū Waka), Waka Kotahi the NZ Transport Agency, and the Waikato District Council, for their consideration of further research and education.

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

Hammell [2022] NZCorC 174 (9 December 2022)

CIRCUMSTANCES

Robert Hammell, aged 59, died at Four Rivers Highway, State Highway 6, Murchison on 14 November 2019 of head injury due to fallen rock.

On 14 November 2019, Mr Hammell was travelling to Nelson. While driving on State Highway 6, shortly before the turn off to Westport, a large rock fell from the right side of the road and hit the windscreen of the car. As a result, Mr Hammell suffered fatal injuries.

The Serious Crash Unit's report concluded that the rockfall was caused by rocks and debris becoming dislodged from the cliff beside the roadway and falling on the car. Recent weather had disturbed vegetation on the cliff rising above the road. Inspection showed that some vegetation had been uprooted, leading to several football sized rocks being dislodged; one of which had struck the car as it travelled on the road.

Waka Kotahi advised the inquiry that geotechnical assessments of the cliff in the area are carried out at two-yearly intervals. An assessment had been carried out in June 2019. A further assessment was conducted after Mr Hammell's death in November 2019.

Since Mr Hammell's death, Waka Kotahi has carried out rock scaling work at the site to reduce the risk of fall debris. It has also requested funding for more substantial works and installed a temporary fence to prevent rock falls.

RECOMMENDATIONS OF CORONER DUGGAL

I. Having given due consideration to the circumstances of this death, pursuant to section 57(3) of the Coroners Act 2006, I recommend that Waka Kotahi carry out the more substantive protection works envisaged to the cliff above the road at O'Sullivans Bridge Cliff along State Highway 6.

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

Hayes [2022] NZCorC 173 (8 December 2022)

CIRCUMSTANCES

Lamar Mervyn Hayes died on 14 January 2022 at Wellington Hospital of complications of multiple blunt traumatic injuries.

On the evening of 2 January 2022, Mr Hayes had been driving his car on the coast road south of Wainuiomata. Also in the vehicle were Mr Hayes's partner, Iona Tomescu, and their 8-month-old baby. Mr Hayes and Ms Tomescu had been drinking alcohol that evening. Mr Hayes was driving at speed when he attempted to negotiate a moderate left-hand curve and lost control of the vehicle, causing the vehicle to travel off the road across the northbound lane and tumble down a steep bank. Neither Mr Hayes nor Ms Tomescu were wearing seatbelts. Mr Hayes was ejected from the vehicle and suffered severe injuries. Emergency Services attended and transported Mr Hayes to Wellington Hospital. Despite receiving extensive hospital treatment, Mr Hayes suffered severe brain injury that he was unlikely to survive. He was provided with palliative care and died on 14 January 2022.

Blood samples taken from Mr Hayes on admission to hospital were analysed. The analysis found that Mr Hayes had a blood-alcohol level of 153 milligrams of alcohol per 100 mL of blood. Police Serious Crash Unit (SCU) investigated the crash and found that Mr Hayes was travelling above the speed limit when he lost control of his vehicle. SCU concluded that the combination of alcohol and high-speed were causative factors in the crash. In terms of the location of the incident, SCU recommended that consideration be given to the installation of reflective Chevron boards to illuminate the change in curvature of the road and thus increase the visibility and awareness for drivers.

RECOMMENDATIONS OF CORONER RYAN

I. The SCU crash analyst considers that the responsible roading authority should look at installing reflective Chevron boards on the corner where the crash occurred to highlight the change in the curvature of the road. The purpose of this is to give drivers warning of the change, in the hope that they will adjust their speed if necessary.

II. Given the information provided by the SCU that there have been other crashes on this corner, I consider this is a worthwhile recommendation that can be made pursuant to section 57A of the Act, for the purposes set out in section 4.

III. I recommend that the Lower Hutt City Council consider installing reflective Chevron boards on the corner where this crash occurred to warn drivers travelling south of the change in the curvature of the road.

Heathcote [2022] NZCorC 175 (13 December 2022)

CIRCUMSTANCES

James Keith Heathcote, aged 60, died on 19 March 2019 at the Tiwai Bridge on Tiwai Road, Southland. The cause of his death was high energy impact injuries; severe head injuries with avulsion of the brain due to him coming off his motorcycle and colliding with the fixed environment (mounting poles at the side of the road, as well as the road surface).

At about 8:00pm on 19 March 2019, Mr Heathcote left work at New Zealand Aluminium Smelters Limited's (NZAS) Tiwai Point Aluminium Smelter at Tiwai Point, near Bluff to return home to Invercargill. He was riding his Suzuki GSXR 1100cc motorcycle and rode north on Tiwai Road. As he was crossing the Tiwai Road bridge Mr Heathcote moved into the southbound lane, in order to overtake the vehicle in front of him. Around the same time a red vehicle in front of him also moved out of the line of vehicles. Mr Heathcote, who was speeding at the time, lost control of his motorcycle and slid under an Armco barrier then crashed into metal mounting poles and was killed.

COMMENTS AND RECOMMENDATIONS OF CORONER JOHNSON

I. Overtaking and speed were factors in this crash. Both Mr Heathcote and the driver of the red car pulled out to overtake at the same time on the bridge.

II. Coroners, Police, and Waka Kotahi NZ Transport Agency have consistently highlighted the dangers of speeding. The dangers are well known and well publicised. A copy of these findings will be sent to media agencies in the hope of raising further awareness of the dangers of speeding.

III. A Coroner may make recommendations or comments for the purpose of reducing the chances of further deaths occurring in similar circumstances.[37] Any person or organisation to whom the comment or recommendation is directed must be given the opportunity to comment on the proposed recommendation or comment.[38] I therefore provided a copy of my proposed recommendation to the Invercargill City Council (ICC) that it make the full length of the Tiwai Road bridge a no overtaking, no passing zone with appropriate markings on the road and signage.

IV. ICC responded to my draft Findings saying it accepts the recommendation and will carry it out by installing painted solid yellow No Overtaking/Passing lines on the bridge structure area. I consider that this will reduce the chances of future deaths occurring due to overtaking on the Tiwai Road bridge.

V. ICC also advised that it has an active educational Road Safety Promotional Programme whereby it educates the public on better speed management and this could be extended to the smelter, though it noted that most of its employees travel by a bus provided by NZAS.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs that show Mr Heathcote taken after his death, in the interests of decency and personal privacy.

Leaf [2022] NZCorC 144 (27 October 2022)

CIRCUMSTANCES

Aroha Tewhaia Erana Leaf, aged 26, died on 29 July 2020 on State Highway 1, about 1 km south of Ōkaihau, Northland. The cause of death was a ruptured liver due to abdominal injuries sustained in a motor vehicle accident.

On the evening of 28 July 2020, Aroha had a party at her home in Ōkaihau which finished at about 2:30am the next morning. For unknown reasons, Aroha and a relative, Te Aroha Harris, later decided to leave Aroha's home and head south on State Highway 1 towards Ōhaeawai.

At 6:30am on the morning of 29 July 2020, two members of the public were flagged down by Ms Harris on State Highway 1, approximately 500 metres south of the Waiare Road turnoff. Ms Harris had a head injury and was in an incoherent state. She said that there had been an accident and pointed towards a nearby paddock.

[37] Coroners Act 2006 section 57A.
[38] Coroners Act 2006 section 57B(1).

The two passers-by found Aroha's damaged car in the paddock, with Aroha lying on her back unresponsive on the far side of the car. Emergency services attended and declared Aroha dead at the scene. Ms Harris could not remember how the accident had occurred but said she had been in the front passenger's seat at the time.

