

Recommendations recap

A summary of coronial recommendations and comments made between **1 January 2017** and **30 June 2017**

Issue 13



OFFICE OF
THE CHIEF CORONER

OF NEW ZEALAND



Coroners have a duty to identify any lessons learned from the deaths referred to them that might help prevent such deaths in the future. In order to publicise these lessons, the findings and recommendations of most cases are open to the public.

Recommendations Recap identifies and summarises all coronial recommendations made over the relevant period. Where received, summaries of responses to recommendations from agencies and organisations are also included.

This issue features 22 recent coronial cases where recommendations were made. Final findings were released by a coroner between **1 January 2017** and **30 June 2017**.

This issue also features a case study report on deaths related to **workplace deaths**, key statistics relating to these deaths, an outline of the issues involved and the legal framework surrounding **workplace deaths with a focus on farming**. It also has a summary of recommendations made by coroners following these deaths.

Disclaimer: The précis of coronial findings detailed within this publication have been produced by Research Counsel of the Office of the Chief Coroner, with the best efforts made to accurately summarise the circumstances, findings and recommendations made by the Coroner in each case. Despite this, it should be noted that they are not exact replications of coronial findings. The original finding should always be accessed if it is intended to refer to it formally.

Please also note that summaries of circumstances and recommendations following self-inflicted deaths may be edited so as to comply with restrictions on publication of particulars of those deaths, as per section 71 of the Coroners Act 2006. Similarly, the contents of summaries and recommendations may be edited to comply with any orders made under section 74 of the Act.

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Recommendations

Adverse Effects or Reactions to Medical/Surgical Care	
Case Number CSU-2015-CCH-282	Catch Phrases Clozapine Treatment, Schizophrenia, Toxaemia, Clozapine induced gastrointestinal hypomotility Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/4.html Responses from Nelson Marlborough District Health Board, Hauora Tairāwhiti, MedSafe, Southern District Health Board, Lakes District Health Board, Hutt Valley District Health Board and PHARMAC See link above
Aviation Accident	
Case Number CSU-2014-PNO-000560	Catch Phrases Helicopter accident, Inexperienced Pilot, Mast-bump leading to rotor divergence, Civil Aviation Authority, Robinson helicopters, Transport Accident Investigation Commission Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/24.html Response N/A
Fire-related	
Case Number CSU-2015-CCH-714	Catch Phrases Accidental Fire, Caravan, Alcohol Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/22.html Response from WorkSafe See link above
Health Care Issues	
Case Number CSU-2014-AUK-001182	Catch Phrases Fall, Acute subdural haematoma, Mental health, Schizophrenia, GP Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/14.html Response from Royal NZ College of General Practitioners See link above

Recreational/Leisure Activities	
Case Number CSU-2016-ROT-000026	Catch Phrases Fall, Tramping, Mountaineering, Mount Taranaki, Crampons, Gaiters, Winter routes Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/21.html Response from New Zealand Mountain Safety Council See link above
Case Number CSU-2016-DUN-000076	Catch Phrases Hunting, Fatal Gunshot Wound, Firearm Safety Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/26.html Response N/A
Self-Inflicted	
Case Number CSU-2016-ROT-000026	Catch Phrases Suicide, Support from loved ones, Recreational drug use, Calling for assistance Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/7.html Response N/A
Case Number CSU-2016-HAM-000124	Catch Phrases Suicide, Mental Health, Face-to-face Triage, Crisis and Home Treatment Team Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/10.html Response N/A
Case Number CSU-2014-AUK-001251	Catch Phrases Suicide, Student Wellbeing Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/15.html Response N/A

Case Number CSU-2014-HAS-153	Catch Phrases Suicide, Youth Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/25.html Response N/A
Transport-related	
Case Number CSU-2015-CCH-000395	Catch Phrases Icy Conditions, Black Ice, Driver vs Bus, Slid on Bridge, High Impact Injuries, NZTA Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/2.html Responses from New Zealand Transport Agency See link above
Case Number CSU-2016-WHG-000014	Catch Phrases Pedestrian, Intersection, Push bike vs Milk Tanker Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/3.html Response from Kaipara District Council See link above
Case Number CSU-2015-ROT-000148	Catch Phrases Drowning, Concrete Protrusion on Bridge, Kope Drain Canal, Driver Disqualified Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/5.html Response from New Zealand Transport Agency See link above
Case Number CSU-2016-ROT-000289	Catch Phrases Motor Vehicle Accident, Driver Education, Icy conditions Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/12.html Response ...
Case Number CSU-2016-ROT-000290	Catch Phrases Motor Vehicle Accident, Driver Education, Icy Conditions Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/13.html Response from New Zealand Transport Agency See link above

Case Number CSU-2014-AUK-001427	Catch Phrases Motor Vehicle Accident, No seatbelt, Alcohol, High Speed
	Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/18.html
	Response N/A
Case Number CSU-2015-CCH-730	Catch Phrases Cyclist vs Car, Intersection
	Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/23.html
	Response N/A
Water-related (general)	
Case Number CSU-2014-CCH-227	Catch Phrases Missing Person, Drowning, Kayak
	Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/9.html
	Response N/A
Case Number CSU-2015-WGN-000562	Catch Phrases Drowning, Scuba Diving
	Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/11.html
	Response N/A
Work-related	
Case Number CSU-2015-PNO-000451	Catch Phrases Crush Injury, Quad-bike, Manufacturers Recommendations, Personal Locator beacon
	Link to Summary and Recommendations http://www.nzlii.org/nz/cases/NZCorC/2017/1.html
	Response from Worksafe See link above

Case Number CSU-2015-AUK-000277	Catch Phrases
	Crush Injury, bulldozer, working alone
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/16.html
	Response
	N/A
Unascertained	
Case Number CSU-2016-HAM-000273	Catch Phrases
	Crushed, cardboard recycling cage, methadone programme
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/19.html
	Response
	N/A

Case study: Workplace Deaths — Farming

In New Zealand, fatal accidents in the workplace continue to be a significant health and safety concern, particularly in the farming and agricultural community. This study reflects on the trends of workplace deaths in New Zealand before and after the recent amendment to the Health and Safety at Work Act 2015.

Workplace deaths at a glance

Workplace deaths occur every year in New Zealand, in all industries and workplace environments. Every year 50-60 people are killed in workplace incidents, and hundreds more die as a result of work-related ill health. Our work-related fatality statistics are three times as high as the UK and nearly twice as high as Australia.¹

Some workplaces are inherently more dangerous than others. Any workplace that uses heavy machinery or involves physical labour exposes employees and others to heightened hazards and risks. Farm work generally involves physical labour while working with heavy machinery and exposure to the weather elements. Reflecting on workplace death statistics helps to identify the main risks and hazards New Zealand employees are exposed to on a daily basis.

