



OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments
made between **1 January** and **31 March 2018**

Focus Recreational boating
deaths

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 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 22 recommendations and/or comments issued by coroners between 1 January and 31 March 2018. It also includes an overview of recreational boating deaths in New Zealand, covering issues which arise frequently, and the response from coroners to those issues.

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

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Focus: Recreational boating deaths

Background

Recreational boating in New Zealand

Recreational boating refers to the use of watercraft for leisure. This includes the use of boats, kayaks, jet skis, dinghies, and stand-up paddleboards, and covers a wide range of bodies of water, such as, the ocean, lakes and rivers.

The Safer Boating Forum¹, led by Maritime New Zealand (MNZ) commissioned research into recreational boating in New Zealand in 2017 and again in 2018. They estimate that almost 1.5 million adult New Zealanders are involved in recreational boating.²

MNZ data shows that 16 people died in each year between June 2015 and June 2017, and 19 in the past year.³ That data indicates that the failure to wear an appropriate lifejacket was the single largest factor contributing to those deaths.

This case study analyses closed coroners' findings issued in 2015 and 2016 involving recreational boating deaths. These findings indicate that, in many cases, death could potentially have been prevented and that changes in behaviour among recreational boaters may reduce the chances of death occurring in the future in similar circumstances.

FOCUS **Leslie Stokes & Arthur Brown CSU-2015-AUK-000731**

Mr Stokes and Mr Brown set out for a day of fishing. When they hadn't returned by the time they were expected back, an alarm was raised and a land and sea search was commenced. The following day, the missing boat was spotted by a search plane and was upturned on a sand bar.

Two life jackets were found on board the boat.

Neither Stokes nor Mr Brown has been found. Both men are presumed dead.

¹ The Forum is made up of boating and water safety organisations, the marine industry, and central and local government agencies. It works to reduce boating injuries and fatalities, and improve boat safety behaviour.

² **2018 Recreational Boating Participation Research**, June 2018, Richard Griffiths, Jonathan Dodd and Yazad Karkaria, Ipsos, Auckland, at p 7.

³ Maritime New Zealand "New research: Boaties behaving more safely!" (15 October 2018) <<https://www.maritimenz.govt.nz/public/news/media-releases-2018/20181015a.asp>>.

Risk factors for recreational boating deaths

The Safer Boating Forum have identified four key risk factors in recreational boating:⁴

- failure to wear lifejackets in small craft
- not being able to communicate when an accident happens
- failure to check forecasts to avoid boating in bad weather and sea conditions
- alcohol consumption, as it is likely to impair judgement and may be a factor in accidents and fatalities

MNZ, the Safer Boating Forum and their partner agencies' education programmes continue to warn recreational boaters of the four key risk factors stated above and encourage boat users to adopt the Safer Boating Code and act to keep themselves and their passengers safe while on the water. The following websites provide safety information for recreational boaters and promote the Forum's campaign and Safer Boating Code:

<https://www.maritimenz.govt.nz/recreational/safety/default.asp>

<https://www.maritimenz.govt.nz/recreational/safety-campaigns/default.asp>

FOCUS **Dhirendra Singh CSU-2015-AUK-000612**

Mr Singh and some friends set out on the Waikato River in a 3.65m aluminium dinghy. All occupants except Mr Singh were wearing lifejackets. Mr Singh declined to wear one as he felt it didn't fit properly and it interfered with his ability to steer the boat.

He told his companions that he would grab a life jacket if anything were to happen.

Some onlookers believed that the dinghy looked overloaded and that the outboard was struggling to push the boat into a headwind. As the boat exited the inlet where they entered the river and got into the main river, large rolling waves caused the dinghy to turn sideways and then capsize.

The boat went straight down and Mr Singh did not have time to grab his lifejacket.

Unfortunately, Mr Singh was unable to be resuscitated and died. His friends survived.

Regulation of recreational boating in New Zealand

The Minister of Transport has the power to make maritime and marine protection rules. These are the overarching rules that regulate safety in boating. Part 91 outlines the Navigational Safety Rules

⁴ 2018 Recreational Boating Participation Research, above n 1, at 5.

which apply everywhere in New Zealand.⁵ These rules are complemented by bylaws drafted by regional councils.

Regional councils have the power to regulate ports, harbours, waters and maritime related activities within their regions.⁶ They may make bylaws regulating the use of waterways and the requirements for users of pleasure craft to carry and use personal flotation devices.⁷

Recreational boating deaths—2015 to 2016

The Office of the Chief Coroner has analysed the 21 deaths in closed coronial findings issued from 2015 to 2016 where a person has died in recreational boating circumstances.

| Type of watercraft | Number of deaths | Percentage of total |
|-----------------------|------------------|---------------------|
| Boat | 10 | 47.6% |
| Kayak | 6 | 28.6% |
| Jet ski | 2 | 9.5% |
| Stand-up paddle board | 2 | 9.5% |
| Inflatable dinghy | 1 | 4.8% |

| Significant circumstance | Number of death | Percentage of total |
|-----------------------------|-----------------|---------------------|
| Lifejacket not worn | 8 | 38.1% |
| Problem with lifejacket | 2 | 9.5% |
| Accident while crossing bar | 6 | 28.6% |
| Medical event | 5 | 23.8% |
| Kayaking in poor conditions | 2 | 9.5% |
| Deceased is male | 18 | 85.7% |

⁵ Maritime New Zealand “Overview of maritime and marine protection rules” <www.maritimenz.govt.nz/rules/rules-overview/default.asp>.

⁶ Section 33C of the Maritime Transport Act 1994.

⁷ Section 33M of the Maritime Transport Act 1994.

This data confirms, at least for the period examined, that the failure to wear appropriate lifejackets remains the leading contributor to preventable recreational boating deaths in New Zealand. It also shows that accidents during bar crossings were a significant contributory circumstance in over a quarter of recreational boating deaths.

Gender also appears to be significant as 18 of 21 (86%) deaths were male. MNZ figures indicate that 54% of recreational boaters are male and 46% are female.⁸ The higher incidence of male deaths compared to female suggests that there is a greater need for behaviour change among male recreational boaters.

Compliance with requirement to carry and wear lifejackets

MNZ measured compliance with lifejacket rules over 8 council areas between December 2016 and February 2017 and found:⁹

- 96% of all vessels were carrying sufficient personal floatation devices (PFD) for all persons on board
- 86% of all vessel occupants were wearing PFDs when legally required to do so
- users of jet skis had the highest rate for having PFDs on board (99%) and for the wearing of PFDs (98%)
- stand-up paddle boarders had the lowest rate of having PFDs on board (72%)
- stand-up paddle boarders and powerboaters had the lowest rate of wearing PFDs; 76% and 84%, respectively

As these figures indicate, compliance with the advice and obligations to carry and wear life jackets is high. Nonetheless, most recreational boating deaths involve PFDs not being worn.

Survey of Recreational Boating Participation

Surveys of recreational boating participation were commissioned by the Safer Boating Forum and released in 2017 and 2018. Some of the key insights noted in the 2018 survey are:¹⁰

- Since 2017 to 2018, approximately one in five recreational boaters report that they wear a lifejacket either 'never', 'not very often' or only 'some of the time'. This figure has not improved over the past two years.
- The proportion of recreational boaters reporting that they wear their lifejackets all or most of the time has remained stable at 75%
- The proportion of recreational boaters reporting having at least two ways to signal or call for help if needed 'every time' has increased to 43% in 2018 from 38% in 2017.

⁸ 2018 Recreational Boating Participation Research, above n 1, at 8.

⁹ Maritime New Zealand "On the water survey" (29 March 2017) < www.maritimenz.govt.nz/recreational/documents/on-water-survey-results-2017.pdf>.

¹⁰ 2018 Recreational Boating Participation Research, above n 1; "New research: Boaties behaving more safely!", above n 3.

- The proportion of recreational boaters reporting that they check the weather before heading out on the water has increased to 85% in 2018 from 81% in 2017.
- The proportion of recreational boaters reporting that they avoid alcohol 'every time' either before or during time on the water has increased to 67% in 2018 from 61% in 2017.

These key insights show that recreational boaters are generally becoming more aware of the risk factors identified by the Safer Boating Forum and of safe boating practices, though there are still improvements that can be made to increase awareness.