An analysis of Aroha's blood taken at autopsy showed a level of 266 milligrams of alcohol per 100 millilitres of blood. Tetrahydrocannabinol (THC) was also detected in the blood, consistent with the positive immunoassay screen for cannabis.

Aroha did not hold a current driver's licence. A serious crash investigator concluded that Aroha had failed to maintain control of her car, resulting in it veering off the road to the left across a drain and into a bank. The car then rolled and tumbled before coming to rest in the farm paddock.

While it was unknown why Aroha's car left the road, the investigator noted that fatigue may have been a contributing factor in addition to her high blood alcohol level. Predictors of fatigue noted in this case included the time of day, a single vehicle accident on a straight segment of road and no evidence of emergency action such as braking.

COMMENTS 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:

   a. Aroha's blood alcohol level was five times the legal limit. It is well recognised that driving whilst under the influence of alcohol and/or cannabis impairs your driving ability. It slows your reaction times, impairs coordination, and dulls your judgement and vision.

   b. Neither Aroha nor Ms Harris were wearing seat belts. The serious crash investigator advised that in his opinion Aroha would probably have survived the accident if she had been wearing a seatbelt. Seatbelt advice on the Waka Kotahi New Zealand Transport Agency website states that wearing a seatbelt reduces your chances of being killed or seriously injured in a road crash by 40%.

   c. The evidence also suggests Aroha may have been tired or fatigued when this accident occurred. Many fatal crashes are caused by people driving when they are tired or fatigued. Fatigue is more than just feeling tired. It is a state of physical and mental exhaustion which results in a loss of alertness. This loss of alertness is accompanied by poor judgement, slower reaction time and impaired coordination and decision-making.

II. Considerable effort is made in New Zealand to promote safe driving. Police, coroners, Waka Kotahi New Zealand transport agency, and others have consistently highlighted safe driving messages.

III. I therefore reiterate these key messages:

   a. Do not drink and drive;

   b. Seatbelts save lives – always wear a seatbelt; and

c. If you feel tired, do not drive.

Note: An order under section 74 of the Coroners Act 2006 prohibits the making public of any photographs taken of Aroha during this inquiry, in the interests of decency.

McLennan [2022] NZCorC 177 (16 December 2022)

CIRCUMSTANCES

Mark McLennan, aged 64, died on 8 March 2018 on State Highway 3 at Mahoenui, Waikato, due to multiple injuries sustained in a motor vehicle collision.

On 8 March 2018, Mr McLennan was travelling with a group of six other motorcycle riders from Hamilton to New Plymouth. At around 3:20pm, the group drove through Mahoenui. After crossing the centre line to overtake a vehicle ahead of him, the tyres of Mr McLennan's motorcycle locked as he braked heavily having seen an oncoming vehicle, and the motorcyle began to wobble, before tilting over and sliding down the road. Mr McLennan was thrown from the motorcycle and collided with an oncoming vehicle in the northbound lane. Emergency services attended and confirmed that Mr McLennan had died at the scene from his injuries.

The crash occurred on a short straight section of road after a moderate curve for southbound traffic. The Waikato Serious Crash Unit (SCU) report, prepared by Senior Constable David Tidmarsh, noted that mature trees at the roadside combined with the slight curvature made it difficult to see further along the road. There had also been a truck and trailer unit ahead of Mr McLennan which had likely blocked his visibility.

The report concluded that the collision occurred due to Mr McLennan's decision to overtake at the location he did. Although he was described as an experienced and careful rider, on this occasion he appeared to have misjudged the distance available to complete the overtaking manoeuvre. The evidence suggested that Mr McLennan had been surprised by the proximity of the oncoming vehicle, and then lost control of his motorcycle while trying to return to the southbound lane.

Senior Constable Tidmarsh made the following recommendations:

(a) Drivers and riders exercise caution in the area.

(b) Guidelines around safe overtaking manoeuvres should be reinforced.

(c) The Roading Authority should consider whether marking a solid yellow line at the scene would discourage vehicles from overtaking on the short straight. However, he noted that the issue is a horizontal curve rather than a vertical one, and that there were no reports of any prior crashes due to overtaking.

RECCOMENDATIONS OF CORONER WILTON

I. Prior to finalising these findings, I provided Waka Kotahi – NZ Transport Agency with an opportunity to comment upon the recommendations of Senior Constable Tidmarsh detailed […] above.

II. I received a response on behalf of Waka Kotahi from Vanessa Browne, National Manager Programme and Standards. Ms Browne advised on each of the three recommendations as follows:

a. Waka Kotahi plans to review the options available relating to the heightened risk associated with overtaking manoeuvres along this section of State Highway 3.

b. Waka Kotahi acknowledges that the 100-metre visibility requirement is only the starting point for drivers, and that there is potential for underestimation of the total visibility required for the whole of the overtaking manoeuvre. It will review the advice given to drivers, in addition to the wording in the Road Code, to better reflect the level of visibility required to safely complete an overtaking manoeuvre.

c. The requirements for the consideration of no passing lines are outlined in the Land Transport Rule: Traffic Control Devices 2004. Waka Kotahi will undertake a review of the corridor to assess the suitability of no passing lines at this location.

III. I endorse the steps that Waka Kotahi are taking. I encourage Waka Kotahi to complete these reviews as soon as practicably possible.

IV. I do not consider there to be any further useful comments or recommendations I can make to reduce the chances of future deaths in circumstances similar to Mr McLennan's.

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

Monopoli [2022] NZCorC 149 (28 October 2022)

CIRCUMSTANCES

Francis John Monopoli, aged 64, died on 21 December 2021 at Croisilles-French Pass Road, Marlborough due to multiple severe open injuries to the head and thoracic/abdominal organs as a result of a motor vehicle crash.

On 21 December 2021, Mr Monopoli's vehicle was travelling south-westwards on Croisilles-French Pass Road at the time of the crash, on an unmarked gravel road which winds along a ridgeway and drops off to a steep drop down to the Te Towaka–Port Ligar Road below. Mr Monopoli approached the edge of the road from the right-hand side of the road and continued forwards at a slow speed without any deviation or sign of heavy breaking. His vehicle exited the gravel road, going across the grass shoulder to the drop-off and slid sideways down the edge of the drop-off. The left-hand wheels dug in the ground and it began rolling down the hillside, travelling approximately 230 metres down the hillside.

The Police Serious Crash Unit (SCU) found that it was likely heavy fog was present in the morning and would have limited visibility in the area. The SCU also noted Mr Monopoli's vehicle light system had been on at the time of the crash, suggesting the crash took place when lighting was poor. There were no roadside markers on either side of the road and care would have been required to observe the edge of the roadway and the drop-off to the left.

The SCU could not determine with certainty why Mr Monopoli did not respond to the developing situation either by stopping the vehicle or applying steering correction, particularly given that: he travelled at very low speed before he went

over the edge; he was familiar with the road; and there was no evidence to suggest the involvement of any other vehicle. The SCU considered it possible that heavy fog resulted in him losing situational awareness.

The Coroner considered it likely that the reduced visibility or some form of incapacitation or distraction resulted in an inadvertent loss of situational awareness.

COMMENTS OF CORONER RYAN

I. With regard to comments that could be made pursuant to section 57A of the Coroners Act 2006, I note the SCU analyst's comment that there are no roadside markers installed along Croisilles – French Pass Road, including along the area of curved roadway and the drop-off where this crash occurred. The SCU identified this as a potential risk to all road users due to little visual assistance for drivers to determine the edge of the roadway. This is especially important when driving in limited visibility conditions, such as fog.