Notes

Care needs to be taken when interpreting and reporting figures relating to workplace deaths. The statistical data gathered in this study involves all active cases before coroners that involve deaths in a workplace environment. The data includes death of retired farmers working on their own farm.

Note: The following deaths are excluded from the data:

- All natural causes deaths such as heart attack or fatal asthma attack;
- All homicides that occur during working hours or at a workplace;
- Motor vehicle accidents in a private car on the way to or from work;
- Deaths of children at a workplace;
- Deaths that occurred as a member of the Armed Defence Force pursuant to s59A of the Act.

Provisional workplace deaths reported to the coroner, by age 2007-2017

In 2016-17, 57 deaths have been classified as occurring in the workplace in New Zealand. The highest rate of workplace deaths was for those aged 50-54 and 60-64. This statistic reflects the number of pre and post retired farmers who die while working on their own farm in later life.

This most recent figure of 57 deaths is lower than that of the previous year (2015-16) which included 62 workplace deaths; however it is notably higher than the 46 workplace deaths in the 2014-15 year.

¹ WorkSafe New Zealand, "Understanding HSWA" (31 July 2017) WorkSafe Website <www.worksafe.govt.nz/worksafe/hswa/understanding-hswa>

Age Range	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017
10-14						1	1	1		
15-19	2	3	1	4		4	1		2	2
20-24	11	5	3	7	2	3	2	5	2	4
25-29	2	4	6	12		2	4		2	2
30-34	4	5	4	10	5	4	1	5	4	3
35-39	7	9	12	4	4	5	1	1	3	4
40-44	3	4	8	7	6	8	2	7	8	6
45-49	11	3	4	10	6	8	9	1	3	4
50-54	6	9	4	7	9	6	5	4	6	10
55-59	5	5	10	9	4	1	7	10	5	5
60-64	2	8	7	10	5	8	6	4	9	10
65-69	2	4	2	3	5	3	7	1	8	3
70-74	5		1		4	1	4	4	9	2
75-79			1	2	2	2	2	1		1
80-84				1	1	1		1	1	1
85 +						1		1		
Total	60	59	63	86	53	58	52	46	62	57

Provisional workplace deaths reported to the Coroner by age, 2007-17

Provisional workplace deaths reported to the coroner, by gender 2007-2017

Although the number of female workplace deaths has increased over the past three years, the ratio of male to female workplace deaths remains extremely high. In the last year, approximately 88% of those killed in the workplace were males.

Gender	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	Total
Female	3	4	3	7	1	3		3	5	7	36
Male	57	55	60	79	52	55	52	43	57	50	560
Total	60	59	63	86	53	58	52	46	62	57	596

Provisional workplace deaths reported to the Coroner by gender, 2007-17

Provisional workplace deaths reported to the coroner, by ethnicity 2007-2017

While the majority of workplace deaths involve New Zealanders, foreigners working in New Zealand are also at risk. The figures reflect the larger number of European and Asian ethnicities working in New Zealand.

Ethnicity	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	Total
North America				2						1	3
South America		1			1		1				3
Australian				3			1		1	1	6
European	3	1	1	2	1	1	5	3	12	3	32
Asian/ Indian	1	4	5	5	1	1	2	1	3	7	30
Maori	12	19	13	7	9	16	9	8	9	7	109
NZ European	39	32	39	57	39	38	33	34	36	34	381
Pacific Island	3		1	3		1	1		1	3	13
South African		2	1	1	2						6
Unknown	2		3	6		1				1	13
Total	60	59	63	86	53	58	52	46	62	57	596

Provisional workplace deaths reported to the Coroner by ethnicity, 2007-17

Provisional workplace deaths reported to the coroner, by location 2007-2017

A high number of workplace deaths occur in our main farming and agricultural centres (Southland (77), Canterbury (64) and Waikato (67)). These statistics reflect the need for increased health and safety initiatives in farming and agricultural industries.

Incident DHB Region	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	Total
Auckland	1	2	1	1	1		1	1		3	11
Bay of Plenty	4	6	5	4	3	3	5	4	9	2	45
Canterbury	10	6	4	6	4	3	6	8	10	7	64
Capital & Coast	2	1	1	2		2		1	1	1	11
Counties Manukau	5	4	6	1	5	4	2	2	2		31
Hawke's Bay	3	3	3	3	1	2	2	1	4	3	25
Hutt								1			1
Lakes	3	3	3	2	1	6	1	1	1	1	22
Mid Central	5	4	5	2	3	2	2	2	2	3	30
Nelson Marlborough	5	5	5	3	3	1	5		5	1	33
Northland	2	2	4	5	3	5	2	2	5	5	35
South Canterbury	1	2				1		3		2	9
Southern	2	8	5	9	9	11	9	8	7	9	77
Tairāwhiti	1	1		1	3	2	3		2	3	16
Taranaki		5	3	2	2	4	1	2		1	20
Waikato	8	3	8	8	8	8	5	4	6	9	67
Wairarapa	1	1	3			1	2	1	2		11
Waitemata	5	3	5	1	5		5	1	3	3	31
West Coast	1		1	33		1	1	2	3	3	45
Whanganui	1		1	3	2	2		2		1	12
Total	60	59	63	86	53	58	52	46	62	57	596

Provisional workplace deaths reported to the Coroner by location, 2007-17

Legislation changes affecting workplace safety

In 2013 the Independent Taskforce on Workplace Health and Safety reported that New Zealand's work health and safety system was failing, prompting a change in legislation. The focus of legislation change was to reduce the high incidence of workplace accidents and fatalities and to make work environments safer for employees.

The Health and Safety at Work Act 2015 (HSWA) came into force on 4 April 2016. The HSWA sets out the principles, duties and rights in relation to workplace health and safety. The HSWA places responsibility on all persons in a workplace to eliminate or minimize risks and hazards arising from work. Senior business leaders are responsible for ensuring that the business is meeting its health and safety responsibilities, including:

- Protecting employees, customers, visitors and the general public from harm in the workplace;
- Consulting, cooperating and coordinating health and safety management with other businesses when working at the same location or through a contracting chain;
- Ensuring the supply of business services in other workplaces do not create health and safety risks;
- Assisting workers and other persons at workplaces in upholding their duty to keep themselves safe and including others in health and safety so as to not cause harm to them.

