OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments made between **1 April** and **30 June 2023**

Office of the Chief Coroner | 2023 (2)

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 45 findings with recommendations and/or comments issued by Coroners between 1 April and 30 June 2023.

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Recommendations and comments

1 April to 30 June 2023

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

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

Drugs and Alcohol

Pita [2023] NZCorC 39 (12 April 2023)

CIRCUMSTANCES

Thomas Junior Te Aranga Pita, aged 32, died on 25 June 2019 at Room 8, 107 Malfroy Road, Rotorua of accidental recreational drug overdose (synthetic cannabis).

In the few months prior to Mr Pita's death, he had started using synthetic drugs on a weekly basis. On the evening of 25 June 2019, Mr Pita went to his aunt's address. Shortly after arriving, his aunt went into the bathroom. Mr Pita was rolling a cigarette at the time. When she exited the bathroom, she discovered Mr Pita unresponsive on the floor next to the bed. He had vomited. She ran outside to seek help and a neighbour rang emergency services and commenced CPR. Mr Pita was pronounced deceased at the scene. It was unclear whether he consumed synthetics prior to arriving at his aunt's address, during his visit there, or both.

Toxicology testing undertaken after Mr Pita's death confirmed the presence of olanzapine, an atypical antipsychotic medication, and the potent synthetic cannabinoid 5F-MDMB-PICA in Mr Pita's blood. 5F-MDMB-PICA acid and 5F-PB-22 3-carboxyindole, both metabolites of 5F-MDMB-PICA, were also confirmed in the blood. ESR conducted testing on the cigarette that was being rolled by Mr Pita but did not detect the presence of any common substances covered in the Misuse of Drugs Act 1975. Tests indicated the plant material contained nicotine, but this was not able to be confirmed. It remains unclear whether the-hand rolled cigarette contained the synthetic cannabinoid 5F-MDMB-PICA. 5F-MDMB-PICA has been reported in a number of coronial cases (deaths) and impaired driver cases since mid-2017. It has a high potency that may pose a threat to public health.

COMMENTS OF CORONER BATES

I. Mr Pita's death was caused by synthetic cannabis use. As noted in Findings by Coroner Duggal:[1]

[1] Coronial inquiry CSU-2019-CCH-000160.

II. The dangers of consuming synthetic drugs include:

a. It being passed-off as a form of synthetic cannabis, although there is no cannabis in the product.

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

c. The pharmaceutical agents from which the synthetic drug is made having been developed to create new medications to treat spasms and epilepsy then being found unsuitable and discarded. The nature of the synthetic drug is unknown to the purchaser and may be unknown to, or poorly understood by, the manufacturers/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 New Zealand and overseas.

e. The quantity and strength of AMB-FUBINACA and 5F-ADB will be unknown. Therefore consumption is a gamble with potentially fatal consequences.

f. The potential for death of individuals who fall unconscious after consumption of synthetic drugs if they do not receive timely and appropriate medical assistance; dying due to a cardiac event induced by consumption of the drug, or as a result of being comatose and asphyxiating or experiencing hypoxic brain injury.

III. Coroner Duggal highlighted comments and recommendations made by Coroner Matenga in reliance on expert evidence from Dr Paul Quigley, Emergency Medicine Specialist, given during a coronial inquiry into a death resulting from synthetic cannabis use.[2] I repeat Coroner Matenga's recommendations, as based upon Dr Quigley's advice:

IV. In order to prevent future deaths from synthetic cannabinoids, Dr Quigley suggested an all encompassing harm reduction approach which reduces demand and supply and provides easy access to treatment for those seeking assistance. He cautioned against an approach that penalises users. Penalising users can create a barrier to seeking medical attention, even in cases of emergency.

V. 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.

VI. Dr Quigley's advice for families or associates of synthetic cannabis users was that if a person has used synthetic cannabis and collapses, they should be shaken immediately in an attempt to rouse them. If the person rouses, they should be placed in the recovery position and a call for help should be made. If the person does not rouse, call for help and commence chest compressions. The emergency call-taker will provide further assistance. There should be no delay in seeking assistance.

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[2] Coronial inquiry CSU-2017-HAM-000336.

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

Drowning

Huggard [2023] NZCorC 68 (28 May 2023)

CIRCUMSTANCES

Kerry Paul Huggard, aged 64, died on 3 February 2023 opposite 195 Marine Parade, Mount Maunganui of drowning.

Mr Huggard was known to be a confident swimmer and swam at his local beach at Mount Maunganui most days. On the afternoon of 3 February 2023 a member of the public was walking along the beach at Mount Maunganui. He observed a man (now known to be Mr Huggard) putting his towel on the beach and walking into the water. He was wearing board shorts and seemed to be confident in the water. However, the bystander became concerned after seeing Mr Huggard up to his neck in the water, which he described as "turbulent". After a short time, Mr Huggard disappeared from view, leading him to contact Surf Lifesaving, NZ (SLSNZ).

Lifeguards arrived and entered the water, searching for Mr Huggard. He was quickly found and brought to shore where resuscitation was started by waiting ambulance staff. Despite extensive efforts, Mr Huggard could not be revived.

COMMENTS OF CORONER TELFORD

I. It is coincidental that I recently concluded an inquiry into a water safety related death in the Tauranga District that occurred in November 2022.

II. In that case, SLSNZ similarly raised concerns about the paucity of appropriate signage and personal protective equipment in this area. The following recommendations were made by me, with the agreement of Tauranga City Council and SLSNZ:

> *That SLSNZ and Tauranga City Council will work collaboratively to undertake a coastal risk assessment and agree an implementation plan which will identify the locations where signage and rescue equipment will be beneficial to public safety.*

III. Given the above recommendations were recently made, I see no merit in making similar or further recommendations in this instant case.

IV. I do, however, comment generally that this recent tragic death highlights yet again the vital importance of water safety and the work being undertaken by SLSNZ and Tauranga City Council. I again commend this approach to all other New Zealand councils.

V. With that in mind, I direct that these findings are to be circulated to the same organisations as those listed in the *Wikeepa* finding, being:

a. The Police;

b. Marty Grenfell, Chief Executive of Tauranga City Council and Anne Tolley, Commission Chair;

c. Stuart Crosby, the president of Local Government New Zealand who is also asked to distribute these findings to all councils within New Zealand;

d. Dr Mick Kearney to distribute to the appropriate people within Surf Lifesaving NZ; and

e. Water Safety New Zealand.

Safety messages

VI. Finally, I reiterate to the public the following beach safety messages provided by SLSNZ:

a. If you see someone in trouble in the water, call 111 & ask for the Police

b. Know your limits. Don't overestimate your ability in the water.

VII. I would add to the above the general importance of following Surf Lifesaver's guidance on the day and to swim (particularly when alone) between the Lifesaver flags.

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

Latimer [2023] NZCorC 71 (6 June 2023)

CIRCUMSTANCES

Verna Dawn Latimer, aged 86, died on 26 December 2019 at Eastcliffe Retirement Village, 118/217 Kupe Stret, Orakei of unintentional drowning.

Mrs Latimer had resided in an apartment in the Eastcliffe Retirement Village for two months. A nurse manager had discussed Mrs Latimer's health when she moved in. She was recorded as taking medication for hypertension and anxiety. However, during a hospital admission in September 2019 Mrs Latimer was found to have hyponatraemia (low serum sodium) which was associated with confusion and increased her risk of falls. A blood test done on 18 December 2019 showed Mrs Latimer still had hyponatraemia.

On the afternoon of 26 December 2019 Mrs Latimer returned to Eastcliffe after spending Christmas with her family. A short time later the receptionist observed Mrs Latimer come downstairs wearing a long black dress and flip-flops with her keys and a towel. Mrs Latimer asked the receptionist to show her the pool. The receptionist was aware that Mrs Latimer had had a past concussion but understood she was physically capable of using the pool. Mrs Latimer was shown the pool lift but said she would use the stairs. The receptionist left Mrs Latimer at the pool.

CCTV footage showed Mrs Latimer entering the unlocked pool area at 1:30pm. She stripped down to her underwear. Once in the pool, at 1:33pm, Mrs Latimer held onto a handrail at the bottom of the steps. She tried to push upwards on the handrail resulting in the top half of her body coming out of the water before falling back in. This occurred twice, once at 1:36pm and again at 1:38pm. By 1:40pm the CCTV footage showed Mrs Latimer letting go of the pool handrail and slowly sinking below the water. Mrs Latimer was not discovered deceased in the pool until after 8:00pm.

COMMENTS OF CORONER TETITAHA

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

II. I have made findings that Mrs Latimer died in a pool at her retirement village. The cause of death was drowning. This was unintentional. I have also found Mrs Latimer's behaviour leading up to her death might have been due to hyponatraemia and/or the known effects of mirtazapine.

III. This is the second decision I have before me involving the drowning of an elderly person at a retirement village that provides a pool.[3] There are commonalities in the circumstances leading to these deaths. These include the pools not being monitored or supervised; the pool barrier door was not self-closing nor had audible alarms if it remained open after entry/exit; neither restricted entry to the pool by residents who were medically unsuitable or unable to swim unless supervised; no signage about the risks of slipping and tripping; and no staff or resident training in water safety provided.

IV. Older adults (65+ years) are becoming increasingly more at risk of drowning in New Zealand, now comprising 1/6 (17%) of all fatal drowning in New Zealand, and 1/5 of Auckland's fatal drowning toll in the 5 years to 2020 (WSNZ drown base, 2021), with most (87%) occurred in open water settings.[4] One reason cited for the increasing risk in drowning among older adults is the inaccurate assessment of their current water competence (Stanley and Moran, 2021). Previous studies suggest that many, young and old, tend to underestimate the risk of drowning as well as overestimate their capacity to mitigate that risk.[5]

Eastcliffe Resthome

V. I directed Eastcliffe to provide a report confirming whether the pool complied with all legislative and regulatory requirements; if they had made any changes to their policies regarding use of the pool since Mrs Latimer's death; and whether there were any protocols for use of the swimming pool including if it was supervised and if access was now restricted in any way.

VI. Eastcliffe have provided two replies. I summarise these below. It confirmed the pool complied with all legislative and regulatory requirements. They had also made changes to the pool barrier and regarding use of the pool since this death. These include:

a. The doctor of each incoming resident is to confirm as part of the mandatory pre-entry medical certificate that residents must provide, whether he/she considers the resident is safe to swim in the pool unsupervised. If the doctor recommends the resident should not swim (unsupervised), Eastcliffe does not allow the resident access to the pool.

b. For the first 2 weeks after this death, Eastcliffe restricted the pool hours to 8 am until 9 pm and encouraged residents to notify reception when going to use the pool. Eastcliffe removed this

[3] An inquiry into the death of Ronald Herman Mattson CSU 2021-AUK-000032.
[4] Drowning Prevention Auckland online publication "Older Adults Research" https://www.dpanz.org.nz/research/older-adults/
[5] See above.

restriction on pool hours as a result of “pushback” from residents who wanted to be able to use the pool at any time.

c. Eastcliffe now requires swipe card access for entry at all of the accessways to the pool. Prior to this death, only the basement access point required a swipe card.

d. Eastcliffe restricts access to the pool to residents and their guests, and occasionally the staff, through use of swipe access cards. Only staff and residents holding apartment keys have access cards.

e. Eastcliffe has established a permanent video camera monitor at reception, which displays real time footage of the pool to receptionists and the night security guard (when he is on duty) and allows them to see what is happening in the pool area. Eastcliffe have instructed the receptionists to be “vigilant” for any potentially concerning activity at the pool. When the night security guard is on duty, he checks the pool area during his rounds and also reviews the monitor at reception.

f. Eastcliffe has increased the regularity of checks of the pool area by the night security guard, so this is now done 3 times a night as part of the guard’s rounds. When the security guard is not completing these rounds, he sits at reception and can see the monitor that provides real-time footage of the pool.

g. Eastcliffe has written rules for pool usage, but the pool remains unsupervised.

h. Eastcliffe includes as part of its information pack to new residents a recommendation that residents notify reception when they intend to use the pool. It is not possible to make this mandatory, as residents value flexibility and independence and want to be able to make their own decisions about when and how to use the pool.

VII. I thank Eastcliffe for their report and the pro-active changes made. However, there may be further changes that could also ensure harm reduction and avoid similar fatalities.

VIII. It is likely Mrs Latimer upon her entry into the retirement village might have been deemed by her doctor as ineligible for unsupervised swimming given her health circumstances at the time of her death. I am aware a diagnosis of hyponatraemia should prompt a doctor to advise a patient not to drive for 3 months and it is likely a doctor would also have advised against her using the pool unsupervised.

IX. However elderly residents especially female over the age of 80 years may acquire hyponatraemia or other illness/disability at any time after they move into the retirement village.

X. This may indicate the need for Eastcliffe to consider educating residents regarding water safety including education about illnesses or disabilities that may exclude them from swimming unsupervised. Researchers state that targeted water safety programs for the elderly including risk and competency assessment activities and simulated practical experiences would best address issues of

underestimation of risk of drowning in a pool and overestimation of ability.[6] Partnering with a swim school to provide water safety education to elderly residents could be considered. Drowning Prevention Auckland also offers online education materials regarding pool safety.[7]

XI. Staff tasked with monitoring the pool should also have water safety training to ensure they can identify dangerous environments or behaviours and can pre-emptively respond. Pool safety equipment such as wall alarms and/or safety alarm bracelets for swimmers to use to signal they require help might also be considered. These measures might have prevented this death.

XII. The CCTV footage showed Mrs Latimer was unable to get herself up and out of the water. This may have indicated a need to warn swimmers about changes in depth. Safety signage warning of the changes in depths, slippery surfaces and areas where it may be hazardous to swim and/or dive should be prominently on display for the benefit of both staff and swimmers alike. This might have ensured Mrs Latimer remained in an area where she could more easily get out of the pool, thus preventing this death.

XIII. I provided a copy of my comments and recommendations to Eastcliffe. I have received a further reply from Eastcliffe that advises as follows:

> Eastcliffe is committed to ensuring the safety and wellbeing of its residents and staff and is already working through a number of improvement options (particularly for pool safety).
>
> Eastcliffe has undergone a change in management since Mrs Latimer's death and has reviewed the implementation and effectiveness of the various remedial actions initially identified and advised to the Coroner. It has become apparent that due to issues such as technology restrictions and limitations of existing procedural systems, some of the improvements previously proposed by Eastcliffe (in particular, those referred to at paragraph [58](a), (c), and (d) of the Coroner's draft findings) have not been implemented as planned. Eastcliffe is working through these issues, which will include consultation with the residents, with the aim of ensuring these controls (or an appropriate alternative) are in place as soon as reasonably practicable.

XIV. This reply indicates Eastcliffe are making efforts to implement changes to prevent further deaths. No recommendation is now required.

Other investigations

Ministry of Health

XV. I had sought the views from the Ministry of Health who undertakes certification and audits pursuant to the Health and Disability Services (Safety) Act 2001. This Act allows the Ministry of Health to set standards for delivery of health services in rest homes.

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[6] These issues were highlighted by Stanley T and Moran K "Perceptions of Water Competencies, Drowning Risk and Aquatic Participation among Older Adults" International Journal of Aquatic Research in Education volume 13 number 2 article 6.
[7] Drowning Prevention Auckland online education programs https://www.dpanz.org.nz/education/

XVI. The Ministry of Health advises that Eastcliffe comprises both a retirement village and a rest home. However only the rest home/hospital is required to be certified under the Health and Disability Services (Safety) Act 2001. The Ministry has confirmed that the swimming pool in the Eastcliffe retirement village is only for use by the independent residents in the village and not by any rest home residents. The Ministry further confirmed there are no certified aged residential care facilities (rest homes) in New Zealand with a swimming pool. Where there is an adjacent retirement village with a swimming pool, the auditing agencies have confirmed that, to their knowledge, rest home residents do not have access to the pool.

XVII. Given the above reply I see no need to make any further comments or recommendations.

Auckland City Council

XVIII. The Building (Pools) Amendment Act 2016 made changes to the Building Act 2004 relating to residential pools which I understand includes pools located at retirement villages as well as rest homes. This now requires an indoor pool to have a means of restricting access. Doors in the pool barrier must be self-closing or have audible alarms to ensure that doors are closed immediately after the door is used. Mandatory inspections of residential pools by territorial authorities such as the Auckland City Council are to occur every 3 years.

XIX. Although this legislation is aimed at preventing unauthorised access by children under 5, it is useful to also prevent access by persons who may be unable to swim unsupervised for any other reason.

XX. I note this death had prompted changes by Eastcliffe to the pool barrier. I sought the views of the Council regarding any changes it could make to prevent unnecessary future deaths such as this one pursuant to the Building Act 2004.

XXI. I have received a reply from the Auckland City Council. The reply confirms that any additional changes I have suggested such as an emphasis on inspections of pools in rest homes (or I assume retirement villages) is unlikely to reduce the chances of another adult drowning in a rest home pool. Further the statutory compliant fencing is aimed at preventing access to the pool by small children as opposed, I assume to restricting access by unwell elderly adults.

XXII. Given that there appears to be little that can be done under the Building Act 2004 to prevent these deaths, no further comments or recommendations are made.

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

Liang [2023] NZCorC 53 (2 May 2023)

CIRCUMSTANCES

Lianpeng Liang, aged 43, died between 5 October 2020 and 11 October 2020 in the ocean near Kauwahaia Island, West Auckland of drowning.

On 5 October 2020 Mr Liang and his friends went rock fishing at Bethells Beach, a west coast surf beach near Auckland. The group made their way to Kauwahaia Island, which can only be reached at low tide. When the group arrived, there was quite a large swell, and the sea was rough. The men started fishing from various positions on the rocks. Mr Liang was sitting on a rock next to a blowhole. There was a cave underneath where Mr Liang was fishing. He was not wearing a lifejacket.

About two hours after they arrived, at about 11:30am, one of the group approached Mr Liang and suggested they leave as he felt the waves were too big and the tide was rising. Mr Liang said he would stay a bit longer. Three of the group left the rocks and climbed up the hill, while Mr Liang and one other friend remained.

At about 1:00pm the friend who was fishing with Mr Liang saw a wave wash over the rocks and sweep Mr Liang and his bucket into the blowhole and into the water in the cave below. Mr Liang tried to make it to safety but due to the waves and rough sea he was unable to get back to the rocks. His friends tried to help him but were unable to. Mr Liang was then seen floating unresponsive out to sea. On 11 October 2020 Mr Liang was found in the water wedged under rocks. He was deceased.

RECOMMENDATIONS OF CORONER FITZGIBBON

I. Rock-fishing is a popular past time for many New Zealanders. Not only is it a productive way to fish, but it also offers freedom, accessibility and affordability for all. However, it is not without its risks and dangers. These comments are made in the hope that if drawn to the public attention, they may reduce the chance of further deaths occurring in circumstances similar to Mr Liang's death.

II. Mr Liang was not wearing a lifejacket and was fishing in an exposed area during large seas. His friends fishing with him expressed concern about the large waves. Mr Liang had previously fished on Kauwahaia Island on multiple occasions but whether he had seen the signage about the risks of rock fishing is not known. Unfortunately, the decision to fish in this location, without a lifejacket and in large seas resulted in Mr Liang's death, which was preventable.

III. Water Safety New Zealand states that rock fishing is an increasingly popular recreational past time, but it is also extremely hazardous. Being swept off rocks by large waves is a major hazard. It recommends the following when rock fishing:

a. Always wear a lifejacket.

b. Pay particular attention to swell and tide information.

c. Never fish in exposed areas during rough or large seas.

d. Spend at least ten minutes observing the sea conditions before approaching the rock ledge.

e. Never turn your back on the sea.

f. Pay attention to warning signs.

g. Never fish from wet rocks where waves and spray have obviously been sweeping over them.

IV. I endorse Water Safety New Zealand's recommendations and particularly highlight the lifesaving importance of wearing a life jacket when rock fishing.

V. I draw to the public attention to:

a. the life jacket borrowing scheme. More information about this can be found on Lifejacket Hubs | Drowning Prevention Auckland (dpanz.org.nz). In particular I note that Bethells Beach Te Henga is one such hub from which life jackets can be borrowed.

b. the DPA's Safer Rock Fishing programme (https://www.dpanz.org.nz/courses/safer-rock-fishing/). This is 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.

VI. I also applaud the steps taken by Drowning Prevention Auckland to extend the community education campaigns to the Asian and non-English speaking communities and encourage the continued development of these campaigns.

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

Mitai [2023] NZCorC 45 (20 April 2023)

CIRCUMSTANCES

Corey Ihaia-Lee Mitai, aged two, died on 14 August 2020 at Mount Wellington, Auckland of causes consistent with drowning.

Corey lived in Mount Wellington, Auckland with his mother and extended family. The property contained an in-ground pool in the backyard. The backyard was fenced, and the pool was separately fenced off from the backyard. The pool had not been used or maintained for around two years and had collected rainwater over this time. In the month before Corey's death, the pool area was used as a play area for the dog, and the gate would sometimes be left open for the dog.

Corey had not had any swimming lessons and had not been in the pool or played in the pool area before. He had also never swum in water alone as someone would hold him while he was in the water.

On the afternoon of 14 August 2020, Corey was seen playing outside on his own. Approximately 10 to 20 minutes later, Corey had not returned, so his mother started to look for him. Corey was found floating face down in the pool. He was pronounced deceased at the scene.

A report from Auckland Council identified that every filled or partly filled residential pool must have physical barriers that restrict access to the pool by unsupervised children under the age of five. The means of restricting access must comply with the requirements of the building code. The requirements must be complied with by owners, occupiers and pool

operators. Residential swimming pools on the Council's register are inspected at least once every three years to determine whether the pool has physical barriers that comply with the law.

The pool at Corey's address was on the Council register and last inspected on 14 June 2019. The pool was compliant and passed the inspection. Following Corey's death, the pool was inspected again and failed for three reasons: horizontal rails on the other side of the back boundary fence were 870mm, climbable rails must be at least 900mm apart; the broken concrete inside the gate on the hinged side left a gap exceeding 100mm, the maximum gap allowed is 100mm; and the gate remained open and did not self-close when approximately half open or more. During a subsequent inspection by the Council on 9 February 2021, the pool had been removed.

COMMENTS OF CORONER FITZGIBBON

I. Corey'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 had barriers which were compliant with the law.

II. Corey's death also emphasises the need for constant checking by pool owners and occupants to ensure even unused pools do not contain water and that the required safety mechanisms are regularly checked and maintained between Council inspections. 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.

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

Wikeepa [2023] NZCorC 58 (13 May 2023)

CIRCUMSTANCES

Reon Graeme Wikeepa, aged 43, died on 12 November 2022 at Moturiki Island, Mount Maunganui, of drowning.

On the afternoon of 12 November 2022, Mr Wikeepa and his daughter, Abigail Wikeepa, attended at a popular spot for rock jumping at the end of Moturiki Island. Abigail jumped off the rocks first. The waves were high and Abigail was experiencing difficulty getting out of the water. Mr Wikeepa jumped into the water and helped her climb back onto the rocks. He then started to be washed back out by the waves. Mr Wikeepa's son jumped in the water to help him but experienced similar difficulties. Surf Lifesavers were notified and immediately dispatched lifeguards. The attending lifeguards radioed for a boat which arrived shortly after. Mr Wikeepa was retrieved from the water and resuscitation was immediately commenced. Mr Wikeepa was taken to shore where ambulance staff arrived and continued extensive resuscitation attempts. Mr Wikeepa did not respond and paramedics pronounced him deceased.

The Coroner considered it likely that Mr Wikeepa would have had a greater chance of survival if those attempting to rescue him had ready access to a flotation device.

A report was provided by Surf Life Saving New Zealand (SLSNZ) who advised that since 1 July 2012 there have been 10 beach and coastal drowning fatalities on Tauranga City Council beaches and coastline. Of these, two have occurred at Moturiki Island. They advised that on 12 November 2022, swimmers were exposed to a considerable number of hazards at Moturiki Island. The Coroner noted the following points from the report provided by SLSNZ:

Signage

There is an Australian/New Zealand standard for water safety signage – Australian/New Zealand Standard 2416:2010 "*Water safety signs and beach safety flags*". Within the Mount Maunganui Beach and Moturiki Island coastal zone there are no water safety signs that adhere to 2416:2010.

Public Rescue Equipment

A survey conducted by SLSNZ found that almost half of all the rescues occurred without the use of any rescue or flotation equipment. SLSNZ advised that there is no public rescue equipment available within Mount Maunganui Beach and Moturiki Island coastal zone. SLSNZ have reviewed the literature in relation to this problem and found that the using some form of flotation device is the safest option for a bystander attempting a water rescue.

The Coroner consulted with SLSNZ and Tauranga City Council as to the following preliminary recommendations:

(a) That after consulting with SLSNZ, Tauranga City Council place appropriate signage on Moturiki and coastal surrounds that is in compliance with Australian/New Zealand Standard 2416:2010.

(b) That after consulting with SLSNZ, Tauranga City Council **urgently** place appropriate public rescue equipment on Moturiki and coastal surrounds.

Tauranga City Council advised that they were already in the process of establishing one warning sign and three sets of public rescue equipment on Moturiki Island. One of the proposed sites for public safety equipment is near the place where Mr Wikeepa lost his life. Tauranga City Council advised they would continue to work alongside SLSNZ to identify other areas that would benefit from safety signs and devices. The consultation included discussion as to the extent and implications of adopting safety measures along the coastline. As the coastline stretches to around 14 kilometres it was accepted that constant patrolling of these areas was not a realistic solution and that signage and safety devices were the appropriate method to provide protection to the public.

COMMENTS AND RECOMMENDATIONS OF CORONER TELFORD

I. In the conference, agreement to the precise wording of my recommendations was established with SLSNZ and Tauranga City Council, being:

> *That SLSNZ and Tauranga City Council will work collaboratively to undertake a coastal risk assessment and agree an implementation plan which will identify the locations where signage and rescue equipment will be beneficial to public safety.*

II. I make it accordingly.

III. Given the goodwill that exists between the two organisations I do not consider it necessary to be more precise than this.

IV. Although I make no further formal recommendations, I urge other councils to take note of this partnership between SLSNZ and Tauranga City Council and consider how they might adopt a similar 'Gold Standard' approach. It is beyond obvious that the risks discussed in these findings are not restricted to the Tauranga district; our narrow Land of the Long White Cloud is, after all, surrounded by water.

V. To this end, I have directed that these findings are distributed to the Chief Executives of all councils of New Zealand.

Further comments

VI. In the report I have from SLSNZ, they have also helpfully summarised their current key safety messages in relation to similar circumstances. These messages are well known, and I do not consider it necessary to formalise them as recommendations under the Act.

VII. However, they are set out below by way as a reminder to us all:

- *If you see someone in trouble in the water, call 111 & ask for the Police.*
- *Know your limits. Don't overestimate your ability in the water.*
- *Always take some form of floatation when attempting a rescue.*

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

Fire

Blackett [2023] NZCorC 60 (17 May 2023)

CIRCUMSTANCES

Karl Frederick Blackett, aged 59, died on 13 January 2022 at 155 Shaw Avenue, New Brighton, Christchurch, of smoke inhalation due to house fire.

Mr Blackett lived in a residential property situated in New Brighton, Christchurch, along with six other individuals. The house was divided into units and also included a separate sleepout.

During the early hours of 13 January 2020, emergency services received several calls regarding a house fire at Mr Blackett's residence. The fire services promptly responded to the scene and extinguished the fire. Mr Blackett was found unresponsive in his locked bedroom and was declared deceased at the scene.

Fire and Emergency New Zealand ("FENZ") carried out an investigation into the incident and noted that they could not identify a specific point of origin or cause of fire. However, they concluded that the fire started in Mr Blackett's room.

FENZ established that there were more smoke alarms installed than required by relevant legislation at the property however the alarms in the two units of the house were not interconnected. The FENZ investigation noted that the occupants of the house lived in a flatting situation with all bedrooms being lockable and with no identified evacuation plan for the residents of the house across the separate units in the property, however, this is not required by current legislation.

COMMENTS OF CORONER DUGGAL

I. While there were smoke alarms through the house, they were not interconnected. Interconnected alarms can alert occupants at an earlier stage of a fire thus increasing their opportunity to escape the fire. Further, the property contained separate units, with lockable doors. There was no requirement in relevant legislation for an evacuation plan in such residences.

II. The Ministry of Business, Innovation and Employment (MBIE) is responsible for setting regulatory requirements regarding smoke alarms in residential housing. MBIE is consulting on proposed changes to the regulations on the circumstances in which interconnected alarms are required. A copy of this finding and the FENZ report will be provided to MBIE for consideration as part of its consultation process on interconnected alarms and evacuation plans in circumstances such as at this property.

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

Leisure Activities

Clausen [2023] NZCorC 77 (30 June 2023)

CIRCUMSTANCES

Anthony Paul Clausen, aged 47, died at Takapuna, Auckland on 21 January 2023. The cause of death was drowning, as a result of a shallow water blackout.

Anthony was described as fit and healthy, and was a confident, strong swimmer. He had previously been a scuba diving instructor.

At the time of his death, Anthony was visiting New Zealand from the UK with his wife and their two daughters. They had been staying at an apartment block in Takapuna with a private swimming pool available for the block's occupants.

On the morning of 21 January 2023, Anthony told his wife that he was going to practise holding his breath at the bottom of the pool. He had done this the day prior for three minutes and wanted to see if he could hold it for longer.

Anthony went to down to the pool on his own at some point between 9:45am and 10:00am. About ten minutes later, Anthony's wife was made aware that he needed help and rushed to the pool. Family members had already brought Anthony to the surface and out of the water. He was lying by the poolside unconscious with blood coming from his nose and mouth. They commenced CPR until ambulance services arrived, but sadly Anthony was unable to be revived.

A post-mortem examination of Anthony confirmed that he drowned. The pathologist noted that Anthony had a mildly enlarged heart (cardiomegaly), which may cause an abnormal rhythm disturbance which can lead to unconsciousness. The pathologist also commented that one way to achieve a longer breath hold is to hyperventilate prior to entering the water. This action "blows off" excess carbon dioxide from the lungs. Carbon dioxide is a gas which drives a person's respiration. By exhaling as much as possible before entering the water the desire to inhale while under the water is diminished. This is an action that some free divers perform before diving. The risk with this procedure is that the drive to breathe is diminished, so even though oxygen levels are reducing, there is no impulse to take a breath. If the oxygen levels become too low, then the person will become unconscious and drown. This phenomenon is known as "shallow water blackout"

While it was not known if Anthony attempted to hyperventilate in this manner, the Coroner accepted that the evidence supported a finding that it was most likely Anthony drowned as result of a shallow water backout.