II. Although it cannot be confirmed with certainty that the lack of roadside markers was a causative or contributory factor in the crash, I will draw this issue to the attention of the Marlborough District Council (MDC), the road authority responsible for maintaining this section of road, with the expectation that consideration will be given to installation of roadside markers. I therefore direct that a copy of this Finding be sent to the Marlborough District Council.

III. After being provided with a provisional copy of this Finding, MDC provided me with a copy of a letter dated 8 July 2022 sent in response to a similar recommendation with regard to a previous coronial inquiry. In essence, the Council advised that relevant guidelines do not require roads carrying less than 500 vehicles per day to have reflective posts. Council informs that the road where this crash occurred carries less than 20 vehicles per day.

IV. In that letter, Council records that, where a hazard has been identified, the policy has been that the hazards be marked by reflective hazard markers or each marker posts. However, the letter notes that it is difficult to maintain these posts in the harsh conditions and intense winds in the outer Sounds. Nevertheless, Council is currently trialling more robust posts.

Murphy [2022] NZCorC 150 (1 November 2022)

CIRCUMSTANCES

Jared Te Rangianiwaniwa Murphy, aged 44, died on 20 September 2021 at Broadwood Road from traumatic asphyxia resulting from motor vehicle accident.

Mr Murphy worked as a truck driver for Mangonui Haulage Limited. On 20 September 2021, he commenced work at around 3:00am. His truck was fitted with a four-axle full trailer designed to carry logs. He was travelling with a passenger in his cab that day.

At around 8:30am Mr Murphy was driving east along Broadwood Road with a full load of logs towards the State Highway 1 intersection at Mangamuka. The road is a rural bidirectional sealed road with numerous windings bends and hills with a

posted speed limit of 100km/h. At one point, Mr Murphy's truck failed to take the left-hand bend resulting in the truck flipping off the road. Mr Murphy was pronounced deceased at the scene while his passenger was extracted with injuries.

The Northland Police Serious Crash Unit (SCU) investigated the crash and considered speed to be a contributory factor. GPS data reported that Mr Murphy entered the crash curve at a speed of 48.7km/h which was within the range of speeds in which the vehicle could have rolled.

Mr Murphy's truck and trailer both had current Certificates of Fitness (COF) at the time of the crash. However, when the truck and trailer were inspected by a VTNZ several brake and suspension faults were found with both vehicles in a post-crash inspection. The SCU considered that these could have affected the braking performance of the vehicles. Mangonui Haulage Limited disputed the inspector's findings stating that the brakes had received a full adjustment on 17 September 2021. They further noted that when the trailer unit was inspected in December 2021 only axel 3 of the trailer required a reline of the brakes and replacements of S-cam bushes, and all of the other brakes and associated components passed a COF inspection on 25 January 2022.

It had been raining earlier in the morning and there had been some wet patches on the road at the time of the crash. The Coroner found that the wet road surface may have contributed at the margins to Mr Murphy's ability to slow down his truck and trailer for the curve. He further considered it possible that the passenger may have caused enough of a distraction to cause Mr Murphy to enter the bend a touch faster than he might otherwise have.

COMMENTS OF CORONER HO

Certificate of fitness

I. A certificate of fitness is a regular check to ensure that the vehicle meets required safety standards. The New Zealand Transport Agency website says that it is the operator's responsibility to keep a vehicle up to COF condition at all times. It warns that if the operator waits until the next inspection to rectify a COF issue the operator may be fined. It is illegal to drive a vehicle that does not meet COF requirements.[39]

II. An inspection of Mr Murphy's trailer after the crash identified worn braking components, some of which the inspector considered were not up to COF standard. If that is correct, and it is disputed by Mangonui Haulage Limited, then the trailer should therefore not have been available to drive that day.

III. While I do not make any formal recommendations under the Act, operators should be aware of their responsibilities under the COF and road user regimes and ensure their vehicles are of a continuous safe operating standard. Operators should consider the frequency and type of checks that they undertake on their vehicles and consider whether changes should be made, especially in cases where the particular use of the vehicle might result in certain parts wearing out faster than others. For example, vehicles frequently operating on hilly and bendy roads requiring more heavy use of brakes might need these checked more often than a vehicle which usually travels on an expressway.

[39] https://www.nzta.govt.nz/vehicles/warrants-and-certificates/certificate-of-fitness/

IV. I direct a copy of these findings be sent to industry groups such as the New Zealand Heavy Haulage Association, the National Road Carriers Association, the Road Transport Association and the New Zealand Trucking Association as a reminder of their obligations under the road transport rules in relation to COFs and the possibly fatal consequences that might result from a non-COF compliant vehicle operating on roads.

V. I do not make any formal recommendations under the Act.

Speed advisory

VI. There was no speed advisory sign on the crash curve. The SCU noted that such signs would be impractical given the number of bends on Broadwood Road. I agree. Drivers will already know they have to travel at a safe speed and will have had experience from negotiating previous curves of that appropriate for the road and the conditions.

VII. I do not make any formal recommendations under the Act.

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

Samuel [2022] NZCorC 135 (5 October 20222)

CIRCUMSTANCES

Valentine Theodore Matiu Samuel, aged 50, died on 22 August 2019 at Lismore Mayfield Road, Mayfield, Ashburton of high energy impact injuries to face, chest and abdomen with lethal internal vascular injury.

On 22 August 2019 Mr Samuel left in a vehicle despite his friend asking him not to drive. Mr Samuel was driving north west on Lismore Mayfield Road when he drove around a slight right-hand bend, crossed the centreline and the right lane, and crossed a grass verge before colliding with a power pole. Once extricated from the car Mr Samuel was pronounced dead.

Samples of Mr Samuel's blood were submitted for toxicological analysis. Methamphetamine and tetrahydrocannabinol (the active ingredient of cannabis) were detected.

COMMENTS OF CORONER DUGGAL

I. The risks of driving after consuming drugs are well publicised in New Zealand. This can include slowed reactions after taking cannabis or depressant drugs and increased confidence from stimulant drugs such as methamphetamine. I endorse the efforts of New Zealand Police and other agencies to discourage driving after consumption of drugs.

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

Tawhai [2022] NZCorC 159 (18 November 2022)

CIRCUMSTANCES

Manuel Angus Tawhai died at Reeves Road, Pakuranga on 1 November 2016 of injuries sustained in a motorcycle collision.

On 1 November 2016, Mr Tawhai was riding his motorcycle on Reeves Road, Pakuranga. He was hit by a taxi driver, Mr Pasahan. As a result of the collision, Mr Tawhai was thrown from his motorcycle and died at the scene as a result of his injuries.

RECOMMENDATIONS OF CORONER TELFORD

I. Section 57A of the Act states that a Coroner may make recommendations or comments for the purposes of reducing the chances of further deaths in similar circumstances.

II. I have received some very helpful correspondence from Mr Tawhai's mother in which she suggests (in essence) that taxi drivers should be first aid trained. Although I have no evidence that Mr Pasahan was not so trained, I believe there are few who would disagree with this suggestion. Mr Tawhai died as a result of a major collision with a taxi and any driver or bystander in these circumstances would ideally have the skills to respond to what became a critical medical emergency.

III. I note several taxi companies in New Zealand require their drivers to be first aid trained. I consider this commitment to the safety of passengers and the wider community to be commendable. I therefore encourage other companies or 'professional drivers' to follow this good example without hesitation.

IV. In fact, **everyone** should ask themselves whether they would know what to do in an emergency. First Aid courses are very readily available throughout New Zealand - even online, and they are relatively inexpensive. I therefore commend such courses to all on the basis that knowing basic first aid can save lives.