Coroners' obligation to investigate workplace deaths

Under the Coroners Act 2006, Coroners have a legal responsibility to investigate workplace deaths that are reportable unexpected deaths (s14). When a workplace death is reported, a coroner is able to take several actions:

- If a death that has been reported to a Coroner is being conducted by another investigating authority the Coroner may either postpone an inquiry into the death, or adjourn an inquiry that is already opened (s69).²
- If a death has resulted in criminal liability of any person, a coroner may postpone opening an inquiry or adjourn an open inquiry until the coroner is satisfied that the proceedings are finally concluded or the person is no longer charged with the offence (s68).
- Where it is in the public interest, a coroner conducting an inquiry may refer the death concerned to another investigating authority to complete an investigation (s119).

After adjourning or postponing an inquiry, a Coroner can open or resume it if he or she is satisfied that:

- an alternative investigation is not likely to go ahead; or
- an alternative investigation is going ahead, but is unlikely to establish the matters that a coronial inquiry would establish; or
- to open or resume the inquiry will not prejudice the investigation or any person interested in it.

A coroner can also request certain information from other investigating authorities:

- Where an investigation has not been completed into a death, a coroner has the power to commission from another investigating authority any reports, medical or otherwise, the coroner thinks proper (s118) or to request a copy of a report/investigation to be made available to a coroner (s120).
- Section 200 of the Health and Safety at Work Act 2015 explicitly provides that if requested by a coroner, the regulator must give the coroner a written report of an investigation that the regulator has carried out, or is carrying out, on the circumstances of any fatal accident that occurs at a workplace.

When a workplace death is reported a coroner has an obligation to investigate the death with the support of other agencies. The purpose of this investigation is to establish what happened and how a death of a similar kind can be prevented in the future.

Themes in coronial recommendations and comments on workplace deaths

Human error

Human error is often a feature of workplace deaths, particularly in circumstances where persons are using heavy machinery or do not have the appropriate safety gear for the activity. While human error can never be eliminated entirely, coroners have made recommendations to reduce the likelihood of human error being a factor. After assessing these recommendations and comments, several themes have emerged as below.

Safety awareness

Coroners have focused on promoting the safe use of equipment and vehicles. In one case, a coroner recommended that organisations such as Federated Farmers New Zealand and Worksafe New Zealand should continue in their efforts to reduce the chances of further deaths occurring in similar circumstances by promoting the safe use of quad bikes. These messages include stressing to all quad bike operators that it is essential they maintain air pressure in the tyres on the bikes in accordance with the manufacturer's recommendations at all times when using the bikes.

In another case, a worker was working alone using a bulldozer in a secluded valley when it tipped and rolled down a hill. The coroner commented that it was significant that the worker was not wearing a

² *Other investigating authority* is defined as including a regulator as defined in section 16 of the Health and Safety at Work Act 2015 or an inspector appointed under section 163 of that Act.

seatbelt and the bulldozer did not have a Roll Over Protection System to help protect the driver from crush injuries.

Experience

Inexperience and a lack of understanding of hazards have been cited as contributory factors leading to deaths at the workplace. In one case a coroner commented that the felling of trees by chainsaw ought not to be undertaken by amateurs, even amateurs with experience in the field.

Working Alone

A recurring theme in workplace deaths is a situation where a worker is using heavy machinery alone without the ability to receive immediate assistance. In one case, a coroner commented that all riders of quad bikes to carry a personal locator beacon when riding in isolated areas with little or no cell phone coverage.

The consistent trend of farming deaths including those with years of experience highlights the inherent dangers of the farming environment and helps to reorient even the most experienced farmer towards safety and precautionary behaviour.

Case Example: Quad bikes

A significant number of farming related deaths occur when riding quad bikes. Of note, a number of children die annually while riding both adult and child appropriate quad bikes. The Worksafe website informs that:

Good practice guidelines for riding quad bikes suggest:

- Quad bike riders should have the knowledge, skills and training necessary to operate a quad bike safely, or be closely supervised until they are assessed as competent.
- Do not allow riders under 16 years of age to ride an adult-sized quad bike.
- Always wear a helmet while riding a quad bike. Consider wearing other PPE such as boots, high visibility clothing, goggles and clothing which covers arms and legs.
- PCBUs must make sure riders are aware of the risks associated with operating a quad bike, and the impact of their own behaviour and attitudes on these risks

Advice on the Worksafe website refers to good practice for children on quad bikes:

Children, under 16, may ride age appropriate quad bikes, that are designed specifically for them. You must:

- Make sure your kids are trained before you let them on any quad bike. Ideally, arrange for them to take a professionally organised riding course.
- Make them wear helmets and boots at all times.
- Don't let them carry passengers – younger kids, their mates – ever.
- Don't let them carry loads – anything that might affect their ability to handle the bike.
- Place limits on them. Give them a speed restriction and place limits on where they can go and the type of terrain.
- Instil good habits. Learn bad habits early and they're hard to break.

Worksafe has also produced a booklet *Good Practice Guidelines: Safe use of quad bikes* with a section dealing specifically with under-age riders: <http://www.worksafe.govt.nz/worksafe/information-guidance/all-guidance-items/guidelines-for-the-safe-use-of-quad-bikes> .

For an example of a recommendation made by a Coroner in relation to the inquiry into the death of Kenneth Francis Cameron please see page 17.

Key Organisations

Worksafe

WorkSafe New Zealand (WorkSafe) is a health and safety regulator. In addition, other government agencies (called designated agencies) can be designated to carry out health and safety regulatory functions for certain work eg:

- Maritime New Zealand for ships as workplaces and work aboard ships
- Civil Aviation Authority (CAA) for work preparing aircraft for imminent flight and aircraft in operation.

WorkSafe's functions include:

- Monitoring and enforcing compliance with work health and safety legislation
- Providing guidance, advice and information on work health and safety
- Fostering a co-operative and consultative relationship between the people who have health and safety duties and the persons to whom they owe those duties and their representatives
- Collecting, analysing and publishing statistics and other information relating to work health and safety.

If somebody dies as a result of work, WorkSafe must be notified as soon as possible. WorkSafe may then investigate and provided a report to the coroner under s 200 of the HSWA.

Maritime New Zealand

Maritime New Zealand (MNZ) is a Crown Entity appointed under section 429 of the Maritime Transport Act 1994, with the responsibility to promote maritime safety, security and the protection of the marine environment. Section 431 of the Maritime Transport Act 1994 sets out MNZ's functions. One of those functions is to investigate and review maritime transport accidents and incidents.

An example of a MNZ investigation can be found in the August 2010 drowning of six workers on a commercial fishing boat off the coast of the South Island, near Bounty Islands. MNZ was able to consider industry-specific issues relating to the life rafts on board, the vessel's ability to remain watertight, and the operational closing mechanisms of the waste chutes. Once MNZ ruled out any such faults contributing to the vessel sinking, MNZ was able to determine there were multiple unsafe employment practices that required addressing with other non-compliant Foreign Charter Vessels to avoid similar deaths in future.

Transport Accident Investigation Commission

The Transport Accident Investigation Commission (TAIC) is the transport safety body of New Zealand. It was established by the Transport Accident Investigation Commission Act 1990 to investigate aviation, marine, and rail accidents occurring in New Zealand. It is a standing Commission of Inquiry and an independent Crown entity, and reports to the Minister of Transport.

Civil Aviation Authority

The Civil Aviation Authority of New Zealand (CAA) was established in 1992 as a crown entity under the Civil Aviation Act 1990. The CAA has the power to undertake an investigation into air accidents under s15A of the Civil Aviation Act 1990. These investigations are carried out with a view to identify any occupational health and safety and regulatory matters relating to a crash.

The TAIC and CAA was integral in the Coronial inquiry into the deaths of 11 people on board the air balloon that crashed in Carteton in January 2012. Following the report released by the TAIC, the CAA made several positive operational changes to aviation standards, including drug and alcohol testing

for adventure aviation operators, which has resulting in New Zealand having the toughest adventure aviation standards in the world.³

Recommendations made by New Zealand coroners

The following collection of cases involves instances where fatal workplace accidents have occurred in a farming/agricultural context. The case study is limited to cases where the coroners have made specified recommendations or comments pursuant to section 57 of the Coroners Act 2006.

Following are 13 coronial findings involving workplace deaths where coroners have made such recommendations or comments.

CASE Howan [2017] NZCorC 16

CASE NUMBER CSU-2015-AUK-000277

DATE OF FINDINGS 20 April 2017

CIRCUMSTANCES

Craig Leslie Howan of Bombay died on 3 March 2015 on the Klondyke Road property, Port Waikato, from fatal injuries sustained to his head and neck when his Komatsu D37E-2 bulldozer slipped off the edge of a dirt track he had been working on, throwing him from the machine and trapping him underneath it.

Mr Howan was 57 years old and was self employed. Mr Howan was a very experienced machine operator and had worked as an earth moving contractor in the area for many years. Mr Howan was in good health, was reasonably fit for his age and was not under the influence of drugs or alcohol at the time of his death.

On 1 March 2015, Mr Howan was contracted by a local property owner to clear some pathways on a remote part of his 560 acre property at Klondyke Road, RD5, Port Waikato. The terrain in question was considered steep, covered by dense native bush and could only be accessed by a winding gravel road used extensively by logging operations in the area.

On 3 March 2015, Mr Howan left home at about 8.00 am to continue work on the site. Mrs Howan become concerned at approximately 7.00 am the following morning when she noted Mr Howan had not returned home.

She contacted the farm owner who set out on his quad bike and located Mr Howan pinned underneath the bulldozer on a part of the track known as "logging roader identification #10 area", also referred to as the hair pin corner due to the sharp turn. He contacted emergency services who subsequently confirmed that Mr Howan was deceased. It was established that Mr Howan was not wearing the machine lap belt when he died and that the bulldozer did not have a Roll Over Protection System fitted to it.

COMMENTS MADE BY CORONER H B SHORTLAND

- In this particular case wearing the seatbelt may have made a difference to whether Mr Howan lived or died.
- The machine, weighing between seven and eight tonnes, is a massive force when rolling uncontrollably down a steep bank. Chances of survival are increased with the use of a lap

³ https://www.caa.govt.nz/assets/legacy/public_and_media_info/caa_releases/carterton_balloon.pdf

belt/seat belt, although it must be acknowledged it is not guaranteed. At the very least, Mr Howan had a chance of remaining close to the machine without being thrown out.

- It also raises the discussion of the use Roll Over Protection Systems (“ROPS”). Examples include steel constructed bars or cage like construction over where the driver sits. These are often seen on tractors; cranes; graders and other machinery that can be at risk of tipping or rolling when in full use.
- The ROPS are often custom designed for the particular machine as a means of protecting the driver in case there is such an event. The objective of the ROPS is to provide a buffer zone of potential safety of the driver if the machine goes into a roll. The intention is to avoid crush injuries for the driver.

RECOMMENDATIONS ENDORSED BY CORONER H B SHORTLAND

- The only recommendation I can endorse is to use the lap belt when working such a machine. The issue of ROPS remains an individual consideration.

CASE Cameron [2017] NZCorC 1

CASE NUMBER CSU-2015-PNO-000451

DATE OF FINDINGS 9 January 2017

CIRCUMSTANCES

Kenneth Francis Cameron of Pahiatua died on 29 August 2015 at Palmerston North Hospital, Ruahine Street, Palmerston North of complications of a crush injury sustained in a quad bike crash.

Mr. Cameron was a 70 year old stock agent of generally good health, who also worked on his own farm, including a block of land he leased. On 28 August 2015, Mr. Cameron was riding his quad bike over paddocks moving stock. Mr. Cameron was riding the quad bike over difficult terrain with a significant slope when the quad bike rolled onto him, trapping Mr. Cameron for an extended period of time before he was able to summon help. Neighbours provided assistance once they were alerted to the situation, but sadly Mr. Cameron later died in hospital.

Factors contributing to Mr. Cameron’s death include Mr. Cameron riding the quad bike over difficult terrain with a significant slope, the right-hand tyres on the bike being overinflated, the left-hand tyres on the bike possibly being underinflated or even deflated, and Mr. Cameron being unable to summon help in a timely manner.

Mr. Cameron was described as a very responsible and cautious rider with an extensive history of riding such machines.

RECOMMENDATIONS OF CORONER H B SHORTLAND

- All organisations involved in promoting the safe use of quad bikes, including Federated Farmers New Zealand and Worksafe New Zealand, should continue in their efforts to reduce the chances of further deaths occurring in similar circumstances to this one, including:
 - a) Stressing to all quad bike operators that it is essential they maintain air pressure in the tyres on the bikes in accordance with the manufacturer’s recommendations at all times when using the bikes; and
 - b) Encouraging all riders of quad bikes to carry a personal locator beacon when riding in isolated areas with little or no cell phone coverage.