Recreational boating recommendations and comments—2014 to present

Coroners have frequently reiterated the need for people to wear appropriate lifejackets that are properly fitted, and their recommendations have contributed to raising awareness to the key risk factors identified by the Safer Boating Forum.

The recommendations made in relation to boating deaths from 2014 to the present are included on the following pages:

Stirling [2014] NZCorC 61 (20 May 2014)

CIRCUMSTANCES

Leslie Grant Stirling of Christchurch died on 22 April 2012 at Oxford, North Canterbury of injuries sustained in a jet boat crash.

On 22 April 2012 Mr Stirling and his brother went to the Waimakariri River Gorge to spend the day in the boat. They travelled upstream through the gorge for about an hour and a half before stopping for lunch at a sandy area. After lunch, they continued upstream for a short distance then became stuck in shallow water. A group of boaters assisted them to free the boat and then they headed back downstream through the gorge and stopped at their trailer. By this time, it was about 3.30pm. The fuel light was flashing, warning that the boat was low on fuel. They were going to call it a day but Mr Stirling told his brother he wanted another quick run. He wanted to try the boat with some fuel in it that did not have the additive to see if it prevented the smoke.

Mr Stirling drove the boat about 1.5km downstream before ending up in a river braid that became very

shallow before running out of water completely. Eventually the boat ran up on the rocks, beaching it. Both occupants tried to move the boat but were unable to do so because it was too heavy and it was high out of the water. They discussed their options, one of which was to try and drive the van across the river and use the winch on the front of it to pull the boat out. But as they walked back to the van they realised that the river was far too deep to drive the van across. They walked back to the van and went for a drive to see if they could get closer access to where the boat was but they could not get much closer.

Again, they discussed their options. Eventually they decided they would return to the boat and try and free it. They took some long aluminium poles which Mr Stirling had in his van and carried them back to the boat. They eventually managed to lever the boat back into water and get it going, only to get stuck again. This happened three or four times, but on each occasion, they managed to lever the boat off the ground.

They agreed on a plan that Mr Stirling would get in the boat and his brother would push him off to free him and he would go downstream until he was confident there was deeper water and stop. Mr Stirling got into the boat and went around three bends then out of sight. Three

loud bangs were heard in the distance and it was assumed the boat had hit the bottom again. Mr Stirling's brother walked towards the boat and located his brother pinned underneath the boat. Mr Stirling was unable to be revived.

A Safety Inspector with Maritime New Zealand examined the boat. His opinion is that the cause of the crash is that the boat was travelling downstream at about 25-35km/hr. Mr Stirling, who was alone, approached a ponded area to the right hand side and approximately 25 metres from a fan on his left he turned slowly left, hitting the bottom of the river bed. Once the boat got to the fan area it hit the slightly larger exposed rocks and rolled.

COMMENTS OF CORONER S P JOHNSON

Water Safety New Zealand recommends carrying at least two reliable forms of communication on a boat, such as a Marine vhf radio, a cell phone, and flares.

Turner [2015] NZCorC 49 (19 May 2015)

CIRCUMSTANCES

Neil Richard Turner of Kati Kati died on 3 July 2014 of cold water immersion.

Mr Turner was a one of a party of five on a private launch. They were on a hunting and fishing trip in Fiordland.

On 3 July 2014, the launch was moored in Precipice Bay. Sea conditions were calm. At approximately 10.00 am, Mr Turner used an inflatable boat to transport one of the party to shore. Mr Turner was not wearing a life jacket.

At about 12.40pm the remaining party members were in another inflatable boat. They passed the launch en route to another hunting site. Mr Turner's body and his inflatable boat were found drifting near the launch.

How Mr Turner came to be in the water could not be determined for certain. It was likely that he fell while attempting to board the launch.

RECOMMENDATIONS OF CORONER D O CRERAR

I recommend that Maritime New Zealand continue with its efforts to make the wearing of life jackets compulsory and continue with its efforts in giving publicity to the dangers of cold water immersion.

I note in particular that no life jackets were carried on the inflatables despite a legal requirement to have enough life jackets of the right size and type for all those on board a vessel under six metres. There was also a regional bylaw requiring life jackets to be worn in vessels of under six metres.

If the skipper of the [launch], ... and his companions had recognised the dangers and taken the precautions, this tragic death may not have occurred.

Finney [2015] NZCorC 55 (8 July 2015)

CIRCUMSTANCES

Eluned Jane Finney of Balclutha died on 15 January 2015 at Surat Bay, Southland of drowning.

Eluned Finney and a friend were on a fishing trip with her father. They were on her father's five metre, fibreglass over plywood, power boat. There were rough sea conditions. The boat was equipped with a two-horse power auxiliary motor. It had a VHF radio and her father carried a cell phone in his overalls.

All three occupants wore life jackets. When they left shore Eluned wore a red Body Glove life jacket that had been purchased for her. At some point and without her father noticing Eluned Finney exchanged this lifejacket for an inferior lifejacket. The lifejacket was not suitable for the rough sea conditions.

After crossing the bar into the open sea, the boat's main engine developed problems. The engine was described as 'failing slowly/struggling'. Eluned's father decided to return to the boat ramp on the high tide. The motor

stopped and could not be restored to its full operating efficiency. It operated only at low revs.

On the return, the boat overturned on the bar. Eluned's father and her friend were able to make it to shore. Eluned was located face down in the water and was unable to be revived by CPR.

RECOMMENDATIONS OF CORONER D O CRERAR

I recommend that MNZ continue with its education programme for those in control of recreational craft. Maritime New Zealand advises boat safely.

- (a) Wear your life jacket
- (b) Check marine weather forecast
- (c) Take two forms of waterproof communication equipment
- (d) Avoid alcohol.

Katene [2015] NZCorC 103 (2 November 2015)

CIRCUMSTANCES

Werahikoteremga Kenneth Katene (Mr Katene) of Invercargill died on 8 November in the Oreti River of drowning.

Mr Katene had left his home in the early morning of 8 November 2014 to go white baiting near the Ferry Road Bridge on the Oreti River. A fellow white baiter (Mr B) has seen Mr Katene shortly after midday in his dinghy on the river. On returning some time later Mr B saw that Mr Katene's dinghy had sunk and was sticking out of the water. Mr B contacted the police and sought help (from other white baiters along the river) who pulled the dinghy out of the water. Mr Katene could not be located, so they continued searching until the Police arrived. At 6.50 pm, the Police located the body of Mr Katene.

When Mr Katene's body was found he was not wearing a life jacket. The Coroner has been told that there was a life jacket available to Mr Katene, and despite his family

urging him to wear it, he did not, and would not, wear a life jacket.

COMMENTS OF CORONER D O CRERAR

I intend to release this Finding to the media, to the Local Authority and to Maritime New Zealand to ensure that publicity is given to the need for boat operators to take the very basic precaution of donning a life jacket before exposing themselves to danger. This will be pursuant to my obligations under s 57(3) of the Act.

Duncan [2017] NZCorC 9 (21 March 2017)

CIRCUMSTANCES

Hamish Alexander Robert Duncan, a Private in the New Zealand Army living at Burnham Military Camp, aged 20, died on 4 April 2015 when he drowned on Lake Coleridge.

Private Duncan went out onto Lake Coleridge, located in inland Canterbury on a kayak on 4 April 2015. There was a strong north-westerly wind and waves were up to 2 metres in height. The conditions were dangerous. Private Duncan came off the kayak when he was some distance away from shore. He was not wearing a life jacket. He was instead wearing a heavy jacket. After he fell from the kayak he was in the water for at least 40 minutes. Given the temperature of the water and the time he was in it trying to remain afloat, Private Duncan became fatigued. He was unable to keep himself afloat and he sank just before the rescue helicopter arrived at 5.22pm. He drowned in the lake and his body has not been found.

COMMENTS OF CORONER ELLIOTT

The death of Private Duncan illustrates the importance of recreational boaters and kayakers assessing the weather and water conditions and refraining from entering the water where it is too dangerous to do so. Where recreational boaters and kayakers decide to enter the water, they should always wear a life jacket.

Horrell [2017] NZCorC 28 (21 July 2017)

CIRCUMSTANCES

Paul Henry John Horrell, of Arrowtown, died on 20 February 2015 at Te Waewae Bay, Southland, from drowning after he fell from a kayak.

Mr Horrell had planned to spend three days hunting, fishing and relaxing with friends near the Waiau river mouth, which runs into the sea in Te Waewae Bay. Near the river mouth, the river runs parallel to the coast for approximately a kilometre, and this body of water is known as the Waiau River mouth lagoon. This is separated from the sea by a large gravel bar, and is known for fishing and white baiting.

Mr Horrell spent most of 20 February 2015 fishing near the river mouth from his kayak, returning briefly to shore for a late lunch before heading out again at 3pm. At 4pm, one of Mr Horrell's friends with whom he was staying spotted Mr Horrell's kayak floating in the surf where the sea meets the shore. Police were contacted and a helicopter located Mr Horrell's body submerged on the ocean side of the gravel bar.

COMMENTS FO CHIEF CORONER MARSHALL

Maritime New Zealand examined the kayak and equipment Mr Horrell had with him and noted that:

- (a) The kayak was likely fit for the conditions within the Waiau River mouth lagoon, which is separated from the sea by a gravel bar, but would likely not have been suitable for the sea conditions at the river mouth.
- (b) Mr Horrell was wearing a properly sized lifejacket when found, but it was of an inappropriate type for the conditions and had ridden up, probably due to the absence of a crotch strap.
- (c) Mr Horrell was wearing inappropriate clothing for the environment and activity.
- (d) No effective, waterproof means of communication was carried.

- (e) Jeans and t-shirts are not appropriate for kayaking in Southland waters as kayaks are prone to capsize and best practice is to layer with synthetic or woollen clothing or wear a wetsuit. Denim and cotton clothing are likely to become waterlogged and offer little insulation.

Chief Coroner Marshall agreed with the Maritime New Zealand advice and noted kayakers should ensure that they are appropriately attired and have the correct safety equipment available.

Singh [2018] NZCorC 4 (22 January 2018)

CIRCUMSTANCES

Dhirendra Singh of Redvale, Auckland died on 24 May 2015 at Port Waikato of Drowning.

On 24 May 2015, Mr Singh was in a dinghy which capsized on the Waikato River. Mr Singh and some friends went out onto the river in Mr Singh's dinghy at about 2 – 2.30pm. All occupants of the boat except for Mr Singh were wearing life jackets. Mr Singh had explained to his friends that wearing a lifejacket interfered with his ability to steer the dinghy and that if anything happened he would put one on.

Some onlookers believed that the dinghy looked overloaded and that the outboard was struggling to push the boat into a headwind. As the boat exited the inlet and got into the main river, large rolling waves caused the dinghy to turn sideways and then capsize. The boat went straight down and Mr Singh did not have time to grab his lifejacket. Mr Singh and a friend were swept down-river; Mr Singh told his friend he was alright initially, but he then developed breathing difficulties. His friend tried to give him CPR. Unfortunately, neither his friend nor emergency services could revive Mr Singh.

A Maritime New Zealand report concluded that the dinghy was in poor condition and was not suitable for the

number of occupants that it was loaded with, and that the overloading and rough conditions caused the dinghy to capsize.

COMMENTS OF CHIEF CORONER, JUDGE D MARSHALL

[Maritime New Zealand] recommends that skippers require all people on a vessel wear lifejackets when the vessel is underway.

Mr Singh's death is a sad reminder of the tragic consequences of failing to follow this recommendation.

Woonton [2018] NZCorC 49; Samuela [2018] NZCorC 50 (30 May 2018)

CIRCUMSTANCES

Kairangi Samuela of Panmure and Terangi Isaia Woonton of Manukau died on 29 December 2014 in the Manukau Harbour after being thrown out of their boat whilst crossing the bar back into the harbour after a day of fishing at sea. Both men drowned.

Mr Samuela and Mr Woonton were part of a party of five whanau members who had organised themselves to go out in a friend's five metre aluminium boat to do some fishing. They headed through the Manukau Harbour out to sea.

At about 2 pm, they headed for home. By then the conditions at the bar had drastically changed and their boat sank as they tried to cross the bar back into the harbour. The men were in the water for about two hours before another boat arrived. Three of the group were rescued by a boat that was in the area at the time but Mr Woonton and Mr Samuela drowned. Both had heart conditions which may have contributed to their deaths given the stress and strain of being in the water and trying to stay afloat.

Emergency services were also alerted and responded. This included the Police helicopter and the Police

Maritime Unit as well as the Westpac helicopter and the Coastguard.

COMMENTS OF CORONER SHORTLAND

The significant information and learning from this tragedy is the use of the "Bar Watch system". The system is available to all mariners. The crossing of bars in NZ waters is inherently dangerous even in perfect conditions. By engaging in the system, it will provide a safer monitoring for any vessel crossing the Manukau Bar and any other bar crossing in NZ.

All recommendations and Comments — 1 January to 31 March 2018

The following are all recommendations and comments that have been issued in Coroners' findings between 1 January 2018 and 31 March 2018. Recommendations and comments which are prohibited from publication by order of law or the court have not been included.

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

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

Homicide

Marceau [2018] NZCorC 18 (5 March 2018)

CIRCUMSTANCES

Christie Alexis Lesley Marceau died on 7 November 2011 at 93 Eban Avenue, Hillcrest, Auckland from multiple sharp force injuries as the result of stab wounds inflicted by Akshay Chand.

Christie lived at home in Hillcrest, Auckland with her parents, grandmother and older sister. She previously worked part-time at a local supermarket.

Akshay Chand moved to New Zealand in 2003 with his parents and younger sister. His parents had divorced, and Mr Chand's father no longer lived in New Zealand. Mr Chand and his mother also lived in Hillcrest, only a short distance from the Marceaus' house. Mr Chand left school at the end of 2010 and started work at the local supermarket. He worked there for a short period of time before resigning, and had not got another job.

Christie and Mr Chand had attended the same primary school for a year, and for a short period in 2011 they

worked at the same supermarket. While working together they had socialised occasionally and communicated on Facebook.

On the morning of 6 September 2011, Mr Chand rang Christie around 10am and told her he had crushed up a number of pills and made them into a drink, and if she did not get to his house in 10 minutes he would drink them. Christie went straight to Mr Chand's house, and when she arrived Mr Chand had a knife. He held the knife to her, demanded she remove her clothes, and threatened to rape her. He eventually allowed Christie to leave. After Christie left, Mr Chand swallowed around 50 of his mother's multivitamin tablets. His sister came home at his request and called an ambulance, and he was transported to hospital. At the North Shore Hospital Emergency Department, Mr Chand told the psychiatric registrar that he had had suicidal thoughts since the beginning of 2011 and these were increasing in frequency. Mr Chand was diagnosed with depression. He was prescribed antidepressants and discharged to a community mental health team for follow-up.

Christie reported what had happened that morning, and Police arrested Mr Chand at the North Shore Hospital. The psychiatric registrar was concerned the arrest would cause an escalation of Mr Chand's suicidal thinking, and recommended he be kept on a direct watch overnight. On the evening of 6 September, Mr Chand was charged with kidnapping, assault with intent to commit sexual

violation, and threatening to do grievous bodily harm. He admitted to the offending. During the Police interview, Mr Chand said the reason he attacked Christie was revenge for her not helping him with his depression, and that his desire for revenge still existed.

Mr Chand was remanded in custody until 5 October. He had a number of court appearances over the following weeks at which bail was discussed, and he had eight face-to-face assessments by mental health professionals who provided reports to the court. Mr Chand appeared for the fifth time on 5 October when he was granted bail. He was placed under a 24-hour curfew to reside at his mother's address. He was ordered not to leave the house by himself, not to associate with Christie and not to go to her address. Mr Chand was due to appear in court again on 9 November 2011.

During the period 6 October to 6 November, Police conducted 23 bail checks at Mr Chand's home at various time of the day, with the last check being on the evening of 6 November. Mr Chand was home each time. Mr Chand continued to receive mental health care while on bail and he was taking prescription antidepressants. After appointments and assessments with community mental health services, Mr Chand was discharged back to his GP on 12 October. At an appointment with his GP on 19 October, Mr Chand said he had no thoughts of harming himself or others.

At 7.04 am on 7 November, Police received a 111 call from the Marceau's house. Mr Chand had pushed his way into their house and attacked Christie. Christie died as a result of her injuries. During an interview with Police that day, Mr Chand said that he had intentionally deceived mental health services. He had started to plan to kill Christie from the day he was granted bail, and left it until two days before he was due back in court so she would let her guard down. Mr Chand was found not guilty of Christie's murder by reason of insanity.

Mr Chand pleaded guilty to the original charges arising from the events of 6 September, and was convicted and sentenced to three years' imprisonment.

RECOMMENDATIONS OF CORONER GREIG

To: the Secretary for Justice/Chief Executive Ministry of Justice I recommend that district court processes are amended to provide that:

I. When an assessment report pursuant to s38 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 is ordered by the Court on its own initiative while bail for a serious offence/offences is being considered, the Judge's notes pertaining to the decision to order the report are routinely made available to the health assessor appointed to prepare the report (to form part of the collateral information the health assessor will consider before making the report).

To: the Secretary for Justice/Chief Executive of the Ministry of Justice and the Commissioner of Police I recommend that, consistent with the legislative framework set out in the Victims' Rights Act 2002, particularly s12, the victim advisor service and the New Zealand Police develop:

II. A protocol identifying the types of information it is appropriate for the two organisations to share routinely on cases referred to the victim advisor service by the police, to enable police and victim advisors to work together more collaboratively in order to undertake their respective responsibilities to victims of crime better; and

III. A process whereby this information is exchanged by police and victim advisors on a nationally consistent and timely basis.

To: the Secretary for Justice/Chief Executive of the Ministry of Justice I recommend that the victim advisor service review its processes for advising victims of crime who wish to provide their views to the Court on a bail application, and consider:

IV. Whether the process that victim advisors use to provide victims with information about preparing letters for the Court expressing the victim's view on a bail application is sufficient to meet the needs and address specific concerns of victims (including helping victims to identify issues they wish to draw to the Court's attention, matters not appropriate to include, and the degree of specificity advisable); and

V. If necessary, amend its processes.

To: the Secretary for Justice/Chief Executive of the Ministry of Justice, the Commissioner of Police, and the Chief Executive of the Department of Corrections I recommend that the Secretary for Justice/Chief Executive of the Ministry of Justice, the Commissioner of Police, and the Chief Executive of the Department of Corrections:

VI. Consult with key stakeholders on the most effective way(s) (including consideration of operational options and potential legislative amendment) to ensure that in all applications for bail simpliciter involving serious offences and where a 24-hour curfew is proposed as a condition of bail, evidence is provided to the Court in a suitable format (e.g., affidavit from the owner/lawful occupant of the proposed bail address), which includes:

- a. Details of the proposed address;
- b. That the occupant of the proposed address is the owner or lawful occupier, and the occupant's relationship to the defendant;
- c. Whether or not the proposed bail address is acceptable to the prosecuting authority;
- d. That the occupant of the proposed address has been officially informed of the nature of the charges faced by the defendant; and has been informed of the nature of any past offending by the defendant; and has been advised of and understands the effects of the 24-hour curfew condition and any other proposed conditions of bail, and the role of the occupant and the expectations of the occupant in relation to supporting the defendant while on a 24-hour curfew;
- e. The level of supervision, if any, the occupant could realistically commit to; and
- f. That the occupant has made an informed decision whether (or not) to consent to the defendant remaining at the bail address for an indeterminate period while on bail with a 24-hour curfew.

To: the Secretary for Justice/Chief Executive of the Ministry of Justice I recommend that:

VII. An in-depth review of the issues relating to document management at NSDC highlighted in these findings is undertaken (including a review of the adequacy of electronic document management systems, particularly in relation to access, accuracy, and interoperability); and

VIII. The changes necessary to address the issues are implemented nationally. (In particular, changes are introduced to ensure that there is an accurate court file on which it is clear what documents have been received (by whatever means), and when, and what documents have been sought (e.g., transcribed notes of decisions and reports by health assessors) and when.

In the interim, I further recommend that:

IX. District Court processes are amended forthwith to ensure that court takers routinely record on the paper-based court file:

- a. that a request for a transcription of the notes of a decision has been made by a judge; and
- b. that the request for transcription has been sent to the National Transcription Service; the date of request; and whether the request was for an urgent or standard turnaround.
- c. Or an alternative process is introduced to ensure that this information is clearly recorded on the paper-based court file.

X. There is consultation as to whether, once the notes of a draft decision that a judge has asked be transcribed are received back from the National Transcription Service, they may routinely be placed on the paper-based court file until a finalised decision is available.

To: the Commissioner of Police, I recommend that:

XI. It may be timely for the Police Prosecution Service processes to be reviewed and, where necessary, amended to ensure that:

- a. The Police Prosecution Service maintains a robust procedure to identify/triage serious high-risk cases (particularly those involving alleged offences of

violence to others) the service is responsible for managing;

b. An appropriate level of active supervision by a senior member of the Police Prosecution Service is available in relation to such serious high-risk cases;

c. A sufficiently robust written protocol setting out the information it is expected a prosecutor will record at the end of the hearing is in place to ensure effective handover of the case to another prosecutor; and that

— compliance with the matters identified above is audited regularly.

To: the Chairperson of Waitemata District Health Board
I recommend that the Auckland Regional Forensic Psychiatry Service:

XII. Review the June 2012 Memorandum of Understanding in respect of Forensic Court Liaison Services in the district courts to ensure that it reflects the amended version of the Court Liaison Nurse Practice Guidelines.

XIII. Adopt as a standard the requirement that clinical assessments documented in HCC by ARFPS staff include reference to any limitations of the assessment that may impact on its reliability or constrain use of the assessment (e.g., length of assessment; lack of collateral information; time constraints; uncooperative interviewee).

XIV. Adopt as a standard the requirement that any limitations of an assessment that may impact on its reliability, or constrain use of that assessment, and/or limitation of any other clinical assessment or report relied upon, are included in all forensic court liaison nurse and health assessor reports to the Court.

XV. Review the Waitemata DHB Court Liaison Nurse Practice Guidelines (issued March 2017) and the Waitemata DHB Professional Clinical Knowledge and Skills document for the Forensic Court Liaison Service (issued February 2017) and amend as required, to ensure that they reflect the recommendation contained in the external review of the care Waitemata DHB provided to Mr Chand (undertaken by Dr Ceri Evans and

Ms Rachael Aitchison) that forensic court liaison nurses set out the limitations of their assessments in their reports to the court — to ensure that the requirement for there to be a circumscribed link between any risk statements and mental disorder as defined within the Mental Health (Compulsory Assessment and Treatment) Act 1992 is included.

XVI. Amend the forensic court liaison nurse template letter to the court to provide prompts for including limitations of the assessment and specific disclaimers it is important for the Court to consider when reviewing that document or opinion.

To: the Chairperson of Waitemata District Health Board and the Secretary for Justice/Chief Executive of the Ministry of Justice and the Commissioner of Police I recommend that:

XVII. The Ministry of Justice and the Auckland Regional Forensic Psychiatry Service (if sensible in conjunction with other regional forensic psychiatric services in New Zealand) and the New Zealand Police:

a. Work together to identify and agree the baseline court documents forensic court liaison staff throughout New Zealand should routinely be provided (e.g., summary of facts/caption summary and POTB) to enable them to work effectively with offenders they are asked to attend or advise on; and

b. Agree which organisation/agency is responsible for providing a full set of the baseline documents identified above to the forensic court liaison staff and the process for, and the timing of, delivery (or provision of electronic or other access) of these documents to forensic court liaison staff.

To: the Commissioner of Police and Waitemata DHB I recommend that:

XVIII. The Auckland Regional Forensic Psychiatry Service identifies (if sensible in conjunction with other regional forensic psychiatric services in New Zealand) whether there are types of evidence (e.g., interviews or job sheets) held by the New Zealand Police that would assist health assessors preparing reports pursuant to an

order under s38 of the Criminal Procedure (Mentally Impaired Persons) Act 2003; and, if so

XIX. The New Zealand Police consider whether such information can be properly disclosed; and, to the extent it can

XX. A process is developed for such information to be made available to health assessors prior to undertaking the s38 assessment.

To: the Chairpersons of Waitemata DHB; Waikato DHB; Capital Coast DHB; Canterbury DHB; and Southern DHB
I recommend that:

XXI. National Court Liaison Nurse Clinical Guidelines are developed to foster consistency of practice in forensic court liaison nurses throughout New Zealand.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of diary notes made by Christie Marceau in the interests of personal privacy.

Self-inflicted

Jolly [2018] NZCorC 1 (10 January 2018)

CIRCUMSTANCES

Benjamin William Jolly of Wanaka died of self-inflicted injuries.

RECOMMENDATIONS OF CORONER A J TUTTON

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

- (a) that the [Southern District Health Board]:
 - (i) establish a working group or dedicated project position to review recommendation from the 2008 best practice guidelines and the SDHB suicide

prevention action plan 2015-2018, consider the introduction of a district-wide stand-alone mandatory staff training day in suicide assessment and the introduction of a structured suicide screening tool, required to be used by all staff district-wide.

(ii) ensure those people responsible for the management of the [Central and Lakes Community Mental Health Team] are competent in the tools, techniques and processes available for dealing with staff members who fail to meet policy and service expectations.

(iii) Review the processes and system at all intake points to the adult mental health service to ensure triage tools and processes are applied consistently, and

(iv) Review the processes and systems at all intake points to the adult mental health service to ensure there are no barriers to those with addiction issues who also require assistance in respect of their mental health.

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

Note: Pursuant to section 71 of the Coroners Act 2006, publication of a particular of the death, other than the name, address and occupation of the deceased, and the fact that a coroner has found the death to be self-inflicted, is prohibited.

Cowley [2018] NZCorC 10 (14 February 2018)

CIRCUMSTANCES

Jessie Jane Cowley of Whangaparoa died on 23 March 2015 at her home of self-inflicted injuries.

COMMENTS OF CORONER D A BELL

I. Coroner Bell endorsed the recommendations made by the Waitemata District Health Board following Mrs Cowley's death that the acute team monitor through audit, every three months, in relation to assertive face-to-face follow ups.

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

Note: Pursuant to section 71 of the Coroners Act 2006, publication of a particular of the death, other than the name, address and occupation of the deceased, and the fact that a coroner has found the death to be self-inflicted, is prohibited.

Clutterbuck [2018] NZCorC 11 (19 February 2018)

CIRCUMSTANCES

Brent Gary Clutterbuck died between 30-31 January 2017 of self-inflicted injuries.

RECOMMENDATIONS OF CORONER ROBINSON

To: All persons

I. Having regard to the factors in this case I would urge all persons who:

(a) are aware of a person who has expressed suicidal thoughts and may be taking steps to act on those thoughts; or

(b) become aware that the person has so acted;

to call emergency services as soon as possible, so that the best opportunity for successful intervention is given.

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death. Pursuant to section 71(3)(b) of the Act, the death may be described as a suicide.

An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs which show the deceased in the interests of decency and personal privacy, and that there is little public interest in such photographs being published.

Mulligan [2018] NZCorC 13 (26 February 2018)

CIRCUMSTANCES

Mary Lorraine Mulligan of Dunedin died due to self-inflicted injuries.

COMMENTS OF CORONER ELLIOTT

I. Mary Mulligan took her own life on 6 April 2016. Unfortunately, alcohol had a destructive effect on her life. Despite seeking and taking part in programmes to curb her alcohol addiction, Ms Mulligan was unable to abstain from alcohol during stressful times. Ms Mulligan also had mental health issues which were exacerbated by alcohol consumption.

II. According to the Ministry of Health, many New Zealanders are affected by alcohol or other drug abuse and dependence throughout their lives.

III. The Health Promotion Agency states that alcohol is a depressant and anxiety can be made worse by heavy or frequent drinking and can contribute to depression. For that reason, getting help with one will often help the other.

IV. The Ministry of Health website has a number of resources and suggestions of ways people can seek help for their alcohol and/or drug dependence issues.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of the deceased in the interests of decency and personal privacy, and that there is little public interest in publication.

Note: Pursuant to section 71 of the Coroners Act 2006, the Coroner has authorised the partial publication of this finding. The comments set out above, and made in [44] of the finding may be published, however, no person may make public any particular of this death other than the name, address and occupation of the deceased, and that her death is found to be self-inflicted.

Neal [2018] NZCorC 19 (7 March 2018)

CIRCUMSTANCES

Peter James Neal of Rotorua died on 9 December 2016 at the Rotorua Crematorium of self-inflicted injuries amounting to suicide.

Mr Neal's wife explained that he had been struggling with his mental health for some time and that he had been talking about suicide and suicidal feelings with her.

Mr Neal had mentioned at a medical appointment in May 2016 that he had been having a very stressful year. At another appointment, he mentioned feeling lonely and isolated. His doctor considered that he did not present with depression but was struggling to overcome a difficult time. At the appointments, there was no indication from Mr Neal that he was considering self-harm and no questions were asked, during his mental health screening, about that issue.

Mr Neal's wife, having become more worried about him, contacted a Mental Health Key Worker who notified the Mental Health Crisis Team and he was recorded as a person of interest. Mr Neal's wife stated that the Key Worker informed Mr Neal's doctor. The Key Worker contacted Mr Neal; however, he denied feeling depressed.

On 9 December 2016, Mr Neal's wife became worried when he did not return home at the time he stated. She contacted police and Mr Neal was some time later found deceased in the Rotorua Crematorium.

COMMENTS OF CORONER MICHAEL ROBB

I. Peter's expressed consideration of suicide had been relatively long-standing and extending back at least 12 months. Peter had outlined feeling stressed on a number of occasions while attending at his medical practice, a mental health screening tool was used but did not extend to consideration of self-harm. Concerns that Peter might self-harm were said to have been conveyed to Peter's doctor. I have received no response from Peter's doctor to either confirm nor deny that those concerns were raised with the doctor.

If information was provided to Peter's medical practice about Peter contemplating ending his life, a record of that should have been made and should have been acted upon.

Peter was providing care and support for his wife who was undergoing her own mental health difficulties. That is a matter that should be recognised as presenting a considerable stress and increasing the risk of the development of mental health issues, depression, and potentially thoughts of self-harm. That is a pattern that has been borne out in a number of coronial investigations that I have conducted, and as a result it is a matter that doctors and mental health professionals should consider in evaluating a patient's mental health. In this instance, it appears that [Mr Neal's wife's] Key Worker took [her] concerns about Peter seriously and did make contact with him and endeavoured to provide him with support.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of the Mr Neal following his death in the interests of decency.

Note: Pursuant to section 71 of the Coroners Act 2006, no person may make public the method or suspected method of the self-inflicted death or any detail that suggests the method or any suspected method of death, unless granted an exemption under section 71A

Croot [2018] NZCorC 20 (21 March 2018)

CIRCUMSTANCES

Nigel James Croot of Dunedin died of self-inflicted injuries.

COMMENTS OF CORONER A J TUTTON

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>

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

Note: Pursuant to section 71 of the Coroners Act 2006, publication of a particular of the death, other than the name, address and occupation of the deceased, and the fact that a coroner has found the death to be self-inflicted, is prohibited.

Motor-vehicle

Davies [2018] NZCorC 3 (18 January 2018)

CIRCUMSTANCES

Maureen Joan Davies of Hamilton died on 1 February 2015 at Waikato Hospital ICU, Pembroke Street, Hamilton of medical complications (circulatory failure and acute bronchopneumonia) following multiple blunt trauma from a motor vehicle crash.

At 4.40pm on 30 January 2015, Mrs Davies was driving a motor vehicle on State Highway 1 near Karapiro. She slowed for traffic which was slow moving. Her vehicle was rear-ended by a vehicle travelling at some speed from behind and she was projected off the road. She was wearing a seatbelt and the conditions were fine. Mrs Davies was taken to hospital, where she died on 1 February.

The driver of the vehicle that hit her was found to have methamphetamine and codeine in their system.

COMMENTS OF CORONER WALLACE BAIN

I. The police traffic crash report refers to preventative recommendations that there be reinforcement of the education regarding the consequences of driving under the influence of drugs.

I direct that the Findings with this comment be sent to the Ministry of Transportation.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of the photographs forming part of the evidence and the addresses, telephone numbers, and email addresses (where applicable) of persons who have provided signed statements in evidence.

Soo [2018] NZCorC 15; Hills [2018] NZCorC 16; Nicholson [2018] NZCorC 17 (27 February 2018)

CIRCUMSTANCES

Jessie Jean Nicholson, David James Hills, both of Palmerston North, and Michael Harley Soo of Foxton died on 12 December 2015 at State Highway 1, Atiamuri, South Waikato. Ms Nicholson died of fractured cervical spine; Mr Hills died of fractured cervical spine along with multiple other injuries; and Mr Soo died of multiple injuries to the brain, skull, spine, heart, liver, spleen and limbs, as a result of a motor vehicle crash.

In the mid-afternoon of 12 December 2015, the Toyota vehicle that Ms Nicholson, Mr Hills, and Mr Soo were travelling in crossed the centre line and collided with a freight liner truck travelling in the opposite direction on State Highway 1, near Atiamuri. They died at the scene from their injuries.

The Toyota was travelling at a speed of 104km/h and the truck at 80-97km/h. A temporary posted speed limit of 30km/h was in effect due to two accidents occurring earlier in the day. The road was displaying extreme signs of flushing; whereby the road's seal texture depth is lost over time, resulting in a loss of skid resistance. It was

also raining and the road surface was wet due to heavy rain earlier; the speed may have been too great for the conditions. The traffic crash report indicates that the traffic management plan set up for southbound traffic was inadequate and may have been a contributing factor. The truck driver had been distracted by an overturned truck from a previous accident and the driver of the Toyota may have been distracted or inattentive also.

COMMENTS OF CORONER WALLACE BAIN

I. Full comments of the crash analysis report should be sent to the relevant authorities in charge of the road, and in particular, the recommendations in terms of managing the road under the conditions prevailing at the time of the accident. Those comments are these:

i) The use of some form of hazard delineation devices, such as traffic cones or tubular delineators set out along the full length and/or along the centreline may have helped to make the hazardous area more conspicuous had SOO not registered the initial advance warning signs and temporary speed limit signs. Furthermore, delineation devices are known to reduce vehicle speed due to the motorist perception that the lane width is narrower.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of the photographs forming part of the evidence and the addresses telephone numbers, email addresses of persons who have provided statements.

Shirnack [2018] NZCorC 21 (23 March 2018)

CIRCUMSTANCES

Brian Desmond Shirnack of Levin died on 18 September 2017 on Oxford Street in Levin of injuries sustained in a motor vehicle accident.

Mr Shirnack was an 83-year-old widower and retired truck driver. He had coronary artery disease and an eyesight problem that affected his left eye, and some deterioration of his sight in both eyes.

On 18 September 2017 at about 6.50pm, Mr Shirnack crashed his car into the rear of a truck that was stationary and waiting in a turning lane to make a right turn. It was dark and raining. Mr Shirnack failed to stop, or steer clear of the turning truck. However, neither the police crash investigator nor the Coroner could determine why he failed to do so.

The Coroner considered that there were three possible reasons for the collision:

(a) Mr Shirnack may have suffered a medical event which caused or contributed to the crash. The Coroner regarded this as possible, but not probable;

(b) Mr Shirnack's eyesight problem may have compromised his vision to such an extent that he either did not see the truck, or if he did, he saw it at the last minute and was unable to avoid it. The Coroner also regarded this as possible, but not probable;

(c) The left-hand tail-light and stop-light on the truck were not working. The crash investigator could not determine whether this was so before the crash, or whether it was a result of the crash. Again, the Coroner considered it possible but not probable that this was the cause of the crash.

The reason for the collision therefore remains undetermined.

The police investigation report found that the right turning lane was too narrow for the truck to fit within it, although there was sufficient space for a vehicle to overtake the turning truck in its left.

RECOMMENDATIONS ENDORSED BY CORONER TIM SCOTT

I. The Coroner endorsed the following recommendation made by the New Zealand Police in their Crash Investigation Report:

that consideration be given to widening the right-hand turning lane (State Highway 1 or Oxford Street to Ward Street), to allow vehicles of legal width (2.5 metres) to remove themselves entirely from the southbound lane (of State Highway 1), when turning.

The Coroner recorded that NZ Transport Agency intends act upon this recommendation.

Gotty [2018] NZCorC 22 (23 March 2018)

CIRCUMSTANCES

Glennard Hirini Gotty of Hastings died on 28 May 2017 at Hawkes Bay Fallen Soldiers Memorial Hospital, Hastings of multiple injuries. He sustained these injuries in a motor vehicle crash at about 6.00pm on 28 May at White Road, Waipawa, Hawke's Bay, about 750 metres west of the intersection with Racecourse Road.

The vehicle that Mr Gotty was driving that day was owned by another person, who had advertised it as being for sale. At about 5.00pm on 28 May 2017, Mr Gotty had discussed with the owner the price to buy the car and stated that he wanted to check the car before purchase. Mr Gotty and the owner travelled in the car around the Waipawa area and stopping at a number of addresses; at one point, the owner told Mr Gotty to slow down as he was driving at about 120 km/h. After Mr Gotty had stopped at an address, entered it, and then had come back to the car, he told the owner to get out of it with the threat of being stabbed. The owner got out of the car, went home and called the police.

Mr Gotty then proceeded along State Highway 2 in the car at some speed. The crash occurred at about 6.00pm and was not witnessed. The area where Mr Gotty crashed the car had a clearly visible chevron board viewable from over 200m away, and a yellow sign indicating a right-angle left bend; it did not have a cautionary speed sign. The Police Crash Investigation Report recommended the placement of a 25km/h cautionary speed sign at before the corner. Mr Gotty failed to navigate the corner and was travelling at 65-80 km/h at the time of the crash. Police conclude that the corner could be taken at a range of between 41-48 km/h. There was no evidence of alcohol or compromised visibility of the road. There is no evidence of Mr Gotty having braked or attempting to turn the car around to the corner; it is unknown why this is so, or why he crashed the vehicle.

Mr Gotty was taken to Hawke's Bay Fallen Soldiers Memorial Hospital, Hastings following the crash. He died there at about 9.00pm.

RECOMMENDATIONS ENDORSED BY CORONER T SCOTT

I. I endorse and adopt the recommendation made by Mr Maddaford in his report that 25 kilometre per hour speed advisory signs should be placed prior to this corner in both directions. After receiving a copy of a draft finding and the proposed recommendation, the Central Hawke's Bay District Council have confirmed that advisory signs will be installed in both directions.

Drowning

Singh [2018] NZCorC 4 (22 January 2018)

CIRCUMSTANCES

Dhirendra Singh of Redvale, Auckland died on 24 May 2015 at Port Waikato of Drowning.

On 24 May 2015, Mr Singh was in a dinghy which capsized on the Waikato River. Mr Singh and some friends went out onto the river in Mr Singh's dinghy at about 2 – 2.30pm. All occupants of the boat except for Mr Singh were wearing life jackets. Mr Singh had explained to his friends that wearing a lifejacket interfered with his ability to steer the dinghy and that if anything happened he would put one on.

Some onlookers believed that the dinghy looked overloaded and that the outboard was struggling to push the boat into a headwind. As the boat exited the inlet and got into the main river, large rolling waves caused the dinghy to turn sideways and then capsize. The boat went straight down and Mr Singh did not have time to grab his lifejacket. Mr Singh and a friend were swept down-river; Mr Singh told his friend he was alright initially, but he then developed breathing difficulties. His friend tried to give him CPR. Unfortunately, neither his friend nor emergency services could revive Mr Singh.

A Maritime New Zealand report concluded that the dinghy was in poor condition and was not suitable for the number of occupants that it was loaded with, and that the overloading and rough conditions caused the dinghy to capsize.

COMMENTS OF CHIEF CORONER, JUDGE D MARSHALL

I. [Maritime New Zealand] recommends that skippers require all people on a vessel wear lifejackets when the vessel is underway.

Mr Singh's death is a sad reminder of the tragic consequences of failing to follow this recommendation.

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

Priestly [2018] NZCorC 8 (1 February 2018)

CIRCUMSTANCES

On 19 June 2016, Raymond John Priestly went to Pourerere Beach to dive for paua. He was located, clearly deceased, by a rescue helicopter at 5pm, submerged at sea approximately 200 metres offshore from where he had entered the water. The cause of his death was drowning. This was an inadvertent consequence of his own actions, and the state of his diving gear.

COMMENTS OF CORONER RYAN

To: Water Safety New Zealand, New Zealand Underwater Association, and all other clubs or associations related to SCUBA diving.

I. I am aware that Water Safety New Zealand and diving clubs and associations consistently promote the message that divers must ensure their diving gear is properly maintained and free of defects, and that divers follow best practice while diving. For that reason it is not appropriate for me to make a recommendation to this effect.

II. Having said that, I encourage such organisations to continue their efforts to educate recreational divers that their lives depend on their diving gear operating properly and upon their own judgement of conditions and best diving practice.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs which show the deceased in the interests of decency and personal privacy, and that there is little public interest in such photographs being published.

RESPONSE FROM WATER SAFETY NEW ZEALAND TO COMMENTS MADE BY CORONER RYAN RE. THE LATE RAYMOND JOHN PRIESTLY

Water Safety New Zealand provided the following response to Coroner Ryan's recommendations:

Water Safety New Zealand point out that they consider there were best practice factors which may not have been followed in Raymond's case. In particular, they refer to the fact that Raymond was diving alone and that if he had been diving with a buddy that person may have been able to provide assistance which may have prevented his death.

Other best practice factors apparently missing in this case were:

- (a) Having a diving-specific health check with the doctor, and continuing these on a regular basis;
- (b) Advising others, preferably shore-based, about the trip and the dive plan; and
- (c) Deploying a dive flag to let others know your location in the water.

Fall

Bates [2018] NZCorC 2 (12 January 2018)

CIRCUMSTANCES

Warren Peter Bates fell down the stairs at his home in Wanaka on 27 February 2015 after drinking with friends. Mr Bates was taken by ambulance to Wanaka Medical Centre, then to Dunstan Hospital on 28 February 2015. Because of his head injuries, Mr Bates needed to be transferred to Dunedin Hospital for CT scans. There were delays in departure for a number of reasons. Mr Bates died in an ambulance while being transported from Dunstan Hospital to Dunedin Hospital.

Mr Bates' cause of death was raised intracranial pressure due to an intracranial epidermoid cyst. The circumstances of Mr Bates' death raise a number of issues relating to the availability of medical facilities and resources at Dunstan Hospital.

RECOMMENDATIONS OF CORONER TUTTON

To: Chief Executives of the Southern District Health Board ("SDHB"), Accident Compensation Corporation ("ACC"), National Ambulance Sector Office ("NASO"), St John, and Otago Rescue Helicopter Trust. Ministry of Health.

- I. That the SDHB:
 - a. prioritise and accelerate arrangements to enable 24 hour, seven day CT services at Dunstan Hospital, and
 - b. coordinate, with the involvement of all services involved, the development of district-wide head injury management guidelines, including clear transfer pathways,
- II. That the agencies involved in the transportation of patients within the district, both by road and air, work collaboratively to ensure the availability of sufficient and appropriate transport options, with contingency plans in place for bad weather.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs which show the deceased in the interests of decency and personal privacy, and that there is little public interest in such photographs being published.

Tong [2018] NZCorC 7 (31 January 2018)

CIRCUMSTANCES

Sybil Tong was 94 years old and lived in a residential care home on the North Shore. Mrs Tong was admitted to the emergency department of North Shore Hospital on 7 August 2015 following a fall at home. She was then placed on a trauma stretcher to be treated for injuries she sustained in that fall. During that process, she was to be turned over. The attending nurse explained this to Mrs Tong but Mrs Tong, who was deaf, unexpectedly turned the opposite way from the nurse and fell off the stretcher onto the floor.

On 10 August, she underwent surgery, however, she deteriorated post operatively and died on 13 August 2015. The cause of death was acute cerebral infarction complicating of fractured neck of femur.

COMMENTS MADE BY CORONER BELL

- I. One issue I had to address was how was it that Mrs Tong managed to fall from the stretcher? To address this I requested a copy of an Adverse Event Falls Investigation Report completed by WDHB in which the hospital has conducted their own investigation as to how Mrs Tong managed to fall out of the stretcher.
- II. The report by the Adverse Events Committee submits a number of recommendations to address falls risk assessment. I endorse those recommendations and request WDHB to adhere to them.
- III. Mr Richard Tong raised a number of matters in particular had WDHB considered using electronic hearing assistance to assist deaf patients to communicate. WDHB advise that all deaf patients have access to a NZ Sign Language interpreter, however unfortunately not all deaf people sign so it is important

for WDHB staff to establish the best form of communication relevant to that patient. They further state that i-pads are provided to deaf patients with which they can access interpreters through video interpreting services. The i-pads are also used for patients to communicate with staff.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs which show the deceased in the interests of decency and personal privacy, and that there is little public interest in such photographs being published.

Kersnovske [2018] NZCorC 9 (9 February 2018)

CIRCUMSTANCES

Gregory Leslie Kersnovske died on Christchurch Hospital on 20 August 2015, from a severe brain injury. Mr Kersnovske sustained this injury on 10 August 2015, when he appears to have slipped and fallen on ice on the ground near the Visitors' Centre at Aoraki/Mt Cook, which he was visiting as a tourist from Australia. The fall itself was not witnessed.

RECOMMENDATIONS OF CORONER TUTTON

To: Department of Conservation

That DOC:

- I. Adds to the information it provides on its website in respect of Aoraki/Mt Cook general information about the weather conditions that can be expected in the village, an alpine environment, in winter, and the associated risks;
- II. Requires its staff to ensure there is a sign warning of ice present in the area in which Mr Kersnovske fell at all times during the high risk season, and
- III. Investigates the options for reducing the known ice hazard in the area in which Mr Kersnovske fell and implements the most feasible and effective option.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs which show the deceased in the interests of decency and personal privacy, and that there is little public interest in such photographs being published.

Fire

Sarginson [2018] NZCorC 5 (24 January 2018)

CIRCUMSTANCES

Alan Sarginson died in the early hours of 2 November 2016 in a house fire. Mr Sarginson was staying in the living room of a friend's flat. The New Zealand Fire Service investigated and considered an electric jug in the kitchen to be the cause of the fire. The battery for the smoke alarm in the hallway had been removed as it would frequently give false alarms.

Mr Sarginson's cause of death was due to inhalation of smoke and fumes caused by the fire.

COMMENTS MADE BY CHIEF CORONER JUDGE D MARSHALL

- I. New smoke alarm requirements came into force (for properties covered by the Residential Tenancies Act 1986) on 1 July 2016. Rental properties must have at least one working smoke alarm within three metres of each bedroom door or every room where a person sleeps. Tenants are responsible for changing batteries in smoke alarms that are designed to have the battery changed during the tenancy.
- II. This death is a sad reminder of the dangers of not having a working smoke alarm.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs which show the deceased in the interests of decency and personal privacy, and that there is little public interest in such photographs being published.

Garbes [2018] NZCorC 14 (27 February 2018)

CIRCUMSTANCES

Timon Arama Garbes of Kaikoura died on 30 January 2016 at 3518 State Highway 1, Kaikoura, from the effects of fire.

Mr Garbes had moved back to Kaikoura to live with his father, in the hope that he could embark on a drug-free lifestyle. He was alone at the property on 30 January 2016. His former partner and son visited, however, they left after Mr Garbes' behaviour changed - he became aggressive and was throwing furniture around. He had been seen lighting a fire, and putting recycling in it.

The fire was noticed by a member of the public and the fire service called. Mr Garbes was found deceased. The cause of the fire was investigated, and found to be the deliberate or accidental placing of combustible material on the grill, reflector shield and elements of a three bar heater.

Intoxication, by alcohol and other drugs (cannabis, codeine, citalopram, quetiapine and zopiclone), was found to have contributed by potentially causing the deceased to become sedated, confused, semi-conscious or unconscious.

COMMENTS OF CORONER ROBINSON

I. This case emphasises the dangers inherent in supplying one's prescription medication to a person to whom it has not been prescribed. This was not simply the case of making available an analgesic obtained on prescription that might otherwise be obtained "over-the-counter". On the admission of the person who supplied an antipsychotic drug to Mr Garbes (an inference is available that she also supplied a hypnotic sedative, though for the reasons expressed above I have not reached any concluded view). She would have had no understanding of the effects it might have on him, what other substances he may have been taking, nor any knowledge of the interactions that might occur.

II. It also stands as a warning to those who might consume drugs that have not been prescribed to them,

for the same reasons - the effects of the drug and combinations of other drugs will simply not be known to the user. Any person who consumes medication that is not prescribed for them runs a very considerable risk of adverse effects.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of and photographs of Mr Garbes entered into evidence in the interests of personal privacy and decency. Further orders pursuant to section 74 were made, prohibiting the publication of the name of the person who supplied an antipsychotic drug to Mr Garbes, and any particulars likely to lead to their identification, including but not limited to their relationship to Mr Garbes.

Aviation

Hertz [2018] NZCorC 23; Hertz [2018] NZCorC 24 (28 March 2018)

CIRCUMSTANCES

Eric Bennett Hertz of Parnell, Auckland died 11 nautical miles north-west of Kaiwhia Harbour on 30 March 2013 of multiple injuries sustained in an accidental aircraft crash. His injuries were immediately fatal.

At 11:47 am on 30 March 2013, Eric Bennett Hertz, piloting his Beechcraft Baron aircraft, N254F, took off from Ardmore Aerodrome bound for Timaru Aerodrome via Mount Cook Aerodrome. On board with Mr Hertz was his wife, Mrs Hertz. Mr and Mrs Hertz were on their way to visit their daughter with a stop-over at Mount Cook for the night.

As at 30 March 2013, Mr Hertz was not entitled to be issued a medical certificate by FAA or CAA.

N254F departed from Ardmore, climbing to Flight Level 180 towards New Plymouth Aerodrome and over the Tasman Sea off the Raglan coast. At around 30 minutes into the flight, N254F was operating in cloud. N254F departed from controlled flight and entered a spin from

which it did not recover. N254F crashed into the Tasman Sea. Police with the assistance of the New Zealand Navy located the wreckage of N254F using sonar. Navy divers recovered the bodies of Katherine Picone Hertz and Eric Bennett Hertz on 6 and 7 April 2013, respectively.

N254F departed from controlled flight because airspeed decreased to a point where control of the aircraft could not be maintained. N254F's airspeed decreased because the left engine failed. No findings can be made as to the cause of the failure of the left engine.

Mr Hertz lost situational awareness and became disorientated during and subsequent to the departure from controlled flight because he was in cloud.

RECOMMENDATIONS OF CORONER G MATENGA

I. Pursuant to sections 57(3) and 143A Coroners Act 2006 I recommend that:

CAA and the Ministry of Transport review Part 67 Subpart B Civil Aviation Rules to consider an amendment which:

In relation to an Application for a Medical Certificate (Form 24067/001 -referred to as the Application) requires, in addition to the applicant, that the applicant's GP or usual medical practitioner (GP) complete question 20 of the Application which shall be submitted to the Medical Examiner who will assess the Application; or

Devise a questionnaire to be completed by the applicant's GP which will provide the Medical Examiner with an up to date medical history of the applicant.

A copy of these findings is to be sent to Transport Accident Investigation Commission and the Federal Aviation Administration (USA).

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Mr and Mrs Hertz following their deaths in the interests of decency.

Sudden unexpected death in infancy

Lemalie [2018] NZCorC 6 (30 January 2018)

CIRCUMSTANCES

Marcus Mataaga Faafouina Lemalie, aged 6 months, of Sunnyside, Auckland died on 9 July 2016 at his home of sudden unexplained death in infancy associated with an unsafe sleeping environment.

In the morning of 9 July 2016, Marcus was found unresponsive on a mattress on the floor where he had slept next to his mother and father. A post-mortem examination concluded that the death was due to sudden unexplained death in infancy (SUDI) associated with an unsafe sleeping environment. It noted that Marcus displayed additional vulnerabilities to SUDI such as small size, prematurity, coexisting infection and passive smoke exposure. The report noted evidence of a potential accidental overlay.

Marcus woke on 9 July at about 6.00am. He was breastfed and then played with his father until he fell asleep again. He was placed in the bed (a small double bed with a sponge mattress) next to his father and the family went back to sleep. His mother woke at about 9.00am and asked Marcus' father to check him; Marcus was not responsive. He attempted resuscitation and this was taken over once emergency services arrived; however, it was unsuccessful.

Marcus had a pepipod (a separate container for sleeping in) but it had not been used much and Marcus was too big for it at 5 months old. He also had a cot in his parents' bedroom but it was not used. The house where Marcus lived is very damp and flooded when heavy rain fell and the SUDI liaison officer stated that this may have contributed to Marcus' ill health.

COMMENTS OF CORONER D A BELL

I. Considerable effort is being made in New Zealand to promote the message that every sleep for a

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

Nevertheless, a copy of these findings will be sent to the Ministry of Health, the Child Youth Mortality Review Committee and Change for our Children – all organisations actively involved in working to strengthen and make consistent the safe sleeping message.

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

Alcohol

Heward [2018] NZCorC 25 (28 March 2018)

CIRCUMSTANCES

Mitchell David Heward, aged 17, of Harihari died on 13 February 2016 at Hans Bay, Lake Kaniere of aspiration of vomitus in the context of profound alcohol intoxication.

On 13 February 2016, Mitchell went to Lake Kaniere with a group of friends aged between 14 and 18, intending to camp there overnight. Members of the group drank a significant amount of alcohol. Mitchell lost consciousness and could not be revived. Mitchell drank beer, vodka and Midori. The level of alcohol found in Mitchell's system ranged between 346 and 404 mg/mL. This amount of alcohol would be expected to cause very severe intoxication in a young person and could, by itself, be fatal.

Two members of the group, who had turned 18 some days before Mitchell's death were jointly charged with supplying alcohol to Mitchell; who was under 18. One pleaded guilty and was discharged without conviction and the other pleaded and was found not guilty.

COMMENTS OF CORONER A J TUTTON

I. Mitchell's death was the tragic consequence of excessive alcohol consumption by a young person, in a group in which pressure to drink was applied. His death was senseless, and a sad illustration of the prevalent drinking culture.

II. It is critical that young drinkers, particularly, appreciate the seriousness of the dangers of binge drinking, and know what to do if someone becomes unresponsive after drinking.

III. The Ministry of Health publishes information on alcohol, alcohol intake guidelines and the risks of alcohol abuse at: <https://www.health.govt.nz/your-health/healthy-living/addictions/alcohol-and-drug-abuse/alcohol>

IV. That information includes advice that drinking large amounts of alcohol can result in confusion, blurred vision, poor muscle control, nausea, vomiting, sleep, coma or even death.

V. The Health Promotion Agency's alcohol.org.nz also provides information about alcohol and the risks associated with it at: <https://www.alcohol.org.nz/help-advice/advice-on-alcohol>

VI. Advice about dealing with those who have drunk excessively can be found at: <https://www.alcohol.org.nz/help-advice/advice-on-alcohol/for-parents/handling-things-that-go-wrong>

VII. New Zealand Red Cross offers a Save a Mate programme, which equips secondary school students to respond to drug and alcohol related emergencies. Information about the programme can be found at: <https://www.redcross.org.nz/what-we-do/in-new-zealand/first-aid-courses-and-education/save-mate-teen-programme/>

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

show the deceased in the interests of decency and personal privacy, and that there is little public interest in such photographs being published.

Accident

Carter [2018] NZCorC 12 (23 February 2018)

CIRCUMSTANCES

Harold Leslie Carter of Christchurch died on 16-17 October 2016 at his home of positional asphyxia in the context of advanced atherosclerotic cardiovascular disease and old age.

Mr Carter was retired and lived on his own. He was in relatively good health for an 89-year-old, but used a medical alert bracelet following previous falls. Mr Carter used a bed lever for support getting in or out of bed. This was a wooden plank with a metal U-shaped loop attached to it. The plank was wedged between the bed base and mattress to provide support.

On the morning of 17 October 2016, Mr Carter was found on the floor against his bed. His head was hard against the bed lever. He was deceased.

The cause of Mr Carter's death was determined to be positional asphyxia, contributed to by the bed lever.

RECOMMENDATIONS OF CORONER ELLIOTT

To: Tas Tech, Enable New Zealand and CDHB

I. The caution sticker applied to bed levers should contain a warning that the bed lever should be placed in the lower torso area and not anywhere near the head or shoulders.

II. This warning should also be included in all instructional material and education in relation to the use of the bed lever.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs which



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CHIEF CORONER
OF NEW ZEALAND