V. I also direct that a copy of these findings is sent to Waka Kotahi / NZ Transport Agency so they can consider the suggestion of Mr Tawhai's mother and my comments in their important work to keep New Zealanders safe.

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

Terry [2022] NZCorC 146 (27 October 2022)

CIRCUMSTANCES

Matthew Terry, aged 65, died on 8 December 2019 at Broadlands Road, Reporoa of chest injuries due to high energy impact sustained in a motorcycle crash.

On 8 December 2019 Mr Terry set out to ride his motorcycle from Reporoa to Cambridge. Prior to departing, he was observed to secure a backpack and a sleeping bag onto the rear of his motorcycle through the use of elastic bungee

cords with metal hooks affixed to each end. As Mr Terry approached the intersection in Reporoa between Broadlands Road and Strathmore Road, he lost control of his motorcycle and was thrown from it, landing onto the sealed road. Mr Terry died at the scene .

The Police Serious Crash Unit (SCU) completed an investigation and noted that a bag containing Mr Terry's belongings, including his sleeping bag, was wedged into the rear wheel assembly. The bag was wedged against the strut, preventing the wheel from rotating forward. The SCU considered that as Mr Terry was approaching the intersection of Strathmore Road and Broadlands Road, the bag became dislodged due to the bungee cord failing, causing it to move onto the rear-wheel. The entanglement caused the rear wheel to lock, preventing it from rotating.

COMMENTS OF CORONER BATES

I. Mr Terry's death is a reminder of the need to take particular care when securing items for transportation on motorcycles. Suitable strapping/binding in well maintained condition, or complete containment within a well secured compartment should be utilised to prevent items moving and becoming a hazard during transit. Movement of items being transported may be caused by general vibration during a journey or impact (one or multiple) between the motorcycle and varying road/terrain surfaces, or due to the speed and/or angle at which motorcycles may be ridden, accelerated and decelerated, creating inertia of motion.

II. I am unsure of the degree of prevalence of motorcycle accidents caused by unsecured loads. Without appropriate data I am unable to make specific comments or recommendations for the purpose of reducing the likelihood of further deaths in similar circumstances.

III. However, I recommend 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, so they may consider sharing it as part of their educational material regarding appropriate securing and transportation of items and accessorising of motorcycles.

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

Self-Inflicted

Carlin [2022] NZCorC 142 (27 October 2022)

CIRCUMSTANCES

Samuel Lloyd Carlin, aged 26, died between 27 October 2019 and 28 October 2019 at his home of 14 Karawa Place, Kawakawa Bay in circumstances amounting to suicide.

Toxicological analysis was undertaken on a sample of Sam's blood taken post-mortem. The analysis revealed evidence of alcohol intoxication.

COMMENTS OF CORONER GREIG

I. The toxicology results show that Sam had been drinking alcohol before he died and had an alcohol level such that he would have been intoxicated. Acute alcohol use is a known proximal risk for suicide and has been identified in approximately one quarter of suicides in New Zealand between 2007 – 2020.[40] Alcohol use can affect people in a number of ways, including increasing impulsivity and disinhibition, weakening psychological barriers to suicide attempts by increasing despair, and cognitively impairing efforts to mitigate despair.[41]

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of the body of Samuel Carlin entered into evidence, in the interests of personal privacy and decency.

France [2022] NZCorC 156 (9 November 2022)

CIRCUMSTANCES

Joseph Andrew France, aged 52, died between 17 September and 19 September 2018 in Beach Haven, Auckland. His death was self-inflicted.

Mr France was a father of two daughters and operated his own marketing company in New Zealand. From around 2016 Mr France resided between New Zealand and the Philippines. He was depressed and subdued after his return to New Zealand from the Philippines in 2018. Mr France had financial difficulties and wanted to "sell the house and move back to the Philippines and be happy".

Mr France also had doubts about bringing his current partner from the Philippines to New Zealand, which caused tension in their relationship.

COMMENTS OF CORONER HESKETH

I. The following comments are made pursuant to section 57(3) of the Coroners Act 2006, for the purpose of public education aimed at avoiding further suicide by anyone in circumstances similar to those in which Joseph Andrew France died.

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 thinking that way.

III. Information about the ways you can support someone who is thinking of harming themselves is available at https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide.

[40] Crossin R, Cleland L, Beautrais A, Witt K, Boden JM. Acute alcohol use and suicide deaths: an analysis of New Zealand coronial data from 2007-2020. N Z Med J. 2022 Jul 15;135(1558):65-78. PMID: 35834835.
[41] Ibid at 65.

IV. The website contains information about what to do if you think someone needs urgent help. If someone has attempted suicide or you're worried about their immediate safety, do the following:

a. Take them seriously. Thank them for telling you, and invite them to keep talking. Ask questions without judging.

b. Call your local mental health crisis service or go with the person to the emergency department at the nearest hospital.

c. If they are an immediate danger to themselves or other call 111.

d. Remain with them and help them to stay safe until support arrives.

e. Try to stay calm and let them know that you care.

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

a. For counselling and support – these are free and generally available anytime: Lifeline – 0800 543 354 Samaritans – 0800 726 666

VI. For children and young people:

a. Youthline – 0800 376 633, free text 234 or email talk@youthline.co.nz (for young people, and their parents, whānau and friends)

b. *What's UP – 0800 942 8787 (for 5-18 year olds; 1 pm to 11 pm)

c. *The Lowdown – visit the website, email team@thelowdown.co.nz or free text 5626 (emails and text messages will be responded to between 12 noon and 12 midnight)

d. *SPARX – an online self-help tool that teaches young people the key skills needed to help combat depression and anxiety.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public a particular of the death other than the name, address and occupation of the person concerned and the fact the death was self-inflicted. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr France taken during the investigation into his death, in the interests of decency and personal privacy.

Gargiulo [2022] NZCorC 143 (27 October 2022]

CIRCUMSTANCES

Jennifer Eleanor Gargiulo, aged 43, died on 1 December 2020 at Gittos Domain, Auckland in circumstances amounting to suicide.

Jennifer worked as the Principal Environmental Specialist for the Auckland City Council. Her stress at work had greatly increased in the few weeks before her death.

WorkSafe investigated Jennifer's death as there was a suggestion it may have been work-related. WorkSafe concluded that, once Auckland City Council became aware of Jennifer's workplace stress, it put in place measures to, so far as reasonably practicable, ensure her health and safety.

COMMENTS OF CORONER MILLS

I. I do not have any comment to make about how the Auckland City Council dealt with Jennifer's workplace stress as I consider this was addressed by the WorkSafe investigation report. However, workplace stress was clearly a factor that contributed to Jennifer's mental deterioration and is increasingly recognised as an issue in the workplace in Aotearoa/New Zealand. I therefore make these comments, to draw the public's attention to workplace stress and to resources and support that is available to both employers and employees.

II. Ongoing work-related stress can lead to both mental as well as physical illness. The following feelings or behaviours when you are at work or in relation to your work maybe signs of work-related stress.[42] Feeling:

    a. irritable, impatient or wound up.

    b. over-burdened.

    c. worried, anxious or nervous.

    d. like your thoughts are racing and you can't switch off.

    e. finding it hard to concentrate or make decisions.

    f. unable to enjoy yourself.

    g. tense and tired.

    h. restless or panicked.

III. Employers have a responsibility to eliminate and/or minimise harm from workplace stress by having effective controls that are proportionate to the risk and appropriate to the work situation.[43] WorkSafe suggest some of the following examples of control measures an employer could take to minimise stress for their employees:[44]

    a. Set achievable demands for your workers in relation to agreed hours of work.

    b. Match worker's skills and abilities to job demands.