23 December 2016

Coroner Ryan
Coronial Services Unit
Auckland

Email: Lynda.Marks@justice.govt.nz

File Ref: 5578809
CSU 2015 PNO00451

Dear Coroner Ryan,

Thank you for providing WorkSafe with the opportunity to make a submission on the draft Finding for the Inquiry into the death of Kenneth Francis Cameron.

WorkSafe notes your recommendations:

That all organisations involved in promoting the safe use of quad bikes continue in their efforts to reduce the chances of further deaths occurring in similar circumstances to this death including:

- (a) Stressing to all quad bike operators that it is essential they maintain the air pressure in the tyres on quad bike in accordance with the manufacture's recommendations at all times; and*
- (b) Encouraging all riders of quad bikes to carry a personal locator beacon when riding in isolated areas with little or no cell phone coverage.*

Promoting the safe use of quad bikes remains an important part of improving safety on New Zealand's farms. WorkSafe's expectations regarding the matters above are set out in the *WorkSafe Guidelines for the Safe Use of Quad Bikes*, which are available on our website. These expectations align with the primary duty of care placed on persons conducting a business or undertaking (PCBUs) by section 36 of the Health and Safety at Work Act 2015 (HSWA).

WorkSafe releases regular communications about the safe use and maintenance of safe quad bikes. A press release in early November advised farmers to make sure that quad tyres have tread depth in line with manufactures instructions and that they are correctly inflated. WorkSafe is currently investigating ways for farmers to access more useable tyre pressure gauges than those provided with the vehicles.

The Health and Safety at Work (General Risk and Workplace Management) Regulations 2016 places a duty on PCBUs to manage risks to health and safety of workers who perform remote or isolated work, this requires the provision of a system of work that includes effective communication with workers. WorkSafe has been engaging with farmers to make them aware of the risks of working alone and possible ways to manage the risk. There are a number of communication systems available for people working alone on farms. These include two-way

radios, personal locator beacons and other real-time locating systems. WorkSafe advises farmers to consider the risks specific to their property and work when selecting an appropriate communication system.

Farm Angel is an example of a real-time locating system that is currently in use on LandCorp farms. It is a satellite and cellular enabled system that detects accidents and raises automatic panic alerts. It also allows users to send messages when they are out of cell phone reception. It lets farmers track where and how quad bikes are being used on the farm. LandCorp has given WorkSafe permission to access the data from the Farm Angel system. We will use this data to gain a better understanding of quad bike use and incident causation, so we can better target our future interventions.

In conclusion there are a range of communication and location technologies available for use by farmers and farm workers, these include but are not limited to personal locator beacons. WorkSafe will continue to promote the use of these technologies to ensure that workers doing remote or isolated work have an effective means of communication.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Phil Parkes', written over a light blue horizontal line.

Phil Parkes

General Manager, Better Regulation

CASE Horrocks [2016] NZCorC 111
CASE NUMBER CSU-2016-PNO-000245
DATE OF FINDINGS 8 December 2016

CIRCUMSTANCES

Mark Lindsay Horrocks, aged 59 years, farmer, late of Parakino, died on 10 July 2016 of chest and abdominal injuries sustained in a tractor roll.

Mrs Horrocks states that at approximately 1330 hours on 10 July 2016 Mr Horrocks left the house on his quad bike to continue doing jobs on the farm. When light faded Mrs Horrocks thought it unusual that he had not returned to the house. She called her neighbours and was advised to ring Police Search and Rescue. Whanganui Police Search and Rescue were activated and the Palmerston North Helicopter was dispatched with a paramedic to the address. Mr Horrocks was later found deceased by his brother, Fraser Horrocks. Mr Horrocks was found beside a fence with his Holder A12 tractor overturned approximately 30 metres away down a steep bank.

A toxicological analysis detected the presence of caffeine. No alcohol or other commonly screened for drugs were detected in Mr Horrocks' blood.

The Serious Crash Investigator, Constable Krieger, reports that at the time of the incident, the weather was fine but the ground was soft and saturated. It is noted that the tractor was fitted with larger diameter tyres, namely size 10 x 24 (right rear) and 11.2 x 24 (other three tyres). The standard factory sized tyres are 5.00 x 16 or 5.50 x 16. It is also noted that it is unknown what quantity of spray was in the tank at the time of the incident but if filled completely it would equate to 600 kilograms of fluid being carried on the rear of the tractor. In his opinion, this would have significantly influenced the handling of the tractor. Although limited to the extent of the damage and the tractor's position, a vehicle inspection failed to reveal any faults with the tractor which would have contributed to the crash. There was insufficient evidence to determine the speed of the tractor at the time of the crash; however, Constable Krieger does not consider that excessive speed was a factor in the crash. Constable Krieger considers that the steep, slippery terrain was the major contributing factor in the crash, and that the configuration of the tractor and its load exacerbated the likelihood of the tractor losing control on the terrain.

WorkSafe New Zealand also completed an investigation and produced a report on this incident. The inspector concluded that there was clear evidence from photos that the tractor slipped sideways a significant distance, creating momentum to the left. The inspector concluded that the underlying causes that culminated in the incident were that the 200 – 300 litres of spray (estimated to the inspector by Mr Fraser Horrocks) were in a non-baffled 600 litre tank that allow the motion to affect the tractor; that the rear of the tractor slipped into a depression causing the tractor rear to slide to the left; and that the centre of gravity changed from the straight-line position.

COMMENTS MADE BY CORONER C J DEVONPORT

- Because of the possibility that the fitted 600 litre capacity tank on the rear of the tractor and the larger than standard fitted tyres may have affected the handling of the tractor, Constable Krieger recommends that any person wishing to modify a tractor to meet a specific farming/operational requirement give consideration to obtaining an engineer's report prior to doing so. Such a report should address any handling/safety issues that may arise from the intended modifications. The coroner also notes the WorkSafe Inspector's view that the spray and a non-baffled tank allow the motion to affect the tractor. As an engineer's report has not been completed to establish whether the modifications made to the tractor in fact resulted in potential instability that may have contributed to the cause of the crash, the coroner does not propose to make any specific recommendation. However, he considers it appropriate that a copy of his findings and Constable Krieger's recommendation be sent to Federated Farmers for appropriate publication.

CASE Newton [2015] NZCorC 67
CASE NUMBER CSU-2014-AUK-000698
DATE OF FINDINGS 8 December 2016

CIRCUMSTANCES

Robert Charles Newton of Clevedon died on 16 June 2014 at Clevedon of haemoperitoneum caused by blunt force abdominal trauma from a tractor accident.

Mr Newton was helping another person on a farm to grade a driveway and remove rubbish with a tractor. The driver's foot became caught in the hydraulic hoses coming from the front-end loader. The driver was wearing gumboots at the time. Mr Newton was struck by the bucket of the tractor and briefly pinned against a building. Mr Newton died from his injuries.

COMMENTS MADE BY CHIEF CORONER JUDGE MARSHALL

- This tragic accident highlights the importance of securing hydraulic hoses properly by using the retaining clip designed for that purpose. According to Agrowquip, it is not uncommon for tractor operators to fail to use the clip. It also highlights the care people need to take when they are in the close vicinity of moving vehicles.
- A copy of these Findings will be sent to Federated Farmers so they can alert their members to the dangers of incorrectly routed hydraulic hoses.

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

CASE Hockly [2014] NZCorC 6
CASE NUMBER CSU-2013-ROT-000112
DATE OF FINDINGS 5 February 2014

CIRCUMSTANCES

Daniel Craig Hockly (Mr Hockly) of Te Puke died on 13 March 2013 at a farm in Te Puke of traumatic crush asphyxia, which occurred when the fertiliser spreader he was operating crashed.

Mr Hockly was an employee of Spreadmaster Limited, and was in that capacity providing fertiliser spreading services for one of their customers; the owner of a farm in Te Puke. He had worked on this property a number of times before and was therefore familiar with it, along with fertiliser spreading work in general. While distributing the last of the fertiliser, it appears that that he didn't fully perceive a dip in the terrain, and the rear of the truck skidded down it, causing the truck to roll down. In the process Mr Hockly was thrown from the cab, and the truck eventually came to rest on top of him. He was unable to be revived and died at the scene.

There was a seat belt fitted in the truck, but Mr Hockly was not wearing it on the day in question, causing him to be ejected from the truck as it rolled. The seat belt was an inertia reel type, and was affixed to the seat rather than the cab. Seat belts, particularly those of this type, are generally regarded as being too restrictive by drivers in this line of work, because they continually lock as the truck goes over the contours of the land and can pose a risk of shoulder injury to the driver. Furthermore they don't allow the driver to raise themselves up, which is a common way of seeing the way the land slopes in front of the truck, even in 'cab over' design trucks which have the cab situated directly over the motor, rather than a traditional bonnet.

In response to this incident, Mr Hockly's employer dropped some customers, so that his employees only ground spread on land that is flat or has a very slight incline.

Cannabis was found present in Mr Hockly's blood stream, and though this drug does have the effect of impairing perception and causing loss of motor control, it was inconclusive how the amount of cannabis present would have affected his ability to safely control the vehicle. There was nothing observed by those who saw him on the day of the crash that would suggest that his judgement or ability was impaired.

COMMENTS MADE BY CORONER G MATENGA

- It is my view that had Mr Hockly been wearing his seat belt then it is most likely that he would have survived this crash. If he had been wearing his seat belt he would have been restricted to the interior of the cab. He may still have suffered an injury, but he would not have been thrown from the vehicle, to have the vehicle come to rest on top of him. This is, in the end, the injury that has caused his death.
- I did consider, in preparing for this inquest today, whether I should make recommendations requiring the mandatory wearing of seatbelts by truck operators whilst spreading fertiliser in this way. Mr Hockly's employer, however, has persuaded me not to go to that extent and make any recommendations given that it could create other problems for the operator. Something should be done to make it safer, but I have reached the view that the best course to adopt at this time, is to restrict myself to these comments, which I ask to be published to raise the issue so that other drivers and those in the fertiliser spreading industry are made aware of the risks and can make an informed decision.

CASE Bath [2014] NZCorC 90

CASE NUMBER CSU-2012-DUN-000465

DATE OF FINDINGS 28 November 2014

CIRCUMSTANCES

Stewart Bath of Winton died on 22 November 2012 at farm property at Roxburgh from multiple injuries sustained when his tractor rolled.

RECOMMENDATIONS MADE BY CORONER R G MCELREA

To: Worksafe New Zealand

- I. That Worksafe New Zealand highlights to relevant industry sectors the facts of this case, with particular reference to the importance of wearing a lap seat belt in a tractor unit fitted with ROPS and the importance of being aware of gravity issues in operating a tractor or other farm vehicle, particularly in steep terrain.

COMMENTS MADE BY CORONER R G MCELREA

To: Worksafe New Zealand

- Mr Bath, an experienced tractor driver, died as a result of multiple injuries when a tractor and hay rake he was operating rolled down a steep slope. The tractor was fitted with a four post rollover protection structure (ROPS) incorporated into the cab and had a lap seat belt. It was also fitted with a front end loader that was in a high raised position causing the centre of gravity of the tractor to be raised and reducing stability. He was not wearing the available lap seat belt.

- Expert evidence is that the webbing-sensitive lap seat belt is designed to only lock when excessive force is applied to the retracting belt thus allowing the driver to move body position in the seat when operating the tractor.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of medical information set out in paragraphs 13 and 14 of the findings in the interests of privacy.

CASE Williams [2014] NZCorC 130

CASE NUMBER CSU-2013-DUN-000055

DATE OF FINDINGS 28 November 2014

CIRCUMSTANCES

George Lewis Williams of Gore died on 18 February 2013 at a farm property in Gore of multiple injuries sustained when he lost control of the tractor he was driving.

RECOMMENDATIONS MADE BY CORONER R G MCELREA

To: Worksafe New Zealand

- That Worksafe New Zealand highlights to relevant industry sectors the facts of this case, with particular reference to the importance of wearing a lap seat belt in a tractor unit fitted with rollover protective structure.

COMMENTS MADE BY CORONER R G MCELREA

To: Worksafe New Zealand

- The expert evidence is that if Mr Williams had been wearing the lap seat belt provided in the John Deere 7810 tractor he would have had considerably greater opportunity to control the tractor and trailer unit as it struck exposed rocks in the terrain in the early part of its descent down a steep hillside over uneven ground. Expert evidence from Senior Constable Patterson of the Police Serious Crash Unit, and Mr Keene of Worksafe New Zealand, is that lap seat belts provided in tractors should be worn at all times.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of some medical information in the Findings in the interests of privacy.

CASE Walker [2013] NZCorC 22
CASE NUMBER CSU-2012-CCH-000077
DATE OF FINDINGS 28 January 2013

CIRCUMSTANCES

Brendon Edward Walker, a farm manager, died at his farm in the Hurunui District on 28 January 2012, as a result of electrocution through accidental contact with 11kV power lines on a farm.

Mr Walker was found by his wife and son, apparently electrocuted by a collapsed power line in a paddock on his farm. His wife, trying to help him, had also received an electric shock and was injured. Their 7 year old son has gone back to the farmhouse by himself to get help and his sister, aged 9, telephoned emergency services. Mrs Walker was transported by helicopter to hospital and treated for burn injuries but Mr Walker was pronounced deceased.

The line that electrocuted Mr Walker was a High Voltage SWER (single wire, earth-return) overhead power line, which is a single "live" conductor. The SWER line, being only a single conductor, is less visible if it collapses than that of a two or three line system. MainPower conducted a Root Cause Analysis and uncovered the causes of the collapse of the power line: The SWER line was held aloft by a series of treated wooden pine poles; these poles are flammable; attached on top of these poles are insulator brackets (either single or double pole top ones) to prevent the electrical current running down the pole to earth; the line had become detached from one of the poles, between two adjacent 80 metre spans over an undulating hill incline, so it hung down low; it became detached because the insulator bracket (together with mounting bolts, insulators and the wire) separated from the pole which was due to a pole top fire.

The pole top fire was caused by arcing which ignited the pole. The arcing happened when a bird contacted between the line and the treated pine pole. (The dead bird with burn marks was found near the base of the pole. This was able to happen because the clearance between the line and the nearest uninsulated part of the pole or attachment was able to be bridged by the bird.

MainPower found that two months previously a pole top fire on a nearby farm on the same Inland Kaikoura Road was caused in the same way. Since 1996 there have been eight pole top fires on its SWER lines (including this one). Of these two were attributed to a bird contacting between the line and the pole. The incidence of pole fires (from all causes) on SWER lines is over 5 times the average for conventional system lines.

COMMENTS OF CORONER S P JOHNSON

- MainPower has since redesigned and installed new pole top insulators on the Inland Kaikoura Road SWER lines so that the clearance between the line and the nearest uninsulated part is too wide to be bridged by a bird.
- Surveys of other parts of the MainPower SWER line systems and similar upgrades are being implemented.
- I endorse this action by MainPower and the education actions undertaken by both MainPower and DOL. I consider they will assist to reduce the chance of the occurrence of other deaths in circumstances similar to those in which Mr Walker died.

CASE Rolton [2012] NZCorC 22
CASE NUMBER CSU-2011-DUN-000112
DATE OF FINDINGS 13 January 2012

CIRCUMSTANCES

Daryl David Rolton of Edendale, a farm worker, died at Pedlor Grange Farm, Rapid 92, Centre Hill Road, Te Anau on 19 March 2011. Whilst entering the chamber of the baler with which he was working to clear a blockage or effect repairs, Daryl Rolton was crushed by the operation of a baler door. Entering the baler chamber, Daryl Rolton did not ensure that the baler was made safe. He either triggered the sensor plate or for some other reason the baler door closed on him causing the injuries which proved fatal.

COMMENTS MADE BY CORONER D. CRERAR

- Daryl Rolton was an experienced baler operator. He had received training in the operation and maintenance of the baler and had several years' experience. He was known by his employer and by Mrs Margaret Rolton to be safety conscious and always willing to take advice. Daryl Rolton was provided with a copy of the Safe Operations Manual for the baler which emphasised several intermediate steps to be taken prior to entering into the cavity. It is clear that sufficient manual and electronic controls are available to ensure that operators are safe? working on the inside of the baler.
- In furtherance of my role to make recommendations or comment to ensure that the circumstances of the death are not repeated, I raise the question whether the existence of such manual controls which incorporate the human element can be eliminated. I observe that it may be possible to create a failsafe device to ensure that the baler cannot operate, and the door cannot close in circumstances that applied during the investigation by Daryl Rolton.
- In recognising immediately that it is often impractical to ensure that experienced and trusted employees such as David Rolton do not work alone, I observe that are often advantages in more than one person being involved in a decision-making process. If another employee had been present when the problem (whatever it was) with the baler was first noticed, the other person may have urged greater caution on Daryl Rolton or physically checked with him the fact that the baler was made safe.

RECOMMENDATIONS MADE BY CORONER D. CRERAR

- I recommend that a copy of this Finding be forwarded to the Department of Labour, to Federated Farmers and to the manufacturers and suppliers of the Vicon baler. The Finding should be used to draw public attention to the tragic circumstances of the death of Daryl Rolton to ensure that these circumstances are not repeated. All those working with machinery ought to follow carefully and explicitly the safe operating procedures established. Employers of such persons ought to reinforce with employees the absolute need to follow safety protocols. Consideration ought to be given to the possibility of employees in such circumstances as those facing Daryl Rolton to be supported by the attendance of another employee to check safety protocols.
- I recommend that a copy of this Finding be forwarded to the manufacturers and suppliers of Vicon balers to draw to their attention the circumstances of the death of Daryl Rolton. The manufacturers could learn from the narrative and investigate whether or not the installation of a further failsafe mechanism is possible. The computer may be able to be programmed to ensure that certain activities or actions, cannot take place if the "safety tap" is not turned to off.

CASE Corboy [2012] NZCorC 132
CASE NUMBER CSU-2012-HAM-000180
DATE OF FINDINGS 18 December 2012

CIRCUMSTANCES

Craig Joseph Corboy late of Te Kawa, Otorohanga died on 19 April 2012 in Te Kawa, Otorohanga of acute cardiorespiratory failure; with severe chronic ischaemic heart disease with old myocardial infarct. Mr Corboy also suffered from positional asphyxiation with compromised breathing at the time of his death.

Mr Corboy was operating an excavator on a farm, he had excavated a large pit, and was in the process of demolishing a shed with the excavator. He was positioned between the pit and the shed. A section of the earth around the pit gave way, causing the excavator to topple into the pit with Mr Corboy inside. He was initially conscious and called for help, but then became unresponsive. He was moved out of the cab by the farm owner and two others. He was clearly deceased by the time emergency services arrived.

The soil in that area was very soft, with a potential for collapse, this hazard had not been identified prior to this accident.

COMMENTS OF CORONER JP RYAN

- Mr Corboy does not appear to have been wearing a seatbelt while operating the excavator. I have no evidence before me to indicate whether wearing a seatbelt would have made any difference, but given that he was ejected from the seat when the excavator toppled into the pit, it is reasonable to suggest that a seatbelt would have held him in the seat.
- In the absence of any evidence on this matter, and on whether wearing seatbelts in the cab of an excavator poses any risks to the operator, I am reluctant to make a recommendation relating to the use of seatbelts in such excavators. I therefore simply make these comments in the hope that industry operators will consider this issue and take any appropriate action.
- These comments are directed to all manufactures and operators of such excavators, and all industry parties promoting the safety of operators of such machinery.

CASE Gill [2012] NZCorC 148
CASE NUMBER CSU-2011-DUN-000400
DATE OF FINDINGS 3 August 2012

CIRCUMSTANCES

Geoffrey Raymond Gill, late of Happy Valley, a farmer died on his property near Tuatapere on the afternoon of the 20th September 2011 from injuries sustained in a quad bike accident. He lost control of the quad bike he was riding in steep and slippery conditions allowing it, and the trailer it was towing, to travel down a slope into a gully where it has overturned, trapping him beneath it.

Mr Gill was an experienced quad bike rider, although this farm's terrain was much more rolling and steep compared to the previous farms he had ridden on. He had previously had two crashes on the quad bike at Happy Valley, and family had advised him not to ride in such steep country, although Mr Gill continued to do so.

COMMENTS MADE BY CORONER D. CRERAR

- There is no evidence of a head injury to Geoff Gill which may have caused or contributed to his death but I endorse the recommendation that crash helmets should be worn, the evidence of their benefits being overwhelming.

RECOMMENDATIONS MADE BY CORONER D. CRERAR

- That all those in charge of 4 Wheel Drive (Quad) Bikes on farms be instructed in their use and in their dangers, notwithstanding their experience. A course of instruction is likely to identify hazards unknown to operators, even those who have been riding them for years.
- That a copy of this Finding is forwarded to the Department of Labour, and to ACC, for them to include the relevant information in their future publications.
- That the Department of Labour Recommendations in their Guidelines be adopted, those being:
 - a. Riders must be trained / experienced enough to do the job
 - b. Choose the right vehicle for the job
 - c. Always wear a helmet
 - d. Do not let kids ride adult quad bikes.

Attached is a response received from the Department of Labour on 28 August 2012.

28 August 2012

Coroner Crerar
c/- Glenn Dobson
Operations Manager
Coronial Services Unit
Private Bag 39819
Wellington Mail Centre
LOWER HUTT 5045

SX10044

Dear Coroner Crerar

Coroner's Ref CSU – 2011- DUN-000400 The Late Geoffrey Raymond Gill

Thank you for sending the Ministry of Business, Innovation and Employment, a copy of your Findings dated, 3 August 2012, regarding the death of Mr Gill.

We note and thank you for your support of the Harm Reduction Programme. We also note you have made recommendations in your Findings that the Department of Labour should include relevant information in its future publications. You will be interested to know the Project Team is planning some proactive media engagement to reinforce its messages. I am advised it will contact you in the near future to discuss how it can use your Findings in this work.

Your Findings have also been registered on the Ministry's database to enable future work.

Yours sincerely



Rae Hankin
Advisor
Business Process and Innovation, Operational Policy
Ministry of Business, Innovation and Employment (Labour)

Department of Labour
TE TARI MAHI



CASE Turner [2012] NZCorC 186
CASE NUMBER CSU-2011-DUN-000432
DATE OF FINDINGS 16 October 2012

CIRCUMSTANCES

Glenn Spencer Turner, late of Lumsden, died on 12 October 2011 at Crofty Farm near Balfour, Southland of blunt force injuries sustained when he lost control of the fertiliser spreader he was operating and it overturned.

Mr Turner had been told that day that he had been driving inappropriately while doing his farm work. This was with regards to safety and the objectives of his job. Mr Turner took no notice of this, and later while driving across the paddock, his fertiliser spreader hit a rock, causing the rear-end to lose traction and slip down a slope. The vehicle came to a sudden stop which shifted its contents to the downhill side, causing it to roll in that direction, ending up on its left side. Mr Turner was thrown from the vehicle and lay face up downhill from it. His colleagues called emergency services and commenced CPR. However, Mr Turner was already deceased.

Mr Turner was not wearing his seatbelt as encouraged by company policy and the industry Code of Practice. Though the wearing of seatbelts in such vehicles is not mandatory, and is seen by some as potentially creating entrapment problems, it is widely accepted that seatbelts save lives and prevent serious injury.

RECOMMENDATIONS MADE BY CORONER D. CRERAR

To: The Department of Labour, and the New Zealand Ground-Spread Fertiliser Association (NZGFA);

- That a copy of this Finding be forwarded to these entities to promote ongoing cooperation in the creation of further safety enhancements. It is asked that they work together to clarify the benefits of operators using safety belts and investigating methods to ensure that restraints are more “user friendly” for operator/drivers in difficult situations.

That consideration should be given to establishing a protocol between customers, contractors and employees, ensuring the fact that employees are not pressured to complete spreading tasks beyond safe parameters.

To: The NZGFA

- That the provision, in the vehicles of its members, of an emergency call and tracking system which are not dependent upon cellphone or radio coverage or the continuing consciousness of an operator/driver who may have been disabled in a rollover should be investigated

CASE Thomas [2012] NZCorC 2
CASE NUMBER CSU-2011-HAM-000172
DATE OF FINDINGS 27 February 2012

CIRCUMSTANCES

Kelvin James Thomas died at Waikato Hospital on 4th May 2011. The cause of death was acute pulmonary thromboembolism, complicating thoraco-abdominal injuries suffered in a bulldozer accident. On 15 April 2011, Mr Thomas was working on a farm in Cambridge, clearing scrub, when his bulldozer rolled, trapping him between the bulldozer and scrub crusher. He was admitted to Waikato Hospital by ambulance. He underwent surgery, and was making slow progress in his recovery when he had an acute catastrophic cardiorespiratory deterioration. Despite extensive attempts to resuscitate him, Mr Thomas died.

In its report, the Department of Labour commented that it may have been prudent for Mr Thomas to have used the bulldozer to build a more stable platform upon which to position it prior to commencing the gorse crushing operation.

RECOMMENDATIONS MADE BY CORONER J. P. RYAN

- In view of the comments made in the Department of Labour report, concerning the benefits of ensuring a stable platform upon which to position the bulldozer, I consider this is something that the Department of Labour may want to give further consideration to, and may wish to publish some guidelines on best practice for the industry.

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