RECOMMENDATIONS OF CORONER MILLS

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

a. The evidence indicates that Anthony died from drowning because of a "shallow water blackout". A shallow water blackout is an underwater "faint" due to a lack of oxygen to the brain. It is brought on by holding your breath for a long period of time. Shallow water blackout is most common amongst physically fit swimmers, spear fishermen and free divers.[8]

b. Shallow water blackout often occurs without any warning, and without an immediate rescue, the swimmer very quickly drowns. Unlike a "regular drowning" where there can be 6 to 8 minutes before brain damage and death, there is only about two and a half minutes before brain damage occurs then death as the brain has already been oxygen deprived.[9]

c. Many people enjoy the pleasures and challenges of free diving, spear fishing, underwater swimming and holding their breath under the water. Children and young people often play breath holding games under the water. Repetitive breath-holding however increases risk of shallow water drowning, as does hyperventilating prior to entering the water.

d. Tips to prevent shallow water blackout include:

i. never hyperventilate before entering the water.

ii. never ignore the urge to breathe.

iii. never swim alone - even confident, ambitious swimmers can drown – you don't have to be a novice or poor swimmer to find yourself in difficulty. Supervision is vital at all times.

iv. never play breath holding games.

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[8] www.shallowwaterblackoutprevention.org; shallow-water-blackout.pdf (swimtawa.org.nz)
[9] Ibid

v. if you are breath-holding for any reason, a buddy should be next to you, tapping you on your shoulder so you can signal that you are OK. Their total focus needs to be you and your safety. They should never breath-hold with you. Do not rely on lifeguards as shallow water blackout is difficult to detect above water.

II. Further information and advice on preventing shallow water blackout can be found on the website www.shallowwaterblackoutprevention.org and shallow-water-blackout-factsheet.pdf (dpanz.org.nz). I would encourage free divers, spear fishermen and anyone contemplating practising holding their breath to familiarise themselves with the risks associated with shallow water blackout and the steps that can be taken to minimise the risk of this occurring.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of: (i) any evidence that relates to Mr Clausen's children, in the interests of personal privacy and justice; and (ii) any photographs taken of Mr Clausen during the course of the inquiry, in the interests of decency.

Lee and Rasiwala [2023] NZCorC 69 (1 June 2023)

CIRCUMSTANCES

Ashwini Rasiwala, aged 20, and Kevin Kum Fike Lee, aged 22, died on 6 February 2020 from drowning while attempting to cross the Makarora River near the confluence of the Makarora and Young Rivers.

On 2 and 3 February 2020 there was a significant weather event which impacted heavily on Fiordland and Mount Aspiring National Park. Up to 300 millimetres of rainfall was predicted in a 48 hour period. The weather event meant that:

(a) The Young River Link Track was closed until 4 February. When it reopened, an updated alert on the DOC website and in the Wanaka Visitor Centre warned that the rivers and streams within Mount Aspiring National Park would still be swollen.

(b) Commercial jet boat operators did not operate on the Young and Makarora Rivers between 3 and 7 February because they were in flood. Hayden Blackburn, a jet boat driver for approximately 15 years, said that the rivers were approximately two metres above normal levels.

The weather on the morning of 6 February 2020 was clear and it had not rained for more than 24 hours. However, river levels were still higher than normal and running at twice their background flow. The rivers did not revert to normal flows until 8 February.

On 4 February 2020 Kevin uploaded a post on social media with a photo of Crucible Lake, which is a side trip on the Gillespie Pass Circuit. He asked if anyone wanted to join him on a tramp leaving either the next day or the one after. The post explained that the destination depended on the weather, which was expected to clear in most parts of the South Island.

Nobody took up Kevin's invitation. He and Ashwini left Dunedin on 5 February 2020. They did not advise any friends or family of their intended plans. A sleeping mat and sleeping bag were in Ashwini's pack. Kevin's computer at home had

open the Gillespie Pass Circuit webpage. This indicates that they were intending to complete a multiday tramp of the circuit.

Kevin and Ashwini's precise movements are unknown after they were captured on CCTV footage purchasing food in Alexandra just after 9:00pm on 5 February 2020. However, Kevin's car was later found in the Young Valley carpark, near the start of the Gillespie Pass Circuit.

Gillespie Pass Circuit

The Gillespie Pass Circuit is a multiday, 58 kilometre loop in Mount Aspiring National Park that can be walked in a clockwise or anti-clockwise direction. The circuit is classified by the Department of Conservation (DOC) as an advanced tramping track for experienced parties.

Trampers who enter the Gillespie Pass Circuit on foot do so by following orange markers across farmland from the Young Valley carpark and then walking along the true left of the Makarora riverbank until reaching the confluence of the Young and Makarora Rivers. They then need to cross the Makarora River to its true right to start the circuit proper. As the river frequently changes its course, the crossing point is not signposted, and trampers are encouraged by a DOC sign at the carpark to identify for themselves a safe crossing point.

There are two ways to access the Gillespie Pass Circuit without crossing the Makarora River on foot:

(a) Trampers can start at the Blue Pools carpark, approximately seven kilometres north of the Young Valley carpark. They cross the Makarora River by bridge near the Blue Pools carpark and then tramp along the Young River Link Track on the true right of the Makarora River to the start of the circuit proper. This adds about two and a half hours to the tramp that would otherwise start at Young Valley carpark.

(b) Trampers can arrange, and pay for, jet boat transport from Makarora township to the confluence of the Young and Makarora Rivers. They disembark on the true right of the Makarora River to start the circuit proper.

Discovery

Ashwini's body was located on 7 February 2020 in the Makarora River about 10 to 40 metres upstream from (north of) the confluence with the Young River. Kevin's body was located on 8 February 2020 about five metres downstream from where Ashwini's body was found.

Mountain Safety Council

Mountain Safety Council New Zealand (MSC) provided the coroner with a report identifying possible contributory factors to Ashwini and Kevin's deaths. The report writers opined that the most likely scenario was that they entered the Makarora River at or near the end of the poled track with the intention of crossing it to start the circuit proper, but fell into the river before they completed their crossing.

The Coroner made the following findings:

a) Kevin was an experienced New Zealand tramper but with unknown experience in river crossings.

b) Ashwini was an inexperienced tramper.

c) The Makarora River was at higher than normal levels and flowing at a higher than normal rate on the morning of 6 February 2020.

d) Kevin and Ashwini decided to cross the river.

e) During their attempted crossing, Kevin and Ashwini were swept off their feet and into the river.

f) Kevin and Ashwini each drowned as a result.

RECOMMENDATIONS OF CORONER HO

I. Part of the purpose of a coronial inquiry is to consider whether any recommendations might reduce the chances of future deaths in similar circumstances.

II. Ashwini and Kevin's deaths raise questions about whether anything can or should be done to warn people about the dangers of crossing at this specific location as well as to generally educate those who might encounter river crossings on their tramps.

Signage at this river crossing

III. DOC reviewed the sign which Ashwini and Kevin would have encountered on 6 February 2020. It was presented in the same colours and font as other DOC information and wayfinding signs, being gold text in DOC's standard serif font against dark green:

IV. I consider that there were several issues with this sign which meant that the safety information was not presented as plainly and clearly as it could have been, and which meant that readers lacked the appropriate context to determine whether it was safe for them to proceed with the crossing:

a. The sign was erected near the carpark and not near the river. It is not possible to see the river from the sign. DOC explained that the sign was located where it was to enable visitors to easily return to their nearby car to make alternative transport decisions if they chose not to cross the

river. However, the inability to see the river from that location meant there was no ready reference point against which visitors could compare the warned danger.

b. In any event, the sign did not include any context about what would be considered a high river flow or provide any information or tools to assist visitors in assessing whether, when they subsequently encountered the river, there was a high flow. It is impossible for visitors reading only the sign to benchmark the state of the river against what is "normal".

c. No information about alternative crossings is presented. Unless exceptionally well researched, visitors encountering the sign are unlikely to know that an alternative exists.

d. The safety critical message ("do not attempt to cross during high flows") is not prominently displayed on the sign such as through red or typical warning colours, use of borders or use of different fonts. The information is presented in the standard DOC design with nothing to indicate the importance of the information contained on it except for an exclamation mark symbol in inverted colours. Further, the sign sandwiches the safety critical message between guidance information ("the track markers are only a general indication of where to cross") and a request for courtesy ("please respect the landowner's property").

V. As to the latter point, DOC's 2019 Best Practice Guidelines state that specific hazard warning signs (red and white) should be minimised in the backcountry because visitors are expected to have skills and experience that enable them to recognise hazards and adopt appropriate behaviour. The Guidelines say that the exception to this should be where hazards are not easily recognisable or where vulnerable visitors are present in sufficient numbers to warrant hazard warning signage to compensate for their lower skill and experience level. The Guidelines note that hazard warning signs should be noticeable and readily understood and provide guidance about how this can be achieved, for example by being a shape, size and colour that attracts attention and with large and well spaced text in easily read fonts with a statement of the hazard and an example of possible consequences. To assist specific hazard signs to be compliance-inducing the Guidelines recommend that they be located near the site of the hazard.

VI. It is unclear to me why DOC considers that hazard warning signs should be minimised in the backcountry based on its assumption, possibly erroneous, of visitor skill experience. It is inexperienced river crossers and vulnerable visitors that are most likely to get into trouble, and who would therefore derive the most benefit from hazard warning signs. DOC itself concedes that vulnerable visitors are present at the Young Valley carpark; and Kevin and Ashwini's deaths show that it is unrealistic to expect visitor experience levels for any particular track to necessarily align with those anticipated by DOC. This is especially so given:

a. DOC's own observation of a considerable increase in visitors to the Mount Aspiring region in the years leading up to 2020, including international visitors who are less likely to appreciate or be equipped to navigate the risks posed by the New Zealand backcountry;

b. the prevalence of information outside DOC managed publications (for example, through social media) about backcountry circuits and which do not necessarily carry commensurate warnings about the skill levels or experience needed to safely complete the excursion; and

c. the fact that the Makarora river crossing forms part of an established DOC track circuit, and which might give the impression to intending trampers that the condition of the river crossing was more organisationally managed, and therefore safer, than it in fact is.

VII. These issues appear to have now been recognised, at least in part, by DOC. After Ashwini and Kevin's deaths DOC installed two new signs at Young Valley carpark in an attempt to better inform all visitors about the hazards before they start their trip or attempt the river crossing, including less experienced trampers who might be considered vulnerable in this particular situation. The two new signs comprise:

a. A green and yellow DOC sign "Access to Young Valley":

> This track crosses private land. Please respect the landowner's property.
>
> The Gillespie Pass Circuit requires crossing the Makarora River twice. This river can become impassable after rain.

VIII. A red and white warning sign:

IX. The new signs improve over the old sign in that it now separates guidance and warning information; and the warning sign attracts attention through its use of colour, graphic symbol and the message that fatal consequences have resulted. However:

a. The warning sign is still located by the carpark and not the river. There remains a lack of immediate context for trampers to assess the relevant risk.

b. There is no information about what constitutes high or fast flow.

Location of warning sign: carpark or river?

X. DOC's Visitor Safety Manager, Nicholas Sutcliffe, advised that the warning sign would not be appropriate by the river. He raised concerns that the sign could be washed away during flooding or could be interpreted by visitors as indicating a recommended crossing point. He noted that placing the sign in the carpark allowed visitors to immediately select one of the alternative transport options outlined on the sign without having to backtrack. Mr Sutcliffe stated that DOC was confident that the carpark location was close enough to the river for visitors to remember the warning when they reached the crossing point.

XI. The choice of where to erect the danger sign is not binary. It is open to DOC to erect signs at both locations and, if necessary, adapt the language on the second sign to warn that the best crossing point may change with the river flow and that the proximity of the sign to the river does not necessarily indicate the best place to cross. The sign at the carpark is out of context in that it warns of a danger of a natural hazard which the reader cannot see and, at that stage of their journey, has no ability to envision. I therefore do not share DOC's confidence that visitors will, when they reach the river, be able to recall or apply detailed guidance from a carpark sign which would to them have likely been abstract information at the time they encountered it.

XII. I recommend that DOC consider erecting a similar dangerous river crossing warning sign by the river.

Information about high flow: necessary or confusing?

XIII. Mr Sutcliffe advised that it is rarely possible to provide a definitive description of what river conditions are safe and unsafe. He says that this will vary between individual trampers. He is concerned that providing objective information about high flows, such as a photograph, would lead visitors to not exercise their own judgement and attempt to cross in conditions that were not safe for them. Mr Sutcliffe says that DOC endeavours to support visitors to make good decisions themselves by providing links on the DOC website to river crossing resources and sharing those resources on social media.

XIV. I confess that I do not entirely understand DOC's response to this issue. It seems fallacious to suggest that it is useful to provide educational resources including objective information about river crossings and high flow through the internet and social media but not to provide that same educational resource to the people who are actually standing in front of the river and about to make a judgement about whether that river is safe to cross. It seems to me that an equally useful place to provide that educational resource is on a physical information panel at that hazard rather than relying on visitors to recall information which they might or might not have viewed or committed to memory through an internet search some time prior.

XV. I recommend DOC consider erecting an information panel at or near one of the danger signs containing the same educational information about river crossings and high river flows. I am conscious that there is a concern about what DOC terms "signage fatigue", in which visitors are less likely to read

and engage with signs if there are too many, but this is less likely to occur if the accompanying information panel is confined to providing the primary indications of an unsafe river crossing, such as those set out DOC's own webpage for the Gillespie Pass Circuit or the general key points set out at [XXIII (b)] below. Consideration could also be given at appropriate locations where there is adequate cellphone coverage of providing a QR code which could link to a webpage providing more detailed information.

Website information update for the Gillespie Pass Circuit

XVI. Information about the circuit can be accessed from the DOC webpage.[10] Immediately displayed on the page are a scenic photograph taken from the circuit and brief information about the current weather, type of track, and the length of and estimated duration to complete the circuit. There is a small map showing where the circuit sits within Mount Aspiring National Park.

XVII. There are also three collapsible feature boxes located below this information, titled "description", "getting there" and "know before you go". Collapsible feature boxes allow web designers to group more content together on a page without overwhelming visitors. Each box can be individually collapsed or expanded to create an accordion effect.

XVIII. Following Ashwini and Kevin's deaths DOC updated the website copy under the "description" box. The following appears in an inset grey box. The new text included by DOC is marked in italics below but is not given any prominence in the website copy:

> You should only do Gillespie Pass if you're experienced with river crossing skills. *All river crossings on this Circuit are challenging. Multiple fatalities have occurred in rivers on this track in recent years.* Be aware rivers can become impassable after rain.

XIX. Under the third "know before you go" box, there appears as a subheading under the main heading "Flood and river hazards":

> **Makarora River**: Be aware that the water in the Makarora River may not show signs of high flow – such as looking discoloured, cloudy or muddy. The river flow may be more dangerous than it appears.
>
> **Stay safe when crossing rivers**
>
> If you plan to cross unbridged rivers, know how to cross safely and be prepared for if you cannot cross.
>
> Do not cross if the river is flooded, you cannot find safe entry and exit points or are unsure it's safe. Turn back or wait for the river to drop. If in doubt, stay out.
>
> https://www.mountainsafety.org.nz/learn/skills/river-safety/ [external link to MSC webpage including video]

[10] https://www.doc.govt.nz/parks-and-recreation/places-to-go/otago/places/mount-aspiring-national-park/things-to-do/tracks/gillespie-pass-circuit/

XX. The authors of the MSC report are unhappy with the placement of this information within the webpage. They say that its placement at the bottom of an accordion of information risk it being overlooked by visitors. I agree that this is safety critical information which should be prioritised in placement over less important information on the same page.

XXI. DOC notes that in total river safety messages appear four times on the website page and that there are also river safety messages in the linked brochure. DOC's Senior User Experience Advisor, who specialises in the effective, impactful presentation of digital content considers that the safety information is strongly emphasised on this page.

XXII. I do not make any recommendations in relation to the webpage but encourage DOC to continue to ensure that safety critical messages are prominently communicated.

General education about river crossings

XXIII. MSC has issued the following guidance for those who intend to tramp a track with unbridged rivers:

a. Learn how to assess whether a river is safe to cross and how to cross safely. Videos, guides and eLearning courses are freely available on MSC's website at https://www.mountainsafety.org.nz/learn/skills/river-safety

b. When encountering an unbridged river, stop and assess whether it is safe to cross. Signs that a river is unsafe include:

i. water moving faster than normal walking pace;

ii. discoloured, cloudy or surging water;

iii. visible debris in the river such as tree branches;

iv. the sound of rolling boulders on the riverbed.

c. Carry a form of emergency shelter such as a tent or tarpaulin so that if a river is assessed as unsafe to cross there is no pressure to cross to get to a hut for shelter.

d. Be prepared to turn back or change route to avoid the need to cross a dangerous river.

XXIV. Those intending to cross rivers as part of their tramp should ensure they have reviewed the above guidance and that they are confident in implementing it.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Ashwini Rasiwala and Kevin Lee taken during the investigation into their deaths, in the interests of decency and personal privacy.

Potter [2023] NZCorC 51 (27 April 2023)

CIRCUMSTANCES

Brian John Potter, aged 66, died on 20 September 2022 at Auckland Hospital from complications of blunt trauma to the head arising out of a road bicycle accident.

On 18 September 2022 Mr Potter left his home address for a regular Sunday bicycle ride with a casual group of other cyclists. He was riding his Pinarello Dogma 2 road performance bicycle which is suitable for pavement uses including racing, touring, fitness riding, long distance rides and daily commute.

At about 7:30am Mr Potter and ten other riders gathered at Dairy Flat Highway by Foley Quarry Road intersection and then started riding north along Dairy Flat Highway towards Silverdale. They were mostly travelling single file along the left side of the northbound lane.

The group built up speed as they progressed on to a downhill section of the highway approaching Potter Road intersection. A few riders started overtaking others, reaching speeds of approximately 50 km/h. The downhill gradient was gradually reducing as the cyclists proceeded north.

Mr Potter went to overtake others in the group as they rode past Potter Road intersection through a mild right hand bend. In doing so, his front wheel clipped another rider's rear wheel, causing both to lose control and fall off their bikes on to the road surface. The force of the impact cracked the left side of Mr Potter's helmet. He was found unconscious and was taken to Auckland Hospital. His condition deteriorated and he died two days later.

The Waitematā Police Serious Crash Unit (SCU) investigated the accident and noted that the New Zealand Code for Cyclists (the Code) recommends that riders ride single file on hills. The SCU found that Mr Potter's decision to overtake may have contributed to the crash by reducing the margin of error for safe riding and increasing the risk of more significant consequences if a loss of control occurred.

Mr Potter's helmet was fractured from the impact. The SCU report noted that a helmet does not provide absolute protection. Impacts which exceed the capacity of the helmet, such as in this case, can still result in head injuries.

COMMENTS 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. I make the following comments pursuant to s 57A of the Coroners Act.

II. Some cyclists in the group opined that it was not safe to overtake at that location because of the median barriers and the downhill slope. It is prudent for cyclists to review the Code and refresh their minds about safe cycling.

III. Cycling websites recommend that riders who are travelling in a group should have a pre-ride briefing covering topics such as communication, bike handling and positioning within the group.

IV. Mr Potter was wearing a helmet. A helmet is designed as a compromise between various factors including impact management, cooling, weight, and cost. Therefore, while a helmet offers a lot of

protection, its capacity can be exceeded and a person wearing a helmet can still be injured. It is still important to ride safely while wearing a helmet.

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

Simpson [2023] NZCorC 67 (23 May 2023)

CIRCUMSTANCES

Stephanie Jane Simpson, aged 32, died on 8 February 2020 at Pyke Creek in Mount Aspiring National Park from drowning occurring in the context of severe blunt force trauma.

On 7 February 2020 Stephanie parked her car in the Fantail Falls carpark, which marked the start of the Brewster Track leading to the Brewster Hut in Mount Aspiring National Park. Stephanie was an experienced tramper and was wearing a Garmin GPS watch for her solo tramp. Data recovered from the watch showed that Stephanie began walking up to the Brewster Hut at 10:39am via the track. She reached Brewster Hut at approximately 12:34pm, one hour and 55 minutes after she started. The Brewster Track is managed by the Department of Conservation (DOC) and the usual time allowed to complete the track is three hours. DOC indicated that Stephanie may have been trail running the track rather than tramping it.

Stephanie's Garmin watch showed she had a 26 minute break at Brewster Hut and left in the direction of Mount Armstrong at 1:09pm. However, rather than continuing to the summit of Mount Armstrong, Stephanie began to contour towards the Brewster Glacier at about 1,700 metres' altitude. She eventually turned around before reaching Brewster Glacier but instead of taking the same route back Stephanie was drawn down into the steep upper headwall of Pyke Creek and dropped down into the valley. Her pace slowed considerably once in the valley as she continued down into the creek's gorge.

After about two hours in the gorge Stephanie's GPS stopped recording. She stopped to rest about 750 metres downstream from when her GPS stopped recording. Stephanie removed her boots and left them neatly about 10 metres away from the creek edge. The section of Pyke Creek where Stephanie was found consists of swift moving white water. For unknown reasons, Stephanie subsequently approached the creek in her socks and involuntarily entered the water, likely as the result of a trip or fall. Stephanie drowned as a result.

RECOMMENDATIONS OF CORONER HO

I. I make the following comments or recommendations under s 57A of the Act for the purpose of preventing future deaths in similar circumstances.

Department of Conservation investigation

II. After Stephanie's death DOC reviewed its communications and policies about the Brewster Hut area. While DOC does not promote or maintain facilities, including tracks, beyond Brewster Hut, DOC identified some factors which could have led visitors like Stephanie into believing that the area was more controlled than it was. This included the use of the word "track" in a DOC brochure to describe

the access through the rocky terrain above Brewster Hut and an information panel in Brewster Hut providing guidance on how to access Mount Armstrong.

III. DOC made several internal recommendations to update its visitor information, including on-site hazard signage, to ensure that Brewster Hut and its surrounding access was managed for the appropriate visitor group. Andy Roberts, DOC's Visitor Safety Manager, gave evidence shortly after Stephanie's death that while the Brewster Track is managed for "backcountry adventurers" (who are expected to have generally moderate to high backcountry skills and experience and who DOC classifies as having the second highest level of risk tolerance), the area above Brewster Hut, including the unmarked and informal access route from the hut to Mount Armstrong, is designed for "remoteness seekers". DOC classifies remoteness seekers as having the highest level of risk tolerance and who have strong backcountry skills and experience.

IV. Mr Roberts also identified that the growth of social media has led to more visitors with less experience and skills than recommended to undertake a particular access, thus increasing the risk of serious or fatal consequences to them. In particular, he noted that DOC has been concerned that the Brewster Track had been increasingly attracting people with a lower risk tolerance and skill ability than was ideal.

V. At the close of my inquiry Nicholas Sutcliffe, Mr Roberts' successor, provided an update on the work that DOC had done since Stephanie's death. Mr Sutcliffe stated that DOC's website and on-site safety information for the Brewster Track had been reviewed and updated. As to the latter, there is now a warning sign in Brewster Hut informing visitors that the area beyond the hut can be hazardous and that there is no hazard management or visitor infrastructure. Mr Sutcliffe advised that DOC also continues to monitor the evolving profile of visitors and changes in the way they use the site; and continues to evaluate and refine its management to ensure that it remains fit for purpose.

VI. I cannot say whether, if the warning signs there today had been there in 2020, Stephanie would have been dissuaded from moving beyond Brewster Hut. The evidence was that she was an experienced tramper with a strong level of fitness. It may have been that such changes would have made no difference to the eventual outcome for Stephanie. However, any improvements to communication messages about the difficulty level of the track and access around the Brewster Hut, and which make clear that there is no marked or maintained access beyond Brewster Hut, can only be beneficial to visitors.

Mountain Safety Council advice

VII. In addition to the issues around navigation and weather identified above, the MSC report writers noted two further factors which might have contributed to Stephanie's death. First, Stephanie did not appear to have a distress beacon which she could have activated for help. Second, Stephanie was walking alone, increasing the risk of not being able to seek timely help if she got into difficulty.

VIII. The MSC encourages all recreating in the backcountry to consider the following:

a. **Choose the right trip for you.** Make sure your experience level matches your objective and that you are well prepared for your trip. Tramping off-track requires experience and skills, especially in terrain such as the area towards the Brewster Glacier. Make sure objectives like this sit within your comfort zone, particularly if venturing alone.

b. **Understand the weather.** Be prepared to change your plans due to the hazards which weather can bring. This does not just mean be prepared for rain or snow; warm and humid conditions can also be hazardous, and cloud cover can affect visibility, leading to navigational challenges. When changing your plan, weigh up the risks that may be involved in the new plan, particularly if it involves going off track.

c. **Pack warm clothes, extra food and a backup means of navigation.** Maps on phones or watches are excellent for getting around terrain, but it's important to have a backup in the event the primary method is unusable. A protected paper map and compass are typically most reliable because they do not need batteries or electronic signal.

d. **Carry emergency equipment** such as a first aid kit that includes a survival blanket and an emergency shelter, especially when heading above the bush line.

e. **Share your plans.** Leaving detailed information about an itinerary with a trusted contact will allow search and rescue teams to be activated and reach the location sooner. Online resources such as planmywalk.nz offer an easy way to do this. It is also useful to leave clear intentions in hut books, even if not staying there overnight, to narrow down search parameters and provide hut occupants a reference point when concerned about a person's plans or whereabouts.

f. **Take ways to get help.** All trampers should carry a distress beacon (either satellite messenger or Personal Locator Beacon) and particularly when intending to travel in remote areas with no cell coverage.

g. **Take care of yourself and each other.** Focus must be maintained throughout your trip, particularly when off-track. Pacing, route-finding and other techniques may have to adjust to being physically and mentally tired. Paying attention to where you have come from can greatly assist if needing to backtrack.

IX. The MSC report writers also stated that extra emphasis should be placed on the above guidance when tramping solo. Margins for error in relation to the ability to call for help, self-evacuation, self-monitoring and decision making are smaller when tramping solo. The MSC recommends in terrain such as that around Brewster Hut and Mount Armstrong that trampers travel in small groups where possible.

X. These safety messages are already well publicised in New Zealand through a variety of sources. However, they bear repeating and emphasising. They may also not be well known to international tourists. For that reason, it is useful to publish them as coronial recommendations so that they reach as wide an audience as possible.

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

Medical Care

Croft [2023] NZCorC 59 (15 May 2023)

CIRCUMSTANCES

Michael Allan Croft, aged 69, died on 9 November 2016 at Southland Hospital of multiorgan system failure due to a small bowel perforation with peritonitis.

Mr Croft had a para-umbilical hernia, along with several other health issues. On the evening of 31 October 2016, Mr Croft sustained an injury while lifting the catcher on his lawnmower. He saw a general practitioner, Dr Andrew Costello, the following day and was referred to Southland Hospital for a possible incarcerated hernia.

At the time of Mr Croft's presentation to hospital, Southern District Health Board (now known as Te Whatu Ora Southern) outsourced various x-ray reporting to Everlight. Everlight generally reported within 48 hours of receipt of a patient's complete set of studies in non-urgent or routine matters. This was a routine reporting/nominal internal timeframe and not a contractual requirement.

Mr Croft had surgery on the evening of 3 November 2016, and a follow up gastrografin study and abdominal x-ray on 5 November 2016 which was sent to Everlight that day. Mr Croft's chest x-ray was also sent to Everlight the following day for reporting.

At the time, all gastrografin x-rays were reported back with "routine" or "non-urgent" priority unless Southland Hospital stipulated or otherwise agreed a report was urgent. Everlight did not receive a request from Southland Hospital to escalate Mr Croft's image reporting to urgent. Southland Hospital also allocated the 5 and 6 November x-rays the same Accession Number and Instance IUD. This resulted in them being grouped together as a single study.

Mr Croft's clinical progress fluctuated, but as at the evening of 7 November he had significantly deteriorated. On 8 November Mr Croft had an urgent CT scan and a second operation done. Also on 8 November, Everlight relevantly reported on the 5 November x-ray, recommending an urgent CT scan in relation to the 5 November x-ray findings (the CT scan had already been arranged given Mr Croft's clinical deterioration). Mr Croft sadly passed away in Southland Hospital early on 9 November 2016.

The Coroner found that while faster reporting of the x-ray of 5 November 2016 would have been of assistance, it would not have made a material difference to Mr Croft's clinical management.

RECOMMENDATIONS OF CORONER MCKENZIE

I. 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.

II. I consider that the primary area in which recommendations might be made is in relation to the processes and practices of handling the 5 November x-ray, via-à-vis both Everlight and Southland Hospital/Te Whatu Ora Health New Zealand Southern.

III. Everlight did not breach any contractual reporting timeframes. The 48 hour timeframe was a nominal internal timeframe usually used for non-urgent matters.

IV. Southland Hospital did not escalate the x-ray to urgent, which would have engaged a contractual timeframe, and it assigned the same Accession Number and Instance UID which saw the studies grouped together. Everlight sent a delay email(s) which relevantly prompted sites to contact Everlight if there were any studies "that you wish to prioritise." I do not understand Southland Hospital to have sought to prioritise Mr Croft's 5 November x-ray in the light of this delay email (in any event, the CT scan was in the process of being done by the time the email would have been received), but note that the request for the report was sent several times. Also, once assigned to Dr Lyons, the studies were reported on in a timely way and sent to the site.

V. I do not have before me the intricacies of Everlight's operations and, more particularly, the cause of the delay in assigning Mr Croft's 5 November study. I have not sought this because Everlight is no longer providing reporting to Te Whatu Ora Health New Zealand Southern, but more so because the greater issue for the purposes of considering recommendations, which are future-focused to avoid deaths occurring in similar circumstances, lies in the practices and processes for assigning a reporting timeframe to an x-ray and this responsibility rests with the requesting site. Further, Everlight was not in breach of any contractual requirements as noted.

VI. In a report for this inquiry dated 8 July 2019, Everlight relevantly made recommendations about the escalating of urgent x-rays and the reporting of significant or unexpected findings as I have set out. It updated its policy in 2018.

VII. In his statement dated 22 September 2019, Dr Lott on behalf of Everlight advised that the 2018 amendments increased the number of listed conditions which, if identified, required a radiologist to notify the responsible person at the hospital site by telephone and to record the details of the time of notification and person contacted in the appropriate documentation. Everlight also introduced an easier reporting / entry mode for significant findings into its reporting interface.

VIII. In these circumstances, I do not make any recommendations directed at Everlight.

IX. I now turn to any recommendations directed at Te Whatu Ora Health New Zealand Southern in relation to the practices and processes in assigning the priority/time frame for x-ray reporting and use of the same accession numbers and Instance UIDs.

X. I have not found that doctors should have escalated Mr Croft's x-ray to urgent on 5 November on the clinical picture then before them. I have observed however that consideration could have been given to escalating the x-ray to urgent at a later time. Urgent reporting would have complemented Mr Croft's

clinical observations and may have prompted a change in management, especially when it is considered (with hindsight) that the 5 November x-ray report recommended an urgent CT scan.

XI. The then arrangement in place saw a gap between reporting on an urgent x-ray within one hour and a routine one within, notionally, 48 hours. The new arrangement is more nuanced as I have set out, including semi-urgent reporting within 24 hours. Te Whatu Ora Health New Zealand Southern has advised this inquiry of anticipated improvements with the new provider:

a. MITs [Medical Imaging Technologists] will be able to select priority for reporting in a computer interface, rather than there being a 'routine' default with a change in urgency needing to be phoned through.

b. Priority can be set by time of day, for example at Southland, all CT exams after 2300 hours would be considered urgent.

c. [The new provider] will provide a 'portal' which Southern DHB staff are able to login to (securely) to track the progress of examinations outsourced for reporting.

d. Additional priorities- instead of "Urgent" (2 hours) and "Routine" (72 hours), there are four:

i. Urgent 90% of reports returned in 60 minutes 100% returned in 90 minutes;

ii. Semi-Urgent 95% within 24 hours (we intend to use this for non-urgent inpatients);

iii. Routine 95% within 48 hours (suitable for most outpatients) and;

iv. Low Urgency 95% within 5 days (Southern DHB electing not to use this category).

XII. With respect to how clinicians manage reporting priority, the Southern DHB also advised in a report of 2 June 2021 (in response to various questions):

> Yes, all gastrografin abdominal exams are reported with routine priority. This occurs unless the clinician decides to escalate the priority level of the case and communicates this with Everlight.
>
> Clinicians do have the discretion to escalate reporting priority of gastrografin exams. In practice, this is done by the clinician informing the Medical Imaging Technologist (also known as 'MIT') to escalate the priority. The MIT will then contact Everlight by telephone to advise them of a change in reporting priority.
>
> The clinicians are in charge of deciding whether to escalate the priority of matters. In practice, once the x-ray is conducted, the clinician will view a copy of it prior to Everlight being sent the x-ray to report on. The clinician's knowledge of the patient's symptoms and the look at the copy of the x-ray will determine the clinicians view on whether the priority level should be elevated from routine.
>
> There is no fixed protocol for escalating reporting time for Everlight. Due to the variation of each patient and the differing needs for care when they arrive at Southern DHB, the decision of clinicians as to when to escalate reporting times is up to the clinician. This decision will be based on the experience and the training of that clinician and the consultation with other clinicians (if that option is explored).

> The clinician who is handling the patient will continue to monitor the patient status. If the patient's status indicates a need for care to be progressed more urgently than initially considered, the clinician will elevate the priority level of both the care and the report. This is able to be done once a routine report has already been requested. The way in which the clinician would elevate the report in this situation is through calling Radiology, asking when the case is going to be reported, or request that Radiology ask Everlight to escalate the reporting priority.

XIII. Dr Wood further advised that x-ray images are all now digital files, so can be viewed on the hospital network independently of being sent for reporting. The images can be viewed by multiple viewers at the same time. In a practical sense, as soon as the Medical Imaging Technician/radiographer completes the x-ray study, the images are ready for review in hospital and are ready to be sent for formal reporting, which could be either a manual or automatic process.

XIV. In the circumstances above of a changed provider with improved and more nuanced time steps for reporting, as well as the evidence of how clinicians review and manage reporting priority as a patient progresses clinically, I do not make any future-focussed recommendations relating to the general practices and processes in assigning a reporting timeframe an x-ray.

XV. However, and following the suggestion of Counsel Assisting, I considered a recommendation directed at Te Whatu Ora Health New Zealand Southern regarding assignment of the same accession number and Instance UID.

XVI. I agree with the potential benefit of the proposed recommendation. Clarity regarding reporting timeframes and education on the risks of grouping studies together (which might delay reporting or make it unclear when reporting is due) may help reduce the chances of deaths occurring in similar circumstances. This is because imaging may be reported on earlier or a different course taken if there would be a known delay in reporting due to grouping numbers.

XVII. Accordingly, I consulted the parties on the following recommendations:

> That Te Whatu Ora Health New Zealand Southern considers at the next contractual round with its relevant imaging provider, or as a variation to its current contract, inserting a clause(s) providing clarity relating to the timeframe for reporting when multiple studies are assigned the same accession number and Instance UIDs. In the interim, I recommend Te Whatu Ora issue guidelines to staff about any implications of assigning the same accession number and Instance UIDs.

XVIII. Te Whatu Ora Health New Zealand Southern agreed with the recommendation. It is willing to insert a clause in future imaging provider contracts that will provide clarity around the use of unique accession numbers and UIDs. Additionally, Te Whatu Ora considered it appropriate to issue guidelines to its staff regarding the correct use of accession numbers and UIDs and the implications of not doing so.

XIX. In these circumstances, I make the recommendations above.

XX. In terms of any other recommendations, I have not identified clear deficiencies material to Mr Croft's death that are amenable to future-focused recommendations. In particular, while I have found that an earlier CT scan, repeat abdominal x-ray, or escalating the 5 November x-ray to urgent might have

been reasonable and informed Mr Croft's clinical picture and management, the results would have had their limitations in what they could have shown. Further, a recommendation must be clearly linked to the factors contributing to death and be expressed in a form able to be actioned going forward. A broad recommendation, for example, that an earlier CT scan or further imaging be done is not workable because, going forward, such a generalised recommendation becomes meaningless in terms of the assessment and management of an individual patient. I cannot make a recommendation that all patients have earlier CT scans and repeat or urgent imaging. The recommendations I have most closely considered making relate to the processes around x-ray reporting timeframes and I have addressed this above. In particular, Te Whatu Ora Health New Zealand Southern has provided evidence that clinicians continue to monitor the patient status and make changes in care or x-ray priority as required.

XXI. I have turned my mind also to whether any recommendations are appropriate in relation to Dr Costello's care of Mr Croft, and the surgeries on 3 and 8 November. I have not found there to be any deficiencies in these matters amenable to future-focussed recommendations.

O'Neill [2023] NZCorC 66 (23 May 2023)

CIRCUMSTANCES

Georgia Lee O'Neill, aged 24, died on 20 September 2021 at Mount Roskill, Auckland from pulmonary thromboembolism secondary to heterozygous Factor V Leiden mutation exacerbated by oral contraceptive pill usage.

Georgia was taking the combined oral contraceptive pill which was prescribed by her general practitioner. On 20 September 2021 at 11:40am, Georgia sent text messages to her flatmate and to her father, stating she was not feeling well and had a lot of pain in her lower back, running down her left leg. Georgia's flatmate replied three times but did not receive a response from Georgia. At 4:30pm Georgia's flatmate found Georgia unresponsive in her bedroom Georgia was pronounced dead at the scene by attending paramedics.

Post-mortem examination identified thrombosis in the right pulmonary artery and Georgia was found to have heterozygous Factor V Leiden mutation. Dr Merriman, Clinical Director Haematology and Lead Thrombosis Clinician at Te Whatu Ora Waitematā, advised that individuals with this mutation have an increased risk of developing a deep vein thrombosis (DVT) or pulmonary embolism (PE) by five to sevenfold, thus increasing their risk from a baseline of 1 in one thousand to between 5 and 7 in one thousand people each year.

Dr Merriman stated that healthy women taking the oral contraceptive pill have a three-to-fourfold increased risk of developing a DVT or PE compared with women who do not take the pill. Women with Factor V Leiden have an approximately 35-fold increased risk of developing a DVT or PE compared with women without Factor V Leiden who are not taking oral contraceptive pills. Dr Merriman noted that the presence of such a mutation does not mean they will necessarily ever develop a DVT or PE, and the absence of such a mutation does not mean they will not develop a DVT or PE.

Georgia had recently received her first Pfizer Comirnaty vaccine on 7 September 2021. The Coroner found no evidence to suggest that this played a role in causing her death.

RECOMMENDATIONS OF CORONER HO

I. Use of the combined oral contraceptive pill increases the risk of developing a deep vein thrombosis or pulmonary embolism. In quantitative terms, the risk remains relatively small, but it is nevertheless increased. The risk also increases with family or personal history of venous thromboembolism.

II. People who take the combined oral contraceptive pill, or those with known risk factors, need to be particularly alert to the signs and symptoms of venous thromboembolism. Medical attention should be sought immediately if there are any of the following symptoms:

a. For deep vein thrombosis:

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. For pulmonary embolism:

i. Unexplained shortness of breath

ii. Rapid breathing

iii. Chest pain anywhere under the ribcage

iv. Fast heart rate

v. Light headedness and passing out.

III. The combined oral contraceptive pill is used by many women. Dr Merriman emphasised that, in general, the consequences of unintended pregnancy can present far greater damage to women than safe oral contraception. The risk of DVT and PE in pregnancy is sixtyfold higher than that from the combined oral contraceptive pill. There are also numerous benefits which women derive from being able to access a reliable and convenient method of birth control.

IV. However, women starting the combined oral contraceptive pill should be counselled that there is an increased risk of venous thromboembolism and advised to seek immediate medical attention if they develop symptoms of DVT or PE. They should also be cautious about attributing such symptoms to pre-existing conditions. It is possible that, had Georgia been more aware about the risks of venous thromboembolism in the context of starting the combined oral contraceptive pill, she would have been more circumspect about attributing symptoms to her pre-existing back condition.

V. In September 2021, another young woman in New Zealand died from pulmonary thromboembolism secondary to heterozygous Factor V Leiden mutation exacerbated by recent commencement of the oral contraceptive pill.[11] I endorse Coroner Anderson's recommendations in relation to that death:

   a. All prescribers of the combined oral contraceptive pill, and other hormone related medications, should ensure they take a comprehensive clinical history and inform patients about the risks of venous thromboembolism, the seriousness of the condition and the symptoms to look out for.

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

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

VI. It is important that the issues raised in relation to the combined oral contraceptive pill are widely disseminated so that future deaths in similar circumstances can be prevented. In addition to public release, I direct that a copy of these findings be provided to Medsafe and the Ministry of Health; as well as the New Zealand Family Planning Association and the Royal New Zealand College of General Practitioners for the attention of their staff and members.

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

Singh [2023] NZCorC 40 (12 April 2023)

CIRCUMSTANCES

Esther Angali Soonafai Singh, aged 17, died on 25 September 2020 at Flat Bush Road, Clover Park of complications of rheumatic fever.

Esther was diagnosed with rheumatic fever in June 2011. The surgery to repair her tricuspid valve was successful, however her mitral valve was not able to be repaired. In January 2012 Esther had further surgery where an artificial mitral valve was placed in her heart. As a result of this procedure, Esther needed to take warfarin, a blood thinning medication, for the rest of her life to prevent blood clots. She also required monthly penicillin injections to help prevent a recurrence of the rheumatic fever that had caused the damage to her heart. The effectiveness of warfarin is monitored through regular blood tests to test clotting levels known as INR tests which check how long it takes an individual's blood to clot.

Between 2012 and 2018, Esther was admitted to Starship Hospital on five occasions due to subtherapeutic INR levels. On each of these occasions, Starship staff provided intensive family education and made home care nursing arrangements for further supervision of Esther's medication and monitoring requirements.

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[11] CSU 2021-AUK-1059.

Esther later developed ventricular ectopy, an extra heartbeat that increases the risk of serious rhythm problems. She was also noted to have a borderline low ventricular function. In January 2018, she was prescribed a beta blocker medication (metoprolol) to treat this condition. Throughout 2018, Counties Manukau DHB staff met with Esther to discuss her medication and provide education regarding the medication and compliance.

In December 2018, Esther moved to Australia. When Esther returned from Australia in 2019, she had stopped taking her medication and refused to take her medication when encouraged by her mother. Her last cardiology assessment was in 2018, at that time, she had borderline low ventricular function and ventricular ectopy.

On 25 September 2020 Esther was at home with her mother and some of her siblings. At around 4:00pm Esther walked into her bedroom and shut the door behind her. A short time later, one of her sisters heard several short cries coming from the room. She went to check on Esther, but the door was locked. Esther's sister climbed through the window and found Esther unresponsive on her bed. She ran to get assistance and family members administered CPR while waiting for emergency services. Paramedics were unable to resuscitate Esther and she died at the scene.

Professor Gentles, a paediatric cardiologist and the Director of the Paediatric and Congenital Cardiac Service at Starship Hospital, considered it possible that Esther's heart muscle dysfunction and/or heart rhythm condition deteriorated over the three years following her last cardiology review and contributed to her death. He noted that metoprolol would have reduced the risk of her heart muscle function deteriorating and may have reduced the chances of a life-threatening heart problem occurring. Professor Gentles advised that at the time he prepared his report, a new cultural navigation service had been introduced and a Rheumatic Heart Disease Nurse Specialist was available to assist patients once they transitioned to adult services. Both these services had been introduced by Te Whatu Ora on a 12-month trial basis.

COMMENTS OF CORONER ANDERSON

I. It appears that Esther's medication compliance was erratic in the years following her heart surgery and that she stopped taking all medications at around 16 years of age. Various health professionals spent time with Esther and her family providing information about the importance of continuing the warfarin and metoprolol and of the serious health risks she faced if she did not do so. When Esther moved to Australia in 2018, she was noted to be engaged with care in that country and was advised to re-engage with care teams in New Zealand if she returned here. Unfortunately, Esther decided to stop taking her medications and chose not to re-engage with health service providers when she came back to New Zealand to live in 2019. Based on the evidence I have received, this decision likely contributed to her death.

II. I do not consider any formal recommendations are required in this case. As set out in these findings, a number of health professionals went to considerable lengths to provide support to Esther and her family over many years and to ensure that they understood the importance of Esther continuing to take the medication prescribed to her and completing regular INR testing.

III. Many people are reluctant to take medication on an ongoing basis, particularly if they are not feeling acutely unwell. Esther's tragic death is a reminder that there can be risks associated with these decisions and that such choices may sometimes have fatal consequences.

IV. While I have chosen not to make any formal recommendations, I strongly encourage Te Whatu Ora, the agency now responsible for the operation of ADHB and CMDHB services, to continue to explore ways to support and encourage young people with chronic and potentially life limiting illnesses to take the medications prescribed to them, in order to maximise their chances of living a long and healthy life.

Vitaliano [2023] NZCorC 47 (24 April 2023)

CIRCUMSTANCES

Teuila Secilia Vitaliano, aged 17, died on 1 December 2020 at Auckland City Hospital of complications of rheumatic heart disease.

Secilia had been unwell between October and November 2020. Prior to this she had been healthy and well and not on any medications. She sought medical attention and visited primary health care clinics on three occasions: 28 October, 7 November and 19 November 2020.

During her first presentation she exhibited symptoms of a sore throat, slight cough, and fever. However, after waiting over two hours for a consultation, she left the clinic without being seen by a doctor.

In her second and third visits, Secilia presented with symptoms of fever, body aches, mild cough, and reduced appetite. Notably, the sore throat was absent during these visits. Her doctors considered the possibility of a viral infection during these presentations. Concerned that Secilia's health was not improving, her family took her to traditional healers for additional assistance.

On 28 November 2020, Secilia's condition deteriorated significantly leading to her being taken to hospital by ambulance. Secilia was admitted with severe septic shock caused by endocarditis affecting her aortic and mitral valves. A CT scan was conducted, revealing a poor health outcome. Given the poor prognosis, a decision was made to provide comfort cares. Secilia passed away at the hospital on 1 December 2020. At post-mortem it was found that her cause of death was complications of rheumatic heart disease.

Dr Murdoch, a medical adviser to the Chief Coroner and Coroners of New Zealand, advised that acute rheumatic fever is an auto-immune response to group A streptococcus (GAS) infection which typically presents with a sore throat.

The New Zealand clinical guidelines indicate that performing a throat swab and prescribing antibiotics are the appropriate course of action for reducing one's risk of developing acute rheumatic fever. Dr Murdoch noted that if Secilia did in fact have GAS infection on 28 October 2020, and if her subsequent illness was in fact acute rheumatic fever, this was a missed opportunity to prevent everything that happened subsequently.

COMMENTS AND RECOMMENDATIONS OF CORONER MILLS

I. Secilia's death may have been prevented had the accepted clinical guidelines for the treatment of sore throats been followed and the significance of her on-going illness been identified.

II. I therefore make the following comments pursuant to section 57A of the Coroners Act 2006 in the hope that if drawn to the public's attention, and particularly to health professionals, may reduce the chance of further deaths occurring in similar circumstances.

III. Although acute rheumatic fever is now rare in industrialised countries, it is a significant cause of disease amongst Māori and Pacific children in New Zealand.[12] It is preventable. The appropriate treatment of sore throats in high-risk populations will eliminate group A streptococcus in most cases and prevent individual cases of acute rheumatic fever.[13]

IV. Te Whatu Ora advises that rheumatic fever starts with a sore throat that is known as 'strep throat' – a throat infection caused by a bacterium called Group A Streptococcus.[14] Most sore throats get better on their own after about four days. But if strep throat is not treated with antibiotics, it can cause rheumatic fever in at-risk children and young people.

V. In 2009 the New Zealand government made rheumatic fever a priority health issue. Funding has been put forward towards the primary prevention of acute rheumatic fever.[15] There are significant resources and guidance available to doctors and health professionals about the importance of treating sore throats for possible group A streptococcus (GAS) infections. Attached as Appendix 1 to these Findings is one such guidance. I encourage all health professionals to re-familiarise themselves with this guidance.

VI. I also encourage all parents who have children with sore throats to seek medical attention and not to hesitate to return to the doctor should their child's condition not improve.

VII. I direct that these Findings be provided to the College of General Practitioners for dissemination amongst its members for educational and training purposes.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Teuila Secilia Vitaliano taken during this inquiry, on the grounds of decency.

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[12] https://assets.heartfoundation.org.nz/documents/shop/marketing/non-stock-resources/diagnosis-management-rheumatic-fever-guideline.pdf
[13] https://assets.heartfoundation.org.nz/documents/shop/marketing/non-stock-resources/diagnosis-management-rheumatic-fever-guideline.pdf
[14] https://www.tewhatuora.govt.nz/keeping-well/health-info-for-public/diseases-and-conditions/rheumatic-fever/
[15] https://assets.heartfoundation.org.nz/documents/shop/marketing/non-stock-resources/diagnosis-management-rheumatic-fever-guideline.pdf

Miscellaneous

Choking Game [2023] NZCorC 79 (30 June 2023)

CIRCUMSTANCES

The following recommendations were made in relation to a death caused by self induced asphyxiation. The Coroner considered that the death resulted from engaging in a "choking game" and that there had been no intention to die as a result.

This summary differs from others in the Recommendations Recap due to extensive orders in place under s 74 of the Coroners Act 2006, as well as the application of s 71 as outlined below.

RECOMMENDATIONS OF CORONER HO

Previous coronial findings into deaths from self induced acute asphyxiation

I. In the United States 82 children between the ages of 6 and 19 died between 1995 and 2007 after engaging in choking "games" or variants of it. Eighty-seven percent of those who died were boys and the mean age was 13.[16] There is no corresponding data in New Zealand, but this information indicates that asphyxia related activities are a significant safety issue for young male adolescents.

II. The name "choking game" is a misnomer because the consequences of it, if taken to extremes, are not fun or gamelike. Death can result. For that reason, I will refer to the activity as "self induced acute asphyxiation" or, where I choose to use the word "game", I use it in inverted commas to illustrate the fallacy of regarding it as such.

III. In 2009 Coroner Bain found that a [young] boy died […] as a result of self-inflicted asphyxia by misadventure.[17] There were indications that the boy had been experimenting with the choking "game".

IV. The forensic pathologist who conducted the post-mortem examination in that death, Dr Sutton, commented that it takes relatively little pressure over the trachea to obstruct it and cause asphyxia and subsequent death. Once a person becomes mildly hypoxic,[18] it becomes difficult for them to make a rational decision. They can become quite agitated but even if they had an intention to extricate themselves from the situation it rapidly becomes impossible even without becoming unconscious. A state of unconsciousness usually develops within one to three minutes. Even relatively trivial neck compression without hypoxia has been associated with sudden death.

V. [Medical professionals have warned of the risk of serious injury if pressure is applied to the neck, no matter how fleeting.]

[16] Unintentional Strangulation Deaths from the "Choking Game" Among Youths aged 6-19 years – United States 1991-2007 – data from the Center for Disease Control and Prevention.
[17] CSU-2009-ROT-147.
[18] Lacking oxygen.

VI. Coroner Bain also received expert evidence from Dr Johan Morreau, an experienced general paediatrician and then chair of the Rotorua Lakes Child and Youth Mortality Review Committee, about the choking "game". Dr Morreau stated that young people are at serious risk of death and self harm if they indulged in this type of behaviour. He identified risks of sudden death and serious brain damage from the deprivation of oxygen. He acknowledged reports that indicated people could experience some euphoria as a response to the loss of oxygen but that this was achieved at the loss of brain cells. He stated that the activity was "very, very unsafe".

VII. In 2010 Dr Morreau's view was independently reiterated by Dr Nick Baker, a paediatrician and then chair of the New Zealand Child and Youth Mortality Response Committee. Dr Baker had been instructed […] to provide expert evidence in [another inquiry].[19] Dr Baker stated that for decades young people had been engaging in asphyxiation "games" as part of risk-taking and thrill-seeking behaviour. He explained that it appears to be thrilling because the restriction of blood flow to the brain caused by such activity creates a brief euphoria, followed by a "rush" which is experienced from the surge of blood flow that follows. Dr Baker stated that such activities were obviously high risk, there being minimal difference between neck pressure which causes altered awareness and that which causes death.

VIII. Dr Baker concluded that for this reason, ideally, self induced acute asphyxiation should not be considered as an "activity" by anyone.

IX. In providing his opinion […], Dr Baker considered the same issues that Dr Morreau considered about publicising the dangers of such activities. Dr Baker phrased the question in this way: should the issue be kept quiet so that it fades from the vocabulary of young people's behaviours or do professionals have a duty to inform of risks? Dr Baker suggested that information about risks might prevent those who know of the activity from trying or continuing to try it, but such information might also suggest it as a possibility for those who would otherwise never have considered the activity. Dr Baker considered that the right balance needed to be determined with reference to the prevalence of the activity in the community: at times of high prevalence, there should be increased warnings and messages about the risks; but at times of low prevalence, silence might be the safest option.

X. In my view, the previous coronial findings and the existence of self induced acute asphyxia activities raise two separate issues:

a. What information is currently available to educators and parents about acute asphyxia activities among adolescents, and is that level of information satisfactory?

b. What information about the risks of acute asphyxia activities should be publicised to adolescents?

Information available to educators and parents

XI. In his evidence to Coroner Bain's 2009 inquiry Dr Morreau felt the best avenue to make educators and parents aware of such activities and the potential warning signs:

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[19] […]

a. mention of the choking “game” or of similar activities;

b. marks on the neck or hidden on the neck by clothing;

c. changes in personality, such as becoming overly aggressive or disorientation after spending time alone;

d. straps, ropes or belts in the child’s room for no clear reason;

e. frequency of headaches;

f. loss of concentration or a flushed face;

g. bloodshot eyes or other signs of eye stress;

h. questions about the effects of strangulation; and

i. a thud in a child’s bedroom or against the wall.

XII. Dr Morreau opined that it was critical that parents and educators be aware of these warning signs and where to go to seek help.

XIII. Coroner Bain accepted Dr Morreau’s opinion. He indicated it was for the Ministry of Youth Affairs, the Ministry of Health and the Ministry of Education to identify the extent of the issue and the level of experimentation then prevalent in New Zealand. He also recommended that the Ministry of Education and the Ministry of Health undertake a targeted education approach to school boards which would then take responsibility for teacher and parent education of the warning signs of asphyxia related activities.

XIV. The Ministry of Education’s 2019 guide to educators about student suicide prevention contains a section which alerts teachers to the known risk of asphyxia or choking games. It is printed on page 28 of a 77-page booklet:

> We recommend that all staff remain alert to the potential for students’ involvement in these types of games. […] If you hear talk about choking as a ‘game’, talk with students about the risk. […] It is also important to send out messages to families and whanau to inform them of this type of game it is occurring in your community. […]
>
> There is a risk that talking about the ‘choking game’ may elicit interest and increase students’ involvement. However, there is also an argument that providing families and whanau with appropriate information helps ensure that students are aware of the risks when and if the issue arises.
>
> Social networking sites and texting are highly effective and students are likely to hear about such ‘games’ before their families and whanau. The Ministry of Education, after consulting relevant experts including the Ministry of Health and the Coronial Services Unit, recommends you provide information to your families and whanau.

XV. The guide also identifies the signs which might indicate that adolescents are engaging in acute asphyxia activities. They are like those identified by Dr Morreau.

XVI. The Ministry guide is plainly intended to help. […]

XVII. There are three main problems with the Ministry’s guide:

a. The guide conflates, and attempts to address, two very different scenarios. The document in question is a "Suicide Prevention Publication". But self induced acute asphyxiation is often not commensurate with an intention to suicide. It is done for the supposed thrill of the temporary asphyxiation and subsequent release. Educators and parents need to be alert to both risks and have the necessary information to recognise that the risk signals for self induced acute asphyxiation could be significantly different to the risk signals for suicide. The information in the guide about self induced acute asphyxiation is not in a logical location.

b. The information in the guide does not go far enough to alert schools to the risk of the game and the importance of educating students and the community about the dangers. It is also buried in the middle of a lengthy document.

c. The approach in the guide does not reflect modern reality and the speed at which information can be shared over social media and other instantaneous forms of communication favoured by adolescents. The way the topic is introduced in the guide suggests that schools should be reactive rather than proactive. The guide appears to envisage a situation where the risks will be discussed with students only when rumours or tangible signs of the asphyxiation activity are manifested. By then, as the Ministry itself identifies, it may be too late. This approach completely fails when adults do not hear the rumours or are sufficiently armed with information about the asphyxiation activity to recognise any physical symptoms which might manifest […].

XVIII. The prevalence of information available through the internet and which can be quickly disseminated through social media is illustrated by a study published in 2019. The authors analysed YouTube videos over a period of two months and identified 194 instructional videos on self induced acute asphyxiation which had been collectively viewed over a million and a half times.[20]

XIX. A March 2018 *Time* article reported companies like YouTube and Facebook have begun to take action against videos which show choking "games" […].[21] Nevertheless, given the history and apparent commonness of self induced acute asphyxiation, and the ease with which information can be readily disseminated through social media and instant messaging, it is likely that such information will remain readily available to adolescents. Education around the dangers of self induced acute asphyxiation, and the steps adults need to take to prevent such activities resulting in unnecessary deaths, needs to respond to and reflect this reality. It is critical that adults be aware of the symptoms of such dangerous activities so they can promptly respond to them.

XX. The timing of the recommended response also needs to be adjusted to reflect the modern reality of information dissemination. The speed at which information can be shared among adolescents in 2023 is much swifter than in 2010. It is too late to educate by the time that teachers hear rumours; like many adolescent trends, school staff are often the last to know about what their students are doing.

XXI. […]

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[20] Ouellette et al, "YouTube and Risky Behaviour in Adolescents: The "choking game"" (2019) 1 American Journal of Emergency Medicine 152.
[21] https://time.com/5189584/choking-game-pass-out-challenge/

Information published to adolescents

XXII. There are online resources dedicated to educating about the dangers of choking "games".[22] They are primarily of American origin but there is no reason why they cannot be used by or adapted to a New Zealand audience. They avoid teaching children how to engage in the asphyxiation activity – thus eliminating any concern of suicide contagion – and instead focus on educating them about brain function and the importance of keeping the brain healthy. This seems to me to strike an appropriate balance between the concerns expressed by those who fear copycat behaviour, and the importance of educating adolescents about the dangerous and fatal results that can occur from applying pressure to the neck.

XXIII. In 2010 Dr Baker opined that there could be a moving balance about publicising such activities, depending on whether there was a high or low prevalence of asphyxia activities in the particular school or region. I doubt that is realistic. […] [A]dults can be unaware that such activities are taking place until it is too late.

XXIV. In my view, a more proactive approach needs to be taken by the Ministry of Education and schools in educating students around the dangers of self induced acute asphyxiation and why such "games" or "social media challenges" are not to be attempted. The approach taken by the United States resources may provide a useful starting point.

XXV. In his evidence […] Dr Baker made the following specific points about publication, which I endorse:

a. Terms such as the "choking game" should not be used. Any reference to a "game" implies an activity of diversion or amusement. Use of terms such as "self induced acute asphyxiation" is unlikely to make the activity seem desirable or come into common use.

b. Any information that reaches young people about self induced acute asphyxiation needs to highlight the dangers and be provided from an authoritative source. Dr Baker referenced research that younger children are more likely to listen to their parents, while older children are more influenced by their peers, near-victims or members of a victim's family.

c. Communication from schools about dangerous activities and tragic events needs to be managed with extreme care with support from experts in these areas of communication.

A current New Zealand perspective

XXVI. In considering the above issues, I was conscious that Dr Morreau's and Dr Baker's views were now over twelve years old. I instructed Dr Rebecca Hayman to provide me with expert advice about whether those views were still relevant today, particularly in light of the modern impact that social media has on adolescent life. Dr Hayman is an experienced paediatrician who currently practices at Kidz First Hospital at Middlemore. She is a member of the national Child and Youth Mortality Review Committee. While I acknowledge the useful work which others have done around self induced acute

[22] See for example Games Adolescents Shouldn't Play (https://www.gaspinfo.com/en/home.html) and Erik's Cause (https://www.erikscause.org/).

asphyxiation in adolescence, including in the United States, Dr Hayman provided me with the New Zealand perspective necessary to inform my analysis and recommendations.

XXVII. Dr Hayman agreed with the views expressed by Dr Morreau and Dr Baker, and in particular the importance of increasing awareness of the risks and signs of self induced acute asphyxiation without promoting copycat behaviour. Dr Hayman also referenced the lack of specific New Zealand data about the prevalence of self induced acute asphyxiation but noted the international evidence of widespread experimentation among adolescents. She agreed that it was important to consider ways to highlight to caregivers the existence of this high risk behaviour among adolescents and to have strategies to support adolescents engaging in this type of behaviour. I understand Dr Hayman's recommended approach to be consistent with those overseas, which promote identification and education about the risks and signs of such activities rather than focusing on the "game" itself.[23]

XXVIII. I provided Dr Hayman with a copy of my intended recommendations and which are recorded at III to XXXII below. Dr Hayman supported those recommendations.

My recommendations

XXIX. I recommend that the Ministry of Education:

a. develop resources using age appropriate and non-sensational language to educate students about the dangers of self induced acute asphyxiation; and

b. develop resources for teachers and caregivers to highlight the signs and risk factors for self induced acute asphyxiation. This should include pathways for teachers and caregivers to manage risk factors or risky behaviour.

XXX. Such resources should be developed in collaboration with child health and communication experts such as SafeKids, the Ministry of Health or the National Child and Youth Mortality Review Committee Health and Safety Quality Commission. Existing resources developed overseas could be adapted or adopted as appropriate.

XXXI. I also recommend that the Ministry of Education update its 2019 Suicide Prevention Publication, either in conjunction with my recommendation at [XXIX.b] or separately, to:

a. restructure the layout of its publications so that the material about self induced acute asphyxiation is put into a separate section or, ideally, a different document altogether (covering dangerous "games" or internet challenges) which can then be disseminated to schools alongside the existing material on suicide prevention;

b. rephrase its guidance about self induced acute asphyxiation to make clearer a preference for schools to take a proactive rather than reactive educative approach to such games, including publicising such information to parents; and

[23] See for example https://www.erikscause.org/program.

c. include reference to resources for schools to educate students about the dangers of self induced acute asphyxiation.

XXXII. Finally, I recommend that schools implement or consider implementing:

a. appropriate processes to proactively and regularly address with, and educate students about, the consequences of risky behaviour such as self induced asphyxiation activities; and

b. policies requiring staff to read, or at least be familiar with, documents and guidance relating to suicide, self-harm or other cases where student safety might be at risk. This includes being aware of symptoms which could identify possible suicidal, self-harm or other dangerous ideation.

Other actions

XXXIII. Dr Hayman also suggested two further actions for consideration:

a. Increasing the awareness of internet regulators about the availability of unsafe content and the role of social media, including ongoing review of legislation which would enable the removal of such content.

b. Collecting more information and data about self-inflicted acute asphyxiation and other unsafe adolescent practices (such as the cinnamon challenge, huffing, car surfing or chubby bunny) to determine the prevalence of such dangerous activities in New Zealand.

XXXIV. Both of Dr Hayman's suggested actions have merit. I direct that my findings be provided to NetSafe, the National Child and Youth Mortality Review Committee (Health and Safety Quality Commission) and the New Zealand Paediatric Surveillance Unit.

Note: Extensive orders issued under s 74 of the Coroners Act 2006 in the interests of justice, personal privacy and decency prohibit publication of a number of matters investigated by the Coroner.

The Coroner found that section 71 of the Coroners Act 2006 did not prohibit publication of, and the public attention being drawn to, the dangers of asphyxia-related activities (sometimes described as "challenges" or "games"). Such publication was deemed by the Coroner to be in the public interest, and he considered that this information could be reported in a manner that does not breach section 71.

Coetzee [2023] NZCorC 76 (22 June 2023)

CIRCUMSTANCES

Eliza-Jayne Coetzee, aged 13, died in a paddock off Airport Road, Omarama on 4 October 2019. The cause of death was blunt force trauma causing a basal skull fracture and significant brain injury.

Eliza-Jayne had been around horses from a young age and had been riding almost every day in the three years preceding her death. In August 2019, Eliza-Jayne's mother bought her a 'project horse' called Boxer. Eliza-Jayne knew

she was not allowed to ride Boxer until he was properly trained, but she was allowed to do groundwork with him, such as grooming him, putting on a saddle and bridle and lunging him.

At approximately 5:00pm on 4 October 2019, Eliza-Jayne was doing groundwork with Boxer to prepare him to be ridden. A family friend, Marju Laukkanen, was present and told Eliza-Jayne not to mount Boxer. When she proceeded to do so, Boxer bolted across the paddock towards a fence. Eliza-Jayne fell off onto the side of the fence, landing on her back on the ground. People quickly came to assist, and various emergency services attended. Unfortunately, despite prolonged resuscitation efforts, Eliza-Jayne passed away at the scene.

Pathologist Dr Wakefield performed an autopsy on 8 October 2019. In his opinion, Eliza-Jayne's death was due to a basal skull fracture following a significant brain injury with associated brain swelling and resuscitation-associated injuries. The resuscitation-associated injuries included a pneumopericardium, bilateral pneumothoraces, and puncture wounds to the free wall of the right ventricle.

The Coroner obtained a report from St John which included a medical opinion and final investigation findings of Dr Tony Smith, Medical Director, St John. The report noted that when a registered nurse (RN) arrived on the scene, CPR had been continuing for almost an hour with no signs of life, including no shockable heart rhythm detected. The RN was advised to stop CPR and perform open finger thoracostomies to decompress Eliza-Jayne's chest, since one of the possible reversible causes of cardiac arrest in this setting was tension pneumothorax. The RN was unfamiliar with the procedure and, it appears, misheard some of the instructions over the phone due to the windy conditions at the time. As a result, the procedure was performed incorrectly with the limited equipment available.

In Dr Smith's opinion, although the injury to Eliza-Jayne's right ventricle was very regrettable, it occurred in unusual circumstances and during attempts to save her life. He noted that if a patient goes into cardiac arrest prior to ambulance personnel arriving at the scene, following blunt trauma, the mortality rate is almost 100% and the very few people that survive do so only because there is an immediately reversible cause that is immediately treated. Dr Smith acknowledged that advising and/or instructing someone to perform an invasive procedure over the phone, when that person has not been trained to perform that procedure, is a complex decision and a balance of risk versus benefit. However, he considered that Eliza-Jayne had an almost 100% chance of dying when the RN arrived at the scene, and that she could have survived only if immediate action was taken. He concluded that the injury to Eliza-Jayne's right ventricle did not cause or contribute to her death, because at that point her death sadly was inevitable.

The Coroner was satisfied that any errors in the resuscitation procedures did not materially contribute to Eliza-Jayne's death.

RECOMMENDATIONS OF CORONER MCKENZIE

I. I endorse the recommendation made by Dr Smith, Medical Director at St John:

> … there is an important lesson to be learned from this incident, and I recommend it is promulgated to doctors and nurses responding to emergencies in the out-of-hospital setting. In my opinion that lesson is that decompressing the chest in the setting of a presumed tension pneumothorax is an invasive procedure with the possibility of saving a life, but conversely it also carries the risk of causing harm. While it is not possible to develop a written algorithm that determines that balance of risk in all circumstances, decompression of the chest should

usually only be performed by personnel trained to do so, and only when the appropriate equipment is immediately available to them.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of the making public of photographs of Eliza-Jayne Coetzee taken by Police or by any other party, in the interests of decency or personal privacy.

Labone [2023] NZCorC 44 (20 April 2023)

CIRCUMSTANCES

Chloe Patricia Jie Labone, aged 5 months, died on 5 October 2020 at Starship Hospital, Auckland of blunt force head injury.

On 5 October 2020, Chloe was briefly left unattended in her stroller outside her home address which had a sloped driveway. Tragically, the stroller rolled down the driveway onto the path of a car travelling along the northbound lane of Lake Road, Northcote. Chloe was transferred to hospital in a serious condition. She later died in hospital as a result of the injuries she sustained in the collision.

Chloe's mother, Denise Zhu, notified the Police that the brakes of the pram worked well initially. However, they had recently been playing up and felt like there was "sludge" on it. Ms Zhu believed that she had applied the brakes on the day of the collision.

The New Zealand Police Serious Crash Unit ("SCU") conducted a full forensic examination of the stroller and concluded that the collision likely occurred as a result of the brake lever not being applied. The SCU also noted that Ms Zhu had poor sleep the night prior. The SCU advised that noticeable signs of sleep deprivation include lack of alertness, daytime fatigue, and impaired memory.

COMMENTS OF CORONER FITZGIBBON

I. This was a tragic accident. However, there were steps which could have been taken to ensure that it did not occur. Pursuant to s 57A of the Coroners Act I have the ability to make recommendations or comments as part of the findings of this inquiry. Recommendations or comments may be made only for the purpose of reducing the chances of future deaths occurring in circumstances similar to those in which Chloe's death occurred.

II. Recommendations or comments must be clearly linked to the factors that contributed to the death to which the inquiry relates, be based on evidence considered during the inquiry and 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. This case highlights a range of stroller user safety precautions which I would like to remind parents and other stroller users to follow as it is understandable that these significant safety steps can sometimes be overlooked:

    a. Never leave your child unattended in the stroller.

b. Do not park or leave the stroller unattended on uneven ground or on an incline. Always park the stroller on a flat, even ground.

c. Always maintain full control of the stroller when operating it. Keep both hands on the handles at all times during operation.

d. Familiarise yourself with the stroller's braking system and ensure the braking system is operational.

e. Ensure that you have read all warnings and instructions in the user guide and on the stroller prior to use.

IV. Having considered the evidence in full and noting the requirements under s57 of the Coroners Act, I make no recommendations.

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

Puangi [2023] NZCorC 61 (18 May 2023)

CIRCUMSTANCES

Tairo Pero Junior Puangi, aged 42, died between 24 April and 2 May 2019, at his home at Unit 10, 22 Felix Street, Onehunga. The cause of death is unascertained.

Mr Puangi lived on his own in a unit managed by Kāinga Ora (Housing New Zealand). He had periods of mental unwellness when he would act aggressively. He had been arrested in November 2018 for an assault against his tenancy manager. He was described by witnesses as lonely and missing his mother who had died.

Mr Puangi was last seen alive on 16 April 2019 when he attended his medical practitioner for his monthly intramuscular antipsychotic medication. His medical practitioner reported no concerns at the time.

In the early hours of 24 April 2019, Mr Puangi's neighbour heard banging coming from Mr Puangi's unit. This lasted five to ten minutes. The following day Mr Puangi's window was broken and one of the tenants, James Thomas, reported this to the tenancy manager who advised them to contact the customer support centre (CSC). On 29 April 2019, the tenancy manager received an email from CSC with a "maintenance follow up" in response to Mr Thomas' concerns over the broken window and not seeing Mr Puangi. The tenancy manager attempted to call Mr Puangi but there was no response. The tenancy manager and another person then visited the complex. They took photos of the broken window but did not knock on Mr Puangi's door due to Mr Puangi's risk rating. Neighbouring tenants advised that they had not seen Mr Puangi.

The tenancy manager arranged to cordon off the hazard area and made an urgent request to repair the glass and the window. On 30 April 2019 at a meeting between the area manager and the tenancy manager, the area manager approved emergency powers of entry to Mr Puangi's home to fix the window and, on 1 May 2019, a safe work plan

(SWP) was completed by Kāinga Ora. On 2 May 2019, a Kāinga Ora representative and a locksmith obtained entry to Mr Puangi's home where they found Mr Puangi deceased.

A report was provided by Auckland District Health Board. They advised that Mr Puangi had a diagnosis of schizoaffective disorder and a history of drug and alcohol abuse. He had a lengthy history with mental health services since 1998. In 2017 he had been discharged to the care of his GP. In February 2019, there was a review of his care and treatment after Mr Puangi had contacted the urgent response service stating he was not feeling good. He was referred for a medical review which took place three days later. Mr Puangi did not present as mentally unwell but he described loneliness and practical difficulties such as shopping. A community support worker was organised for Mr Puangi.

Kāinga Ora provided a report to the Coroner in response to questions about their maintenance and welfare policies. In summary the report noted:

a) The service standard is to contact the tenant within 48 hours. There is no set process if the customer cannot be reached by phone.

b) Where a customer is risk rated and a visit is required, a SWP must be prepared. This includes that the tenancy manager must be accompanied by one other person when visiting.

c) If there were indications of the person being in danger due to anti-social criminal behaviour, the expectation would be to notify the Police.

d) At the time of Mr Puangi's death, Kāinga Ora did not conduct welfare checks for customers.

e) In April 2021 Kāinga Ora began conducting welfare calls for all customers as a response to COVID-19. If the customer was assessed as vulnerable, this was noted on the tenancy file and more regular welfare checks were undertaken. The following criteria were used to assess if a customer was vulnerable:

- someone at the property is over 70 years;
- other risk factors for COVID-19 for example health issues, insufficient and difficulties accessing medication;
- if the customer lives alone without support or access to usual support or insufficient supplies;
- if the property is overcrowded;
- if the customer's income is impacted;
- if there are property issues.

Kāinga Ora believes its "response to Mr Thomas' notification was adequate, reasonable and proportionate and consistent with internal policies and processes."

COMMENTS OF CORONER TETITAHA

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

II. There is evidence Mr Thomas clearly communicated his concerns to Kāinga Ora about Mr Puangi's continued absence as well as the broken window on 24 April 2019. The 2019 statement explicitly referred to those concerns. When Kāinga Ora finally entered the unit to repair the broken window on 2 May 2019, Mr Puangi was found inside deceased.

III. Mr Puangi was a vulnerable tenant given his health background. His alleged absence should have generated more inquiry and investigation. The 2022 statement confirms Kāinga Ora were aware of his "mental unwellness" but this was classified as a risk as opposed to a vulnerability.

IV. I note and support Kāinga Ora's policy change in 2021 to begin checking on vulnerable tenants. However, the classification of vulnerable tenants does not include those with mental health conditions such as Mr Puangi. There is little doubt he was vulnerable to injury including self-harm due to his mental health. His death may have been prevented by a welfare check on 24 April when concerns about noises from his apartment and his absence were raised. Vulnerable tenants who present risk factors may require Police assistance with the welfare check. They should not be excluded from support measures due to their mental unwellness.

V. These comments are directed to Kāinga Ora.

RECOMMENDATIONS OF CORONER TETITAHA

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

- Kāinga Ora consider reviewing their policies regarding:

    i. A wider definition of vulnerable tenants to include those with mental health conditions such as Mr Puangi;

    ii. Urgent welfare checks on vulnerable tenants where concerns are raised;

    iii. Staff undertaking urgent welfare checks on vulnerable tenants with risk factors should seek Police assistance.

Replies

II. I have received replies from the members of the Puangi whānau and Kāinga Ora.

III. The Puangi whānau wished to review the file and initially met with the coroner. After conducting a review they advised they had no further information or concerns to raise with the coroner.

IV. Kāinga Ora advise they support the above recommendation and note the following:

- if we are made aware of personal circumstances such as health concerns, we try to adapt our service response and engagement appropriately;

- we could consider including in the "vulnerability criteria" where our staff are aware that a customer has mental health conditions;

- we would continue to use Police to support staff or conduct welfare checks.

V. Both the Puangi whānau and Kāinga Ora are thanked for their replies.

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

Sran [2023] NZCorC 52 (1 May 2023)

CIRCUMSTANCES

Harsimar Singh Sran, aged two months, died on 19 June 2019 at Starship Hospital, Grafton, Auckland from penetrating sharp force injury to head sustained in accidental fall.

On 19 June 2019 Harsimar travelled with his parents to Sky City, Auckland where they parked their car in the car park underneath the complex. Harsimar was seated in an infant capsule child restraint of a type that was able to be attached and removed from a pram and then placed into the car. Before they returned to the carpark, Harsimar's mother was the last person to put Harsimar inside the capsule and said his safety harness was not secured as it was irritating Harsimar and he was sleeping.

When the family returned to the car, Harsimar's father removed the car seat, with Harsimar in it, from the pram. Also in the capsule was a glass milk bottle, by Harsimar's feet, and a blanket over Harsimar, possibly obscuring the safety harness. Harsimar's father was unaware the safety harness was not secured. He approached the vehicle holding the capsule and as he did this, the glass milk bottle fell from the capsule and smashed on the ground. Almost immediately after the bottle fell, Harsimar slipped out of the capsule too and fell to the ground, the back of his head striking the broken bottle, causing a cut to his head. Harsimar was transported to the hospital but died from his injuries.

An expert report commissioned by the Police found that the capsule was functioning as designed. It was noted that Harsimar was not correctly harnessed into the restraint, and the carry handle of the capsule was in the incorrect position. Additionally, the narrow gap between the parked vehicles was insufficient to allow a safe insertion of the capsule into the vehicle in the manner it appears to have been done.

The Coroner found that Harsimar's father picked up the handle in the incorrect position and with the harness not buckled up and tightly fitted against Harsimar. Had he been correctly harnessed in the capsule it would have functioned as designed and he would not have fallen out. Had the capsule been dropped, the vertical handle position would have prevented any impact injuries with the surface as both the handle and high sides of the capsule would have prevented any contact.

COMMENTS OF CORONER FITZGIBBON

I. This was a tragic accident and one which Harsimar's parents did not intend to occur that day. On reviewing the evidence, I am satisfied Harsimar's death was preventable. Not only was the handle not in the recommended position but the harness was not in place securing Harsimar into the capsule. If the harness had been secured it is likely this tragic accident would not have occurred as Harsimar would have been restrained within the capsule.

II. The manufacturer's instruction manual outlines how a capsule is to be used to ensure maximum protection for an infant while in the capsule. It is important for those using a capsule to familiarise themselves with the manufacturers manual and ensure the capsule is always set up in the correct manner, while in a motor vehicle and when the capsule is being used outside a motor vehicle. Importantly, fully restrain infants with the harness even when carrier is used outside the vehicle and ensure the carry handle is upright and locked when being carried. This will ensure that maximum protection is engaged should the capsule be dropped while being moved and carried. The harness will keep the infant within the capsule.

III. As well as the manufacturer's instructions, there is a range of information available online about the correct type and use of infant capsules and car seats. I encourage families to read this information or contact a Child Restraint Technician.[24]

Safekids Aotearoa - https://starship.org.nz/safekids/car-safety-birth-to-11-months

Whānau Āwhina Plunket - https://www.plunket.org.nz/being-a-parent/preparing-for-your-baby/car-seats/about-child-restraints

Waka Kotahi NZ Transport Agency - https://www.nzta.govt.nz/safety/what-waka-kotahi-is-doing/education-initiatives/child-restraints/

IV. I direct that a copy of my written findings is sent to the following entities for their information and consideration as to whether their specific education around infant capsules can be extended to include "out of vehicle" safety when using infant capsules for whānau.

- Te Whatu Ora NZ
- Safekids Aotearoa
- Whānau Āwhina Plunket
- Waka Kotahi NZ Transport Agency

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

[24] https://www.nzta.govt.nz/safety/what-waka-kotahi-is-doing/education-initiatives/child-restraints/find-a-child-restraint-technician/

Motor Vehicle

Amies [2023] NZCorC 38 (5 April 2023)

CIRCUMSTANCES

Paul Dickinson Amies, aged 76, died on 23 January 2020 at Waikato Hospital of traumatic chest injuries sustained in a motor vehicle crash, against a background of chronic obstructive pulmonary disease and coronary atherosclerosis.

Mr Amies had Obstructive Sleep Apnoea (OSA) for around 20 years and Chronic Obstructive Pulmonary Disease (COPD) for around six years. The latter meant he was susceptible to chest infections and would often need time in respite at Te Aroha Community Hospital to regain his strength.

On 19 January 2020, while admitted to Te Aroha Community Hospital, Mr Amies had an unwitnessed fall during a coughing fit and hit his head. He did not lose consciousness but sustained minor injuries and was kept under neurological observation for 48 hours. On the morning of 22 January 2020, Mr Amies was reviewed by a doctor and deemed fit to be discharged home.

On the afternoon of 22 January 2020, Mr Amies drove his Toyota Rav4 southbound along State Highway 1 towards Putāruru. He was following directions from a GPS unit. He missed the turnoff to his destination and continued to travel south when his vehicle crossed the centreline into the path of an oncoming Suzuki Ignis, resulting in a head-on collision. He was airlifted to Waikato Hospital where he died from his injuries on 23 January 2020.

The Serious Crash Unit investigated the crash and determined that Mr Amies did not apply the Toyota's brakes before impact, and the Toyota was in the opposing lane when the impact occurred. The SCU considered that the main causative factor of the crash was Mr Amies' fatigue and that he may have been fatigued to the point of falling asleep or having a micro-sleep. The SCU advise that:

> A micro-sleep is described as a fleeting, uncontrollable, brief episode of sleep that can last anywhere from a fraction of a second up to 30 seconds and commonly occurs when a fatigued person is trying to fight sleep and remain awake. Research suggests that some individuals are often unaware that they have had a micro-sleep.
>
> Some of the signs of experiencing micro-sleep are, among others; inattentiveness, brief memory lapse, missing an exit while driving, hitting the highway rumble strip and car crashes. [Citation omitted].

In considering whether Mr Amies should have been allowed to drive on 22 January 2020, the Coroner considered a booklet produced by the New Zealand Transport Agency, Waka Kotahi titled Medical Aspects of Fitness to Drive: A Guide for Health Practitioners ("the Booklet"). The Booklet explores medical conditions which may impair an individual's ability to drive safely.

COMMENTS OF CORONER BATES

I. Mr Amies' death was a tragic accident. I have established the primary cause of the motor vehicle crash was Mr Amies experiencing a micro-sleep due to fatigue. Objectively, he was fit to drive when discharged from hospital.

II. Nevertheless, Mr Amies' death is a reminder that patients experiencing respiratory or other medical conditions, such as OSA, combined with the potential for sleep disturbance during hospital admission, may suffer severe fatigue.

RECOMMENDATIONS OF CORONER BATES

I. Prior to hospital discharge of patients with conditions such as OSA, or others causing disturbed sleep, the discharging doctor should enquire regarding their level of fatigue. The doctor should have regard to the frequency and nature of clinical observation of the patient during their admission, to gauge the amount of sleep they have had. If concerned or in doubt regarding their level of fatigue, the doctor should instruct the patient to not drive for an appropriate period of time, until they have been able to rest adequately.

II. I acknowledge this type of conversation may be uncomfortable at times and may extend the discharge process. However, the following advice contained in the Booklet from Waka Kotahi is pertinent:

> Health practitioners cannot assume that the driver licensing system will pick up individuals who are unfit to drive, so it is important that you consider medical fitness to drive in your everyday dealings with patients […] Determining that someone is no longer fit to drive is a weighty responsibility, but the alternative is to allow them to continue to drive when they put their own and others' lives at risk. Thankfully, health professionals are just as committed to road safety as we are.

III. The Booklet also helpfully states:

> Health practitioners can usually successfully negotiate short-term cessation of driving with patients. However, if longer periods are necessary, it is recommended that health practitioners advise their patients both verbally and in writing. It is also recommended that the patient be told how soon they might expect to have this situation reviewed. If a practitioner suspects that a patient is continuing to drive against medical advice, they are legally obliged to inform the Transport Agency under section 18 of the Land Transport Act 1998.

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

Bell [2023] NZCorC 42 (18 April 2023)

CIRCUMSTANCES

Annie Pareumuroa Bell, aged 18, died on 11 November 2019 in the waters of the Mangaokewa River of drowning.

On the morning of 11 November 2019, Ms Bell got into an argument with her partner. After the altercation, she sped off in her Mitsubishi vehicle. At approximately 1:15pm, a concerned member of the public alerted the Police about a potential motor vehicle accident on Rangitoto Road, Te Kuiti, noting recent damage to a fence leading to the Mangaokewa River. The Police conducted an initial investigation but found no evidence of a submerged vehicle. The following day, a Mitsubishi vehicle was discovered submerged, and Ms Bell was identified deceased at the scene.

A comprehensive investigation of the crash was undertaken by the New Zealand Police Serious Crash Unit ("SCU"). The SCU noted that approaching the scene of the collision from the north, the road had a sharp left turn followed by a sharp right turn. The section of Rangitoto Road where the collision occurred has a posted speed limit of 100km/h.

The SCU opined that the left front wheel of the Mitsubishi left the road seal when it entered the first part of the 'S-bend' causing Ms Bell to overcorrect the steering to the right. The overcorrection resulted in the Mitsubishi to begin to rotate causing it to lose speed. As the Mitsubishi decelerated and rotated it impacted the concrete culvert, subsequently causing the vehicle to drop down the embankment, towards the river.

The SCU noted that Ms Bell was travelling below the critical curve speed when she entered the S-bend but the tyre tread of the Mitsubishi did not meet the required limit for warrant of fitness. The SCU advised that Ms Bell was driving outside the conditions of her learners' driver's license at the time of the collision, indicating driver inexperience as a contributing factor. Distraction or inattention was another contributing factor as Ms Bell was upset prior to the collision.

As part of the post-mortem process, samples of Ms Bell's blood were tested and detected tetrahydrocannabinol in the blood, consistent with the positive immunoassay screen for cannabis. The SCU considered that this would have compromised her ability to respond in an emergency. Accordingly, intoxication was a contributing factor to the collision.

The Coroner noted that while Ms Bell entered the S-bend at a speed below the critical curve speed, the speed she was driving (being 85km/h) was inappropriate for the road configuration. The death was deemed accidental and the result of a combination of Ms Bell's actions and the poor condition of her vehicle.

RECOMMENDATIONS OF CORONER HESKETH

I. The SCU suggested several recommendations following their investigation into the collision. Specifically, continued education and enforcement regarding:

   a. Driver behaviour on rural roads.

   b. Driving whilst distracted or driver inattention.

   c. Driving licence conditions.

   d. Driving under the influence of drugs.

II. The SCU also recommended:

   a. Placing an advisory speed limit on Rangitoto Road.

   b. Reducing the speed limit on Rangitoto Road.

III. In light of the above and having established, as best I can, the circumstances of Ms Bell's death, I formally endorse as a comment under s57A of the Act, the recommendations posed by the SCU on the points of further driver education and enforcement.

IV. Furthermore, I concur with the SCU's suggested recommendation to install a speed advisory sign on the section of Rangitoto Road leading up to where the collision occurred. Accordingly, pursuant to s57A of the Act I recommended to Waka Kotahi NZ Transport Agency that it conduct speed analysis

on that section of Rangitoto Road and install corresponding speed advisory signs in both directions of travel. Waka Kotahi passed my recommendation onto the Waitomo district council who are responsible for the road in question.

V. I subsequently received confirmation from the Waitomo District Council that it has conducted speed analysis on the section of Rangitoto Road being part of the subject matter to the report and appropriate curve and speed advisory signs have now been installed in both directions. The advisory speed is now 55km/h.

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

Blackford and Meers [2023] NZCorC 72 (6 June 2023)[25]

CIRCUMSTANCES

Russell Allan Blackford and Timothy James Meers died on the Riverton-Otautau Road near Fairfax, Southland, on 17 November 2018 due to multiple traumatic injuries sustained in a motor vehicle collision.

On 17 November 2018 Mr Meers was riding his motorcycle as a participant in a charity bike and car run, organised by the Southern Brotherhood Motorcycle Club (SBMC), and involving approximately 200 motorcycles and 40 classic motor vehicles. That morning, participants in the run met and registered at an inn in Invercargill, where a briefing was given by a member of the SBMC covering the rules of the event, and expected behaviour of participants, along with details of the proposed route. Despite this briefing, several participants in the run, including Mr Meers, failed to adhere to the road rules and rode in a dangerous manner.

Participants left a hotel in Riverton at around 12:40pm, heading north on the Riverton-Otautau Road. Approaching a bend with the road rising to a brow, Mr Meers was seen overtaking a car at an estimated speed of 160km/h. He continued at speed through the bend in the middle of the southbound lane in an attempt to overtake a further vehicle. Other motorists saw Mr Meers' motorcycle begin to "fish tail" and brake, which caused the rear wheel to lock and Mr Meers to lose control of his motorcycle. It rotated, turning sideways and colliding with an oncoming motorcycle ridden by Mr Blackford, who was travelling south to visit his sister in Colac Bay. Both Mr Meers and Mr Blackford sustained fatal injuries and died at the scene.

The Coroner found that the collision occurred because Mr Meers, riding at excessive speed, was on the 'wrong' side of the road while negotiating a bend which he could not clearly see around.

COMMENTS OF CORONER KAY

I. I have considered whether there are any recommendations or comments I can make that, if drawn to public attention, may reduce the chances of further deaths occurring in similar circumstances to those in which Mr Meers' and Mr Blackford's deaths occurred, and I make the following comment:

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[25] The Coroner issued two identical findings, one for each deceased, with identical comments. These were combined into one summary in order to avoid unnecessary repetition.

> Too many motorists are dying on New Zealand's roads as a direct result of the poor decisions they, or, as in this case, other road users make. Public highways are not racetracks. Motorists, be they motorcyclists or users of other vehicles, who wish to speed, or engage in racing-type behaviour, should do so by taking part in one of the many available 'track days', or in a racing series, arranged by reputable organisations.

Note: Orders under section 74 of the Coroners Act 2006 prohibit the publication of any photographs taken of Mr Meers and Mr Blackford during these inquiries, in the interests of decency.

Bryers [2023] NZCorC 64 (22 May 2023)

CIRCUMSTANCES

Crystal Mary Bryers, three months old, died on 2 December 2020 near 1446 Kaitaia-Awaroa Road from head injuries as a result of blunt force trauma as a result of a motor vehicle crash.

On 2 December 2020, Crystal's mother was driving on the Kaitaia-Awaroa Road towards Ahipara when she drove off the left side of the road into a drain or ditch area. The car continued moving before hitting a driveway and concrete culvert causing the car to roll. Crystal and her brother were both passengers in the car. At the time of the accident, Crystal was in a rear facing baby capsule in the front passenger seat. The capsule base, which the capsule is designed to click into, was not used and the capsule was held in place by the front seat passenger seat belt. Crystal had been placed on top of the capsule's harness and was therefore not secured in the capsule. As a result of the accident the front seat passenger airbag was deployed hitting the rear of the baby capsule and ejecting Crystal from the seat. Crystal sustained unsurvivable injuries and died at the scene.

A blood sample was subsequently taken from Crystal's mother which was found to contain methamphetamine. Crystal's mother was charged and convicted of being in charge of a motor vehicle while under the influence of drugs and causing Crystal's death. The Police Serious Crash Unit provided a report which concluded that the cause of the accident was Crystal's mother driving under the influence of drugs, being fatigued, possibly being distracted by Crystal, or a combination of all three.

Bruce Wilson, an expert in crash investigation and road safety, provided a report to the Coroner emphasising the importance of correct installation and use of car seats. He observed that Crystal's capsule was not set up correctly. Mr Wilson also made comments on the risks associated with air bags. He advised that even if Crystal had been correctly restrained in the capsule in the same location, the force of the airbag deployment would have resulted in fatal injuries. In Mr Wilson's opinion, if the capsule had been correctly installed and placed in the back passenger seat of the vehicle, Crystal would have sustained minimal, if any, injuries from the crash.

Mr Wilson further advised that there is a need for effective education and support for parents on child restraints as car restraints use was not always well covered in antenatal new parent classes. Additionally, education on safe child restraint use and installation was not adequately prioritised. Mr Wilson also advised that cost does not need to be a major barrier to parents having safe car restraints.

The Coroner also received advice from Plunket/Whānau Āwhina who advised that there are no specific guidelines for antenatal education on child restraints. They noted that the education that is provided varies greatly and also acknowledged that not all expectant parents attend antenatal classes. The Coroner received advice from Te Whatu Ora (Te Tai Tokerau) who advised that education on car restraints takes place in formal antenatal classes and should also be covered in pre-discharge education before whānau leave a birth facility. The Coroner referred to the advice of Mr Wilson that not all hospital staff are properly trained in the use and installation of car seats and Te Whatu Ora provided the Coroner with a copy of their service specifications for pregnancy and parenting information and education.

COMMENTS OF CORONER MILLS

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

a. Crystal's death is a tragic and poignant reminder of the importance of the proper use of child car restraints.

b. Crystal's family wanted to do the right thing by purchasing an age-appropriate car restraint for her. The failure to use it in the appropriate position of the car and properly restrain Crystal resulted in her subsequent death which has had a devastating impact on all her whānau.

c. The expert evidence was that if Crystal had been properly restrained in a car seat and in the back seat of the car, (not the front seat), she would probably have survived the accident with minimal injury.

d. Airbags pose a significant, but possibly not well understood, risk to children particularly if the child is in a rear facing car seat with an active airbag in front of it. There is a common misconception that airbags are like soft inflated balloons when, in reality, they deploy at a speed of about 300 km/h and with a force of approximately 900 kg. The impact of this force and speed on a rear facing car seat can cause it to rotate around the seatbelt. The acceleration alone can cause massive head trauma.

e. The evidence before me suggests that many children are not restrained appropriately despite the best intentions of parents. Getting it "right" is not always straight forward. Attached as **appendix 1** is my expert's list of "Most common mistakes with car seats". This provides a handy check list for parents to think about when buying and installing car seats. I encourage all who travel with children to review this document and to check they are using their car restraints properly.

f. There are trained child restraint technicians throughout the country, although their services may come with a cost. Information about where to find a child restraint technician can be found on Find a child restraint technician | Waka Kotahi NZ Transport Agency (nzta.govt.nz).

g. Buying a new car restraint can be expensive, however there is a range of options on the market and the most expensive is not always the safest. I encourage people to seek advice on the options. You may be able to apply to Work and Income NZ (WINZ) for a special needs grant to buy one. It is also possible to hire car restraints.

RECOMMENDATIONS OF CORONER MILLS

I. Community education on the proper use of car restraints, particularly those hard-to-reach communities, is essential. While Te Whatu Ora Te Tai Tokerau advised that safe car restraint use was covered in some detail in the antenatal/Hapū Wānanga courses they run, the evidence more generally indicated that there is a broad variation in the education regarding child restraints provided in antenatal course across providers.

II. The Ministry of Health service specifications for pregnancy and parenting education courses is quite generic.[26] Car restraint safety is slotted in alongside safe sleeping and other items in a list under the topic "Preparing for parenthood." No guidance on what should be included under this heading is provided. There is no specific requirement that safe car restraint use education be provided by a suitably skilled and trained person.

III. I therefore recommend that the Ministry of Health review the service specifications for pregnancy and parenting education courses with a view to providing greater guidance and requiring specific education, by appropriately trained car restraint technicians, on the correct use of child restraints, including placement in the car, setting up of the harness, and the risks associated with airbags and placement in the front seat. The Ministry of Health was provided with the opportunity to comment on my proposed recommendation, but no response was received.

IV. I acknowledge that not all new parents attend antenatal courses. There are many reasons for this. For those who live rurally, such as Crystal's parents, attendance is difficult. However, my expert adviser, Mr Wilson, has advised that he has been involved with other learning and development specialist in the development of plain language on-line video training modules. The aim of these modules is to provide accessible, multilingual plain language advice to the community about car restrain safety, where to get advice, and what questions to ask. While this has not yet "gone live" it is hoped that it may provide an additional opportunity for broader community education on safe car restraint use. I endorse this initiative.

V. Finally, I strongly encourage and remind all people who travel with children to ensure that the child is properly restrained in a safely installed car restraint that is appropriate to their age and size. I emphasise the real dangers air bags pose to children and the importance of car restraints not being positioned in the front seat especially when airbags are installed.

VI. Plunket/Whānau Āwhina, Te Whatu Ora (Te Tai Tokerau) and Mr Wilson supported my recommendations and comments.

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

[26] Maternity Services - DHB Funded - Pregnancy And Parenting Information And Education Tier Level Two Service Specification

Frecklington [2023] NZCorC 65 (22 May 2023)

CIRCUMSTANCES

Mark Alan Frecklington, aged 65, died on 20 January 2018 at Waikato Hospital from multiple non-survivable injuries including fractures to multiple ribs, injury to heart and possible cervical spine injury, caused in a collision between a motorcycle and a motor vehicle.

Mark was an experienced motorcycle rider, described as a safe and cautious rider by family. Around 2:15pm on 20 January 2018, Mark was riding his motorcycle west on Whangamata Road, Kinloch. He travelled around a right-hand corner and encountered another vehicle, a Toyota Highlander, on a straight section of the road, travelling in the same direction. The Toyota Highlander had three mountain bikes affixed to the back of the vehicle.

The Toyota Highlander was travelling at a very low speed when Mark entered the straight section of Whangamata Road, a road with a 100km/h limit. Mark moved to overtake the Toyota Highlander, indicating to pass and riding into the opposing lane which was free of oncoming traffic. As Mark was in the process of overtaking, the Toyota Highlander began turning across the eastbound lane to their destination, across Mark's path. A collision occurred resulting in Mark being thrown from his motorcycle and into a fence post. Mark was taken to Waikato Hospital but died shortly after. The driver could not recall checking the rear vision or side mirrors before turning into the eastbound lane.

The Serious Crash Unit (SCU) investigation noted that at the point when the Toyota Highlander pulled into the eastbound lane there was insufficient stopping distance for Mark to be able to avoid the collision. Additionally, the location of the three mountain bikes attached to the back of the Toyota Highlander obscured the brake lights and indicator lights, resulting in Mark having little or no opportunity to observe the right indicator on the Toyota Highlander. The driver of the Toyota Highlander had at least 8 seconds to observe Mark before turning into the eastbound lane. However, the mountain bikes would also have impacted the driver's ability to use the rear-view mirrors to observe what was happening behind them.

The Coroner concluded that the primary causative factors of the crash were that the driver of the Toyota Highlander had laden the vehicle in a manner such that road users following behind the vehicle would not have clear view of the vehicle's rear lamps, and rearward vision obstructions were such that, had the driver actually checked the mirrors, he would have still failed to detect road users rapidly approaching from behind. The driver also failed to perform any form of mitigation to counter the various vision obstructions present over the moments leading to the collision. The Coroner noted that Mark's decision to overtake the Toyota Highlander had been reasonable in the circumstances.

RECOMMENDATIONS OF CORONER ROBB

I. One of the contributors to this collision was obstruction of the taillights due to the three mountain bicycles attached to the rear of the Toyota Highlander. The Serious Crash Unit recommended the compulsory use of light boards by motorists carrying bicycles on the rear of their vehicle. Despite legislation already providing some guidance on the use of light boards, I adopt and make that recommendation now.

II. In the absence of light boards being compulsory, I highlight the existing requirements. The Land Transport Rule: Vehicle Lighting 2004 requires the following:

6.3(12) The light emitted from a direction-indicator lamp must be visible in daylight from a distance of 100 m, and during the hours of darkness from a distance of 200 m.

6.3(13) A direction-indicator lamp…must, when operated, emit light that is visible within an angle of at least 15 degrees above and below a horizontal plane passing through the lamp 45 degrees inboard, and 80 degrees outboard, of a vertical plane that is parallel to the longitudinal centre-line of the vehicle and passing through the lamp.

III. I consider that if the carriage of bicycles on the rear of a vehicle prevents brake lights and/or indicator lights being readily observable from behind, and thereby fails to comply with the Land Transport Rule: Vehicle Lighting 2004, a light board should be mandatory.

IV. I recommend that when utilising bicycle racks on the rear of vehicles, road users conduct thorough checks to ensure all of their taillights are visible. If these lights are not visible, and in breach of the Land Transport Rule: Vehicle Lighting 2004, a light board must be used.

V. The Police have provided me with an explanation as to why the driver of the Toyota Highlander was not charged with any breach or offence. I have considered and accept that explanation.

VI. I asked the Police to provide me with information about what education promotions were undertaken by the Police or partner agencies. Inspector Crowe the Road Policing Manager Bay of Plenty DHQ has advised that he was not aware of any promotional activity presently being undertaken.

VII. In New Zealand campaigns to ensure that road users understand the need to wear seat belts and the consequences of not wearing seat belts has likely led to a change in attitude by most road users over time. Those campaigns I consider having been effective in slowly changing society's attitudes. Likewise, educating the public about the requirement to wear bicycle helmets has again seen a gradual shift in public attitudes.

VIII. The circumstances in which this avoidable death occurred could so easily arise again. Biking, and mountain biking are sports growing in popularity with consequent use of bike racks. It is easy for any of us to load bikes to the rear of our vehicles without fully anticipating the impact this may have on the visibility of rear lights. This can result in an accident, such as this tragic but avoidable accident that had fatal consequences for Mark, and whose family who continue to grieve for him. I recommend an educational initiative be undertaken to promote the need for light boards when transporting bikes using towbars. As noted at the outset of these recommendations I recommend light boards be compulsory in those circumstances to take the guesswork out of considering if rear lights are obscured when using a bike rack.

IX. I further highlight the dangers of vehicles crossing lanes in a 100 kilometres per hour zone. While the principal concern for drivers will understandably be to avoid crossing in front of oncoming vehicles, it is easy to forget, or to adequately check for road users travelling from behind. The circumstances of this death bring this concern into acute focus. Where a driver is crossing over a lane in an open road speed limit area it is important to check, not only for oncoming traffic but also to check for other road users

who are behind the driver, before travelling across traffic lanes. Under the Land Transport legislation, it is incumbent on drivers to check their surroundings, not only in front of them, but to their side and behind them, before crossing over traffic lanes. Failure to take adequate care can result in prosecution. There appears to be little in road safety campaigns to address this risk.

X. This finding will be distributed to the media for publication.

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

King [2023] NZCorC 63 (22 May 2023)

CIRCUMSTANCES

Steven King, aged 57, died on 1 January 2022 at State Highway 12 near Kaihu from hypovolemic shock with contributory flail chest.

At about 3:00pm on 1 January 2022, Mr King and his friend went for a ride on his Harley Davidson motorcycle. Mr King was driving and his friend was pillion passenger. Both were wearing helmets. They travelled to Opononi Pub where they each had a beer. Afterwards they rode through the Waipoua Forest. At about 5:00pm they stopped at a swimming hole where they shared a 40-ounce bottle of vodka. At about 10:00pm, they left and rode south along State Highway 12. While negotiating a left-hand bend, Mr King and his friend were thrown from the motorcycle onto the bank. Mr King was later pronounced dead at the scene.

Toxicological analysis identified that Mr King had an alcohol content of 219 milligrams per 100 millilitres of blood. For comparison purposes, the legal blood alcohol limit for a New Zealand driver aged 20 years or older is 50 milligrams per 100 millilitres of blood.

Senior Constable Cramp of Police Serious Crash Unit investigated the crash and found that as Mr King was riding downhill along a section of road that comprised an easy right-hand bend followed by a tight left-hand bend, he took the left hand bend wide, crossing the centre line and causing the rear wheel to lose traction. As the rear wheel regained traction it created a large torque causing the motorcycle to violently spin, throwing Mr King and his passenger off. State Highway 12 is a rural high speed road which winds through rural hill country. It is unlit. The speed limit is 100 kilometres per hour. There were no speed advisory signs or chevron curve indicator signs for the corners along that section of the highway. Senior Constable Cramp concluded that the cause of the crash was a combination of Mr King's alcohol consumption, some speed, the darkness and some degree of fatigue. The Coroner accepted Senior Constable Cramp's conclusion except to the extent that speed was a contributory factor as there were no speed calculations in Senior Constable Cramp's report to support this conclusion.

RECOMMENDATIONS OF CORONER HO

I. Senior Constable Cramp recommended in his report that chevron signs be installed at the crash location.

II. Such signs might have provided more advance notice to Mr King of the upcoming left-hand bend thus allowing him to negotiate it safely.

III. I advised Waka Kotahi New Zealand Transport Agency of my intention to recommend that it consider installing chevron signs at the crash location and to review other sections of SH 12 to determine the appropriateness of also installing chevron signs elsewhere. Waka Kotahi responded that it would undertake a review of this section of highway corridor to identify any high risk or "out of context curves", including the requirements for curve warning signs, chevrons and advisory speeds as appropriate. Waka Kotahi also noted that the installation of any recommended treatment would be prioritised according to the risks of each individual curve and that treatment consistency along the length of corridor is an important aspect of providing predictability for road users, especially those on two wheels.

IV. I recommend accordingly.

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

Leach [2023] NZCorC 75 (16 June 2023)

CIRCUMSTANCES

Graeme Michael Leach (known as Mike), aged 67 years, died on 5 April 2017 at the Te Rapa Road and Sunshine Avenue roundabout in Hamilton from head injuries caused by the impact from a truck and trailer unit while riding his bicycle.

Mike was riding his bicycle through the two-lane roundabout when he was hit by a truck and trailer unit 20 metres in length. The impact caused unsurvivable head injuries and Mike died at the scene.

The driver of the truck was prosecuted for careless driving causing death. He had failed to see Mike and was unaware of the collision at the time of impact. He pleaded guilty and was sentenced in the Hamilton District Court on 19 April 2018.

The Leach family raised a number of issues relevant to the cause and circumstances of Mike's death, and as a result of those concerns a coronial inquest was held on 7 and 8 March 2022. The four main issues considered at inquest are covered below.

Does the expectation that a cyclist "take the lane" at roundabouts adequately address the safety of a cyclist?

All experts at the inquest agreed there are inherent safety issues with "taking the lane" and with raised platforms at multi lane roundabouts. Their evidence indicated that this rule is not well known by both cyclists and drivers and therefore poses inherent risks The Coroner did not consider that the "take the lane" rule for multi-lane roundabouts was appropriate or safe, and endorsed the Leach family's suggestion that more and better education was required to make all road users aware of the take the lane rule.

Does the recent modification to roundabouts (green marked cycle lanes exiting and entering the roadway) adequately address the safety of cyclists?

The Coroner considered that the modifications adequately address cycle safety if a cyclist is turning left. However, if the cyclist is travelling straight through the roundabout the modification still presented safety issues for cyclists. She noted that one option suggested by those responsible for road safety is the use of raised platforms, but that these also have inherent safety issues for cyclists. Accordingly, she concluded that multi-lane roundabouts continue to be hazardous for cyclists.

How does the Hamilton City Council (HCC) monitor roadways to ensure cyclists are safe users of the roadways?

The green cycle markings at the roundabout where Mike died were in contravention of the Manual of Traffic Signs and Markings (MOTSAM). Section 3.18.07 of MOTSAM recommendations provided that cycle lanes should be terminated 30 metres prior to the intersection, or at a connection to an off-road alternative path.

Eight days prior to Mike's accident, the green cycle markings at the Te Rapa Road and Sunshine Avenue roundabout were resealed. The roadmaking contractor was instructed not to reinstate the "edge lines" which led cyclists to the start of the roundabout entrance. However, the contractor mistakenly reinstated the markings. HCC were unaware of the road marking error.

There was no dispute that the green cycle lane marking leading up the roundabout was non-compliant with MOTSAM recommendations. HCC readily accepted responsibility for this breach. Senior Constable Tidmarsh, who prepared the Crash Investigation Report, concluded that the green cycle lane as marked on 5 April 2017 encouraged and led Mike to the left-hand side entrance of the roundabout. This position meant the truck driver could not see Mike, who was positioned alongside the truck. Senior Constable Tidmarsh was of the opinion that this was a factor in the accident.

At the inquest, HCC advised that they now have additional quality assurance processes in place to check that markings are compliant. They also advised that the safety audits now in place will determine compliance is completed post project completion. They assured the Coroner that any changes still required to be completed would be identified through this process and therefore would avoid the erroneous cycle markings at the Te Rapa Road and Sunshine Avenue roundabout at the time of Mike's accident.

The Coroner considered there were shortfalls with HCC's traffic monitoring, in that it failed to address cycle activity and did not include near misses. She concluded monitoring should be improved by HCC to ensure they are adequately addressing cyclist safety and can identify intersections where safety issues are occurring.

Would any modification to the truck have reduced the truck's blind spot, and are modification recommendations realistic and appropriate to reduce the risks of this in similar circumstances?

The Coroner found it difficult to conclude with any certainty whether any modification to the truck that impacted Mike would have changed the outcome. It was accepted that blind spots are present all over a truck, even at the front of it. She also accepted that Mike's positioning to the front left side of the large truck at a busy multi-lane roundabout was inherently dangerous, and a contributing factor to the accident.

The Leach family suggested that trucks should be equipped (or modified) to ensure that there are no blind spots for the truck driver. The suggestion was that 360-degree cameras and sensor systems should be installed in trucks and should be mandatory.

However, Wayne Holden, a Road Safety Specialist for heavy motor vehicles, resisted the suggestion that truck modifications would rid a large truck of potential blind spots. He also indicated that for the trucking industry, mandatory modifications to trucks were financially unviable and would not necessarily alleviate the inherent problem of blind spots. Waka Kotahi noted there are currently no global standards for modifications to trucks, including the installation of 360-degree cameras and sensor systems

The Coroner accepted the difficulties raised by Waka Kotahi and the trucking industry regarding mandating modifications to older trucks. She concluded that it was not realistic for her to make any recommendations relating to truck modifications.

RECOMMENDATIONS OF CORONER DUNN

I. Pursuant to section 57A of the Coroners Act 2006 a Coroner can make a recommendation for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which Mike's death occurred. Any recommendation made must be clearly linked to the factors that contributed to Mike's death

II. I consider recommendations are required to reduce the chances of any similar deaths occurring in the future. My recommendations are as follows –

- HCC and all other road controlling authorities (RCAs) are to ensure that all current roundabouts (both single and multi-lane) have correct cycle markings so that they are compliant with MOTSAM requirements.
- If roadway markings for cycle paths are found to be non-compliant this must be promptly addressed by HCC and all other road controlling authorities to ensure compliance is met.
- If cycle lanes at intersections are remarked following roadways being undertaken, HCC and other road controlling authorities are to ensure that following completion of the project, the new markings are MOTSAM complaint with best practice and in accordance with directions given to the contractor. HCC and other road controlling authorities must have a transparent and robust audit/check systems and carry out these checks within **5 working days following the roadworks being completed**.
- HCC and other road controlling authorities have a responsibility to ensure our roadways are safe for cyclists. Monitoring of the roadways is a crucial tool for them to carry out their responsibilities. Monitoring should include obtaining information relating to near misses between vehicles and cycles, cycle volume and cycle activity on our roadways. It is accepted in making this recommendation that HCC and other road controlling authorities are dependent on cycle safety incidents involving near misses being reported to them by a member of the public or Police. These incidents should be able to be reported to HCC – either via an 0800 number or directly to a staffed member of HCC responsible for such matters. Such information should provide the council with

useful data as to what roadways are hazardous to cyclists and enable the council to take evasive action to avoid a cyclist being involved in an accident or fatality at that site.

COMMENTS OF CORONER DUNN

I. I endorse and encourage all cycling advocate groups to continue their demands for better driver education for cyclists. It is apparent during the course of this inquest that drivers are unaware of the "take the lane" rule at roundabouts. Better education and publicity regarding "taking the lane" may hopefully address this issue and avoid unwanted confrontation between cyclists and motorists.

II. Equally adult cyclists must be aware of the dangers of large trucks on our roads and the need to be cautious when large trucks navigate intersections and roundabouts. Cyclists are vulnerable and tragically often unseen by truck drivers. The message that caution is required when sharing the road with a large truck must be made clear to cyclists.

III. I encourage Waka Kotahi to engage with cycling groups to ensure that they provide safer roads for cyclists. A sign recently erected outside Waka Kotahi premises in Hamilton from a cycling group Bike Action Hamilton urges Waka Kotahi to provide increased funding for safer cycleways, to provide HCC with surety of funding and to undertake significant driver education around cyclist and bike lanes. I endorse Bike Action Hamilton's message to Waka Kotahi and trust that it provides some positive changes.

Feedback from interested parties

IV. Pursuant to section 57B of the Coroners Act 2006 a copy of my draft finding was provided to Waka Kotahi, HCC, Wayne Holden, Chris Foggin and the Leach family in October 2022. Responses were received from HCC, Waka Kotahi and the Leach family. As a result of the responses received by those parties amendments were made to my draft finding. Those amendments are recorded in my Minute dated 14 February 2023.

V. Mr Terry Leach (Terry), Mike's brother, provided comprehensive submissions and material urging me to make a recommendation that all heavy vehicles be retrofitted with technology to reduce blind spots. The technology he referred to include a Hi-Vue self-adhesive Fresnel lenses, direct vision/blind spot eliminating widows, cameras/sensors with alert systems, under-run prevention skirts and externally audible "left turning' warning annunciators. Some of these technologies were not referred to during the course of the inquest hearing.

VI. I subsequently directed that Terry Leach's submissions and material be provided to the independent trucking expert, Wayne Holden and Waka Kotahi. I sought a further report from Mr Holden and Waka Kotahi requesting they address the following issues:

- Are any of the truck modifications referred to (above) by Terry Leach a viable and realistic option for the trucking industry and if not, why not?

- Are these options capable of providing better and safer visibility to truck drivers to ensure cyclists and vulnerable road users are seen and therefore safer when sharing the road? Do they assist with reducing a truck driver's blind spots?
- Does he (Mr Holden) and Waka Kotahi maintain their earlier opinion that the modification of a truck compromises the truck's cab safety and strength.
- Does he (Mr Holden) and Waka Kotahi maintain their earlier opinion that any modifications to a truck is financially unviable.
- Does an under-run skirt installation on a truck provide better safety for a cyclist when sharing the road with a truck?

VII. Waka Kotahi provided a written response dated 29 March 2023. Mr Holden provided to me his report received by me on 19 May 2023.

VIII. Waka Kotahi respond that some of the technologies identified by Terry Leach may be a viable option for regulation. They submit camera and sensor systems are used in the UK and Europe however there are not as yet any global standards for this equipment and regulating it may impact the use of manufacturer-produced safety systems appropriate for each model of heavy good vehicles. They consider as regulations are implemented a consensus standard may emerge and Waka Kotahi expect these modifications will become more frequent.

IX. Waka Kotahi maintain their earlier opinion that the installation of windows in a truck cab can impact structural integrity depending on the product. They reiterate that such installation carries a huge cost to the industry however they note this could change depending on methods utilised of improving safety of heavy goods vehicles.

X. In relation to the use of Fresnel lenses Waka Kotahi note that there are no global standards for these products however recognises that they can be more cost effective. In response to the installation of under run skirts Waka Kotahi states the research on them is inconclusive in relation to cyclist safety.

XI. Mr Holden reiterated that he is an independent expert on truck driving not an engineer. He has expertise in driver training, driver assessments and crash investigations. He also has worked as a commercial helicopter pilot. In preparation of his report, he consulted with various trucking companies, owner operators, sales personnel and truck manufacturers representatives.

XII. In response to my questions (paragraph [VI] above) Mr Holden states that modifications to trucks should be presented to manufacturers for approval before being carried out as they affect the design, structural integrity and effectiveness of their product. He states this would require a lot of time, effort and cost. Such vehicles are required to meet testing before being manufactured. Each truck manufacturer must meet International Standards. He records that New Zealand does not manufacture trucks accordingly all trucks in our country are designed for use elsewhere. He notes it is the responsibility of Waka Kotahi to set design and safety standards of all vehicles including heavy goods vehicle that come into New Zealand.

XIII. Mr Holden is of the opinion that given the many different types of trucks in New Zealand that one particular modification may not suit a every type of truck. Given the number of different types of trucks and different modifications the issue is complex. Mr Holden reiterates his earlier evidence that he does not consider truck modification are a viable or realistic option for the trucking industry.

XIV. In relation to the various modifications referred to by Terry (in paragraph [V] above) Mr Holden responds –

- Fresnel lenses can be helpful however the truck that impacted Mike had various mirrors fitted and nonetheless there was a blind spot.
- Blindspot eliminating windows (the lower part of the window) are not frequently used by truck drivers.
- Cameras and sensors are common on modern trucks and manufacturers are proactive in this regard. He advises caution in relation to over use of such devices as they add to driver distraction.
- External audible left turning annunciators were retrofitted to motorcycles in New Zealand in the late 1970's. Mr Holden notes that complaints were made by the public about the loud beeping noise however he takes no particular view about their use on trucks.

XV. While Mr Holden acknowledges that potentially such measures could improve safety, he is of the opinion that their benefit would be limited and may cause distraction and add increasing costs.

XVI. In regard to modifications to a truck window Mr Holden maintains his earlier opinion that retrofitting would compromise the trucks safety and strength. He repeats his earlier view that such modifications must be made at the design stage by the manufacturer. He also maintains the view that modifications are financially unviable. He accepts that while some are low-cost items, citing Fresnel lenses and warning annunciators he however advises that direct vision/eliminating windows, cameras/sensors and under run prevention skirts would be cost prohibitive for small truck operators.

XVII. Mr Holden advises that following his consultations the general consensus of opinion is that under run skirt installation could be hazardous to cyclists and other road users and they may not be suitable to the New Zealand roads. He reports that under run skirts are easily damaged, trap heat, and are impractical on rough roads. Mr Holden states that under run skirts were trialled in Auckland on freight trucks and the issues identified were evident and in his opinion there are potential dangers.

XVIII. Mr Holden concluded his report by making observations of the difficult relationship heavy good vehicle drivers have with cyclists and the need for both users to be cautious and aware of each other when sharing the road. He took issue with Terry's comments regarding a so-called cavalier attitude of truck drivers on the road and advocated that truck drivers are professional, dedicated and well-trained drivers.

Conclusion

XIX. I have carefully considered Terry's submissions and the Leach family concerns regarding truck modifications. Having consulted with Waka Kotahi and the independent expert on truck driving safety I do not consider that any further recommendation should be made recommending that trucks be retrofitted with the various safety measures referred to in this finding.

XX. While I agree that the truck that impacted Mike had a number of blind spots I also consider that Mikes positioning himself alongside the large truck and trailer unit was a contributory cause of the fatal accident, as was the incorrect road markings that led him to that position.

XXI. I accept that some of these truck modification measures referred to may be helpful in keeping vulnerable road users visible on the roads however I do not consider such recommendations are currently practical or viable for current heavy vehicle trucks on our roads.

XXII. In reaching this decision I have taken into consideration that heavy vehicle trucks are not manufactured in New Zealand and there are inherent issues prescribing a particular safety measure to heavy vehicle trucks when there are such a wide variety of trucks on our roads. The concerns raised by Waka Kotahi regarding lack of global standards illustrates this complexity.

XXIII. To make any such recommendation I must be satisfied that recommendation is clearly linked to the factors that contributed to Mike's death. Here the factors that led to the accident include the incorrect road marking, Mike positioning himself beside a large truck and trailer unit, and the truck's blind spots. The truck driver may not have seen Mike regardless of whether modifications as sought were made to this truck. Mike's position was always problematic as confirmed by the evidence of Senior Constable Tidmarsh.

XXIV. As stated earlier in this finding I have no doubt the Leach family will be disappointed that no recommendation is made regarding truck modifications however for the reasons outlined I decline to make such a recommendation.

XXV. I encourage Waka Kotahi to ensure a consensus can be reached regarding global standards for trucks manufactured with technology aimed at eliminating blind spots on heavy vehicle trucks and to continue and promote the education of cycle safety on our roads.

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

Mani and Quin [2023] NZCorC 50 (26 April 2023)

CIRCUMSTANCES

Josiah Mani, aged 24, died on 4 July 2020 at King Edward Street, Dunedin from smoke inhalation due to a motor vehicle collision (car v truck with resultant fire).

William Matthew Joseph Quin, aged 20, died on 4 July 2020 at King Edward Street, Dunedin from a compound depressed skull fracture, with severe brain injury, sustained in a motor vehicle collision (car v truck with resultant fire).

Josiah and William worked together at a farm in Palmerston and would occasionally socialise. On 3 July 2020, Josiah picked up William and a friend in his 2004 Mazda Axela and they went out drinking in Dunedin. They drank alcohol and smoked cannabis until the early morning of 4 July 2020, when they left a club near the Octagon after it closed. The friend climbed into the back of Josiah's vehicle, while Josiah was in the front driving and William was in the front passenger seat. The friend fell asleep and had no memory of the drive.

At around 3:30am Josiah's car was seen driving fast southbound along King Edward St, Dunedin. While navigating a right-hand bend, the car crossed the centreline into the northbound lane. The driver of an oncoming truck was unable to avoid the collision. Following the collision, the truck driver called emergency services and while on the phone, noticed flames coming out of the car's bonnet. He attempted to extinguish the flames, but they quickly engulfed the whole vehicle. Their friend had been able to exit the vehicle prior to the fire and survived but Josiah and William were pronounced dead at the scene.

Toxicology results from Josiah's post mortem blood sample detected alcohol in the blood at a concentration of 254 milligrams per 100 millilitres of blood. No drugs were detected in his blood.

The Serious Crash Unit (SCU) investigation noted that Josiah had a blood-alcohol level that was over five times the legal limit. CCTV footage also showed Josiah's car having crossed the centreline prior to the crash in an area 1.7km from the crash location. The SCU report noted that the car may have been speeding when it crossed the centreline and was entirely in the northbound lane when it struck the oncoming truck. It was also found to be unlikely that William had been wearing his seatbelt when the car crashed.

The Coroner concluded that the deaths of Josiah and William resulted primarily from the combination of excessive alcohol consumption and driving.

COMMENTS OF CORONER BORROWDALE

I. Having given careful consideration to all of the circumstances of these deaths, I consider that there are comments that can usefully be made pursuant to section 57(3) of the Coroners Act 2006.

II. The motor vehicle collision that claimed Josiah and Williams' lives, and badly injured their friend, was awful to behold, with Josiah's car quickly becoming an inferno from which rescue was impossible.

III. Their deaths were entirely avoidable. Josiah was extremely intoxicated while driving that evening, and on more than one occasion crossed the centreline and into the path of oncoming traffic.

IV. It is simply unsafe to drive while intoxicated.

V. There is a wealth of publicly available information advising against drinking and driving. I encourage all drivers – and especially young and learner drivers – to follow the alcohol awareness and driving safety advice that is made available by the Ministry of Transport, Waka Kotahi New Zealand Transport Agency and other entities, and abstain from driving while affected by alcohol.

VI. When going out with the intention of drinking, always make sure to arrange transport by others, such as by organising for a sober, designated driver to take the wheel. Do not take risks with your life, and the lives of your friends and loved ones, by drinking while under the influence of alcohol.

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

Nelson [2023] NZCorC 37 (5 April 2023)

CIRCUMSTANCES

Shannon Bruce Nelson, aged 29, died on 16 November 2019 at the corner of Timaru Road and Regent Street of high energy impact internal injuries.

On 16 November 2019 Mr Nelson and his partner were at a barbeque at a friend's house. Mr Nelson was drinking alcohol and had smoked cannabis. As Mr Nelson wanted to continue drinking, they decided that he would ride his motorcycle back to their house. His partner would follow and bring him back to the barbeque in her car. Mr Nelson rode along Timaru Road.

At the same time, Hayley Smith was driving in the same direction as Mr Nelson on Timaru Road. Ms Smith saw a motorcycle in the distance in her rear vision mirror as she slowed to turn into a driveway. Mr Nelson's motorcycle collided into the right rear of Ms Smith's vehicle. Mr Nelson died at the scene.

Toxicology analysis established the presence of alcohol and cannabis in Mr Nelson's blood. The level of alcohol in Mr Nelson's blood was 57mg per 100ml. For comparison purposes, the legal blood alcohol limit for a New Zealand driver aged 20 years or older is 50mg per 100mL.

The Serious Crash Unit investigated the crash and calculated that the speed that Mr Nelson was travelling at was no less than 101 kilometres per hour in a 50 kilometres per hour zone.

COMMENTS OF CORONER DUGGAL

I. The risks of driving above the speed limit and driving after consuming alcohol and / or drugs are well publicised in New Zealand. This can include slowed reactions or increased confidence or disinhibition.

II. Having given due consideration to the circumstances of this death, I endorse the efforts of New Zealand Police and other authorities to educate the public on the effects of speeding and driving after consuming alcohol / drugs and deter these behaviours.

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

Parmentier [2023] NZCorC 46 (21 April 2023)

CIRCUMSTANCES

Dean Andrew Parmentier, aged 52, died on 3 February 2019 at Auckland City Hospital from complications of blunt force injuries to the head.

On 2 February 2019, Dean was riding his motorcycle westbound along Mill Road in the Bombay area, which has a speed limit of 100km/hr. Yi Peng Jiang, known as Ivan, was driving a Toyota Rav4 in the same direction some distance ahead. Ivan's wife and young son were in the car with him.

Ivan attempted to pull into a driveway on the right-hand side of the road to attend to his infant who was crying. As he did this, he checked his right-side wing mirror and did not see any vehicles behind him. However, as he initiated a turn into the driveway, Dean began overtaking Ivan's vehicle. Dean's motorcycle collided with the rear of Ivan's vehicle, causing significant injuries. He was taken to Auckland City Hospital but passed away later that day due to the severity of his injuries.

The New Zealand Police Serious Crash Unit ("SCU") investigated the crash and concluded that the main causative factor was Dean attempting to overtake the Toyota while it was signalling a right turn and in the process of making that turn. The SCU noted that Dean may have been in the Toyota's blind spot when he tried to overtake.

The Toyota had a Blind Spot Monitor which was turned off at the time of the collision. The monitor can detect vehicles that are travelling in adjacent lanes in areas that are not reflected in the vehicle's rear view or wing mirrors. The SCU noted that there are some conditions under which a Blind Spot Monitor will not detect certain types of vehicles or objects.

As part of the post-mortem process, samples of Dean's blood were tested and detected tetrahydrocannabinol (THC) in the blood, consistent with the positive immunoassay screen for cannabis. The SCU noted that drugs may have been a factor in the crash. Further, inattention/distraction on Ivan's part could not be ruled out as a factor in the crash, given that Ivan's son had been crying in the background.

RECOMMENDATIONS OF CORONER ANDERSON

I. Overtaking, and turning on an open road, are both high risk driving situations. Drivers and motorcycle riders should take particular care when passing other vehicles or when conducting turns. Extra caution needs to be exercised at these times, and drivers and riders should be vigilant for the presence of other road users.

II. There is no guarantee that the Toyota's Blind Spot Monitoring function would have detected the presence of Dean's motorcycle if it had been operational at the time of the crash. However, it may have done so and for the purposes of reducing the chance of further deaths occurring in similar circumstances I make the following recommendation in accordance with s 57A of the Act:

    a. Blind Spot Monitoring functions, where available, should be turned on and used during every trip to maximise the chance of drivers detecting motorcycles and other objects located in a vehicle blind spot.

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

Phillips [2023] NZCorC 70 (2 June 2023)

CIRCUMSTANCES

Gary Wayne Phillips, aged 65, died on 14 January 2021 at State Highway 8, Omarama Twizel Road, Omarama of severe cervical spine injury with multiple fractures of the cervical spine following a single motor vehicle rollover incident.

On 14 January 2021 Mr Phillips' wife was driving their new Swift caravan with their Toyota Hilux on State Highway 8. As she drove Mrs Phillips commented that the caravan was not towing as smoothly as it had on their previous journey. She later noticed that the caravan started "wobbling" or swaying from side to side. Mrs Phillips took her foot off the accelerator to correct the swaying. The swaying increased and the caravan violently swerved off the road. During this process, the caravan disconnected from the Toyota as it flipped. The Toyota rolled onto its roof. Mr Phillips died of his injuries at the scene.

The Serious Crash Unit (SCU) investigation found that the caravan's tyres were inflated to a pressure lower than the manufacturer's recommendation. This could intensify any lateral movement and result in the vehicle losing control faster than if at the correct pressure. The Al-KO stabiliser coupling the caravan and the Toyota became partially or fully disengaged during travel and contributed to the caravan's swaying. In addition, there was no evidence to suggest that the caravan was loaded to one side or that there was excessive "nose loading" (predominantly to the front of the caravan).

COMMENTS OF CORONER DUGGAL

I. Based on the SCU report, it appears that the distribution of weight in the caravan, the stabiliser becoming disengaged during travel and the tyres being under inflated were all potential contributing factors to the accident.

II. The SCU advised that anti-sway devices such as the stabiliser are manufactured to help reduce the chances of the caravan getting into a sway. They are a friction lock and do not have the ability to stop a swaying movement after it begins. This is a fundamental difference between such devices and remote braking systems. Caravan users may not be aware of this issue and there may be a misconception that an anti-sway device stops sway from occurring completely. The manufacturer of the stabiliser used by the Phillips encourages the use of a remote braking system to optimise safety.

III. The SCU advised there is no way for the driver to know that the stabiliser has become disengaged once the towing vehicle and caravan are moving apart from experiencing the vehicle swaying. The first indication Mrs Phillips may have had of an issue was the swaying of the caravan shortly before the accident, providing no opportunity for the issue to be recognised and addressed.

IV. It is my view that the stabiliser becoming disengaged was a significant contributor to the accident with the tyres being under inflated making it harder for Mrs Phillips to reduce the sway. Distribution of weight in the caravan may have been an issue, however, this is very difficult to determine with any accuracy.

V. Mrs Phillips' driving did not contribute to the accident. She was an experienced and careful driver who acted quickly and appropriately but was unable to prevent the Toyota and the caravan from rolling.

This is a tragic event with several contributing factors aligning to cause the accident which resulted in Mr Phillips death.

VI. Having considered the evidence including advice from the SCU, I make the following comments to caravan and trailer operators and sellers:

VII. An anti-sway device reduces the chances of sway occurring but does not have the ability to stop a lateral swaying movement once it is underway. Caravan sellers and/or rental companies should provide this information to their customers in a clear and easy to understand manner.

VIII. Correct loading is important for trailer/caravan stability and control. Utilising a loading scale will enable drivers to determine that the correct percentage of loading is on the tow ball. This significantly reduces the chances of a caravan or trailer entering a sway.

IX. I have asked for a copy of this report to be provided to the Automobile Association and the New Zealand Caravan Association to draw to the attention of their members. I thank both associations for their assistance.

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

Tawhara [2023] NZCorC 54 (8 May 2023)

CIRCUMSTANCES

Joseph Rangataua Tumoanakotore Tawhara, aged 19, died on 28 September 2021 at Waiomatatini Road, Ruatoria of extensive craniofacial injuries sustained in a motor vehicle crash.

On the evening of 28 September 2021, Mr Tawhara left his home address in his Toyota vehicle to make a short trip to the shops in Ruatoria. At some point after 6:00pm, Mr Tawhara was travelling west on Waiomatatini Road. As the Toyota vehicle was negotiating a moderate left-hand bend, it travelled off the opposite side of the road landing on the grass bank below the road. Mr Tawhara was ejected from the vehicle coming to rest a short distance nearby. There were no witnesses to the crash.

When Mr Tawhara did not return home as expected, his whānau reported him as missing to Police and commenced a search operation around the area. Mr Tawhara's mother located his crashed Toyota vehicle down a steep bank on Waiomatatini Road. He was found nearby and was declared deceased at the scene.

As part of the post-mortem process, samples of Mr Tawhara's blood were tested and tetrahydrocannabinol was detected, consistent with the positive immunoassay screen for cannabis.

A comprehensive investigation of the crash was undertaken by the New Zealand Police Serious Crash Unit ("SCU"). The SCU advised that Mr Tawhara held a Class 1 Learner License. While he had the appropriate driver license for the vehicle he was driving, he was breaching the conditions of the license by being unaccompanied. The SCU noted that Mr Tawhara was not wearing a seatbelt at the time of the crash.

The SCU concluded that the main causative factors to the crash were Mr Tawhara failing to negotiate the moderate left-hand bend, the lack of brakes on the vehicle and the speed of the vehicle. The SCU advised that the presence of cannabis could not be overlooked as a factor.

The SCU noted that Waiomatatini Road had reflective roadside marker posts present at sporadic intervals along each side of the road. There were no Armco barriers protecting vehicles from leaving the roadway. The SCU advised that a crash reduction consideration would include installing more reflective marker posts along the section of the road advising motorists of the upcoming bend. The SCU further noted that advance warning signs and the installation of Armco barriers on the outsides of the bends would prevent motorists from leaving the roadway.

COMMENTS OF CORONER RYAN

I. Considerable effort has been made in New Zealand to promote safe driving messages. Police, Coroners, and Waka Kotahi New Zealand Transport Agency (Waka Kotahi) have consistently highlighted the dangers of driving at an excessive speed, not wearing a seatbelt, driving under the influence of cannabis, and driving an unroadworthy vehicle. I again highlight them but make no comment.

II. I note that the SCU has suggested further installation of reflective markers, advance warning signs and Armco barriers on Waiomatatini Road to prevent motorists from leaving the roadway. I endorse their suggestion and as such, I have forwarded a copy of this Finding to the Gisborne District Council and Waka Kotahi for their consideration.

III. In the circumstances of this case, I make no formal recommendations.

Thompson [2023] NZCorC 62 (18 May 2023)

CIRCUMSTANCES

Dylan Grant Thompson, aged 31, died on 21 February 2021 at Gisborne Hospital of hypovolemic shock associated with severe pelvic injury secondary to motor vehicle crash.

On 21 February 2021 Mr Thompson and his stepfather met the rest of their motorcycle club. The group planned to ride to two monuments in Gisborne. Mr Thompson was riding his Triumph Rocket motorcycle.

The group travelled to the first monument before visiting a tavern where Mr Thompson had one handle of beer. At about 3:30pm the group left and made their way towards another tavern in Patutahi. Approximately 30 minutes later Mr Thompson was riding near the front of the group as they travelled along Lavenham Road. He was travelling between 100 and 110km/hr when he accelerated and overtook the other riders and headed towards a bend at the end of the long straight. He failed to negotiate the bend and crossed the centreline and continued into a ditch. When he came to rest, his motorcycle was on top of him but he was conscious and talking. Once paramedics arrived they noticed a large laceration on his buttock which was bleeding excessively and Mr Thompson was taken to hospital. His condition deteriorated and went into a cardiac arrest from which he could not be revived.

Toxicology analysis identified alcohol in Mr Thompson's blood at a level of 27 milligrams per 100 millilitres. For comparison purposes, the legal blood alcohol limit for a New Zealand driver 20 years old or over is 50 milligrams per 100 millilitres. The presence of cannabis was also confirmed in Mr Thompson's blood. However, the analysis could not advise when Mr Thompson took this substance, and in what quantities.

The Police Serious Crash Unit (SCU) investigated the crash and considered Mr Thompson was travelling too fast to negotiate the bend, which was the primary cause of the crash.

RECOMMENDATIONS OF CORONER TELFORD

I. At the conclusion of their full investigation, the SCU team made the following suggestions to help increase road safety in this locality:

   a. Installation of chevron boards on the entry to the bend advising motorists of the upcoming bend;

   b. Installation of Armco "W" barriers on the outside of the bend to prevent vehicles travelling into the open drain; and

   c. The 80km/hr speed limit be extended further north onto the straight, so the bends are within the lower speed limit.

II. Before proceeding to make formal recommendations under s57A of the Act, I have given Gisborne City Council (GDC) the opportunity to comment, as required by s58A. I have received a response from Council, which I reproduce (without amendment) below:

   a. **Installation of Chevron boards** – this has been included in our work program to install, currently awaiting updates on timeframes from the Council's contractors.

   b. **Installation of Armco W Barriers** – This is included in our low cost low risk program in which is currently being prioriti[s]ed across our region.

   c. **Lowering of the speed limit** – GDC has completed a speed management plan that has been approved by Waka Kotahi. GDC consulted on 'safe and appropriate speeds' across our network with our community and feedback from this was that they did not support widespread changes at this stage and only speed reductions supported were around schools and townships.

III. Therefore, the Council largely concurs with the SCU recommendations, but it seems that public feedback has led to a decision that the current speed limit should be maintained "at this time". However, I proceed on the solid and detailed analysis carried out by the SCU and in the context of this unfortunate accident. I therefore maintain that the recommendation in respect of the speed limit is correct and encourage the Council to revisit this matter in their future analysis and planning.

IV. Accordingly, I make the following recommendations to Gisborne City Council pursuant to s57A:

   a. That they install chevron boards on the entry to the bend advising motorists of the upcoming bend;

   b. That they install Armco "W" barriers on the outside of the bend to prevent vehicles travelling into the open drain; and

c. That the 80km/hr speed limit is extended further north onto the straight, so the bends are within the lower speed limit.

V. I am of the view that the implementation of these recommendations is likely to lower the risk of further accidents in the above area and thereby reduce the chances of further deaths occurring in similar circumstances.

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

Self-Inflicted

Alizai [2023] NZCorC 48 (26 April 2023)

CIRCUMSTANCES

Shabana Alizai, aged 24, died on 9 October 2020 at Woolston, Christchurch in circumstances amounting to suicide.

Dr Alizai had immigrated to New Zealand from Afghanistan on 3 August 2020 with her parents and brother, and settled in Christchurch. In Afghanistan, Dr Alizai had been training to be a gynaecologist. Dr Alizai had no known history of mental health difficulties.

Following the move to New Zealand, Dr Alizai repeatedly expressed concerns that her qualifications would not be recognised in New Zealand and was stressed about finding work. She was worried that she lacked sufficient English language skills to gain employment and expressed feelings of worthlessness to her mother prior to her death.

COMMENTS OF CORONER BORROWDALE

I. Having given careful consideration to all of the circumstances of this death, I do not consider there are any recommendations that could usefully be made pursuant to section 57(3) of the Coroners Act 2006. In particular, I have no evidence that is suggestive of any shortcomings in the support that was available to Dr Alizai and her family upon migration to New Zealand, in a way that might have made any contribution to her death.

II. However, I make the following comments pursuant to section 57(3) of the Coroners Act 2006. These comments are directed to new migrants to New Zealand, who may need help and support with what is undoubtedly a stressful and challenging process of integration into a very different community.

III. Free and confidential support for new migrants can be obtained from the local Citizens Advice Bureau, or via its website www.cab.org.nz.

IV. Immigration New Zealand also operates 30 Migrant Connect sites, providing a targeted service for new migrants. Information can be obtained via freephone (0800 776 948) or via the website https://www.live-work.immigration.govt.nz/move-to-new-zealand/access-help-and-support.

V. Support with mental health for new immigrants can be accessed through the Mental Health Education & Resource Centre by phoning (03) 365 5344 or through its website at https://mherc.org.nz/directory/refugee-and-new-migrant-services.

VI. Christchurch Resettlement Services assists people in Canterbury from refugee or migrant backgrounds, and particularly supports Canterbury's muslin community. The service can be contacted by telephone (03) 335 0311 or by email at admin@crs.org.nz.

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 Dr Alizai entered into evidence in this inquiry, in the interests of personal privacy and decency.

Burridge [2023] NZCorC 49 (26 April 2023)

CIRCUMSTANCES

Barbara ("Barbie") Theresa Burridge, aged 53, died on 7 December 2021 at the Mt Vernon Track, Cashmere, Christchurch in circumstances amounting to suicide.

Ms Burridge had a history of depression and suicidality beginning at the age of 14 and last had contact with mental health services at the end of January 2021. Ms Burridge's mood had worsened in the week prior to her death and she had expressed some suicidal impulses.

COMMENTS OF CORONER BORROWDALE

I. In the interests of public awareness, I make the following comments pursuant to section 57(3) of the Coroners Act 2006:

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

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

II. I do not consider that there are any recommendations that can properly be made for the prevention of further deaths in similar circumstances.

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 Ms Burridge entered into evidence in this inquiry, in the interests of personal privacy and decency.

Ellison [2023] NZCorC 56 (10 May 2023)

CIRCUMSTANCES

Orewia Adrienne Ellison, aged 14, died on 4 March 2019 at her home in circumstances amounting to suicide.

On 4 March 2019, Orewia and her boyfriend returned home from school. A discussion ensued between Orewia and her grandfather about Orewia taking her younger brother's mobile phone. After the discussion, Orewia's grandfather left the house to get some food. Orewia asked her boyfriend to leave so she could have some time alone. He left the address but returned a short time later and found Orewia deceased.

Reports provided by the Lakes District Health Board and Oranga Tamariki (OT) showed that on 8 December 2017, Orewia presented to Rotorua Hospital Emergency Department having attempted suicide following the suicide of her cousin some months earlier. She was seen by the consultant child and adolescent psychiatrist who emailed the consultant paediatrician noting his concerns and asking for a comprehensive safety plan be put in place, together with psychoeducation being given to Orewia's parents. The consultant also made a report of concern to Oranga Tamariki (OT) who were then involved in the pre-discharge meeting with whānau. Prior to Orewia's discharge, the OT social worker and the paediatrician agreed to grant Orewia two hours of leave from hospital with her mother and agreed to develop a Safety Discharge Plan on their return. However, on 12 December 2017, Orewia's mother took Orewia from the ward and did not return. No Safety Discharge Plan was completed.

On 14 December 2017, a social worker located Orewia with her parents who reported no concerns. The same day, a Tūrangi Police Youth Aide Officer made a report of concern identifying chronic parental neglect, drug use and unresolved grief/suicide/self-harm ideology. On 22 December 2017 a request was made by Towards Wellbeing Suicide Consultation and Monitoring Programme for a social work assessment due to concerns over Orewia's mental health. The OT social worker responded that they had passed information to an aunt about Toward Wellbeing for her to pass on to whānau.

On 2 April 2018, OT were notified that Orewia had not been attending school. The social worker met with Orewia and identified no issues, while the family expressed no concerns. However, a subsequent meeting with Orewia's cousin revealed concerns about Orewia self-harming. On 30 April 2018 the OT social worker contacted Orewia's grandfather to arrange to see Orewia. The grandfather advised that he would contact the social worker when he considered the need arose.

In May 2018 a school counsellor raised concerns with OT as Orewia reported feeling unsafe at home due to her father's violence. On 2 and 3 May 2018, Orewia's grandfather provided assurances to OT that there were no issues at home and his belief that Orewia became upset when the death of her cousin was discussed. Professional counselling support was encouraged.

On 10 May 2018 the Tūrangi Police Youth Aide Officer notified OT of care concerns including neglect and methamphetamine use in the household. A whānau hui was held with agreement reached for support by OT for the family. There were ongoing concerns documented in OT files over the following months.

On 30 May 2018, the Family Court made a Place of Safety Order for Orewia and her siblings as a result of the children not attending school, the parents preventing the access of services, supervisory and medical neglect, parental drug use, family violence and non-engagement with services. While Orewia's siblings were placed with the grandmother, Orewia

was allowed to remain at her mother's address at Orewia's request as it was assessed that moving her had a likelihood of traumatic impact on her well-being. On 6 June 2018 interim custody orders were imposed. Orewia remained with her mother. A whānau hui resulted in an agreement by whānau that the children should have counselling as a result of suicide contagion risk concerning their cousin's death. A further family group conference occurred on 29 June 2018 after which Orewia went to live with her grandfather at her request.

In August 2018, Orewia attempted suicide again. On 20 August 2018 she was assessed by the Crisis Assessment and Treatment Team following an altercation with her father resulting in Orewia making suicidal statements. OT made a referral to Infant Child and Adolescent Mental Health (ICAMHS). From 21 August 2018 through to 31 January 2019, OT had ongoing contact with Orewia and her whānau. There was no evidence available of any communication between ICAMHS and OT during this time, and no ongoing mental health support was provided to Orewia from August 2018 through to her death.

OT reported that on 18 September 2018 an email referral was made to Youth Horizons Trust for Orewia and her whānau for therapy. OT reported they received a response from Youth Horizons Trust on 24 September 2018 advising that the referral would be allocated as soon as possible. By contrast, Youth Horizons Trust advised that they had email contact with OT on 28 November 2018 and 3 December 2018 advising that a referral to their services was required in order for them to provide support to the whānau. OT have no record of those emails. The ultimate result was that no support was provided by Youth Horizons to Orewia or her whānau.

COMMENTS AND RECOMMENDATIONS OF CORONER ROBB

I. A draft including the recommendations and comments was provided to each of the report writers with an opportunity to respond. Below I have referenced aspects of the response received from Oranga Tamariki.

II. The evidence before me indicates difficulty in whānau appreciating the level of risk of self-harm and a lack of psychoeducation to enable them to appropriately recognise and deal with behaviours and risks. There is evidence of a level of resistance at times, and likely a lack of appreciation of the need for Orewia to receive wraparound support including ongoing mental health support necessary to keep Orewia safe.

III. Educating whānau as to the level of risk and the behaviours to be aware of and putting in place an appropriate safety plan appears to be absent in the support provided to best protect Orewia. This was a missed opportunity to put in place something that may have reduced the risk of self-harm.

IV. Those difficulties were exacerbated by a lack of communication between, or miscommunication, between those entities that could have assisted in providing this additional support. This poor communication occurred at a crucial time in November 2018 through to Orewia's suicide.

V. The inadequate communication is highlighted in the interaction as between Oranga Tamariki and ICAMHS, and Oranga Tamariki and Youth Horizons. This resulted in no counselling or other whānau support, no psychoeducation of whānau, and no psychotherapy support for Orewia.

VI. I recommend that Oranga Tamariki, ICAMHS, and Youth Horizons review their communication processes to ensure appropriate communication and engagement of necessary support services in the future. By way of response Oranga Tamariki has advised:

> *Oranga Tamariki accepts and agrees with the Coroner's recommendation. Oranga Tamariki has relationships with ICAMHS and Youth Horizons Trust at a regional leadership level. However, these relationships could be further strengthened and Oranga Tamariki is committed to doing so. As is the case with many front-line social services, local resourcing can, at times, be a barrier to Oranga Tamariki accessing appropriate services for tamariki and whānau.*
>
> *The Oranga Tamariki Action Plan is a social sector accountability mechanism which focuses on tamariki and rangatahi with the greatest need and requires joint agency collaboration across government both within and between agencies.*
>
> *Oranga Tamariki collaborates with key people and professionals to ensure the needs of te tamaiti and their whānau or caregivers are identified and addressed. These people include iwi and cultural specialists, GPs, mental health professionals, psychologists, NGO workers, or education professionals. Oranga Tamariki social workers rely on the specialist services of these professionals to help keep young people safe.*
>
> *The Oranga Tamariki Practice Standard 'Work closely in partnership with others' describes quality practice when working with another agency or other professionals. This includes building respectful and trusting relationships and communicating clearly and openly.*

VII. Those matters identified in the Lakes DHB report including an understanding of the importance of psychoeducation for whānau living with and trying to care for Tamariki suffering from Orewia's difficulties I endorse. There were significant risk factors in respect of Orewia's living circumstances and problematic childhood, contagion from others she was close to having suicided, and her own significant suicidal ideation and what appears to be two suicide attempts. The need for Oranga Tamariki to understand the need for ongoing long-term psychotherapy and to facilitate this is essential, but sadly appears to be missing from the support provided to Orewia and her whānau. By way of response Oranga Tamariki advised:

> *CYRAS case notes record consistent attempts by social workers to engage whānau in discussions about Orewia's mental health. Social workers spoke with Orewia, her parents, and extended whānau during hospital visits, home visits and phone calls. The responses from whānau varied from stating they were concerned, to others not having concerns about Orewia's wellbeing. At the time, Oranga Tamariki social workers were also engaging with the whānau and professionals in respect of concerns for Orewia's siblings' mental health and wellbeing.*
>
> *The Oranga Tamariki practice framework recognises historic, generational, and current trauma, and promotes whānau resilience and oranga (wellbeing), and informed whānau decision making practices. This includes recognising the need for long-term therapeutic supports, as recommended by mental health specialists. Oranga Tamariki relies on specialists to then deliver that therapy and education.*

Oranga Tamariki social workers require support from other agencies to do their job and build trust with whānau. We rely on specialist advice from ICAMHS and Toward Wellbeing1 suicide prevention programme about the appropriate therapeutic interventions to support the individual needs of te tamaiti or rangatahi and their whānau or caregiver. For rangatahi and whānau Māori this includes access to appropriate cultural advice and culturally appropriate specialists or specialist health services that can work with the whānau to support the recovery of their rangatahi.

As the agency with expertise in adolescent mental health, ICAMHS is responsible for assessing, diagnosing, and making recommendations in respect to the mental health needs of tamariki. Oranga Tamariki understands, when recommendations are related to specific mental health treatments, it is the responsibility of ICAMHS to engage with the whānau around how this treatment will be delivered. Oranga Tamariki would then engage with ICAMHS to support their recommendations, plans, and referrals, as well as support the whānau in their engagement with ICAMHS.

When suicide risk is identified, we work together with te tamaiti or rangatahi and their whānau or caregiver and other professionals to secure their immediate safety and develop a collaborative plan to manage the risk to te tamaiti or rangatahi and to support them to become well again.

Where the risk of suicide contagion exists, strategically working with other key stakeholders in ways that promote relational, inclusive, and restorative outcomes for tamariki and whānau instead of working in isolation, is the shift in practice Oranga Tamariki is seeking to make.

VIII. I acknowledge the need for whānau to engage with and be willing to accept support. In the face of resistance and/or a lack of understanding of the significant risk of self-harm for a child with Orewia's difficulties I acknowledge the need for all relevant agencies to work together. To work together to help educate and to endeavour to find a way to provide appropriate support to youth and their whānau.

IX. Other than the responses received from Oranga Tamariki no other agency or report writer responded to the draft finding, recommendations and comments.

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 Orewia taken during the investigation into her death, in the interests of decency and personal privacy.

Foster [2023] NZCorC 43 (18 April 2023)

CIRCUMSTANCES

Alexandra Claire Foster, aged 36, died on 16 October 2020 at Auckland in circumstances amounting to suicide.

Alexandra had a history of anxiety, depression, and post-traumatic stress disorder (following an incident in Bali in 2015). She used alcohol as a coping mechanism. This escalated to the point of abuse, leading to hospitalisation at Auckland Hospital on 30 September 2020 due to liver failure.

Alexandra received intensive care at the hospital for several weeks. On 16 October 2020, Alexandra's father had a conversation with her about her treatment plan following discharge. Alexandra found this conversation distressing. After her father left the hospital, she self-discharged without notifying the ward staff or her family. Approximately two and a half hours passed before her family were notified of her leaving the hospital. Upon notification, her family went to her home address and located her deceased.

Auckland Hospital provided a copy of their Clinical Guidelines of what to do when an adult in-patient is discovered to be absent without leave (AWOL). The Guidelines state that they apply to all patients who have left the ward without notifying a staff member. However, the Nurse Director noted that this would be unworkable, and the Guidelines are only used in situations where it is believed that there is a risk of the patient harming themselves or another person or there is a clinical risk to leave.

COMMENTS OF CORONER HESKETH

I. Alexandra's absence from the Medical Ward was not investigated as soon as it was noticed she was not in her room at 7:40pm. It appears from the A[dverse] E[vent] R[eview] that not even basic enquiries were made to see if she was present in some other part of the Ward (e.g., a bathroom).

II. However, as already mentioned, the Clinical Guidelines around patients being absent without leave are not hospital policy. Rather they are provided to offer guidance only and it is not expected that they be strictly adhered to in all circumstances. The Guidelines provide the golden standard approach when a patient leaves the Ward without notifying the Ward staff, but they do not apply to every patient on every Ward in every situation because the process would be unworkable if they did.

III. On 12 October 2020 Alexandra was considered for discharge to her father's house on 14 October. However, she developed a fever on 13 October and was diagnosed with hospital acquired pneumonia. She received ongoing treatment and on 14 October her immediate family and the multi-disciplinary medical team join her in her room for a meeting. That led to arrangements being made for her to stay with her parents and eventually a residential treatment programme.

IV. Auckland hospital report that patients who are competent to make decisions leave their Wards all the time for a variety of reasons without notifying staff and the AWOL guidelines do not get triggered. It is only where the patient is considered to be a risk to themselves or others should they leave the ward, or where there is some clinical risk, that the AWOL guidelines would be followed.

V. The evidence does not support Alexandra was a risk to herself in view of her expressed desire to get well and her concerns she may die. I am satisfied she masked her true feelings and intentions from those trying to offer her care.

VI. Auckland hospital is in the process of reviewing the AWOL guidelines at present and this case has highlighted the need for clarity around when the guidelines should be triggered more clearly.

RECOMMENDATIONS OF CORONER HESKETH

I. I make the following recommendations:

a. Te Whatu Ora – Te Toka Tumai Auckland amend its Absent Without Leave (AWOL) Clinical Guidelines to further refine the risk-based approach to AWOL patients;

b. Te Whatu Ora – Te Toka Tumai Auckland develop mechanisms to make the guidelines easily accessible to staff needing to refer to them in time critical circumstances.

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 any reference to the cause of Alexandra's PTSD or of the photographs of Alexandra entered into evidence, upon the grounds of personal privacy and decency.

Huurdeman [2023] NZCorC 36 (4 April 2023)

CIRCUMSTANCES

Goossewinus Johannes Huurdeman, aged 63, died on 4 May 2020 at 29 Ratanui Road, Paraparaumu in circumstances amounting to suicide.

Dr Michael Doran, Consultant Psychiatrist, reported that Mr Huurdeman had engagement with mental health services in 1998, 2006 and 2020. In February 2020, a home visit was conducted by mental health clinicians. No acute risks were identified, and it was postulated that Mr Huurdeman may have been experiencing mood complications following a stroke. It was therefore recommended that his GP perform a full physical examination and for him to have a further mental health assessment. Mr Huurdeman declined to engage in this plan and he was discharged from mental health services.

RECOMMENDATIONS OF CORONER TELFORD

I. During my inquiry I became aware that Dr Doran did not have access to Mr Huurdeman's clinical notes prior to 2020 when preparing his first report for my inquiry. It is also evident to Dr Doran that, when the mental health clinicians saw Mr Huurdeman in 2020, they also did not have access to these historic notes. Accordingly, they had no knowledge of Mr Huurdeman's prior episodes of care with mental health services when assessing him in 2020.

II. When seen shortly before his death, Mr Huurdeman's last previous episode of care with mental health services had been fourteen years prior. I am satisfied that when he was last seen in February 2020, he was well assessed and supported (or as well as he would allow). Of course, the clinicians would have no doubt derived some value from knowing his clinical history, as is invariably the case. However, I do not consider this to be so critical to their assessment in 2020 as to be clearly linked to the factors that contributed to his death. I am therefore jurisdictionally confined in making comments and recommendations on this issue pursuant tos57A and 58.

III. That said, I consider it important to record that it has long been recognised that the situation in New Zealand relating to patient records requires significant resourcing. Health New Zealand are well aware of this issue and have a workstream in place, known as 'Hira' which they state is needed for the following reasons:

a. *Currently, health and wellbeing information is stored in different places, in different formats, and can be difficult to access and use effectively.*

b. *People and whānau often have to repeat their health information and history a number of times to different service providers and cannot easily access that information themselves.*

c. *Health care providers can't always get a full picture of a person's health to enable them and the consumer to make the best treatment decisions.*

d. *It can be difficult for policy makers, researchers and planners to get the latest information to base their advice and thinking on.*

IV. Health New Zealand's commitment to New Zealanders is that this workstream aims to transform the way people access, use and share health information. Their stated aims are to deliver:

a. *A personal health record – an app/website allowing healthcare consumers/whānau to see their health information in one place and update some of it.*

b. *A platform allowing healthcare providers to access and update patient data held in different databases.*

c. *A secure, carefully controlled digital ecosystem enabling vendors to build apps for healthcare consumers, whānau and providers, to help people manage their own health.*

V. The aim is to complete the necessary work by 2026.

VI. I commend this work programme in the strongest possible terms and look forward to a time when clinicians have ready access to the comprehensive information they need to best serve their patients. On this occasion, I find that the inability to access a single patient record was unhelpful, but not critical. However, I am conscious that this is not always the case.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may, unless granted an exemption under section 71A of the Coroners Act, 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 Huurdeman entered into evidence, in the interests of personal privacy and decency.

Luffman [2023] NZCorC 73 (13 June 2023)

CIRCUMSTANCES

Zoe Louise Luffman, aged 18, died at Hudson Hall, Lincoln University, Ellesmere Junction Road, Lincoln between 15 and 16 July 2022, in circumstances amounting to suicide.

At the time of her death, Zoe was a first-year student at Lincoln University. She had previously experienced a period of anxiety and low mood while at school, including self-harming and an attempt to end her life, and was under the care of Child and Adolescent Mental Health Services from mid-2019 until February 2020.

In March 2022, Zoe's mental health declined again. She began attending counselling with Student Health Services for help with her feelings. A friend also raised a wellbeing concern for Zoe with the faculty Dean after discovering Zoe had self-harmed. This led to a follow up by the Dean and university health staff, with Zoe reassuring a counsellor that she was coping. She was also referred to and saw a doctor in May 2022 after experiencing a bad anxiety attack.

During a mid-year break, Zoe spent time with her parents at home in Blenheim and at other locations around the South Island, during which she appeared positive and future focussed. She returned to the Lincoln University campus on Thursday, 14 July 2022. The next day, Zoe advised several friends and accommodation staff that she would be off campus over the weekend. Her access card records showed that she entered the hall for the final time at 10:27pm that evening.

On Monday, 18 July 2022, Zoe's parents became concerned about the lack of contact from her and called Lincoln University to request a welfare check. At 6:40pm accommodation staff entered Zoe's room and found her deceased.

Zoe's diary, letters she left for friends and family, and other documents written in anticipation of her death, revealed her growing anxieties and determination to end her life, which she had kept largely private from her family and friends. She had revealed some of her difficulties to her counsellors and GP, but had misled them into thinking that her prescription medications were proving effective.

The Coroner noted that Lincoln University had been active in mobilising staff to help Zoe with the mental health issues of which it was made aware. A subsequent review by the New Zealand Qualifications Authority endorsed the university's good practices and compliance with the Education (Pastoral Care of Tertiary and International Learners) Code of Practice 2021.

The Coroner also noted that while it was understandable for Zoe's parents to wonder whether her GP and counsellors should have disclosed more information to them about her mental health concerns, as an adult Zoe was properly the person in control of her health information. A provision allowing for health practitioners to disclose personal health information to others was not applicable in Zoe's case, as she did not disclose any suicidal intent or planning and denied suicidality when questioned.

COMMENTS OF CORONER BORROWDALE

I. I make the following comments pursuant to section 57(3) of the Coroners Act 2006, for the purpose of public education aimed at avoiding further suicide by young people in circumstances similar to those in which Zoe 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, which I repeat here:

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 others call 111.**

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

e. Try to stay calm and let them know 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:

b. Lifeline – 0800 543 354

c. Samaritans – 0800 726

d. For children and young people

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

f. What's Up – 0800 942 8787 (for 5–18 year olds; 1 pm to 11 pm)

g. 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)

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

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

Note: Section 71 of the Coroners Act 2006 applies. 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 making public of any photographs taken of Zoe Louise Luffman entered into evidence during this inquiry, in the interests of personal privacy and decency.

Sudden Unexpected Death in Infancy (SUDI)

Mafi [2023] NZCorC 78 (27 June 2023)

CIRCUMSTANCES

Silongo Mihaka Mamaia Mika Mafi, aged three months, died on 22 August 2020 at Manukau, South Auckland of sudden infant death associated with unsafe sleeping.

Silongo's mother and father were both living in temporary emergency housing prior to and after Silongo's birth and their relationship was punctuated by family harm incidences. Oranga Tamariki ("OT") had been involved prior to Silongo's birth due to concerns about his mother's ability to care for her unborn child. As a result, a safety plan in collaboration with OT was put in place to ensure the newborn pēpi would be safe.

Silongo was born on 5 May 2020 and his mother breastfed him initially. He was then commenced on formula due to breastfeeding being considered inappropriate because of the medication Silongo's mother was taking for her mental health conditions.

OT continued to have intermittent contact with the family following Silongo's birth, and also received further reports of family harm from the Police. The family had moved on several occasions to various motels and other emergency accommodation.

Midwifery notes show that Silongo was a settled baby with no major concerns. He received the expected post-natal visits from the midwife and no issues were identified. Silongo had been enrolled with Plunket following the referral from the midwife but unfortunately due to the transience within the whānau, he was never seen by a Plunket nurse. Plunket contacted OT several times to get an updated address and contact details, but they were slow to reply or did not reply at all.

On 31 July 2020 the OT social worker noted that the family did not have blankets, bed linen or a portable cot, but there is no evidence that any steps were taken by the social worker to seek financial approval to buy these items.

On 19 August 2020 OT spoke with Silongo's father who advised that Silongo was sleeping in a double bed with pillows on either side of the bed to stop him from rolling. The social worker noted she would speak with her supervisor regarding possible support to purchase a cot. On 21 August 2020 the social worker spoke to Silongo's mother on the phone. The social worker advised Silongo's mother that she had sought approval to purchase a cot, and this would be arranged soon. However, there is no evidence on OT's electronic system that financial approval was sought for the cot.

On the evening of 21 August 2020 Silongo was put to bed in a large adult queen size bed with two pillows on either side of the bed to stop him from rolling off. Silongo's mother stated she would usually lie Silongo down on his tummy with his face towards the mattress. Silongo's mother and father later joined Silongo in the same bed. At about 6:00am Silongo's mother advised his father that she was going to take Silongo and sleep with him in Silongo's room.

On the morning of 22 August 2020 Silongo's father woke to find Silongo's mother screaming and holding Silongo who was purple in the face and not breathing. Emergency services attended but sadly, despite resuscitation efforts, Silongo could not be revived and was pronounced dead at the scene.

Silongo's father stated he and Silongo's mother both smoked but not around Silongo. However, Police who attended the scene noted there was an ashtray and a lighter in their bedroom and it smelled of stale smoke.

COMMENTS AND RECOMMENDATIONS OF CORONER MILLS

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

II. It would be easy to simply say Silongo's death was a result of "unsafe" sleeping and place the responsibility for this on Silongo's parents. However, this does not reflect the complexity of how and why Silongo was not sleeping in a "safe sleeping" environment.

III. Silongo was a vulnerable pēpi. Oranga Tamariki knew this and had been actively involved with him due to concerns about his safety prior to his birth.

IV. Safe sleeping requires both education and resources. The evidence suggests that, despite Oranga Tamariki and other interventions this family missed out on both.

V. Oranga Tamariki knew on 31 July 2020, 3 weeks prior to his death, that Silongo did not have a cot. This was confirmed on 19 August when his father again told the social worker that Silongo was sleeping on a double bed with pillows to stop him from rolling. Oranga Tamariki confirmed that while the social worker indicated on 31 July that they would look into getting a cot for Silongo, there is no record of any steps being taking to seek financial approval for one to be purchased.

VI. Oranga Tamariki also knew that, due to their lack of secure housing and the resulting transience, Silongo had not been seen by Plunket. Oranga Tamariki also knew that Silongo's mother had not engaged particularly well with her health care providers both before and after Silongo's birth. This would indicate that the family had missed opportunity for education and support with ensuring their pēpi was sleeping in a safe environment.

VII. The evidence suggests that Silongo's mother, may not have been aware of the standard advice on safe sleeping. She acknowledged she usually placed Silongo to sleep on his front, face down on the mattress with pillows around him to stop him from rolling off the bed. Silongo was also additionally at risk as he was not in a smoke free environment and was not breast fed.

VIII. I am very concerned that Oranga Tamariki social workers did not take immediate steps to ensure Silongo was provided with something as basic as a cot. It is highly possible that if Silongo was in his own cot, without pillows around him, this death may have been avoided.

IX. I am also very concerned about Oranga Tamariki's slow response to requests from Plunket for contact details and address updates. Good coordination and communication between those involved with vulnerable children and pēpi such as Silongo is vital. It should be much better than what was reported

in this case. Had Plunket or other Well Child Tamariki Ora health service providers been able to visit Silongo and his parents, there would have been further opportunities to discuss safe sleeping, provide advice and support and also possibly expedite the purchase of a cot.

X. I therefore recommend that Oranga Tamariki:

a. review their practice guidelines to ensure that their front line staff working with pēpi under one years of age and their whānau, prioritise resourcing safe sleeping equipment such as cots, wahakura or bassinets.

b. circulate these findings amongst staff with an aim to educate social workers about the importance of safe sleeping.

c. review, in consultation with Well-child Tamariki Ora service providers, their communication protocols with a view to ensuring timely responses to requests for contact details and updates.

XI. As required by the Coroners Act 2006[27] Oranga Tamariki were given an opportunity to comment on my comments and recommendations. Oranga Tamariki accepted my comments at paragraphs [VIII] and [IX]. It advised that they have now updated their guidance on safe sleeping for frontline practitioners. This has been circulated to front-line staff via their internal Te Pae intra web and through the weekly leaders update email.

XII. Oranga Tamariki also referred to the Oranga Tamariki Action Plan which is focused on identifying the un-met housing, health and education needs of children and young people. It notes that the plan includes a statement that relevant agencies will work in conjunction to respond to the identified needs and to improve access to services. It noted that this could include options for expanding or replicating collaborative practices that are already working well.

XIII. I thank Oranga Tamariki for their consideration of my comments and recommendations. I encourage the on-going education of their front-line staff about the importance of safe sleeping and reinforce the importance of timely communication between agencies working with pēpi and tamariki.

XIV. In addition, I make the following general comments:

a. Sudden unexpected death is a risk to babies until they are about 12 months old, but most deaths can be prevented. I therefore reiterate the importance of making every sleep a safe sleep for all pēpi/ babies by:

i. Placing baby in their own baby bed in the same room as their parent or caregiver for at least the first six months. Put your baby to sleep in their own safe sleep space – a bassinet or cot, or a wahakura or Pēpi Pod if you choose to have your baby in bed with you.

[27] Coroners Act 2006 s 57b and s 58.

ii. Position baby flat on their back to sleep, with their face clear of bedding or anything else. They should sleep with their feet to the end of their bed, on a firm flat mattress. When pēpi sleeps on their back, their airway is clear and open and this helps them breathe easier.

iii. Eliminating smoking in pregnancy and protect baby with a smokefree whānau (family), whare (home) and waka (car). There's a strong link between SUDI and smoking. Healthy babies have an inbuilt 'wake up' response that protects their breathing. This response in babies is seriously weakened by smoking, especially in pregnancy.

iv. Encourage and support breastfeeding and the gentle handling of baby. Mothers can sustain tikanga ūkaipō (traditional practice of breastfeeding) with positive breastfeeding experiences.

v. If you're on a low income, you might be able to get help from Work and Income to buy a baby bed. See more information on WINZ website - https://www.workandincome.govt.nz/eligibility/children/having-a-baby.html.

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

McKee [2023] NZCorC 57 (11 May 2023)

CIRCUMSTANCES

Luna Pauline Urzula McKee, aged 1 month and 26 days, died on 6 December 2018 at her home from sudden unexpected death in infancy with an underlying condition of methamphetamine toxicity.

On the night of 5 December 2018, Baby McKee and her parents went to sleep. Baby McKee woke up several times during the night which was unusual for her as she would normally sleep through. She woke two or three times crying. Her mother fed and cuddled her back to sleep. Generally Baby Mc Kee was sleeping in a bassinet and sometimes next to her mother on the bed. Early in the morning of 6 December 2018, Baby McKee woke. Her mother took her into her bed to breastfeed her. Her mother fell asleep while Baby McKee was still breastfeeding. At around 10:00am, Baby McKee's mother awoke and realised that Baby McKee was not breathing. Emergency services were called. Attempts by the parents and paramedics to resuscitate Baby McKee were unsuccessful and she was confirmed deceased.

A post-mortem examination was conducted which included toxicological analysis of Baby McKee's blood. Methamphetamine and amphetamine (a metabolite of methamphetamine) were found in the blood. A level of 0.04mg/L of methamphetamine was detected. The amphetamine level was too low to confirm. The pathologist reported that both can be transferred to the breast milk of lactating recreational users. Methamphetamine has been reported in three deceased infants at levels of 0.03 mg/L, 0.04 mg/L and 0.13 mg/L.

Expert evidence was provided by toxicologist, Dr Leo Schlep. Dr Schlep reported that young children are particularly vulnerable to the toxic effects of methamphetamine. The most common route of exposure to methamphetamine or amphetamine for young children is breastfeeding by mothers who are recreationally taking these drugs.

Baby McKee had a cardiac blood concentration of 0.04 mg/L which was within the range of concentrations described in Dr Schlep's report. The report refers to the evidence of Baby McKee's agitation in the evening of 6 December 2018, which is a common symptom in young children poisoned with methamphetamine. Dr Schlep was of the view that methamphetamine could have contributed to Baby McKee's death. Dr Shlep recommended that a sample of the mother's breast milk in infant deaths be obtained in order to ascertain the presence of this drug and its concentration.

The Police reinterviewed the mother who denied any recent use of methamphetamine. The father admitted that he was using the drug but could not recall the number of times he smoked it after Baby McKee's birth. He reported smoking it in the lounge area away from where the cot. He denied there was a possibility of cross contamination between his methamphetamine and Baby McKee's milk formula as he kept the drugs in a "Systema Click plastic container", stored in a safe. The Police did not obtain a sample of the milk formula for testing.

The Coroner noted that there was insufficient evidence to conclude how methamphetamine ended up in Baby McKee's blood.

COMMENTS OF CORONER TETITAHA

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

II. There is a link between infant deaths and exposure to methamphetamine. Since December 2015, ESR have analysed 20 cases of deaths of infants under one year where they have detected methamphetamine and/or amphetamine, including the death of baby McKee. These cases included deaths due to blunt force trauma, a dog attack, and a series of apparent SUDI/unexplained deaths. The ages range from one day to nine months. Some include other toxicological findings including synthetic cannabinoids and THC.[28]

III. A 2020 report by Oranga Tamariki stated that their review of cases where babies were taken into care when under 30 days old showed methamphetamine was a factor in half of those cases. In the case of maternal alcohol and drug use, 59% involved methamphetamine. Overall methamphetamine was a factor in half (49%) of entries to care in the sample.[29]

IV. To prevent deaths of babies, such as baby McKee, who have been exposed to toxic levels of methamphetamine, requires a more comprehensive strategy then punishment. Harm reduction strategies that seek to reduce the harm caused to infants and children by adult methamphetamine use should also receive priority.

V. An initiative occurring in Northland known as Te Ara Oranga seeks to reduce the demand for methamphetamine through community and individually targeted projects that align with the resources of the Northland Police, Northland District Health Board (now known as Te Whatu Ora), and non-government agencies in the community.[30]

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[28] Email W Popplewell dated 13 September 2022.
[29] Oranga Tamariki Evidence Centre "Methamphetamine and care: what we know to date" July 2020 online publication https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Research/Latest-research/Methamphetamine-and-care/Methamphetamine-and-Care.pdf
[30] Northland District Health Board website https://community.northlanddhb.org.nz/NoP/

VI. Te Ara Oranga comprises the matrix model (a 16 week outpatient therapeutic program to support users to abstain from use incorporating kaupapa Māori), motivational interviewing by Police to induce behaviour change and referrals to alcohol and drug treatment (AOD), a Meth Harm Reduction Team within the Police, Pou Whanau Connectors (PWCs) to support and influence service users to connect with AOD, tools such as screening, brief intervention and referral to treatment (SBIRT), employment services and after-care to locate jobs and roles for people to assist recovery and reintegration.[31]

VII. An evaluation of Te Ara Oranga confirmed it reduced post-referral offending by approximately 34%. The evaluation also concluded that methamphetamine use was a major driver of life cause criminality i.e. methamphetamine users often had significant offending histories usually involving property related offending.[32] This reduction in post-referral offending by 34% is significant for the wider community.

VIII. The circumstances leading to baby McKee's death include alleged criminal offending together with methamphetamine use. The availability of Te Ara Oranga to her parents might have prevented baby McKee's exposure to methamphetamine and possibly her death. Her father's evidence confirmed that since he obtained employment, he is no longer using methamphetamine because he undergoes drug testing.

IX. There is also merit in the Police producing a SUDI protocol where an infant death occurs in the context of adult drug use or manufacture especially methamphetamine. Police at the scene should ensure samples of the child's food including formula and breast milk are uplifted for testing purposes.

X. There may also be a trend emerging where SUDI/unexplained deaths may have been connected to adult methamphetamine use. There is merit in Te Whatu Ora monitoring these trends through the coroners' office.

XI. All of the above actions may assist in producing future recommendations to prevent similar deaths such as Baby McKee's.

XII. These comments are directed to Te Whatu Ora and the Commissioner for Police.

RECOMMENDATIONS OF CORONER TETITAHA

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

II. Te Whatu Ora consider funding Te Ara Oranga throughout New Zealand/Aotearoa.

III. Te Whatu Ora consider monitoring any emerging trends between SUDI/unexplained deaths and methamphetamine toxicity.

IV. New Zealand Police consider drafting a SUDI protocol where an infant death occurs in the context of adult drug use or manufacture especially methamphetamine. Police at the scene should also ensure samples of the child's food including breast milk are uplifted for testing purposes.

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[31] The Evaluation of Te Ara Oranga: The Path to Wellbeing https://www.health.govt.nz/system/files/documents/publications/the-evaluation-of-te-ara-oranga-mar22.pdf
[32] See above at p 141.

Replies to Comments and Recommendations

V. I have received replies from Te Whatu Ora and New Zealand Police.

VI. Te Whatu Ora states $3.5 million of funding has been allocated to expand Te Ara Oranga across the Eastern Bay of Plenty, beginning in Murupara led by Te Whatu Ora's mental health and addiction commissioning group. Any further investment in addiction services is at the discretion of the [Health] Minister.

VII. Te Whatu Ora welcomes the opportunity to work with the coroners' office to monitor trends where SUDI/unexpected deaths may be connected to adult methamphetamine use.

VIII. The New Zealand Police do not consider it necessary to develop a SUDI protocol where an infant death occurs in the context of adult drug use or manufacture due to the sufficient guidance and policy in existence.

IX. The Police are currently reviewing the Police forms "report coroner" and "report coroner-sudden unexpected death in infancy". They will include a section on recreational drug use in the household which will provide guidance for attending staff when completing their investigation.

X. Where the death is suspicious, the Police can operate under the Search and Surveillance Act 2012. The ability to take food samples including previously expressed breast milk, and other cases is less clear.

XI. The Police suggest section 131 of the Coroners Act 2006 provides a power to seize a thing where it may be "relevant to the post-mortem of the body directed under section 31". This could suggest substances found in the baby's drinking vessel or food on or near the baby's body could be seized in these circumstances where the constable believes on reasonable grounds that it may be relevant to the post-mortem.

XII. Both Te Whatu Ora and New Zealand Police are thanked for their above replies.

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

Tuitama [2023] NZCorC 74 (13 June 2023)

CIRCUMSTANCES

Leonardo Alo Tama Alea Lelangi Tuitama, also known as Leonardo De Silva Tuitama, aged 5 months, died at 6 Vin Santo Lane, Te Atatu Peninsula on 31 January 2020. The cause of death was accidental asphyxia.

Leonardo was born at Waitakere Hospital on 7 August 2019 with no complications. The Waitemata District Health Board (WDHB) reported that his mother spent very little time in the birthing unit and went home with Leonardo just three hours after giving birth. While it was usual practice for staff discharging a mother and baby to discuss safe sleep as part of going through the discharge papers, this conversation did not occur as Leonardo's mother did not wait to be issued with

the paperwork. The WDHB said it was likely the only safe sleep information she had received was information supplied on the cot card.

Leonardo was of Māori and Samoan descent. Prior to his birth, there were care and protection concerns due to allegations of family harm and historic drug use by his parents, as well as his mother's difficulties finding housing. These difficulties resulted in Leonardo moving around four different districts in the Auckland and Northland areas during his life. Oranga Tamariki social workers visited the family on several occasions, with no issues raised about Leonardo's general state of health.

At the time of his death, Leonardo was living with his mother, an older sibling and four other adult whānau members. He usually slept with his mother but also had a bassinet to sleep in. His mother advised that Leonardo could roll both ways, from front to back and from back to front, and that he was almost beginning to crawl.

At about 11:00am on 31 January 2020, Leonardo's mother fed him then lay down with him on her king-sized bed until he fell asleep. She put a cotton wrap over him and left him sleeping on his back in the middle of the bed, with pillows above his head, to his right side and below his feet, and a wall on his left side. Upon returning to the bedroom after having a shower, she saw that Leonardo was still sleeping, so left him to rest while she went downstairs to look after her three-year-old daughter and do housework.

When she returned to the bedroom about 30 minutes later, Leonardo's mother found him wedged in a gap between the wall and the mattress, with his face against the mattress and his back against the wall. His mother picked him up and realised that his lips were blue and that he was not breathing. There was also vomit around his mouth and on his clothing.

Leonardo's mother ran downstairs with him calling out for help. Several neighbours, including a first aid instructor, came to assist and began performing CPR on Leonardo. He remained unresponsive and vomited twice. Emergency services arrived shortly afterwards and continued resuscitation efforts, but sadly Leonardo was unable to be revived.

Attending Police noted that Leonardo's bassinet may have been too small for him, as it was the same length as his body. Leonardo's mother also expressed some confusion about the safe sleep advice she was given by her midwife and Plunket.

The pathologist's report was unable to determine the cause of death due to a limited post-mortem examination. However, the Coroner was satisfied on the balance of probabilities that Leonardo's death was due to accidental asphyxia due to him falling into the gap between the mattress and the wall. There was no evidence to indicate that he had been subjected to physical harm or any toxic substances that may have contributed to his death. There was also no evidence to suggest he was suffering from any natural disease at the time of his death.

COMMENTS OF CORONER TETITAHA

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

II. I have made a finding that baby Leonardo died of accidental asphyxia due to the infant falling into the gap between a mattress and a wall while sleeping on an adult bed. The WDHB accepted no safe sleeping advice was given to the mother at the time of baby Leonardo's birth. The safe sleeping advice

given to baby Leonardo's mother about him sleeping in an adult bed was to ensure the infant slept on top of the duvet/cover (presumably to prevent smothering). The mother believed this would have allowed the child to roll off the bed so did not adhere to this advice. This indicates the possibility that the maternal health advisor and mothers such as baby Leonardo's are possibly speaking past each other.

III. There are already barriers to Māori accessing primary health care services for their children in New Zealand. A study has shown there are ethnic gaps in the uptake of primary care services and immunisation. Access to healthcare was strongly influenced by socio-economic, mobility and social factors including ethnic discrimination. The study recommended that addressing healthcare disparity requires "interventions tailored to specific ethnic groups, as well as addressing underlying social determinants and structural racism."[33]

IV. What was required was ongoing assessment and advice regarding baby Leonardo's safe sleep needs. The evidence indicates the mother did not receive safe sleeping advice regarding the dangers for a 5-month-old who could roll over, sleeping on an adult bed.

V. At the time of this death, all of the available bedding options for baby Leonardo had safety concerns. The adult bed he slept in with his mother was unsafe because of the risks of asphyxia. His only other bedding choice of a bassinet was inappropriate given his size and age of 5 months including the ability to roll over and push up on his hands.

VI. This mother had not engaged with any post-natal care agency such a midwife or Plunket who could have provided continuous safe sleeping assessment and advice. The mother's circumstances mirrored the barriers shown in the above study for Māori accessing healthcare. Safe sleeping advice and assistance could have prevented this death.

VII. The mother was required to engage with Oranga Tamariki due to care and protection concerns for baby Leonardo. This was an opportunity to provide the mother with safe sleeping advice and resources in the interests of baby Leonardo's welfare. Ongoing review of vulnerable infants' safe sleeping needs including access to appropriate bedding and healthcare advice while under 12 months of age might have prevented this death. Oranga Tamariki was the only agency capable of providing this service in the circumstances where the mother was moving between districts and not engaged with post-natal care.

VIII. I directed the above comments and below recommendation to Oranga Tamariki for comment.

RECOMMENDATIONS OF CORONER TETITAHA

I. I am making the following recommendation pursuant to section 57A of the Coroners Act 2006:

[33] Lewyca S & Ors "Determinants of ethnic differences in the uptake of child health care services in New Zealand: a decomposition analysis" *International Journal for Equity in Health* (2023) 22:13 https://equityhealthj.biomedcentral.com/counter/pdf/10.1186/s12939-022-01812-3.pdf

II. That Oranga Tamariki upon receipt of a care and protection concern for a vulnerable infant, include an ongoing review of the infant's safe sleeping needs including access to appropriate bedding and healthcare advice while aged under 12 months of age. This assessment could also extend to assisting vulnerable infants accessing immunisations on time.

Replies

III. I received the following reply from Oranga, Tamariki summarised below:

IV. There is no recorded evidence the social worker held safe sleeping conversations with baby Leonardo's mother. On 5 September 2019, the social worker visited the whānau home and noted baby Leonardo in a crib next to the bed and that he was alert and well.

V. Oranga Tamariki were aware that appropriate community services and the midwife was supporting this whānau.

VI. Oranga Tamariki has just completed updated guidance on safe sleeping for frontline practitioners. The updated guidance was to be published in May 2023 and will have a communication plan to ensure frontline staff are familiar with this. This includes guidance on vaccinations.

VII. Oranga Tamariki are also leading discussions on housing, health and education with relevant agencies.

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

Workplace

Fitzpatrick [2023] NZCorC 55 (9 May 2023)

CIRCUMSTANCES

Ethan David Fitzpatrick, aged 16, died on 19 March 2020 at Lake Rotoma, Matahi Road, Rotorua from drowning.

Ethan was a Year 12 student at Tarawera High School (THS). He was a competent swimmer and had achieved unit standard credits for diving and snorkelling. On 19 March 2020, Ethan was on a second visit to Lake Rotoma for snorkelling instruction and assessment as part of his NCEA school studies. Two teachers (referred to as Teacher A and Teacher B) and 15 students, including Ethan, were at the lake. Students had received a safety briefing prior to leaving THS that morning and another at Lake Rotoma before entering the water. The students wore goggles, snorkels, fins and full-length wetsuits. The students were put into pairs as snorkelling buddies. They went into the water with Teacher A to a point where the lake was about 3.5 to 4 metres deep. They were treading water in a half circle formation facing Teacher A, while Teacher A gave further instruction. The pairs then found their own space in the water to complete further exercises, including clearing their masks while floating, while Teacher A began assessing the pairs in turn.

Teacher B remained on shore preparing food for the students while providing additional supervision. Ethan's snorkelling buddy turned and swam toward Teacher B to ask whether they could be assessed next. He did not leave the water and his back was turned to Ethan for 15 to 25 seconds. During this time Ethan was not being observed by anyone. When Ethan's buddy turned back toward Ethan, he saw Ethan had rolled onto his side under the water, appearing to panic and started to kick wildly. Ethan returned to the surface gasping for breath and kicking wildly. One of Ethan's kicks struck the back of Teacher A's head as Ethan travelled past him. Teacher A grabbed Ethan's ankle and pulled him back. Ethan was in distress.

Teacher A and Ethan's snorkelling buddy took Ethan to shore. He was unresponsive. Teacher A commenced CPR. There was patchy cell phone coverage where the group was located and so Teacher B drove a short distance down the road to get reception and call emergency services. Members of the public in the vicinity, including an off-duty Emergency Medical Technician and first responder Fire Officer assisted with CPR. There was no defibrillator at the scene. Ambulance crews attended with a defibrillator and continued resuscitation efforts but Ethan did not regain consciousness and was pronounced deceased at the scene.

COMMENTS AND RECOMMENDATIONS OF CORONER BATES

I. Following Ethan's death, several matters became known which merit comment and recommendations. I make the following comments and recommendations pursuant to s 57(3) of the Coroners Act.

General comments

II. Through their investigation, WorkSafe NZ determined there had been contravention by THS of sections of the Health and Safety at Work Act 2015. WorkSafe alleged Ethan's death was due to THS's failure to undertake effective emergency planning and to ensure effective supervision.

III. THS cooperated fully with WorkSafe. Their education outside the classroom (EOTC) safety management systems were reviewed and either updated or amended where improvements could be made, and further staff training/up-skilling was completed. In my view, THS took appropriate steps following Ethan's death and there is no need for me to make further recommendations for them to alter current practices.

IV. I am aware that THS shared lessons learned with other schools in the region. Therefore, I do not intend to repeat the findings of the WorkSafe investigation. However, some matters merit further publicity.

Teacher to student ratios (supervision)

V. There is no set ratio of teachers to students and all EOTC activities are assessed on a case-by-case basis. This includes an assessment of associated risks and the experience and number of supervising/instructing teachers. Level of risk between EOTC events can vary markedly.

VI. The Ministry of Education met with Education Outdoors New Zealand (EONZ)[34] to discuss my provisional comments in relation to supervision of snorkelling activities. Their response referred me to the EONZ Good Practice Guide – Snorkelling, Version 1, released in 2020 (the Guidelines). For the reasons specified at page 5 of the Guidelines, no specific ratios of leaders or supervisors to participants for snorkelling are mentioned. This is due to varying supervision needs according to age and ability of participants, the activity, the location and environmental conditions and the skill and experience of the leaders and supervisors.

VII. The Guidelines include statements that:

a. Supervision in a water environment needs to include the ability for direct physical intervention. The question to ask is: *how quickly can a competent leader or supervisor get to someone in the water who needs immediate assistance?*

b. When there is more than one supervisor, clearly defined roles and responsibilities should be delegated. *This* is particularly important when using assistant leaders, accompanying teachers (who are not the activity leader), student leaders or parent helpers.

c. Supervision of larger groups of participants is likely to involve supervision from both in and out of the water e.g. a *spotter* on the shore or an ancillary vessel.

d. For groups of six or *more* it is advisable to have someone overseeing and not involved in direct supervision. This person can step into a direct supervision role if a supervisor is required to give 1:1 assistance.

e. In addition to having designated supervisors, a supervision structure should include a buddy system of having *participants* watch out for one other participant or buddy. The “one up one down” rule should apply to duck diving.

VIII. As noted by WorkSafe, there were two teachers to supervise fifteen students giving a ratio of 1:7 (if both were constantly supervising the group as a whole). This increased to 1:15 whenever Teacher B was attending to other tasks on shore (for example preparing food for the group). At times Teacher A was conducting individual assessments of students with his face below the surface of the water. When this occurred the supervision ratio was, at times, 1:1 for the student being assessed, and may have been 0:14 for the remaining students if Teacher B was not purposefully watching them.

IX. When Teacher B was involved in preparing food for the group he was positioned near a fixed barbecue some 30 m away. Hardly an ideal distance from which to closely supervise, particularly when engaged in other activities at times.

X. I accept that a buddy system and the “one up one down” rule were being applied. However, there was a period of approximately 15 to 25 seconds when this lapsed in Ethan’s case and he went unsupervised.

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[34] EONZ is a national professional organisation that leads, supports, and influences education outside the classroom and outdoors in New Zealand (EONZ website).

XI. Had Teacher B remained closer to the students, maintaining constant supervision, or had there been additional supervision on 19 March 2020, in the water or from shore, the chance of Ethan being unobserved for 15 to 25 seconds would have reduced. Despite this, there are simply too many variables to make a determination that an additional supervisor, or someone overseeing and able to step in as a supervisor, would have noticed Ethan from the moment he got into difficulty, while Teacher A was engaged in 1:1 supervision with others. A different outcome for Ethan may not have been achieved.

XII. Obviously, the greater the degree of supervision the better. However, given the clear instruction provided to the students, the equipment worn by them (including buoyant full-length wetsuits), combined with Ethan's level of competency in the water and his familiarity with the exercises, and the skill sets possessed by Teacher A and Teacher B, I am not prepared to conclude that the supervisor to student ratio was clearly insufficient that day.[35] Had there been a third person supervising, either in the water or from shore, which would have represented a perfectly acceptable teacher to student ratio in the circumstances, the same tragic outcome would still have been possible. Again, it remains unclear exactly why and when Ethan initially got into difficulty.

XIII. I have no concern regarding the level of qualification and general competency of the teachers accompanying the students on 19 March 2020. They appear to have been suited to the task. An additional set of eyes on the students, particularly when Teacher A was engaged in the 1:1 supervision of others, or having Teacher B focused solely on the students, *may* have made a difference. I cannot put it stronger than that.

XIV. In addition to the obvious need for vigilant supervision during EOTC water-based activities, several further matters arose that, if brought to wider public attention may prevent further loss of life in similar circumstances.

Communication

XV. The THS emergency communications plan approved by the EOTC Coordinator[36] for 19 March 2020 was to call 111 by cell phone. When Ethan's emergency arose, it became apparent there was patchy or no cell phone coverage, depending on exact location, and Teacher B had to travel by motor vehicle approximately half a kilometre before he could contact emergency services.

XVI. Lack of reliable cell phone coverage should have been realised during a pre-activity site visit, as part of safety planning, and noticed upon arrival at the site on 19 March 2020, when communications should have been checked.[37]

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[35] THS was operating under Ministry of Education EOTC Guidelines (Bringing the Curriculum Alive, 2018), which do not specify a teacher to student ratio. I note, by way of contrast, the assessed ratio for a qualified dive instructor is 1 teacher to 10 students.
[36] Each school, including THS, has a designated EOTC Coordinator responsible for assessing risks associated with proposed EOTC activities, for satisfying themselves that it is safe for activities to proceed, with appropriate safety management systems in place, and finally for approving (or refusing as the case may be) the EOTC activities to proceed.
[37] Teacher A was aware cell phone coverage could be patchy in the area but may be available in certain spots. He had previously made phone calls and sent texts from the area. Unfortunately, he did not check reception upon arrival on 19 March 2020 and did not communicate to others potential issues with coverage.

XVII. I note THS's communication plan has been updated and a satellite phone is now taken on all EOTC trips.

XVIII. On the evidence before me, I am unable to determine whether or not immediate communication with emergency services would have altered the outcome for Ethan.

XIX. However, **I recommend** that prior to commencement of EOTC school activities, there is confirmation with the school EOTC Coordinator of the ability to establish and maintain communication from the activity site. If there is patchy or no cell phone coverage, as in the present case, this may necessitate use of a satellite phone.

Defibrillator

XX. There was no immediate access to a defibrillator to assist with resuscitation efforts. A defibrillator became available with the arrival of St John Ambulance crew at 11:02 am, 14 minutes after they received notice of the incident. Notice was given only after a teacher travelled approximately half a kilometre in a vehicle to get phone coverage. Obviously, there was delay from the time Ethan was removed from the water until a defibrillator was available. Although it is a possibility, it remains unclear whether more immediate access to a defibrillator might have changed the outcome for Ethan.

XXI. THS recognised the need for timely access to such a vital piece of emergency first aid equipment. As a result, THS purchased a defibrillator and transportation pack, which are now taken to EOTC activities and school camps.

XXII. MOE and EONZ responded to my provisional comments that 'Access to a defibrillator has been highlighted in the revised toolkit and the safety management plan template for schools. The advice is for schools to be aware of the closest available AED where practical. There is also an app that identifies the location of the closest AED that staff are advised of in First Aid courses.'

XXIII. **I recommend** that EOTC and school camp activities include as part of safety planning confirmation of quick access to a defibrillator for the duration of the activity. It may be that some locations have a defibrillator installed. Other locations, such as in the present case, may require the school to provide one.

Bottled oxygen

XXIV. As noted in the WorkSafe report[38], Ethan drowned by inhaling water and being unable to draw another effective breath from that point onward.

XXV. The presence of bottled oxygen for EOTC water activity in remote locations is not required in EONZ guidance. However, I note the presence of bottled oxygen and a trained provider is dive industry best practice in New Zealand. In my view, this should be considered when planning for EOTC events. I endorse WorkSafe NZ's comments in this respect. The New Zealand Underwater Association (NZUA)

[38] WorkSafe NZ report dated December 2021, page 17 from paragraph 3.

express a view that "it is essential that any activities involving snorkelling or scuba diving have an appropriate amount of emergency oxygen immediately available."[39]

XXVI. MOE and EONZ responded to my provisional comments that when developing the Snorkelling – Good Practice Guide, the experts discussed bottled oxygen. It was decided that whilst it would be essential for commercial activity, it is not a 'must have' for this level of activity. If it were brought in as a 'must have' it would mean these activities could only be done through commercial providers and schools would not be able to run activities such as snorkelling themselves.

Specific guidance for open water snorkelling in New Zealand

XXVII. Perhaps the uncertainty described in this Finding in relation to whether the teacher to student ratio was adequate (ratio not specified in Ministry of Education Guidelines), and in relation to whether safety management planning for the activities on 19 March 2020 met acceptable standards, would be avoided if there was specific guidance adopted by the Ministry of Education and incorporated in its guidelines.

XXVIII. WorkSafe identified that New Zealand does not have any specific guidance for open water snorkelling. WorkSafe also identified that Workplace Health and Safety Queensland has a code of practice for recreational snorkelling which states:

> 'If a duty holder is providing recreational snorkelling for one or more persons they must have at least one person as a lookout, or the snorkelling is done with a guide and 10 snorkellers or less, and the guide has conducted a proper assessment of risks involved in not having a lookout, and it is reasonable having regard to those risks not to have a lookout.'[40]

XXIX. The Queensland code of practice is a practical guide to achieving regulated standards of health, safety, and welfare in relation to Recreational Diving, Recreational Technical Diving and Snorkelling. It applies to anyone who has a duty of care in circumstances described in the code. Duties require duty holders to consider all risks associated with the recreational activity. In Queensland, the code is admissible in corporate settings and courts may regard it as evidence of what is known about a hazard, risk or control and may rely on the code in determining what is reasonably practicable in the circumstances to which the code relates. Inspectors may refer to the code when issuing an improvement or prohibition notice.

XXX. WorkSafe also referenced Workplace Health and Safety Queensland's practice guide: Snorkel safety, a guide for workers.[41] The lookout role is described within this document as a critical role, most effective when the lookout is at an elevated and distraction free location. Before being allocated the role, the lookout should be assessed for their ability to scan effectively.[42]

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[39] 23 March 2023 response to Provisional Findings, Mr Andy Stewart, NZUA Board Member.
[40] Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2018, Office of Industrial Relations, Workplace Health and Safety Queensland, at 4.4 page 28.
[41] Snorkel safety. A guide for workers. Office of Industrial Relations, Workplace Health and Safety Queensland.
[42] Snorkel safety, a guide for workers, at page 14.

XXXI. Essentially, the Queensland example provides practical guidance and sets out minimum standards for the health, safety, and welfare of persons engaged in open water snorkelling activities (amongst other water-based activities). It centralises and simplifies the obligations of duty holders. In the present example that would capture the school BOT, EOTC Coordinator, and instructors/teachers/supervisors.

XXXII. The MOE, as the body responsible for setting requirements and processes for school EOTC snorkelling activities, were provided with my Provisional Findings and afforded an opportunity to comment. MOE and EONZ discussed the Provisional Findings and, in addition to their responses specific to snorkelling supervision ratios, access to a defibrillator and bottled oxygen (detailed earlier in these Findings), have commented that the Good Practice Guide – Snorkelling presently outlines the scope for snorkelling and is accessible to schools for EOTC activities at EONZ: EOTC Management – Good Practice Guidelines.

XXXIII. In response to my Provisional Findings, WSNZ describe the Queensland code of practice for open water snorkelling as a 'thorough, practical document that has potential benefits for New Zealand.' WSNZ advise that, although a project to create a similar code for New Zealand has value, WSNZ would need to consider its current priorities and resources before taking on any new projects. WSNZ is a small team of ten people, with limited time and capability. It prioritises work carefully to effect the biggest change possible. Interventions, small or large, require ongoing support from WSNZ. My recommendation for development of a New Zealand open water snorkelling code is acknowledged by WSNZ, who advise they are able to enter into conversation with the NZUA to provide assistance when resources are available. WSNZ acknowledge that every fatality is devastating. However, given the relatively small proportion of snorkelling deaths in New Zealand[43] and WSNZ's limited resources, their focus is currently on the bigger risks affecting many people each year, seeking behavioural change in those key areas, and developing water skills for tamariki.

XXXIV. WorkSafe NZ considered my Provisional Findings and responded that my recommendation for the development of an open water snorkelling code for New Zealand, akin to the Queensland code, has been considered by the relevant areas in WorkSafe NZ responsible for supporting the development of guidance, regulations, or other regulatory tools. No advice was received regarding whether WorkSafe NZ intend to progress the matter further.

XXXV. Until such time as a New Zealand code for open water snorkelling is developed, I encourage those responsible for facilitating open water snorkelling activities in New Zealand (including those facilitating EOTC snorkelling) to consider the Queensland code of practice and practice guide and turn their minds to the matters explained therein. They are excellent resources. More specifically in the school setting, they may assist schools with effective safety management planning and compliance with the provisions of the Health and Safety at Work Act 2015. Hyperlinks to these resources are footnoted below.[44]

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[43] 23 March 2023 correspondence from Ms Felicity Fozard, Senior Advisor – Information and Research. Ms Fozard advises that, on average, there are 82 preventable drowning deaths in NZ per year; of those, 2.5% are snorkelling deaths. Deaths from swimming are 23% of the drowning fatalities, with boating deaths a further 22%.

[44] Recreational Diving Recreational Technical Diving and Snorkelling Code of Practice 2018 (worksafe.qld.gov.au)
Snorkel safety: a guide for workers (worksafe.qld.gov.au)

XXXVI. **I recommend** the development of a code of practice and practice guide in relation to snorkelling in New Zealand, similar to those developed and utilised in Queensland, Australia.[45]

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

Mr T [2023] NZCorC 41 (17 April 2023)

CIRCUMSTANCES

Mr T, aged 43, died on 14 March 2016 at Totara Street, Mount Maunganui of massive crush injuries to his upper abdomen and lower chest.

Mr T was employed by Priority Logistics Ltd (PLL) as a truck driver. PLL is a trading division of Coda Group Limited Partnership (CODA). Ron du Plessis was the General Manager of CODA from 2015 to 2017, Grant MacLachlan was the CODA fleet manager at the time of Mr T's accident, and Ian Pauling was the Transport Compliance and Hub Manager at CODA. Clinton Burgess was the Business Development Manager at PLL at the time of Mr T's death.

In the course of Mr T's employment with PLL, he operated a side loader (also known as a swing lift) truck and trailer unit designed to lift and transport shipping containers. Induction materials at PLL included the Safe Operating Procedure (SOP) for side loaders.

Hammar New Zealand Limited (Hammar), of which Ian Johnston was a director, were the original equipment manufacturer (OEM) and supplier of the side loader used by Mr T at the time of his death. The side loader Mr T operated was part of the 150 series of side loaders. One of the safety features built into the 150 series at the time of manufacture were proximity sensors on the lifting arms which prevented the lifting arms from being deployed before the stabiliser legs were extended and safely positioned. When the side loader was converted by Hammar in 2011 from a 151 model to a 155 model, the HOPE and proximity sensors were not tested as it was not a requirement. The HOPE sensor was designed to assist with correct positioning of the side loader for a container lift and the proximity sensor was designed to prevent container lifts being conducted in an unsafe manner.

PLL operated a workshop to maintain its vehicle fleet. Some of the work required to be conducted on the vehicles was outsourced to Mount Auto Electrical Limited (MAEL). Captured in PLL's computer database, 'OnTap', were records of repairs to faults with the side loader remote control and other componentry used by Mr T. No documentary evidence was discovered of notice provided by Mr T to the PLL workshop or anyone else at CODA/PLL in relation to any issues with his truck and trailer. The absence of logbook or other documentation and the presence of OnTap repair records suggested Mr T preferred an informal (verbal) fault-reporting approach, most likely directly to the PLL workshop.

On 14 March 2016, Mr T drove his side loader from the PLL yard to the Ports of Tauranga yard in Totara Street to uplift a 40 foot shipping container. Mr T attached the side loader's chains to the container and adjusted the stabiliser legs of the side loader. The front stabiliser leg should have been fully extended, but it was not. When the container had been lifted

[45] In response to my Provisional Findings, Mr Andy Stewart, NZUA Board Member, confirmed that NZUA welcomes the recommendation that a code of practice for snorkelling in New Zealand is developed and that, in the interim, the Queensland code is supported as providing guidance.

about one metre off the ground, it suddenly started to drop, moving away from the side loader deck. As this happened, the rear passenger side wheels of the side loader lifted off the ground. This resulted in the driver side deck of the side loader tipping down toward the ground, and toward where Mr T was standing. Mr T attempted to get out of the space between the side loader deck and the container. However, the deck tipped toward Mr T too quickly for him to avoid being caught between it and the container. Mr T died at the scene from his injuries.

Sensors on the side loader that were designed to prevent the type of unsafe container lift Mr T was attempting were not functioning at the time of the accident. Mr T had positioned himself in an unsafe location at the time the container lift was attempted.

Mr T's death resulted in a WorkSafe New Zealand (Worksafe) investigation and the prosecution of CODA and Hammar. CODA pleaded guilty to a single charge of failing to take all practicable steps to ensure the safety of an employee. Hammar pleaded guilty to a single charge of failing to take all practicable steps to ensure the side loader being used by Mr T was designed, made, and maintained so that it was safe for its intended use. Sentencing took place in the Tauranga District Court on 3 August 2017. CODA were fined and directed to pay consequential loss and emotional harm reparation to Mr T's whānau. Hammar were fined. Mr T's name was suppressed by the District Court.

After Mr T's death, new warning signage has been developed and placed on truck and trailer units to clearly identify safety/exclusionary zones during container lifts. The revised and enlarged signage replaces the previous basic bird's eye view diagram of a side loader working area. Several areas are now clearly identified as hazard zones. A further surrounding area is identified as space that must be kept clear. Operator zones have been added. In addition to clear warning signs and symbols, the following message is now prominently displayed in block capitals 'KEEP CLEAR 5 METRES EACH SIDE OF VEHICLE DURING LIFTING'.

COMMENTS OF CORONER BATES

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

II. Mr T's death, whilst incredibly tragic, has driven considerable positive change. As a result of his death, steps have been taken by Hammar, CODA, and MAEL with the intention of preventing further deaths in similar circumstances. As a result of these steps, in the current workplace climate amongst these parties, I doubt whether similar circumstances could be repeated.

III. Action has been taken to:

a. Inspect other side-loader units around the country to ensure their safety features are working as intended. Any faults noted were remedied

b. Improve driver induction

c. Improve induction materials with increased emphasis on site-loader units and safety around them

d. Dramatically expand and improve the driver pre-start safety checklist

e. Empower and encourage drivers to opt-out of any task that may be unsafe

f. Expand and improve safe operating procedure

g. Expand and clarify safe operating zones for side-loaders

h. Improve truck safety signage

i. Increase the frequency of driver and equipment audits/checks

j. Formalise a process for driver log-book auditing

k. Improve lines of communication and keep better records of correspondence

l. Create and maintain more thorough records with respect to equipment maintenance

m. Promote a culture of safety first

n. Renew equipment while ensuring replacement equipment contains the latest safety features

o. Consolidate and update equipment manuals and make them widely accessible

IV. Mr T's death has been the catalyst for this positive change. Although it may be of little comfort to his whānau, it is certainly worth noting, and my hope is that they receive some assurance from it that other families are less likely to experience the loss and hurt they have.

RECOMMENDATIONS OF CORONER BATES

I. Although there has been significant positive change, there is still room for improvement. I make the following recommendations pursuant to s 57A of the Coroners Act 2006.

CODA - Standardised and audited fault reporting

II. At the time of Mr T's death, there were several methods drivers used to notify issues regarding their equipment. These ranged from very informal (verbal) to more structured (notes left in trucks or made in logbooks).

III. Because there was no uniform approach adopted by drivers, and they appear to have favoured verbal communication directly with the workshop team, it was difficult to track any issues drivers had raised in late 2015/early 2016, the time of Mr T's employment at PLL. Records are scarce.

IV. In accordance with the investigation report completed by CODA, Mr du Plessis agreed that, at the time of Mr T's accident, fault reporting systems were not especially well understood by CODA's drivers.[46]

V. A clearly defined, standardised, and regularly audited method for drivers to notify issues with their equipment is required. It is my hope that the structured logbook auditing system now in place, along with the opt-out process, is effective. To ensure that drivers notify equipment issues via these channels, a program of ongoing education is required. Emphasis should be placed upon drivers producing a clear written record of equipment issues and they should be discouraged from direct verbal approaches to the workshop team unless the circumstances make is absolutely necessary. In

[46] NOE 64 from line 8.

which case, the discussion should be reduced to writing as soon as practicable, either by the driver or a member of the workshop team. Clear written records are required to ensure that issues are logged, followed-up when necessary, and remedied. These records should be transferred into OnTap.

VI. For OnTap to effectively provide a fleet overview, to be a tool used for auditing purposes, and to promote safe use of equipment that is fit for purpose, the minimum requirement would be for it to contain clear and detailed records of:

a. Work due for completion

b. Who is to undertake the work

c. Work completed

d. Work outstanding

e. Additional issues detected during completion of work

f. Safety features checked

g. Equipment fit for return to service.

h. Keeping clear records of the above matters would require pre-commissioning hazard analysis and would eliminate any assumption that outsourced work had included testing safety systems and completion of any additional matters that had been observed and discussed while the equipment was outsourced. This should ensure equipment is working as intended prior to being put back into use.

Regular equipment tests

VII. The service schedule for Hammar 150 Series side loaders recommends, amongst other things: load holding check/test hoisting (always made after repair or the like); and opening and cleaning the control box, letting it dry indoors and spraying it with contact spray.[47] Crane testing shall be carried out at least once a year by a trained expert.[48]

VIII. There is no record that either one of these tasks was completed regularly in relation to the side loader operated by Mr T. Mr MacLachlan was not aware of any such annual testing being completed by CODA/PLL.[49] Mr Johnston's evidence is that, aside from the June 2014 crane overhaul work, Hammar had no dealings whatsoever with the side loader after its conversion in 2011.[50] Therefore, Hammar were obviously not involved in servicing the side loader on a regular basis. The Workshop Manager at PLL thought it was the manufacturer's responsibility. No records were produced to demonstrate the side loader had actually been subjected to annual load tests/inspections as the manufacturer's service schedule recommended.

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[47] IB 628.
[48] IB 630.
[49] NOE 247 from line 18.
[50] IB 425 at para 10.

IX. There is absolutely no clarity about who was responsible for ensuring the load tests and control box checks took place.

X. I recommend that a clear policy is developed which assigns responsibility for ensuring regular tests and checks are conducted as recommended in OEM documentation. Records of these tests and checks should be kept. This information would clearly be needed by CODA, contained in OnTap, if they are to maintain a thorough fleet overview.

XI. Additionally, I recommend that regular load tests incorporate examination of safety sensors to ensure they are working as intended.

The wider side loader industry

XII. This inquiry revealed areas where safety improvements could be made to the side-loader industry as a whole.

Positional sensors

XIII. When Mr Pauling was asked about the possibility of HOPE sensors emitting an audible sound when side loaders were lined up correctly, because a driver's attention is often in their mirrors, he advised he had never thought of that, but it was something he would take away and investigate further. He did point out that some drivers might be hearing impaired, and there was also a possibility that others might become reliant upon listening for a sound only at the expense of thoroughly checking for hazards around them. However, he accepted that a combination of checking surroundings and use of an audible indicator could be a good thing. [51] I am unsure whether this idea has been explored further. In my view it seems to have merit. An audible alert when a side loader and a container are properly aligned for a lift would be an extra layer of assistance for drivers. I recommend that equipment manufacturers and fleet operators utilising these positional sensors investigate the utility of an audible alert. The obvious place to start is with the drivers.

Truck signage

XIV. The new truck signage developed by CODA is a vast improvement over the old.[52] I recommend that similar signage it is displayed on every side loader unit, in a prominent position on each side and at the rear.

Industry regulation - tracking side loaders

XV. Mr Johnston gave evidence that, apart from larger freight companies who appear to be phasing out older machines in favour of machines with up-to-date safety features, there are operators purchasing second-hand or third-hand machinery. This may have flow-on safety consequences if the machinery is

[51] NOE 211 from line 27.
[52] IB 553/554 and as discussed in this Finding at paras 349-353.

not well maintained.[53] This may largely be due to the high cost of buying and maintaining this type of machinery, which can be prohibitive to smaller operators.

XVI. Mr Johnston was asked whether he thought there would be value in creating a national database of side loaders, starting from when they are first sold by the manufacturer, recognising they may be on-sold throughout their working lives. Owners would be required to update the database if they sold the unit. The intention being an ability to track side loader ownership, and perhaps their maintenance to ensure they are serviced as recommended, and not operated beyond a typical lifespan. Any modifications to units could also be tracked. Essentially this would be a chain of ownership that the manufacturer could access so they had a point of contact if for example user manuals were updated or issues with any particular type of side loader were identified and needed to be communicated.[54]

XVII. Mr Johnston accepted there would be merit in this idea and advised that he has been working on something similar with the National Road Safety Council.[55] He stated that, not only were they looking into annual trailer inspection via a system similar to a warrant of fitness for a car, but they were also looking at how to capture information on the database so that trailers, including side loaders, are continually maintained to the original equipment manufacturer standard regardless of their age.[56]

XVIII. Hammar, together with side loader manufacturers Steel Bros and Patchell, became involved with the NZIMSG.[57] Mr Johnston has worked with this group in relation to an annual trailer inspection requirement and standards.[58] He states that he formulated the first couple of drafts of a document which was circulated amongst all transport operators. That document has now been reduced to a fairly simple but comprehensive one-page sheet which the National Road Safety Council will take. The intention is to have the content of that sheet recognised as a legal document through VTNZ or Waka Kotahi. Alongside this annual inspection document is a register to track which trailers have had an annual inspection so that if they are sold the buyer can check whether everything is up-to-date. Mr Johnston states that all three side loader manufacturers are involved in this work.[59]

XIX. There is clearly merit in creating a national database of side loaders so that ownership, maintenance, and safety can be tracked. I recommend the implementation of such a system. To that end, this recommendation is to be brought to the attention of the National Road Safety Council, Waka Kotahi, and VTNZ.

Industry regulation – the New Zealand Intermodal Safety Group (NZIMSG)

XX. At present there is no side loader industry regulation. Operation of a side loader carries inherent risks. Mr T's death was the realisation of several of those risks. Perhaps it is time for formal side loader industry regulation to ensure consistent safety practices at a high standard.

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[53] NOE 522 from line 5.
[54] NOE 505 from line 21, 506.
[55] The National Road Safety Council is an advisory body that was established under s 215 of the Motor Vehicles Act 1988 with the objective of improving road safety aspects in the road transport sector.
[56] NOE 506.
[57] NZIMSG (New Zealand Intermodal Safety Group) discussed from para 411 of this Finding.
[58] Refer to Findings section, 'Tracking Side Loaders.'
[59] NOE 529 from line 7.

XXI. Although there is a unit standard available for side loader operators[60], a driver can legally operate without having passed that unit standard. As long as a person had the appropriate class of license, they could obtain a side loader and operate it legally without any formal training in how to safely operate one.[61]

XXII. At the time of Mr T's death, health and safety in relation to side loaders was informally regulated by SOP advice and documentation, which were the product of various reviews by senior operators and supervisors. The SOP in place at CODA at the time of Mr T's death was issued in 2015 and set out correct lifting procedure in step-by-step format, with what were considered to be clear diagrams. It covered hazard identification, where to stand and where not to stand. It did not include specific instructions for various models of side loaders.[62] It was simple and fairly generic. It is commendable that CODA had created and implemented a SOP. I suspect not all operators have done the same. The quality of and compliance with SOP amongst the operators who have one will no doubt vary.

XXIII. Side loaders are not covered by the Code of Conduct and Guidelines for Cranes.[63] According to Mr du Plessis, who led the CODA investigation into Mr T's death, there is a regulatory/guideline gap in the side loader industry. Because of this, there was and still is a need for owners and operators to take responsibility for safety in the industry. In October 2017 Mr du Plessis led a meeting in Auckland that was supported and attended by the Road Transport Forum, and about 50 operator representatives.[64] Following that meeting the NZIMSG was formed.

XXIV. Mr Burgess recalls that about 10 side loader operators from around the country were involved initially. CODA were trying to cover the entire country with roadshows. Several operators dropped off along the way. As of June 2021 (the date of inquest) about eight operators were still involved, comprised of a range of small and large businesses, and different types of loaders. All of the loader manufacturers were involved and attended the meetings.[65] A proposed Code of Practice for side loaders was developed.

XXV. Mr Pauling is a member of the NZIMSG. His evidence was that if an operator wanted to be known as a good operator, they would follow the steps in the proposed Code of Practice. He stated that larger freight companies only want to associate themselves with good, safe operators. However, there are 'renegades' in the industry. Some operators may not have drivers that have been assessed for competent side loader operation. Their equipment may not be safe. While initially it is hoped that all operators would choose to engage with a Code of Practice for side loaders developed by the NZIMSG, the intention is to make it a legislative requirement.[66]

XXVI. Mr Pauling stated that the wider side loader industry wanted to ensure there was no repeat of Mr T's accident. The purpose of the group is to lead the side loader industry whilst making health and safety

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[60] NZQA Unit Standard 17679.
[61] NOE 185 from line 1.
[62] IB 138 and 496 at paragraphs 23 and 24.
[63] IB 97 and 495 at paragraph 20.
[64] IB 497 paras 33 & 34.
[65] NOE 148 from line 14.
[66] NOE 183 from line 25, 184.

of paramount importance. Having produced a proposed Code of Practice they provided it to WorkSafe NZ and have continued to liaise with them seeking their support. The Code is specific to side loaders and designed to support the industry in the safe manufacture, operation, and maintenance of side loader equipment. It covers all aspects of side loader use. It applies to all persons conducting side loader business and regulates the way they act and communicate. It covers:[67]

a. Operational requirements

b. Strong recommendations for people operating side loader equipment

c. Side loader checklists and inspection requirements

d. Personal protective equipment relation to side loader operation

XXVII. Mr MacLachlan confirmed the NZIMSG was formed in 2018 and has continued to work with WorkSafe NZ on development of a Code of Practice specific to side loaders. He reviewed an early draft of the Code and added his knowledge to the Code.[68]

XXVIII. Mr Pauling and Mr Burgess advised they were both present when the NZIMSG met in Wellington a few months before the inquest. WorkSafe NZ also attended. The purpose of the meeting was to provide Worksafe NZ with a final draft of the Code of Practice for consideration and feedback. Mr Pauling understood this would be a 6 to 8 week process for WorkSafe NZ. He was hoping they would sign off on the final draft. Once that was done, the NZIMSG intended to strongly push the Code to the wider side loader industry. Mr Burgess advised that at the meeting a WorkSafe NZ representative gave a 'very, very strong recommendation' that he thought the Code of Practice was 'fantastic, well-needed in the industry, and he didn't see any flags with it that would stop it from becoming available.' Mr Burgess expected to see the Code of Practice out within a few months of the meeting and WorkSafe NZ gave a strong indication they would have it available on their website and were quite happy to promote it. Mr Pauling understood the side loader manufacturers all supported the Code and what the NZIMSG were doing.[69]

XXIX. Apparently, the process has stalled. The Code drafted by the NZIMSG remains with WorkSafe NZ, but promotion and implementation of it has been delayed by groups who have appealed against or objected to its content. Mr Burgess understands that WorkSafe NZ await the result of those objections/appeals.[70] I am unaware of the nature of the objections to the proposed Code and whether or when they may be resolved.

XXX. The Code prepared by the NZIMSG is intended to promote the safety of side loader operators and members of the public in their proximity. It has the support of the three main side loader manufacturers, Worksafe NZ, and a number of side loader operators. Implementation of the Code would in my view reduce the chance of further deaths occurring in the course of side loader operation.

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[67] IB 515.
[68] IB 531 at para 12.
[69] NOE 112, from line 12, 177 from line 24, 178,
[70] NOE 148 from line 23.

I therefore recommend some form of regulation of the New Zealand side loader industry through a published and enforceable set of minimum operational requirements and safety standards. To that end, this recommendation is to be brought to the attention of the National Road Safety Council, Waka Kotahi, and VTNZ.

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

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CHIEF CORONER
OF NEW ZEALAND