[42] https://www.healthnavigator.org.nz/health-a-z/s/stress-at-work/
[43] https://www.worksafe.govt.nz/topic-and-industry/work-related-health/mental-health/work-related-stress/
[44] https://www.worksafe.govt.nz/topic-and-industry/work-related-health/mental-health/work-related-stress/

c. Support workers to have a level of control over their pace of work.

d. Involve workers in decisions that may impact their health and safety and have processes to enable workers to raise issues and concerns they might have.

e. Ensure managers and supervisors have the capability and knowledge to identify, understand and support workers who may be feeling stressed.

f. Provide workers with access to independent counselling services.

g. Have agreed policies and procedures to prevent or resolve unacceptable behaviour.

h. Engage and consult with workers before implementing change processes, and ensure they genuinely have the ability to influence the decisions you make.

IV. Some strategies employees can take help manage their workplace stress can include:[45]

a. Make sure you take your scheduled breaks during the day.

b. Use your leave – that's what it's there for, to give you time away from work to return refreshed and reinvigorated.

c. Exercise is a great stress-buster. Any form of physical activity helps, even if you just manage to take a walk outside your workplace at lunchtime.

d. Your food choices can have a huge impact on how you feel during the workday. When stressed, you can crave sugary snacks or comfort foods. But eating frequent healthy meals helps your energy and focus.

e. Avoid using substances, such as smoking or vaping, or having caffeinated drinks when you're feeling stressed. This might seem calming in the moment, but these are stimulants and can lead to higher levels of anxiety.

f. Take a few slow, deep breaths – this can calm down your nervous system and lower your stress in the moment.

g. Reduce interruptions if you can and 'chunk' your time, eg, only answer emails during certain blocks of time.

h. In an increasingly digital world, it can be easy to feel the pressure to be available outside work hours. It's important to establish clear work-life boundaries for yourself. Make sure this works for you and your workplace and if this creates stress talk to your manager.

i. If you have too much work, talk to your manager or pass on some of it if you can.

[45] https://www.healthnavigator.org.nz/health-a-z/s/stress-at-work/

j. Develop good relationships with the people you work with – they can be a support to you.

k. Practice being mindful by taking a few minutes each day to focus on your breathing, allowing your thoughts and emotions to pass by without getting stuck in them. This will also help you to focus better on what you are doing.

V. Further information about workplace stress and how to manage it can be found on:

a. https://www.worksafe.govt.nz/topic-and-industry/work-related-health/mental-health/work-related-stress/

b. https://www.healthnavigator.org.nz/health-a-z/s/stress-at-work/

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Jennifer taken during this inquiry (being photographs of a deceased person), in the interests of decency.

Halkyard [2022] NZCorC 134 (4 October 2022)

CIRCUMSTANCES

Paradise Reitu Halkyard, aged 17, died on 16 December 2018 at Whangape in circumstances amounting to suicide.

Prior to her death Paradise had contact with a Counties Manukau District Health Board ("CMDHB") specialist Child and Adolescent Mental Health Team (CAMHS). She was initially assessed as being at moderate risk of suicide. A semi-urgent assessment was arranged but Paradise did not attend. CAMHS staff visited her at home on 18 July 2018 when she showed features of anxiety, both social and generalised, as well as depression. She was allocated a Māori mental health clinician, who was a social worker by training. When the social worker contacted Paradise, the latter asked her to call back after 5:30pm. There is no record of this being done or any further contact being made at that time. The treatment plan developed by CAMHS staff for Paradise was not able to be discussed or actioned with her.

On 5 September 2018 CAMHS staff determined that there was "no current risk" for Paradise and that a referral be made to Mahitahi, a non-government provider of support services for mental health clients. The purpose of the referral was for peer support and behavioural activation. However, no referral was made.

On 5 October 2018 the CAMHS social worker contacted Paradise by telephone. Paradise reported that she was doing well at that time and agreed to be discharged from mental health service care. No steps were taken to complete the discharge process.

A different clinician later took over case management for Paradise and was not prepared to discharge her because the initial planned assessment had not been completed, there was no diagnostic assessment, and a treatment plan/intervention for discharge had not been discussed at a multi-disciplinary team meeting. The new case manager attempted to contact both Paradise and her mother on 9 November 2018 but was unsuccessful.

The CMDHB subsequently reviewed the care it provided to Paradise and identified a number of issues. Based on this, the Coroner formed the view that the health services provided to Paradise were inadequate. However, Paradise's contact

with the CMDHB occurred some months before she died and there is no way of knowing whether the nature of the care she received had any impact on the events that later took place.

Since 2018 the CMDHB has made a number of changes to improve the services that are provided to children and adolescents under its care.

RECOMMENDATIONS OF CORONER ANDERSON

I. I have carefully considered the circumstances of Paradise's death and I have reviewed the information provided to me by Counties Manukau District Health Board, which is now known as Te Whatu Ora / Health New Zealand – Counties Manukau.

II. As identified by the DHB, there were deficiencies in the care that was provided to Paradise. It is clear that she was a troubled young woman who sought advice from a specialist mental health service. After some initial input, the planned assessment and follow up services were not actioned and no further contact was made with her for two and half months. When she was eventually telephoned on 5 October, she indicated that she was doing well and "agreed to be discharged". Despite this, the CAMHS social worker who spoke to her did not complete the expected discharge procedures and did not discuss the proposed discharge with the multi-disciplinary team. Later attempts by another clinician to re-engage with Paradise and her mother in order to complete the assessment process and progress discharge requirements were unsuccessful.

III. It is not clear why the planned follow up and assessments did not take place, why the referral to Mahitahi was not made and why there appeared to be no attempts to make contact with Paradise between 20 July and 5 October 2018.

IV. Having made an effort to get help, Paradise deserved a much better response from the DHB. However, I note that her death occurred over 2 months after her last contact with CAMHS and during the telephone call on 5 October she reported she was doing well. Before she died, Paradise also moved from Auckland back to Kaitaia to live with her mother, who has stated that Paradise seemed happy in the days before her death. It seems that Paradise acted impulsively on the day she died, after a period of relative stability.

V. It is not possible to conclude that Paradise's death could have been prevented if the expected assessment, treatment, and discharge processes had been followed by CAMHS. However, it is self-evident that service users who get the right supports are likely to have a better chance of improving their mental health and achieving good outcomes. It is well established that Rangatahi Māori have high rates of suicide, making appropriate care and intervention particularly important. For the purposes of reducing the chance of further deaths occurring in the future, I recommend that Te Whatu Ora/ CMDHB:

    a. Continue to take steps to ensure that there are clear, equitable and timely responses to all CAMHS referrals.

    b. Ensure that there is adequate input and/or oversight from a CAMHS psychiatrist at all stages of the CAMHS triage, assessment, treatment and discharge process.

c. Continue to improve CAMHS responsiveness to Rangatahi Māori.

d. Actively monitor adherence to CAMHS processes and policies to ensure that care is provided to children and young people in accordance with the expected standards and within expected timeframes.

VI. As required under s 57B of the Act, I advised Te Whatu Ora/CMDHB of my intention to make the above recommendations. Te Whatu Ora advised me that it accepted my findings and it agreed to implement the recommendations that I have made.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Paradise entered into evidence, in the interests of personal privacy and decency.

Martin [2022] NZCorC 166 (1 December 2022)

CIRCUMSTANCES

Henry Samuel Martin, aged 17, died on 16 April 2015 at Wellington Hospital in circumstances amounting to suicide.

Henry had a history of mental health issues throughout his teenage years and had been receiving treatment from his GP, Capital and Coast District Health Board (CCDHB) and Child and Adolescent Mental Health Services (CAMHS). Henry had been prescribed citalopram by his GP in October 2012, but this had not been effective.

In February 2014, Henry was referred to CAMHS again, as his depression and anxiety were getting worse. He was allocated a Case Manager and had regular appointments with CAMHS from that point on. During this time, CAMHS referred Henry to WorkFirst, a supported employment service co-located within CHDB to assist him with work and study options. He was encouraged to try cognitive behaviour therapy, but he did not attend as he found socialising difficult. At times, Henry's mood would deteriorate and he would report suicidal thoughts, thoughts of harming others and incidents of self-harm. CAMHS responded to Henry's ongoing mental health issues by initially increasing his dose of citalopram and then switching him to fluoxetine in May 2014 with an initial daily dose of 20mg. This was gradually increased in response to Henry's deterioration.

On 5 January 2015, Henry's mother sought immediate assistance from CAMHS as Henry was having difficulties with his girlfriend and no longer felt safe with respect to his suicidal thoughts. He was also experiencing more side effects due to an increase in his medication. As a result, he was admitted to a community mental health respite facility, Headspace, for 48 hours. By March 2015, Henry was being prescribed 80mg of fluoxetine daily.

From late March 2015, Henry's mother reported a serious decline in his mood as he had been unable to resolve the differences with his girlfriend. On 11 April 2015, Henry's mother contacted the Crisis Assessment and Treatment Team (CATT) at Henry's request as he was distressed and feeling acutely suicidal. CATT advised her to take him to Wellington Hospital Emergency Department. At hospital, Henry was assessed by a junior psychiatric registrar who suggested that Henry go to Headspace for respite.

Henry arrived at Headspace on the evening of 11 April 2015. There was only one other resident staying at the facility. On 12 April 2015, Henry was still having suicidal thoughts. That afternoon, he spent time at home with his mother and then

returned to Headspace where he chatted to the other resident before going to bed. On 13 April 2015, he was reviewed by two psychologists from CAMHS and reported having suicidal thoughts and feelings of hopelessness. He was also suffering from nausea, fatigue and low appetite due to his increased medication. Headspace staff were instructed to carry out 30-minute checks. In the evening of 13 April 2015, the other resident left the facility. The next day, Henry was reviewed by the psychiatrist and reported that he was still having suicidal thoughts and grieving the end of his relationship with his girlfriend. As a result, he was to stay at Headspace and remain on 30-minute checks. At his home visit that afternoon, his mood was very flat. He returned to Headspace at about 4.30pm. He was the only resident, and there was a sole staff member who was stretched, trying to fulfil her responsibilities at Headspace and a transitional client facility in a separate building on the same site. That evening Henry was found unresponsive in his bedroom at Headspace. He was taken to Wellington Hospital where he died on 16 April 2015.

In April 2015, Headspace was operated by Richmond Services. In July 2015, Richmond Services and Recovery Solutions merged to form 'Emerge Aotearoa', which had legal responsibility for the operations of Headspace at the time of Henry's death. In 2018, Headspace closed and a new six bed community mental health respite facility and accommodation service for youth aged 13-17 was opened.

Following Henry's death, CCDHB conducted a Serious Adverse Event Review (SAER) and concluded that the full extent and duration of Henry's depression and illness was not recognised by his treatment team, which may have indirectly contributed to his death. The goals for Henry's treatment did not appear to have been reviewed, in spite of his lack of improvement and his missed appointments did not trigger any review or analysis of the underlying meaning of his poor attendance. The SAER also found that individual CBT, even though recommended, did not take place as Henry's Case Manager was unable to obtain the services of an experienced CBT practitioner. When she asked for help at multi-disciplinary team (MDT) meetings and other group settings, her requests were neither documented nor actioned. The only response was the involvement of the WorkFirst coordinator. SAER also noted that on the night of 14 April 2015 there was only one staff member at Headspace because of an unfortunate weather event. The sole staff member managed to do the 30-minute observations but did not have time to sit and engage in conversation with Henry.

Five care delivery problems were identified:

(a) The treatment team had difficulty identifying the severity and duration of Henry's depression and formulating and providing treatment accordingly. The systemic factors identified as contributing to this included not using written self-report structured assessments. The nature of the electronic risk assessment may also have been a factor, and only two Multi-Disciplinary Team reviews were noted in the file. In relation to structured assessment, the reviewers noted in the report that the use of structured written assessments such as the Beck Depression Inventory for Youth or the Child Depression Inventory, which are independent of personal style, may have more clearly demonstrated the extent of Henry's depression.

(b) Lack of evidence-based treatment apart from medication. The clinical notes did not document attempts to either provide an individually delivered evidence based psychological treatment (such as CBT), or to explain the risks to Henry of failing to engage in such a treatment.

(c) There were no CAMHS specific protocols available to staff and in particular protocols addressing the needs of a young person who has presented multiple times to CAMHS.

(d) There was a lack of continuity of medical care, with Henry seeing three treating doctors in eight months (two paediatric registrars and a consultant psychiatrist).

(e) Staffing levels did not meet usual Headspace requirements on the night of 14 April 2015.

As a result of the above, SAER made 16 recommendations for improvement within CCDHB (now replaced by Te Whatu Ora Capital Coast and Hutt Valley). All but one were completed at the time the SAER report was finalised on 10 March 2016.

During the coronial inquiry, Henry's parents raised a number of concerns about the treatment he received and disagreed with some of the SAER conclusions. Their concerns related to the adequacy of the Emergency Department assessment on 11 April 2015, the level of supervision provided at Headspace, changes made to Henry's medication and the availability of therapy and support for Henry.

The Coroner engaged Dr Craig Immelman, a specialist child and adolescent psychiatrist, to review the care provided to Henry and provide an independent expert opinion. Dr Immelman agreed with the problems identified by the SAER. In regard to parents' concerns, he observed that the usual practice following an Emergency Department assessment is for an on-call registrar to have a discussion with the on-call child psychiatrist to formulate a treatment plan but it was not clear if this had occurred in Henry's case. As for Henry's medication, Dr Immelman noted that his prescribed dosage of fluoxetine was much higher than usually prescribed by other child and adolescent psychiatrists and that it would have been more common to have a formal second opinion, a review of the overall formulation and multi-disciplinary treatment plan, with medication being only one component of an integrated plan. Ultimately Dr Immelman found it hard to disagree with the parents' view that that repeated systemic failures directly contributed to Henry's death.

The Coroner accepted Dr Immelman's advice that individual psychological therapy would have given Henry the best chance of a different outcome and that he was a good candidate for this type of intervention. In her view, focussing on escalating doses of medication and attending individual sessions with his Case Manager and employment activation with WorkFirst, was not a sufficient response to Henry's clinical presentation.

RECOMMENDATIONS OF CORONER ANDERSON

I. The purpose of an inquest is not to place blame and it is clear to me that the individuals who cared for Henry tried their best. However, there are lessons that can be learned from these tragic events and these lessons can help inform the care provided to other young people in the future.

II. I acknowledge the steps that have been taken by CCDHB to improve the services provided to children and young people over the intervening years. I also note that staff vacancies and the critical shortage of psychiatrists and psychologists in Aotearoa/New Zealand have had a significant impact on the ability of mental health services to provide care to young people experiencing mental distress. However, I have formed the view that there are additional steps that should be taken in order to reduce the chance of further deaths occurring in similar circumstances.

III. As required by s57 B of the Act, I notified the organisations to whom the recommendations are directed about the nature of the proposed recommendations and I provided them with the opportunity to comment. As a result of the

response, I received from Te Whatu Ora – Capital, Coast and Hutt Valley, I have made some minor modifications to the final recommendations. While I note that Te Whatu Ora – Capital, Coast and Hutt Valley has indicated that some of these recommendations have already been actioned, or are in the process of being implemented, I do not consider that this advice eliminates the need to formally make the recommendations for the purposes of these findings.

Te Whatu Ora – Capital, Coast and Hutt Valley

IV. I recommend that Te Whatu Ora – Capital, Coast and Hutt Valley:

a. Undertake a comprehensive review of medication prescribing practices within the Wellington CAMHS team to determine whether these comply with current clinical guidelines and best practice.

b. Ensure that there is clarity regarding the criteria for admission, and the process for admission, to respite facilities and inpatient child and adolescent mental health services, and that all relevant staff are aware of the criteria and processes.

c. Review processes and policies regarding suicide risk identification, and management of suicide risk within child and adolescent mental health services, to ensure that these align with current best practice.

d. Ensure that there is clarity around the process for referring clients for individual psychological therapies, and that all CAMHS clinical team members are aware of these processes.

e. Ensure that MDT meetings are appropriately documented and that reasons are given if a service user is declined access to a treatment modality that is requested by the individual's Case Manager.

f. Continue to audit the changes and improvements made as a result of the SAER report to ensure that the changes that were made are still occurring, and that the improvements have been sustained.

g. Ensure that clinicians receive copies of Serious Adverse Event reports regarding clients whose care they are involved with, and encourage them to read the reports, reflect on the contents and incorporate any areas of learning into their future practice.

h. Continue to engage with the Health Quality and Safety Commission to ensure that MHAIDS mental health service adverse events review processes, and associated learning activities, are aligned with best practice and any applicable national guidelines or protocols, and that they remain in line with these standards.

i. Explore ways in which the views of service users and whānau members can be effectively incorporated into MDT review processes.

Emerge Aotearoa

V. I recommend that Emerge Aotearoa:

a. Ensure that there are clear processes in place for dealing with unexpected staff absences, so that the quality and nature of care provided to clients is not compromised.

b. Ensure that there is a process for notifying clinical teams of any unplanned change in staffing levels that might have an impact on the ability of the service to provide the care anticipated by the clinical team at the time an individual is admitted to the service.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of the following details, in the interests of justice, personal privacy and decency: any of the photographs of Henry entered into evidence; the name of Henry's sister and any reference to her medical conditions or health status; any reference to the health status or medical conditions of Henry's parents; the name or identifying details of either of Henry's two former girlfriends; the name or any identifying details of the Headspace Manager; the name or any identifying details of Henry's CCDHB Case Manager.

Quin [2022] NZCorC 158 (18 November 2022)

CIRCUMSTANCES

Clevelyn John Quin, aged 21, died between 10 and 11 February 2020 in Featherston in circumstances amounting to suicide.

Mr Quin lived with his partner and her young son at a property on the dairy farm where he worked. Mr Quin's father died in a train accident when Mr Quin was aged two and half. Mr Quin experienced further family tragedies when his sister died by suicide in 2015, and his mother died in a workplace accident in 2018.

Mr Quin had a history of mental health issues from at least 2012, when he was first seen by the Community Mental Health Service (CAMHS). He was last seen by a CAMHS psychiatrist on 15 February 2016. After cancelling appointments and refusing to engage with services offered, Mr Quin was discharged from CAMHS.

Mr Quin was depressed after losing his job on 7 February 2020 and having to move out of his farm accommodation as a result. On 10 February 2020 Mr Quin and his partner argued all day. His partner last saw Mr Quin at around 6:30pm when he walked off into the paddocks. She reported that Mr Quin had told her the day before that he would kill himself if he ever lost her.

Mr Quin was located by a friend and family member around 1:20am the following day. Emergency services were notified and a doctor at Wairarapa Hospital confirmed Mr Quin was deceased.

COMMENTS OF CORONER HESKETH

I. The following comments are made pursuant to section 57(3) of the Coroners Act 2006, for the purpose of public education aimed at avoiding further suicide by anyone in circumstances similar to those in which Clevelyn John Quin died.

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 thinking that way.

III. Information about the ways you can support someone who is thinking of harming themselves is available at https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide.

IV. The website contains information about what to do if you think someone needs urgent help. If someone has attempted suicide or you're worried about their immediate safety, do the following:

    a. Take them seriously. Thank them for telling you, and invite them to keep talking. Ask questions without judging.

    b. Call your local mental health crisis service or go with the person to the emergency department at the nearest hospital.

    c. If they are an immediate danger to themselves or other call 111.

    d. Remain with them and help them to stay safe until support arrives.

    e. Try to stay calm and let them know that you care.

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

    a. For counselling and support – these are free and generally available anytime: Lifeline – 0800 543 354 Samaritans – 0800 726 666

VI. For children and young people:

    a. Youthline – 0800 376 633, free text 234 or email talk@youthline.co.nz (for young people, and their parents, whānau and friends)

    b. *What's UP – 0800 942 8787 (for 5-18 year olds; 1 pm to 11 pm)

    c. *The Lowdown – visit the website, email team@thelowdown.co.nz or free text 5626 (emails and text messages will be responded to between 12 noon and 12 midnight)

    d. *SPARX – an online self-help tool that teaches young people the key skills needed to help combat depression and anxiety.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Quin taken during the investigation into his death, in the interests of decency and personal privacy.

Sionelua [2022] NZCorC 171 (5 December 2022)

CIRCUMSTANCES

Johnnie Sionelua, aged 17, died on 3 March 2020 at Auckland Hospital in circumstances amounting to suicide.

During Johnnie's relationship with his girlfriend, Leenas Fotu-Moala, Johnnie threatened to end his life on a number of occasions.

COMMENTS OF CORONER BELL

I. One role of the Coroner is to make comment or recommendations that may prevent deaths in similar circumstances in the future. In this case the issue of how best to deal with a person talking of taking their own life requires comment. This is not a circumstance most people are faced with. Knowing how best to respond if confronted with such a situation is important.

II. I do not intend to or imply any criticism of Ms Fotu-Moala in making the following comments. There are key things to bear in mind. The first is that if someone expresses thoughts and feelings about suicide take them seriously. Urge the person to obtain help and if you are concerned, get help immediately, by contacting a doctor or mental health service. If you need to, call emergency services on 111. If the person is feeling unsafe, or you think they are at high risk, do not leave them alone. People in this situation need someone with them.

III. I note the Ministry of Health gives the following advice for people who are concerned about suicidality in others: https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal#urgenthelp

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Johnnie entered into evidence, in the interests of personal privacy and decency.

Wii [2022] NZCorC 154 (6 November 2022)

CIRCUMSTANCES

Tangaroa-Witaiawa Wii (also known as Ngawhare Witiawa Wii), aged 34, died on 12 January 2021 at Kaniere-Hokitika Tramway Cycleway in circumstances amounting to suicide.

During the early hours of the morning on 12 January 2021, Police were contacted to conduct a welfare check on Ngawhare. Constables Edsel Taylor and Damon Subritzsky met with Ngawhare and were satisfied that there were no sufficient grounds to detain him under the Mental Health (Compulsory Assessment and Treatment Act 1992 (the Mental Health Act). They also did not contact the Crisis Response services as they had been told in the past that the Crisis Team would only see people who have been detained under the Mental Health Act.

Following Ngawhare's death, Police conducted a review of the welfare check. The review found that the constables had complied with relevant policies and statute and that there were no failures in service. The Coroner accepted the findings of the review.

The Coroner asked West Coast District Health Board to consider the incident and provide details regarding the Crisis Response service.

COMMENTS OF CORONER CUNNINGHAME

I. In response to the comments made by the constable about their perception of Crisis Response's management of individuals who do not meet the threshold for detention, the Clinical Director, Mental Health Service advised:

> I would be very disappointed if such a black and white stance was taken by members of the Crisis Response team and would expect that any call be that from Police or any other agency or person would be triaged according to the information provided in conjunction with any other available collateral. Use of alcohol or other substances should not preclude an assessment being undertaken as outlined above.

II. Because I have found that Ngawhare's death could not have been prevented even if Police had managed to speak to someone at Crisis Response, I do not make any recommendations to the WCDHB, or to Home Care Medical.

III. The Clinical Director, Mental Health Service, has further advised:

> If Police are not satisfied with the outcome of a referral to Crisis Response they can, and indeed do, draw this to the attention of the Senior Sergeant who liaises with the nurse consultant or me if the matter is pressing. Regular liaison meetings between Police and WCDHB mental health services including Crisis Response also occur on a monthly basis. This provides a forum for both agencies to raise any interface issues or mutual cases of concern, share perspectives and identify any misconceptions and opportunities for learning and has proven to effect resolution between parties and led to a shared management approach for mutual clients on a number of occasions in recent months.

IV. I endorse the use of this forum as a way to improve the management and care of vulnerable individuals on Te Tai o Poutini/West Coast.

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death. Pursuant to s 71(3)(b) of the Act, the death may be described as a suicide. An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs that show Ngawhare entered into evidence in this inquiry, on the grounds of decency and personal privacy.

Sudden Unexpected Death in Infancy (SUDI)

Tereapii-Pavai [2022] NZCorC 168 (1 December 2022)

CIRCUMSTANCES

Noora Junior Christian Tre Tereapii-Pavai, a 6½-week old infant, died on 1 June 2019 at his home due to sudden unexpected death in infancy (SUDI).

Noora was of Cook Island Māori descent and lived with his parents and two siblings. He was born at Middlemore Hospital on 17 April 2019 by emergency caesarean section at 39 weeks and three days gestation. He developed respiratory distress eight hours following birth and was found to have salmonella for which he received antibiotics. Investigations in the hospital also showed a soft systolic murmur (heart murmur). Echocardiograms showed a dysplastic mitral valve with moderate to severe mitral regurgitation, severe dilation of the left atrium and pulmonary hypertension of unknown cause. Eventually, Noora's condition improved, and he was taken off respiratory support and discharged home on 9 May 2019. Following discharge, he slept and ate well.

On 31 May 2019, Noora was bottle-fed at 7:30pm and then placed in his cot by his father at about 10pm. Noora's cot was situated in his parents' bedroom. At about 3am, Noora's mother went to check on him. Her evidence regarding Noora's sleeping position varied but it appears she found him face down. Noora's mother saw that his face was purple and picked him up and ran into the living room where his father commenced CPR. Emergency services were called and took over CPR on arrival, but some time later confirmed that Noora had died. At that point, Noora's father became upset and punched holes in the walls. Police attended and Noora's father was arrested for aggressive behaviour.

The pathologist who performed a post mortem examination opined that it was unlikely that Noora's underlying cardiac condition caused his death. The Coroner was not satisfied that Noora's sleeping position contributed to his death as there was insufficient evidence to confirm this.

COMMENTS OF CORONER TETITAHA

I. There is a need to comment upon the frontline policing policies and practices regarding SUDI and its impact upon the coroner's later investigation into the cause and circumstances of the death. Coroners rely upon frontline Police to investigate and provide contemporaneous evidence to support findings and recommendations into deaths.

II. Prior to Baby Noora's death the parents had been co-operative. The father's anger at the death was understandable. His subsequent arrest including the stated grounds was concerning. De-escalation techniques could have been employed to prevent any self-harm. His removal from the scene appeared to be sufficient to de-escalate this situation. This arrest is a matter that could be referred to the Independent Police Conduct Authority for review.

III. Only the mother was interviewed. Her witness statement did not detail the child's sleep position when placed in the cot. She was equivocal regarding the child's final sleep position. Her witness statement appears more

concerned with justifying the father's behaviour and good parenting skills. No other persons, including the father were interviewed.

IV. Both parents subsequently declined any further interviewing by the SUDI interviewer from Communio.

V. The position the child was placed in prior to sleep and the position he was found are important to the circumstances leading to an infant's death by SUDI. This data is used to inform research and recommendations to prevent future similar deaths.

VI. From the evidence, the father was responsible for placing the child into bed and for checking on him during the night. Following the father's arrest, it is unsurprising the parents have become uncooperative with any investigation into this death. This was a lost opportunity to identify possible reasons for the cause of Baby Noora's death from the circumstances known to his parents.

VII. There is need to ensure that parents recently bereaved due to SUDI are treated sensitively and appropriately given their circumstances. Exercising powers of arrest in these circumstances should be used sparingly (if at all). The impact of the father's arrest may have also made all of the other witnesses reluctant to provide statements, especially given there are none on file.

VIII. Academics have commented upon the negative impact of Police actions on grieving families experiencing unexpected infant deaths:[46]

> The behaviour of the police was identified as a major influence on outcomes for families dealing with SIDS [sudden infant death syndrome]. The police were involved because SIDS – by definition unexplained death – inevitably required a police response. Because they were among the first to respond to the situation, they tended to arrive when turmoil and distress were very high for the bereaved. The care-workers said that unless the police behaved with exceptional sensitivity, there were many points at which their activities could have a profound negative impact. They were always in danger of being seen as blaming or judgmental, so over-reaction to the call-out, pursuing peripheral or irrelevant inquiries on the scene and explaining the need for autopsy in terms of implied guilt on the part of parents were examples of behaviours that needed to be avoided.

IX. The circumstances of Noora's death might indicate the need for a specific SUDI protocol/practice or training to be provided to frontline Police. An earlier coroner's decision also involved Pacific Island parents of a SUDI who expressed distress regarding Police behaviour.[47]

X. Appropriate behaviour by the Police towards the father could have provided important source information about the cause and circumstances of this death and informed recommendations to prevent similar SUDI deaths in future amongst Pacific Island families.

[46] T McCreanor, D Tipene-Leach and S Able "The SIDS Care-Workers Study: Perceptions of the Experience of Māori SIDS Families" Social Policy Journal of New Zealand issue 23 at p 160.

[47] An Inquiry into the death of Elizabeth Dianna Isabella Hepoto-Vailahi Vuna CSU 2018-AUK-001356 where the SUDI report noted "[the parents] found the Police process very challenging, they were separated and not allowed to comfort each other. They found it distressing that baby Elizabeth was left on the ground and that they weren't allowed to touch her until the Police had taken photos. Both [parents] felt criminalised by the process. They have not been contacted by victim support, and therefore had not been advised of any support services."

XI. An appropriate protocol might include:

a. A senior Police officer being part of the first response team attending a SUDI. This officer should be responsible for all decisions made including the exercise of arrest powers.

b. Provision to the parents of an iwi/pasifika liaison officer to provide assistance and support about the Police process involving SUDI death investigation.

c. A detailed history taken from all witnesses to understand the cause and circumstances of death. This history should include statements from the person who last saw the infant alive as well as the person who found the deceased infant.

d. Inclusion of SUDI material within Police training.

XII. These comments and recommendation have been directed to the Commissioner of Police and the Minister of Police for comment prior to release of this decision. No reply has been received.

RECOMMENDATIONS OF CORONER TETITAHA

I. It is recommended:

a. That the Minister of Police and/or the Commissioner of Police draft and implement a SUDI death investigation protocol for frontline Police.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Noora during this inquiry in the interests of decency.

OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND