



OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments
made between **1 April** and **30 June 2018**

Coroners' recommendations and comments

Coroners perform essential functions within our society. They inquire into a range of unexpected deaths to establish the identity of the person who has died and the cause and circumstances of their death.

While inquiring into a death, a Coroner may make recommendations or comments for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred.

The Office of the Chief Coroner maintains a public register of these recommendations and comments and publishes summaries of those which are not prohibited from being published by order of court or law. Recommendations Recap includes all those recommendations and comments which have been summarised and published. This edition includes 25 recommendations and/or comments issued by coroners between 1 April and 30 June 2018.

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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All recommendations and Comments — 1 April to 30 June 2018

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/>

Health care

Maguire [2018] NZCorC 28 (9 April 2018)

CIRCUMSTANCES

Lorraine Grace Maguire of Ashburton died on 22 March 2015 at Ashburton of acute renal failure due to haemolytic reaction secondary to an ABO incompatible blood frustration.

On Saturday 14 March 2015, Mrs Maguire, aged 90 years, had a fall in her rest home at Ashburton. She was initially admitted to Ashburton Hospital, where a blood test was done to identify her blood group. This was delivered to the New Zealand Blood Bank in Christchurch but it was rejected as it did not meet labelling requirements.

Mrs Maguire was then transferred to Christchurch Hospital for surgery the following day to repair a fractured femur. The surgery was uneventful. However, she was later examined by a doctor who found her haemoglobin to be low. The doctor then completed request forms for blood tests, including testing for her blood type as he noted that there was not one.

An IV technician then arrived on the ward to insert an intravenous line into another patient and the doctor

asked the technician to take blood from Mrs Maguire. However, instead of taking blood from Mrs Maguire the technician took blood from another patient in the room and labelled the sample with Mrs Maguire's details. This was sent to the blood bank and was accepted as it met the labelling requirements. The blood group of the sample was B positive.

On 16 March 2015, Mrs Maguire was given blood transfusions. Her blood group was O positive but she was given a transfusion of B positive blood. She developed a reaction to this which was not initially diagnosed. A nurse had stopped the transfusion of the first unit of blood due to concerns that she may have been having a reaction to the transfusion. This advice was passed on to medical staff but it was not acted upon. Mrs Maguire subsequently sustained a severe kidney injury due to this reaction and died on 22 March 2015.

RECOMMENDATIONS ENDORSED BY CORONER S P JOHNSON

- I. The Coroner endorsed the following recommendations made by the Canterbury District Health Board in its Serious Adverse Event Review:
 - i. Significant changes have been made to workflow processes maximising use of staff

time and minimising or eliminating interruptions and distractions; training of IV technicians is updated every year with an annual audit of practice undertaken; three casual IV technicians have been employed to cover sick leave and annual leave, and a lead Clinical Team Coordinator (CTC) is now responsible for rostering and oversight after hours (with a backup CTC when the lead CTC is on leave).

- ii. The Hospital Health Pathways link on the front page of the CDHB intranet now contains information on what to do if a transfusion reaction is suspected and this has been promoted to staff.
- iii. The NZBS now has a system whereby a blood bank scientist contacts a NZBS Medical Officer when a health professional contacts the blood bank about a possible a transfusion reaction.
- iv. The NZBS has carried out a review of the overall process of managing reporting of transfusion reactions and developed new tools, including posters and new reporting forms, to help nursing and medical staff recognise and immediately manage acute transfusion reactions. These are currently in the final stages of being signed off. Nursing and medical staff will then be made aware of them and the NZBS will incorporate them into NZBS training and refresher courses for those staff.
- v. A new patient safety initiative is in place, with work continuing on it to improve it, to reduce blood sample errors across the CDHB (with targets set). It includes obtaining and measuring the detail of sample errors and monitoring the rate of labelling errors. All incidents of wrong blood in the tube for a group and hold test, including near misses (regardless of harm) are to be reported and are investigated in depth. Changes have been

made to training of staff who take blood from patients, to ensure they positively identify the patient.

- vi. A recommendation to reduce the reluctance of blood bank scientists contacting medical staff has been implemented and is ongoing: staff are to treat the NZBS with respect and inappropriate behaviour will be reported and followed up in accordance with the CDHB Code of Conduct.
- vii. Changes have been made to the CDHB Blood and Blood products Policy including: notifying an adverse reaction to a blood product to the blood bank immediately; and the following Safety Notice changes:
 - i. **ALL** staff have permission to call **STOP** during pre-transfusion testing and the transfusion process or at any stage where they have concern for patient safety.
 - ii. All identification checks must be undertaken at the patient's bedside against the patient's wristband.
 - iii. There must be no discrepancies
- viii. A recommendation, to be implemented before July 2018 is:

The CDHB works with the NZBS to consider implementation of systems to reduce the likelihood of similar incidents occurring in the future. These might involve the use of a system that electronically identifies patients, to reduce patient specimen and laboratory testing errors, or involve a requirement for the results of testing on two independent blood samples to be available in the NZBS computer system before release of red cell units, other than blood group O, for transfusion. Ideally recommendations arising from this work should be implemented nationally.

Self-inflicted

Bain [2018] NZCorC 27 (9 April 2018)

CIRCUMSTANCES

Michael John Bain of Christchurch died on 21 December 2015 at his home of self-inflicted injuries amounting to suicide.

Michael, aged 18 at the time of his death, had recently finished Year 13 at St Andrews College (StAC) in Christchurch. Michael had seen a psychiatrist for anxiety and St Andrews College had been made aware of his anxiety problem before he enrolled in early 2014. Michael's anxiety had become a point of concern for staff of St Andrews College in mid-2015.

Two of Michael's friends had informed staff at the college that Michael had expressed suicidal ideation. Staff state that they discussed this concern with Michael's mother; however, she disputes that Michael's suicidal ideation was raised with her. Staff of the college state that the Michael's suicidal ideation was raised as a concern informally and likely at a Pastoral Care Committee meeting. However, the notes do not adequately record this. Staff also stated that they had discussed their concerns and Michael's suicidal thoughts with his mother, and a safety plan for him. His mother did not accept that this discussion included reference to suicidal thoughts or a safety plan.

Michael met with his psychiatrist in mid-2015 and she noted that he had experienced some suicidal ideation but that this did not present as him wanting to harm himself. She noted that Michael's anxiety took the form of moderately severe social phobia and that he had been unable to form friendships at college; he had experienced significant panic attacks, especially during class breaks; he feared that his peers would judge him negatively; and that he described symptoms of a major depressive episode that was secondary to his anxiety.

Michael's psychiatrist had prescribed diazepam for his anxiety and had trialled him on anti-depressants. In his subsequent meeting with her, she noted that he had remarkably improved.

On 9 November 2015, Michael was taken to Christchurch Hospital after an incident of self-harm. Michael was adamant that the incident was accidental. Both Michael's psychiatrist and his mother believed that this incident was not deliberate. The Canterbury District Health Board Specialist Mental Health Service received a referral from the hospital for Michael; however, it was withdrawn before contact had been made with him. Two of Michael's friends recalled that in Michael frequently discussed self-harm before his death. His psychiatrist reported that Michael strongly denied any suicidal ideation.

RECOMMENDATIONS OF CORONER BRIGETTE WINDLEY

- II. I... make the following recommendations pursuant to section 57(3) of the Coroners Act 2006 to the Rector and Board of Governors of StAC:
 - a. Review and revise the StAC Pastoral Care Practice Guidelines to make clear:
 - i. the primacy of the PCC fora in providing oversight of the management of students of concern. Specifically, the expectation that informal discussions in relation to students of concern involving new issues, assessments, or contact with parents or external parties must be captured on the concern database and do not substitute for referral and discussion at a formal PCC forum;
 - ii. the importance and expectation that all staff who are engaged in pastoral care for a student of concern, maintain appropriate records of their pastoral care interactions and activities;
 - iii. the responsibilities and key leadership role the school counsellor has in managing high risk students, irrespective

of the existence of a current therapeutic relationship;

- iv. the thresholds for escalation of concerns to the Rector, in particular what constitutes a “significant mental illness” and who is qualified and responsible for making that assessment.
- b. Consider mandating the recording on the concern database details of agreed information sharing protocols and safety plans with periodic review prompts.
- c. Provide training to all StAC teaching staff in relation to the identifying students of concern, referral pathways, and the functionality of the concern database in providing a central repository for relevant information.
- d. Provide a regularly scheduled proactive review process to ensure StAC’s pastoral care structure and processes align with best practices identified in government agency guidelines in relation to youth suicide prevention and postvention (such as the shortly anticipated MoE Resource Kit update).

III. IMPLEMENTATION OF RECOMMENDATIONS

In response to my provisional Findings and an invitation to comment on my proposed recommendations, counsel for StAC advise that the recommendations made above are accepted by StAC. Following the independent report commissioned by StAC in 2017, and advice of my proposed recommendations, I am advised that a further internal review has taken place and that steps have been taken by StAC that fully address the recommendations.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of the name, identifying particulars and any medical information of the Michael’s mother in the interests of justice.

Note: Pursuant to section 71 of the Coroners Act 2006, the Coroner has authorised the publication of the circumstances of Michael’s death, other than the method

of death and as otherwise stated in the final publication prohibition order, and the recommendations made.

Drug

Graham [2018] NZCorC 36 (30 April 2018)

CIRCUMSTANCES

Stephen Edward Graham of 10 Scorpio Place, Windsor Park, Auckland died on 17 August 2016 at his home of an unintentional gabapentin overdose.

Mr Graham’s medical history included alcohol dependency, depression, essential hypertension, chronic back pain and irritable bowel syndrome. Mr Graham had been prescribed gabapentin (an anti-epileptic medication which also treats neuropathic pain) for his back pain for at least two years. Additionally, Mr Graham had been prescribed an array of other medication to assist with sleeping, depression, hypertension, to protect against dementia, and to support mental and physical recovery from alcohol use disorder.

On the evening of 17 August 2015, Mrs Graham went up to the spare room and discovered Mr Graham curled up on the bed, feeling cold to touch. She was unable to rouse him so called the ambulance. When the paramedics arrived, they confirmed that Mr Graham had died.

COMMENTS OF CORONER D BELL

- I. I do not believe there are any recommendations which should be made in this case, due to a lack of information around the causative factors of the gabapentin toxicity. Nevertheless, I think there is value in making a comment with respect to awareness within the medical and pharmacology fields of the potential for chronic toxicity from gabapentin.

- II. Gabapentin is widely considered an extremely safe drug, with few adverse reactions and a safe toxicological risk profile. Despite this relative safety, it is important for healthcare providers to remember that for a medicine like gabapentin, (which is excreted unchanged through the kidneys) ongoing exposure as a result of an underlying renal condition, or one which inhibits clearance of faecal matter may increase the risk of chronic toxicity.
- III. Furthermore, there is scope for more research into the chronic, and acute-on-chronic toxicity of gabapentin, especially in light of this case, which displays the highest level of gabapentin ever found in the blood. In time, further research into the chronic toxicity of gabapentin may warrant warnings to be included on the label and in the distribution of gabapentin regarding its contraindication with ongoing medical conditions.

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

Fall

Meechan [2018] NZCorC 29 (17 April 2018)

CIRCUMSTANCES

William Hugh Meechan died on 31 August 2014 at Auckland City Hospital, Grafton from a pulmonary thromboembolus, secondary to bleeding on the brain (subdural haematoma), with the underlying cause of blunt force trauma from a fall (down stairs). Mr Meechan had bacterial meningitis as a complication from neurosurgery, but this was not causative of death.

At the time of his death William Hugh Meechan was a 49-year old sickness beneficiary. He was a heavy drinker of alcohol, and had atrial fibrillation (an abnormal heart

rhythm), for which he was being medicated with the anticoagulant medicine, warfarin.

On 23 August 2014 Mr Meechan was drinking with his friend, Ian Gordon. On his way home, Mr Meechan was involved in a minor single motor vehicle crash. Later that day, he fell down some steps at his Great Barrier Island home. He hit his head and was knocked unconscious for up to 30 minutes. Over subsequent days Mr Meechan had a chronic and worsening headache.

On 26 August, Mr Meechan's partner, Judith Hale, drove him to see his GP, Dr Lillian van Alphen, at Aotea Health. Mr Meechan described the fall, and an ongoing headache that persisted despite taking paracetamol and tramadol for pain relief. He had vomited that day after taking tramadol. Mr Meechan told Dr van Alphen he was worried that he was bleeding into his head because he was taking warfarin. Dr van Alphen found no neurological deficit on examination. She advised Mr Meechan that the best way to exclude a brain bleed would be to go to Auckland Hospital for further investigation. However, Mr Meechan wanted to return home and Dr van Alphen agreed to this plan without consulting further, or taking a collateral history from Ms Hale. She prescribed alternative pain relief and advised Mr Meechan to call or come in for further review if there was no improvement, and/or if he continued vomiting. The safety plan was not communicated to Ms Hale, and no follow-up appointment was scheduled.

At 7.30am on 27 August, Ms Hale found Mr Meechan partially off the bed, unconscious and having seizures. He was subsequently flown to Auckland Hospital and

triaged with a Glasgow Coma Score of 4/15.¹ A CT scan showed Mr Meechan had a large right-sided brain clot. His outlook was bleak and, initially, surgical intervention was not an option. He instead received medical care, involving intubation and ventilation, and salts and mannitol to reduce the swelling in his brain. This resulted in unexpected improvement, and Mr Meechan consequently became a candidate for surgery.

On 28 August, Mr Meechan had neurosurgery to remove a blood clot and release the pressure in his brain. Post-operatively, Mr Meechan made a rapid and relatively unexpected recovery and, while in the Department of Critical Care Medicine Intensive Care Unit (DCCM ICU), regained consciousness. He was transferred to the Neurological High Dependency Unit (NHDU) on 30 August.

Early in the morning of 31 August 2014, Mr Meechan's condition rapidly deteriorated and a code red (an emergency call for clinical assistance) was called. Doctors suspected three possible causes for his presentation; infection, a pulmonary embolism (PE - a blood clot in the pulmonary arteries, impacting on his heart/lung function), or pneumonia. Over subsequent hours there was telephone discussion between the DCCM duty Intensivist, Dr Gillian Hood, and several Registrars as to whether Mr Meechan should be returned to the DCCM ICU. Dr Hood's clinical impression was that Mr Meechan's care could be managed in the NHDU. After two further code red calls indicating Mr Meechan's ongoing clinical decline, Mr Meechan was eventually transferred to the DCCM ICU (at 9am) where medical imaging took place and he was substantially diagnosed with PE. There was intra-disciplinary discussion and consideration of surgical and medical treatment options. When the clot could not be located on medical imaging, surgical intervention was ruled out and thrombolysis (treatment of the clot with 'clot busting' medication) was

commenced. Mr Meechan's condition continued to decline and he died at approximately 1.50pm on 31 August 2014.

RECOMMENDATIONS OF CORONER MCDOWELL

To the Accident Compensation Corporation²:

- I. That it consider clarifying the *Traumatic Brain Injury: Diagnosis, Acute Management and Rehabilitation Guidelines*, regarding the extent to which the Acute Phase of Care section (from p 11 of those Guidelines) applies to those patients with delayed first assessment (greater than 24 hours after the injury) of traumatic brain injury.
- II. That it consider providing further guidance, if possible, to practitioners for the assessment and management of patients presenting with delayed first assessment (greater than 24 hours after the injury) of traumatic brain injury.

To Aotea Health:

- III. That it review its system to ensure that all patients who have suffered a suspected traumatic brain injury receive written head injury advice, and that the provision of such written advice is recorded in the patient's clinical record.
- IV. That it draw these Findings to the attention of clinical staff, noting in particular that it is advisable to call the on-call neurosurgical team at Auckland City Hospital contemporaneously with patient presentation for traumatic brain injury, if the diagnosis or management is not clear, and/or advice is required as a back-up to a clinical decision not to transfer to hospital.

To the Auckland District Health Board:

¹ The Glasgow Coma Score measures level of consciousness from the lowest score of 3 to a high of 15 out of 15.

² The New Zealand Guidelines Group went into voluntary liquidation in 2012. Accordingly, the recommendation is directed to the Accident Compensation Corporation.

- V. That the DCCM roster be analysed by appropriately qualified experts in sleep and fatigue, to identify fatigue-related risks, and whether alternative roster design and/or other strategies could be implemented to mitigate such risks (if identified). Such expert advice should include, if necessary, appropriate consultation with DCCM staff, about how the roster works in practice. Any review of the roster should also have regard to the back-up intensivist role, and the extent to which the effectiveness of that role can be maximised (while at the same time minimising any fatigue-related issues for the back-up duty Intensivist).
- VI. Following such review, that it consider the findings of that review with a view to potentially re-designing the roster (if indicated) and/or implementing strategies to mitigate any identified risks;
- VII. That it consider implementing higher organisational oversight (that is, oversight higher than individual services/departments) of duty rosters and actual on-duty/on-call practice relating to Senior Medical Officers, with a view to identifying and managing fatigue-related risks.
- VIII. That it consider whether Section 7 “Dispute Resolution” should be amended to make clear the expectations of which service should invoke the consultant-to-consultant discussion.
- IX. that it remind all medical staff, including junior doctors, of the process for when a dispute occurs regarding transfer/admission from one department to another.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Meechan on the grounds of personal privacy and decency. A section 74 order also prevents publication of personal health information of Dr Gillian Hood arising in the course of the inquest on the grounds of personal privacy.

Mountaineering

Hollaway [2018] NZCorC 53; Thistlethwaite [2018] NZCorC 54 (26 June 2018)

CIRCUMSTANCES

Stuart Jason Hollaway and Dale Amanda Thistlethwaite died on 29 December 2015 on Mt Silberhorn in Aoraki/Mt Cook National Park from critical chest wall injuries, and head injuries, respectively. Their injuries occurred due to a tumbling fall from a height while he was descending Mt Silberhorn. Their deaths were an accident.

Mr Hollaway and his partner, Dale Thistlethwaite, had come over from Australia to go climbing in Aoraki/Mt Cook National Park. They were both experienced climbers, with Mr Hollaway the more experienced of the pair, being an internationally qualified mountain guide with the International Federation of Mountain Guides Association (IFMGA).

On 23 December 2015, the pair had flown to Plateau Hut in Aoraki/Mt Cook National Park. They did some climbing around the hut on 24 and 25 December. Early in the morning on 28 December, Mr Hollaway and Ms Thistlethwaite left Plateau Hut to climb Mt Silberhorn, planning to return late on 29 December. They were seen on Mt Silberhorn that day by other climbers in the area. On the evening of 28 December, Mr Hollaway contacted the Department of Conservation (DoC) office via radio to advise of their location and to get the weather forecast. They were not seen from or heard from again.

A Search and Rescue operation was launched on 31 December given the pair were overdue. On 1 January, the bodies of Mr Hollaway and Ms Thistlethwaite were found on the side of Mt Silberhorn. The two climbers were found to be attached together with ropes when their bodies were recovered.

A Mountain Safety Council (MSC) Report indicated that the pair had camped on top of Mt Silberhorn, and began descending on 29 December. MSC suggested that Mr Hollaway set up an anchor on two ice screws to belay Ms Thistlethwaite down a section and that she slipped and fell, causing the anchor to fail and pull both climbers down the mountain. A fall of this nature would have been between a factor 1.5 to 2 fall (fall factor), meaning that the length of the fall from the nearest anchor point was 1.5 to 2 times longer than the distance of the length of the rope in use. It is likely that this shock-loaded the anchor and caused its failure.

RECOMMENDATIONS OF CORONER JOHNSON

To: New Zealand Mountain Safety Council

I adopt the recommendations proposed by the New Zealand Mountain Safety Council. Mountaineers should:

- I. Be vigilant with their footwork from beginning to end, right through the day, especially on the descent. Concentration and focus needs to be maintained through terrain that is less technical but with high consequences, in the event of a slip. Every step has to count, and the summit is only halfway. Particular attention should always be given to sections that expose mountaineers to the possibility of high factor falls, and all steps should be taken to minimize this possibility.
- II. Discuss among the group the best method and equipment to use as an anchor, factoring in the current conditions. Making decisions as a team will create conversation, allowing for a more informed decision to be made. Make sure the anchor points are correctly established in order to remove the possibility of a factor two fall.

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

Greville [2018] NZCorC 55 (26 June 2018)

CIRCUMSTANCES

Roger Paul Greville died on 10 August 2015 of suffocation when caught and buried in an avalanche while heli-skiing in the Hector Mountains, near Kingston.

Mr Greville was over from Sydney for a skiing holiday in August 2015. He registered for heli-skiing with Southern Lakes Heliski, and when doing so, he ranked himself as an advanced skier.

On 10 August, Mr Greville was part of a Southern Lakes Heliski group of four others, led by an International Federation of Mountain Guides Associations (IFMGA) qualified Mountain and Ski Guide, Roy Smith. There were four other Southern Lakes Heliski groups in the area that day.

Mr Smith was the Snow Safety Officer. He identified the avalanche risk as moderate with fair snow stability and, consequently, chose not to ski above 2000 metres elevation that day. Tests were carried out at 10.30am to assess the snow stability, which showed a weakness about 45 cm down from the surface, that would require a large load to propagate into an avalanche. It was decided that it would be safe to ski, providing that the group remained spread out. All guides and clients went through a safety briefing and all members of the group were carrying avalanche transceivers.

After lunch, the groups settled on skiing the South West aspect of James Peak. Mr Smith's group were the second to ski the face. Mr Smith skied the face before his clients, having told them to maintain a 100 metre spacing before following the skier in front. At the top of the slope, another client in the group waited to ski after Mr Smith, and saw Mr Greville dropping onto the top of the slope to queue up behind him.

At this point, around 2.15pm, the slope avalanched. The client waiting after Mr Smith managed to escape the

avalanche and ski to a safe area, but Mr Greville was engulfed in the avalanche. It also partially engulfed Mr Smith and a client from another group.

Due to the multiple people being buried and some issues with the use of avalanche transceivers, it took at least 10 minutes before the group began searching for Mr Greville. Mr Greville was located and dug out but he was unresponsive and not breathing. CPR and oxygen was given and a rescue helicopter arrived from Queenstown at 3.05pm. Resuscitative procedures were attempted but they were unsuccessful. Mr Greville was pronounced dead at 4pm.

The NZMGA carried out an Accident Investigation to ascertain what caused the accident to happen and identify any lessons that might be learnt from it to prevent a similar accident occurring in the future. The report shows that the NZMGA investigation concluded that the avalanche was most likely triggered by the members of the group who were standing in an adjacent safe area while approaching the slope. They found that all operations on 10 August 2015 were within the current guidelines at that time. And that a great deal of things went well during the day such as anticipating and eventually verifying the hazard and pilots keeping eyes on guiding activity.

RECOMMENDATIONS ENDORSED BY CORONER JOHNSON

- I. I endorse the suggestions made by the NZMGA [below]. In particular I endorse the suggestion that all clients are provided with radios that can be switched to communicate with other guides and guided parties. This is because the NZMGA investigation found that having such radios may have sped up the process of finding out who was missing and shortened the time to finding Mr Greville.

The NZMGA report is stated to be intended for the use and review by the NSMGA Committee members and NZMGA members directly involved, which

means that it will be shared by Southern Lakes Heliski and its guides. I do not consider that I need to make any recommendations, but I invite the NZMGA to share its findings and suggestions with the wider NZMGA membership to benefit guiding practice, with a view to preventing a similar accident occurring in the future.

The NZMGA made suggestions in some areas where improvements may be possible. These are summarised as follows:

Interpretations of snowpack instability test results and guiding practice:

The identification of the hazard present was very well anticipated and verified in the field. Acting on that information was within accepted practice by spacing the group widely but could be further refined.

- Consider a more conservative group management strategy when instability tests indicate avalanche trigger potential and specifically consider the depth of snowpack in the start zones, the slope configuration regarding consequences and escape routes, the presence of rocks indicating potential thin areas (of higher triggering probability), the increased potential snowpack stresses (tension) that might be associated with a steep convex roll,
- Consider larger spacing between skiers and to demonstrate the gap required between the members of the group by raising the guide pole or hand to indicate the spacing to be used on a run. Also, to consider that sometimes a 100metre gap might not be enough.
- Consider where groups gather, when similar snowpack characteristics are present, such as persistent weak layers, and thus a possibility of remote triggering of avalanches.

Better communication

- between guides as to intended runs and minimising the number of clients and guides exposed to risk on an avalanche path,

- between guides and clients at safety briefings by providing translated written briefing cards to clients attached to transceivers.
- between guides and clients before dropping in as to
 - who should go next and
 - where the escape path is on that run,
 - particularly the guide and the client with the client rescue pack who should always go last and carry a minimum of probe, shovel and radio This allows the guide to always be able to determine what is happening to the group behind him
- Between guides and client and pilot when an avalanche has occurred. Consider radios that all clients can use to communicate with each other in their group but that can be switched to communicate with other guides and guided parties. The Investigation found that having such radios may have sped up the process of finding out who was missing and shortened the time to finding Mr Greville.
- Specifically communicate specific hazards and other factors influencing stability.

Equipment

- Request clients have releasable bindings or, are at least warned of the risks of not having these if they are involved in an avalanche.
- Give clients the option of renting an avalanche airbag. Avalanche airbags can increase the chance of surviving an avalanche by helping maintain an air pocket. They are commonly carried by guides.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Greville's body in the interests of decency and personal privacy.

Fire

Kafle [2018] NZCorC 40; Kafle [2018] NZCorC 41; Kafle [2018] NZCorC 42 (30 May 2018)

CIRCUMSTANCES

Tej Narayan Kafle, Tika Kafle and Prem Kafle, 8 years old, of 59 Queen Street, Waimate died on 5 August 2015, at his home, of carbon monoxide poisoning caused by the inhalation of smoke fumes.

Tej Kafle and Tika Kafle owned the Everest Indian Restaurant at 59 Queen Street in Waimate. Mr and Mrs Kafle lived in a flat above the restaurant with their daughters, Tulsi, Manisha and Mamata, and their son Prem. There was a fire in the upstairs flat on the morning of 5 August 2015. Unfortunately, Mr and Mrs Kafle and Prem died.

The fire investigator determined that the point of origin of the fire was a plastic, electric kettle which was sitting on top of a stainless-steel benchtop in the upstairs kitchen. It is not possible to determine what caused the kettle to ignite. There is no evidence that the kettle was faulty at the time of sale or that this type of kettle is inherently faulty.

The fire investigator found that:

While there was a smoke alarm installed in the hallway and one near the bottom of the stairs, these were removed (hallway) and had the battery removed (stair) due to the alarms buzzing or emitting false alarm signals... This was due to the operating temperatures of most smoke alarms of between 4 degrees centigrade and 38 degrees centigrade. Outside of these temperatures the alarms may malfunction and generate spurious alarms. We know that the flat

was extremely cold and any smoke alarm would have likely been removed.

COMMENTS OF CORONER ELLIOTT

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

Tej Kafle, Tika Kafle and Prem Kafle died in a fire on 5 August 2015. The fire originated in a kettle in their kitchen, although it is not possible to determine what caused the fire to start.

The risk of death or injury due to a fire is reduced when small appliances such as kettles are monitored when being used and then turned off at the wall/socket after use.

Properly placed, functional smoke alarms can save lives. Battery powered smoke alarms are more likely to function properly in a warm, insulated environment. If the temperature is 4°C or less or 38°C or more, a battery powered smoke alarm can malfunction.

Optimum smoke detection is provided by long-life photoelectric smoke alarms which are hard-wired and interconnected and installed in every bedroom, living area and hallway in the house (see the Fire and Emergency New Zealand website- <https://fireandemergency.nz/at-home/smoke-alarms/>).

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

Drowning

Seiuli [2018] NZCorC 35 (26 April 2018)

CIRCUMSTANCES

Sililo Seiuli of Mount Wellington, Auckland died on 25 April 2015 near the Waipuna boat ramp from accidental drowning.

At about 10am on 25 April 2015, Mr Sililo Seiuli launched an aluminium dinghy with some friends at the Waipuna Boat Club into the Panmure estuary. Their intention was to go fishing. While launching, the boat capsized, throwing all men into the water. They were less than 10m from the shore. Nearby members of the public went to the men's assistance. Mr Seiuli's friends were eventually rescued. However, there were difficulties retrieving Mr Seiuli who kept sinking under the water. By the time he was brought onto a nearby walk bridge, he was unresponsive and was unable to be revived.

The factors contributing to the capsizing included the boat being overloaded and the weight being unevenly distributed within it, and there was no clutch on the motor, so when the motor was started the boat was propelled forward very quickly. Further, Mr Seiuli had put a lifejacket over his head, but it was not properly fitted and secured. It, therefore, came off him when the boat capsized.

COMMENTS OF CORONER M A MCDOWELL

- I. I do not consider that there are any recommendations that need to be made in this inquiry.
- II. I do however, take this opportunity to comment on the need to wear properly fitted and secured life jackets aboard small recreational vessels.
- III. At the time of Mr Seiuli's death, the wearing of personal floatation devices on small recreational

vessels – of 6 metres or less in length – had become a legal requirement in Auckland under the Auckland Council Navigation Safety Bylaw 2014. Safety signage affixed to the jetty at the time, identifies lifejackets as the first safety feature: “Life Jackets, Take them, Wear them.” It can be inferred that Seiuli intended to wear a life jacket. However, perhaps underestimated the risks associated with launching the boat.

- IV. I note further to my findings in relation to the overloading of the dinghy and its role as a contributing factor to this accident.
- V. While I do not propose to make any recommendations, it is important to reemphasise the safety messages associated with recreational small vessel usage. Accordingly, I direct that a copy of these findings be sent to the Chief Executive Officer, Maritime New Zealand, the Chief Executive, Ministry of Transport, the Chief Executive, Water Safety New Zealand, and the Chief Executive, Auckland Council – as a potential means of informing any future safety messages.

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

Smith [2018] NZCorC 37 (16 May 2018)

CIRCUMSTANCES

Virginia Lee Smith of 74 Manning Street, Rawene died on 17 January 2015 at Takou Bay Beach, Northland, of drowning.

On 17 January 2015 Ms Smith, 54 years old, went swimming with her partner at Takou Bay Beach near Kerikeri. Ms Smith and her partner were catching waves with a boogie board. The surf was described as sloppy and was about 80cm high with a strong undertow. A big

wave swamped Ms Smith and she lost her board. Her partner retrieved it and for a time they both clung to it. Ms Smith’s partner made it back to shore but Ms Smith was hit by another wave. By the time members of the public on the beach could get to her, she was face-down in the water. They brought her to shore but she was unable to be revived.

Takou Bay Beach is not patrolled by Surf Lifesavers. It is characterised by sandbars, in-shore holes and gutters and is influenced by the Takou River. The beach is exposed to considerable wave energy and strong currents. Neither Ms Smith nor her partner were aware of the hazards posed by the beach or sea conditions that day

RECOMMENDATIONS OF CORONER M A MCDOWELL

- I. To the Takou Trust
 - a. That it installs water safety signage (which complies with AS/NZS 2416:2010) at all access tracks to Takou Bay, and at the entrance to Takou Bay;
 - b. That it considers creating a pamphlet on site hazards (particularly relating to water safety) for visitors to Takou Bay, and that such pamphlet be available to visitors even when no one is on-site to manage access.

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

Parker [2018] NZCorC 38 (21 May 2018)

CIRCUMSTANCES

Christopher John Parker of 11 Thompson Road, Mangapai, Whangarei died on 3 March 2018 at Pakiri Beach of drowning.

Mr Parker was 49 years old. On 3 March 2018, he took his daughter boogie boarding at Pakiri Beach. The water was described as being very rough and it was windy. Mr Parker was separated from his daughter and called for help. Another swimmer, Jack, went to his aid and tried to bring him into shore but Mr Parker seemed to be exhausted and Jack had to let go of him. Another beach-goer, Albert, then intervened but by the time Albert reached Mr Parker, Mr Parker was face-down in the water and unresponsive. Albert and his friend brought Mr Parker to shore and attempted resuscitation. Emergency services responded, but Mr Parker could not be revived.

COMMENTS OF JUDGE D MARSHALL, CHIEF CORONER

- I. Water Safety New Zealand publishes a number of guidelines to encourage safety in and around water. Two very important guidelines are making sure that you are aware of the water conditions (and the presence of any rips or currents) and being alert to dangers. These are simple messages which should be heeded by all swimmers.

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

Woonton [2018] NZCorC 43; Samuela [2018] NZCorC 44 (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 2pm, 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 H B SHORTLAND

- I. In the light of the reports and evidence considered, I am satisfied that the response of the search and rescue teams involved in this incident were both appropriate and timely.
- II. I also acknowledge Mr Turner, his family on board and their efforts to help all those in the water on this day. It was fortunate that Mr Turner and his boat were present and capable of rescuing the three surviving members of the party. It could have worse.
- III. 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.
- IV. 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.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of both Mr Samuela and Mr Woonton, taken during the investigation

into their deaths, in the interests of decency and personal privacy.

Faitaua [2018] NZCorC 45 (1 June 2018)

CIRCUMSTANCES

Johnny Perese Faitaua of 1/149 Rosier Road, Glen Eden, Auckland, died on 15 January 2015 at O'Neill Bay, Auckland, of drowning.

On 15 January 2015 Mr Faitaua, aged 23, went swimming at O'Neill Bay near Bethells Beach. His girlfriend Hannah was with him. She reported that the waves suddenly got much bigger and started to take them both out to sea. They were initially holding hands but became separated. She saw him floating and unresponsive soon after and the waves prevented her from rescuing him. Mr Faitaua was dragged out to sea. Hannah made her way back to shore and called emergency services.

Despite an air and sea search Mr Faitaua was not located for four days. On 19 January 2015, his body was located near Te Henga Point.

RECOMMENDATIONS OF CORONER M A MCDOWELL

- V. I recommend to the Department of Conservation:
- That it liaises with Surf Life Saving New Zealand, and (if considered necessary) the Auckland Council for the purpose of installing, and (if necessary) re-locating water safety signage at access tracks to O'Neill Bay/beach from the Te Henga walkway.
- VI. The Department of Conservation should also consider providing a link to the SLSNZ's *Find a Beach* website, on its website for the Te Henga walkway.

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

Faitaua entered into evidence upon the interests of personal privacy and decency.

Medical condition

Taylor [2018] NZCorC 31 (23 April 2018)

CIRCUMSTANCES

East'ly Andolini Taylor of 11 Mayfair Place, Henderson died on 8 August 2018, at his home, of acute bronchopneumonia in the context of an unsafe sleeping environment.

At the time of his death East'ly was 13 months old and generally in good health. In the fortnight preceding his death, he had a runny nose, flu-like symptoms and a cough.

On 7 August East'ly, whilst improving, still had a cough and a runny nose as well as a slight fever.

East'ly and his sister (who was just under 3 years old) went to bed at 10.30pm. They were each given a bottle of milk. East'ly was dressed in a nappy, and a one-piece grow-suit with arms, but no legs. He had long pants and socks on, and two bibs tied round his neck. The two children shared a bed with their mother. East'ly was placed next to the wall, his sister slept in the middle, and his mother slept on the outside.

At 7.30am on 8 August 2014 Ms Taylor awoke to find only East'ly's sister beside her. She found East'ly under the bed covers, lying face up, across the bed with his sister lying over his chest and stomach area. He was deceased.

The pathologist concluded that it is likely that the combination of East'ly's lung infection, coupled with the unsafe sleeping environment, led to his death. Although East'ly was outside the usual age range for SUDI deaths, the presence of multiple risk factors, coupled with

vulnerability stemming from his lung infection, meant East'ly was likely to be more susceptible to overheating, inhibited breathing from the bed coverings and compression of his stomach and chest.

COMMENTS OF CORONER H B SHORTLAND

- I. Coroners have made multiple recommendations to ensure that consistent safe sleeping messages are given to parents.
- II. It is important to reaffirm the messages which health professionals, including midwives, and organisations such as Plunket and Coroners have made over years.

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

Bisset [2018] NZCorC 39 (30 May 2018)

CIRCUMSTANCES

Jack Henry Bisset of Dunedin died between 13 and 14 April 2017 at 911 Cumberland Street Dunedin of hypoxia on a background of epilepsy.

Jack was an 18-year-old student at the University of Otago. In September 2016 Jack was seen by a neurologist after he experienced three seizures in a two-week period. He was prescribed Levetiracetam to control the seizures and he and his family were provided with information regarding the safety implications of seizures. Sudden unexpected death in epilepsy was also discussed with the family but he was considered to be at low risk.

Jack experienced a number of further seizures and his medication was increased accordingly.

In 2017 Jack moved into Halls of Residence at Otago University to pursue studies in law and medicine.

On Saturday 15 September 2017, after not hearing from Jack since the previous Thursday night, Mrs Bisset contacted the residential assistant at the University and asked her to check on Jack. University staff found Jack in his room, face down on his bed. He was deceased. It appears that Jack had suffered from a seizure and died from hypoxia.

COMMENTS OF CHIEF CORONER, JUDGE D MARSHALL

- I. Control of seizures and education about risks is vital for anyone living with epilepsy and for those, such as family members, who support them. Organisations such as Epilepsy New Zealand (epilepsy.org.nz) provide support and education to people living with epilepsy. I urge those living with epilepsy to avail themselves of the education and support offered and to work closely with their health professional to ensure the risk of seizure is controlled as well as it can be.

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

Charman [2018] NZCorC 50 (29 June 2018)

CIRCUMSTANCES

Colin Keith Charman of Pukekohe, Auckland died between 23 November and 24 November 2016 at his home. He died from the combined effects of alcohol and coronary artery atherosclerosis related cardiomyopathy.

In spite of an elevated quantity of paracetamol in his system, the pathologist found that his death was not drug related and was due to the combined effects of alcohol and coronary artery atherosclerosis related

cardiomyopathy. The Coroner found, therefore, that his death was not a suicide.

RECOMMENDATIONS ENDORSED BY CORONER D BELL

- I. One of the purposes of a coronial inquiry is to make recommendations which may serve to reduce the chances of further deaths in similar circumstances to the instant case. Mr Charman's death does not raise any issues requiring recommendations.
- II. I am in receipt of Serious Incident Review Plan (SIRP). The investigation was led by Dr Beydals, Clinical Head Integrated Care Adult Mental Health and Addictions. The review discusses the processes in place, in particular the follow up call made to Mr Charman on 23 November 2016. The SIRP identified the need to have a process to review and update the risk assessment plan for service users with long term mental health issues whose presentation appears to remain the same over recent years and is a frequent user of the after-hours services. I agree with the findings and recommendations stated in the SIRP.

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

Motor-vehicle

Jefcoate [2018] NZCorC 26 (5 April 2018)

CIRCUMSTANCES

Kevin Taylor Jefcoate of 1 Domain Terrace, Waikuku Beach, Christchurch died on 22 June 2015 on Gressons Road in Tuahiwi of positional asphyxia in the context of late stage Duchenne Muscular Dystrophy.

Mr Jefcoate was a 25-year-old man who was wheelchair bound as a result of Duchenne muscular dystrophy. On 22 June 2015 Mr Jefcoate was a passenger in a vehicle driven by his caregiver. The vehicle crashed and rolled, becoming inverted, and Mr Jefcoate died at the scene.

At the post-mortem, it was determined that Mr Jefcoate had severe weakness of the chest muscles required for respiration, distortion of the chest by scoliosis and severe underlying heart disease would make Mr Jefcoate unable to cope with being suspended upside down in a seatbelt, with the weight of his body pressing down against the belt, as he would not have the strength to continue to inflate his chest to breathe (positional asphyxia). Dr Newman recorded that it was entirely true to say that Mr Jefcoate would not have died when he did if he had not suffered positional asphyxia in the accident.

It was determined that if the wheelchair had been properly restrained it would have been displaced far less and would have remained in the centre of the van, where the roof did not collapse as significantly, providing the occupant with a better chance of avoiding contact with any vehicle structure.

It was noted that the van in which Mr Jefcoate was travelling was first registered prior to October 2003 and consequently certain seat belts are not required to be fitted to any seating position in the rear. He noted that it appeared that many older and "less desirable" disability vehicles are still in use. Mr Myers reported that two requirements aimed at the education of users are to require signage in the vehicle recording the loading capacity and the rating of the restraints, and the provision of clear operating instructions for any equipment such as hoists or ramps, either pictorially or in English.

RECOMMENDATIONS OF CORONER TUTTON

- I. I recommend that the Ministry of Transport, Low Volume Vehicle Technical Association, Ministry of Business Innovation and Employment, New Zealand Transport Agency and any other relevant

organisations and groups collaborate to identify ways of ensuring that:

- a. Prospective purchasers of any vehicle modified as a disability vehicle have access to information as to whether or not the vehicle complies with the current requirements under the standard relating to wheelchair restraints; and
- b. Vehicles modified as disability vehicles display signage in the vehicle stating the loading capacity and rating of the wheelchair restraints, and clear operating instructions for hoists and ramps, either pictorially or in English.

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

Hyde [2018] NZCorC 30 (23 April 2018)

CIRCUMSTANCES

Richard Philip Hyde of 12 Carver Street, Sommerville, Massachusetts, in the United States of America died on 15 April 2016 at Lakes District Hospital in Queenstown of multiple traumatic injuries with severe chest trauma.

Mr Hyde, an American citizen, was on holiday in New Zealand as part of a tourist group. On 15 April 2016, the bus on which the group were travelling arrived at a woolshed at Mt Nicholas Station where the passengers disembarked. Mr Hyde went to the rear of the bus with his camera.

The driver, unaware that Mr Hyde was behind the bus, reversed the bus in order to park it. In doing so she reversed over Mr Hyde. He was airlifted by helicopter to the Lakes District Hospital but he did not survive his injuries.

The bus that was used that day did not have a rear mounted reversing mirror nor a camera system. The

mirrors that were fitted did not provide a clear view to the rear of the vehicle. This meant that there was a large blind spot behind the bus due to its height and length.

The Land Transport Rule - Glazing, Windscreen Wipe and Wash, and Mirrors 1999, requires that buses of the age of the one that hit Mr Hyde must have outside rear-view mirrors on both the left and right-hand sides. The Rule provides that a rear-view mirror must provide a clear view to the rear of the motor vehicle, its load and any trailers.

COMMENTS OF CORONER TUTTON

- I. Had an additional external rear view mirror or reversing camera system been fitted to the bus, it is likely the blind spot described would not exist, and the tragedy that befell Mr Hyde might have been avoided.
- II. It is self-evident that tourist bus operators generate income by transporting tourists, many of whom will take the opportunity to take photos at stops during the transportation and/or tours. It is inevitable that some passengers will walk around and behind the bus to do so.
- III. The tourist demographic increasing most rapidly in New Zealand is that of individuals of between 60 and 69 years old, and it is expected that, with the world's aging population, the numbers of older tourists will continue to increase.
- IV. It is imperative that those driving buses as part of tourist operations are able to see around and behind the buses they drive.

RECOMMENDATIONS OF CORONER TUTTON

- V. I forwarded to the Ministry of Transport and the New Zealand Transport Authority the following proposed recommendation:

I recommend that the Ministry of Transport consider introducing a requirement that all buses used for tourist operations be fitted with

an outside rear view mirror fitted at the back of the bus or a reversing camera system.

- VI. The Manager Mobility and Safety of the Ministry of Transport responded that the Ministry of Transport agreed that the recommendation had merit and would consider it as part of the development of a new road safety strategy, which will include consideration of measures to improve the safety of vulnerable road users, including improving visibility from buses and other heavy vehicles.
- VII. The acting Senior Manager Operational Police, Planning and Performance of the New Zealand Transport Agency responded that the Agency saw merit in the proposed recommendation and understood that it is likely to be considered as part of the development of a new road safety strategy "alongside" the Ministry of Transport.
- VIII. I recommend that the Ministry of Transport consider introducing a requirement that all buses used for tourist operations be fitted with an outside rear view mirror fitted at the back of the bus or a reversing camera system.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of the name of the bus driver, in accordance with the corresponding order made by the District Court, in the interests of justice.

A further order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Hyde in the interests of decency and personal privacy.

Katu [2018] NZCorC 32; Grainger [2018] NZCorC 33; Wright [2018] NZCorC 34 (24 April 2018)

CIRCUMSTANCES

Amy Maree Katu of 418 Mangawhero Road in Otorohanga, Timothy Robert Edward Grainger of 14 Butler Street, Te Kuiti and Logan Alan Wright of 37 Main

North road in Otorohanga died on Oparure Road in Te Kuiti of multiple unsurvivable injuries sustained in a motor vehicle collision.

At about 12:50 p.m. on Wednesday, 13 January 2016 Amy Katu was driving a 1990 Mazda Familia motor vehicle east on Oparure Road which is a rural road in the King Country, near Te Kuiti. Timothy Grainger was the front seat passenger and Logan Wright was the rear seat passenger. As Amy Katu drove east she navigated a narrow and winding section of road before entering a short straight section of road that passed in front of the entrance to the Graymont Limestone Quarry.

As Amy Katu rounded the right-hand corner, and travelled east towards the quarry entrance, a truck and trailer unit driven by John Turner, travelling west, began to cross the centreline to enter the quarry. A collision occurred to the left-hand side of the eastbound lane of Oparure Road. The collision resulted in unsurvivable injuries being sustained by Amy Katu, Timothy Grainger, and Logan Wright, all three died at the scene.

Following the crash, multiple changes were made in the area of the quarry entrance. The entrance now incorporates a median barrier to separate inward and outward quarry traffic. The position of the median barrier ensures that trucks travel further along Oparure Road, with a longer window to identify incoming traffic, before being able to enter the quarry road. The roadside east of the quarry entrance has been cleared of vegetation, the two large trees that shaded Oparure Road have been removed, and the scrub and tall grasses on the quarry side of the road kept below fence level. A yellow "no passing" centre-line is now in place, and a second lane for trucks to pull in to, and if necessary, stop, has been created on the westbound lane of Oparure Road (this allows vehicles travelling west on Oparure Road to continue past a stationary truck even when the truck has stopped awaiting an opportunity to turn into the quarry). Vegetation on the roadside at the corner to the east of the quarry was to have been maintained by mowing it low, to ensure vehicles travelling from the east past the

quarry entrance had a clearer and longer view, as they travelled around the corner and entered the straight.

However, there were reports that the foliage on the opposite side of the road to the quarry entrance had again become overgrown, preventing a clear view for vehicles travelling from the east past the quarry entrance. Together with reports that trucks entering the quarry still proceed up Oparure Road and into the quarry entrance at speed, and the roadway in the region of the quarry entrance appears to continue to present some risks.

RECOMMENDATIONS OF CORONER ROBB

- I. I remain concerned that the roadside is not maintained to keep the foliage low thereby reducing the opportunity to view the view ahead for eastbound traffic as they negotiate the final corner before the quarry entrance. I recommend that efforts to ensure that foliage is removed or kept short is undertaken more regularly, as set out below I understand that this is a budget issue.
- II. I also recommend that there be a speed restriction leading up to and continuing past the quarry entrance. The purpose being to restrict the maximum permissible speed of vehicles, but to also reduce the need for haste in the trucks crossing into the quarry. A reduced speed limit would better allow any vehicle to successfully stop in an emergency situation and thereby reduce the risk of death in similar circumstances.
- III. A copy of this Finding in draft form was provided to the Waitomo District Council ("WDC") who responded as follows:

" ... The road reserve vegetation is maintained in accordance with WDC' s agreed levels of service. It is cut three times a year under contract. There are two mowing cycles undertaken at a cut width of 1.2 metres and one cycle cut to a width of 2.4 metres from the road edge.

This level of service has been approved and allowed for within road maintenance budgets. It is the same level of service that is provided across all roads within the Waitomo District Council jurisdiction.

With reference to the specific site, any vegetation which is outside the 2.4 metre range is not maintained by WDC, however this does not preclude adjacent owners, in this case Omya, from maintaining an extended area themselves.

... Any review and setting of new speed limits on roads where WDC is the road controlling authority is required to go through a specific review process which is informed by Land Transport Rules and Guidelines.

WDC is in the process of conducting a review on local road speed limits as part of the Safer Roads Initiative. This review will include consideration as to whether the speed limits along Oparure Road are safe and appropriate.

It would be appreciated if the Coroner could consider whether a speed restriction of 80 km/hr, which would be consistent with the NZTA Speed Management Framework and Guide . . . could achieve similar goals in terms of reducing the risk of road fatalities in the area."

- IV. I recommend that the open road speed limit for Oparure Road be reduced to 80 kilometres per hour this is particularly important for the area of roadway near the quarry.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Ms Katu in the interests of decency.

Madera [2018] NZCorC 46 (18 June 2018)

CIRCUMSTANCES

Johnatan Manjar Madera of 315 Blackford Road, Mount Hutt, Methven, died on 25 September 2016 from high energy impact injuries to the chest and abdomen as a result of a collision whilst riding a quadbike.

On 25 September 2016, Mr Madera rode his quad bike along the race towards the collecting yards, ahead of the herd of cows. Mr Madera was running late, and it was dark and raining. It appears he did not see the bungee, possibly due to the weather, the speed at which he was travelling and the fact he was travelling from the dark towards the light.

Mr Madera rode into the bungee and it became entangled across the handle bars of the quad bike. The orange gate break handle "pinged" off the fence and the knot pulled through the orange handle as the bike continued to move forward. The knotted end of the bungee became lodged between the handle bar and thumb throttle, so that the throttle jammed on. The bike travelled at speed up the incline, struck the milking yard gates, knocked one gate off its hinges, continued across the yard, struck the fence, and crashed through the two bottom rails of the fence, ripping the left front wheel from its mount. It appears Mr Madera hit the top rail with his upper body as the bike went through the fence. It appears he had been wearing a crash helmet, but that it was knocked from his head, as it was found lying beside him. A co-worker said Mr Madera always wore his helmet, done up.

COMMENTS OF CORONER TUTTON

- I. Mr Madera died as a result of his quad bike hitting the white bungee cord gate across the race. As is usual in the dairy industry, he was bringing cows in for milking in the dark. On this occasion, it was raining, which is likely to have worsened visibility.

- II. Had the bungee cord been more visible, the accident leading to Mr Madera's death might not have occurred.
- III. It is clear from the response of the farm owners that reflective bungee cord is available, as are flags, which can be attached to the cord to make it more highly visible. The farm owners noted that weather, wear and tear, and mud, affected the visibility of the reflective cord and flags over time.
- IV. Worksafe reports that there are no standards in existence, or any guidance available, in relation to taped or bungee gateways, the use of which is "standard" on dairy farms.

RECOMMENDATIONS OF CORONER TUTTON

- V. Pursuant to section 57B of the Act, I consulted Worksafe in respect of proposed recommendations.
- VI. Mr Tony Smith, Investigations Manager (Canterbury and West Coast), Worksafe, responded to that notification and advised that the Worksafe good practice guidance document "Safe Use of Quad Bikes" is due to be reviewed later this year, and that there is an opportunity for Worksafe to consult with the agriculture industry in respect of the use of bungee cords and the proposed use of high visibility material as an improved safety measure.
- VII. Mr Smith wrote that the guidance is produced to influence and educate people who conduct a business or undertaking to help reduce the risk of injuries and fatalities by providing practical guidance.
- VIII. Pursuant to s57A of the Act, I recommend that Worksafe New Zealand considers the development and dissemination of good practice guidance relating to taped or bungee gateways used on farms of any type to ensure that the tape or cord used is highly visible.
- IX. Such guidance may draw the attention of farmers to the dangers of using materials that are not "high

visibility", and encourage them to use materials that are "high visibility".

- X. The use of such materials may reduce the chances of further deaths occurring in circumstances similar to those in which Mr Madera died.

Pursuant to section 74 of the Coroners Act 2006, I am satisfied that it is in the interests of decency or personal privacy to prohibit the making public of any photographs of the deceased taken by police.

Loving [2018] NZCorC 47 (20 June 2018)

CIRCUMSTANCES

Phillip Anderson Loving of 3 Closeburn Station, 1020 Glenorchy-Queenstown Road, Mount Creighton, Queenstown, died on 10 April 2017 at his home of massive traumatic head and neck injuries.

Mr Loving died after being struck by a liquid waste truck as it rolled backwards down an incline.

Mr Loving's home was on a residential property at a high country station on the outskirts of Queenstown. The property has an aerated wastewater system housed in a concrete tank, which is emptied by specially modified trucks.

On this occasion, the truck that arrived parked on the newly formed access, with the rear of the truck close to the tank. The driver ensured the truck was parked level on the site. After emptying the tank, the driver began to pack away the hoses. Mr Loving went to the top of the tank to look at the filter inside. The truck driver joined him and another man. As they all looked down into the tank, the truck rolled backwards and both Mr Loving and the driver were struck by the rear of the truck.

Mr Loving sustained massive traumatic head and neck injuries and died instantly.

The truck's configuration is such that, while the suction pump is operating, the vehicle cannot be left in gear, as the truck's transmission needs to be disengaged from the engine while it is driving the suction pump. This places a total reliance on the handbrake to hold the vehicle during the suction operation.

The truck was fitted with Cardan shaft brakes. An identified issue with such brakes is that they work better in forward than reverse. This disparity is believed to have contributed to several situations nationwide where a vehicle has "held" in a forward direction but failed in reverse.

When testing handbrakes for an annual Certificate of Fitness, assessors conduct a stall test, which demonstrates the effectiveness of the handbrake going forward but not backwards, meaning that potentially a vehicle could achieve an annual Certificate of Fitness without any test on the effectiveness of the handbrake to hold a vehicle in reverse.

RECOMMENDATIONS OF CORONER TUTTON

- I. Worksafe reported that, when testing handbrakes for an annual Certificate of Fitness, assessors conduct a stall test, which demonstrates the effectiveness of the handbrake going forward but not backwards, meaning that potentially a vehicle could achieve an annual Certificate of Fitness without any test on the effectiveness of the handbrake to hold a vehicle in reverse.
- II. Mr Loving died as a result of a handbrake not holding when a vehicle moved backwards down an incline. Had the handbrake held, Mr Loving's death would not have occurred.
- III. It would seem prudent that the testing of handbrakes for a Certificate of Fitness, or Warrant of Fitness, should test the effectiveness of the handbrake going forwards and backwards.
- IV. As required pursuant to s 57B of the Coroners Act 2006, I notified NZTA of my proposed

recommendation that NZTA consider amending the testing requirements for handbrakes so as to test the effectiveness going both forwards and backwards.

V. Mr Dave Schumacher, Principal Engineer, Vehicle Standards, NZTA responded that NZTA will consider a review of the requirements and testing of parking brakes. Mr Schumacher included reference to the procedure for testing of the parking brake during a Certificate of Fitness inspection; namely the "stall test" method, or "if there is doubt" testing on a 1:5 gradient in both directions, and outlined the details of such test.

VI. He stated:

Generally speaking, the parking brake should be as effective at preventing backward motion as it is preventing forward motion. The "stall test" involves placing the vehicle into an intermediate gear to reduce the amount of torque transferred from the engine to the brake. As most vehicles only have one reverse gear, performing the "stall test" in reverse is likely to cause permanent damage to either the parking brake or driveline and wouldn't be recommended. Notwithstanding mechanical damage, performing the "stall test" in reverse is also likely to create its own health and safety concerns at vehicle inspection facilities due to the inherent reduced field of vision.

In summary, the agency questions the utility of testing the parking brake's effectiveness going forwards and backwards as implementing a test regime creates its own safety risks and the actual usage remains dependent on the drivers input. However, we will consider a review of the requirements and testing of parking brakes to ensure the risk to safety is minimised.

VII. I note again that Mr Loving died as a result of a handbrake not holding when a vehicle moved backwards down an incline.

VIII. Safety requires that handbrakes hold, whether the vehicle is moving forwards or in reverse. I note the issues raised by the author of the NZTA response to the proposed recommendation, but remain of the view that a vehicle should not pass a Certificate of Fitness, or Warrant of Fitness, inspection if the hand brake will hold if the vehicle moves forward, but not in reverse.

IX. The NZTA position as stated by Mr Schumacher is that it will consider a review of the requirements and testing of parking brakes to ensure the risk to safety is minimised.

X. I consider a review of the requirements and testing of parking brakes is required, so as to assess and ensure their effectiveness going both forwards and backwards. Such a review, together with implementation of testing processes that assess the effectiveness of parking brakes in either direction, is likely to reduce the chances of further deaths occurring in circumstances similar to those in which Mr Loving's death occurred. A recommendation in relation to those issues may also raise public awareness of the safety issues relating to the effectiveness or otherwise of parking or hand brakes.

XI. I recommend that NZTA consider amending the testing requirements for handbrakes so as to test their effectiveness going both forwards and backwards.

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

Murray [2018] NZCorC 49 (28 June 2018)

CIRCUMSTANCES

Robert James Murray of 4 Old House Road, RD 2, Upper Moutere died on 15 September 2016 in Nelson Hospital,

of hypovolemic shock due to extensive blood loss caused by injuries sustained when he was run over by a logging truck.

Mr Murray was 83 years old and had difficulty with both his hearing and his eyesight and he also had Parkinson's disease. Mr and Mrs Murray had pulled into a petrol station to fill their vehicle. Mrs Murray was filling the vehicle. Mr Murray got out of the vehicle to retrieve his small dog who had jumped out.

The petrol pump was on the right-hand side of the Murrays' vehicle and on the other side of the pump was a logging truck. The driver of the truck was inside the petrol station at the time the Murrays pulled in.

As the truck driver returned to his truck, Mr Murray walked on an angle in front of the truck. The truck driver did not see Mr Murray as he set off, and the front of the truck hit him and ran him over.

Emergency services attended and transported Mr Murray to Nelson Hospital but he did not survive his injuries.

During the crash investigation, it was found that there were three blind spots which could have affected the ability of the truck driver to see Mr Murray. One of these was caused by the driver's safety hard-hat which was sitting on the dash shelf in the middle of the windscreen. However, the report also found that "Even without the blind-spots when approaching the truck from any frontal position within 1.2 metres, the 170cm tall target subject became lost to the driver's sight because of the high driver's position and upraised dash."

COMMENTS OF CORONER ELLIOTT

- I. Senior Constable Burbery recommended that a copy of his crash report be forwarded to WorkSafe NZ for possible use in advising heavy haulage operators, particularly those operating forward control cab trucks, of the potential hazard affecting close range sight-lines when placing objects on the shelf below the windscreen.

- II. It was found that the height of the driver in the truck which collided with Mr Murray meant that objects 1.2 metres or less in front of the truck would be in a blind spot. The hard-hat on the middle of the truck's dashboard added to the size of the blind spot that Mr Murray was in as he walked in front of the moving truck.
- III. The New Zealand Transport Agency (NZTA) have information on their website which addresses the need for good vision while driving. This covers factors such as eye tests for licensing, keeping windscreens and eyewear clean, looking in rear vision mirrors and keeping speed down if the weather conditions reduce visibility. The issue of objects inside the vehicle obstructing the driver's view is not mentioned.
- IV. A copy of the Serious Crash Report and a copy of this finding will be sent to NZTA, as well as WorkSafe NZ, so that they can consider whether information needs to be provided to drivers about this issue.

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

Kerr [2018] NZCorC 51 (29 June 2018)

CIRCUMSTANCES

Allan Robert Kerr of 32 Snell Drive, Chartwell, Hamilton died on 10 July 2016 at the intersection of Helenslee Road and Razorback Road in Pokeno from severe head injury with associated injuries.

Mr Kerr, aged 63, was a motorcycle enthusiast who rode daily. He had recently moved back to New Zealand after spending 38 years living in Western Australia.

On Sunday 10 July 2016, Mr Kerr went for a ride on his 2005 Yamaha FJR 1300 motorcycle. As he travelled southbound on Razorback Road he lost control of his

bike at a bend in the road leading onto Helenslee Road. He died from crash related injuries at the scene.

The southbound section of the road where the accident occurred has a slight left-hand bend, followed by a sharp right-hand bend approximately 27m after. There are no warning or advisory signs approaching either bend. As Mr Kerr attempted to negotiate the right bend the rear tyre of the motorcycle lost traction. As the tyre regained traction, the motorcycle fell onto its left side.

Mr Kerr was travelling within the speed limit of 100km/h, however, the speed limit forms a maximum speed for the stretch of road, and is not necessarily indicative of the speed that can be safely used on particular portions of the road. Therefore, although excessive speed was not a factor, Police determined that Mr Kerr was travelling at speeds too great for the conditions, and that the line he had taken into the second corner was inappropriate.

The Police investigation in to the crash concluded that a lack of warning signs, speed, and loss of control were all factors in the crash.

RECOMMENDATIONS OF CORONER BELL

- I. Constable Monk identified that one of the causative factors in this accident was the lack of warning or advisory signs on Razorback Road.
- II. Approaching this bend in the road from the north, the sharper right-hand bend cannot be seen until after travelling through the crest of the left-hand bend. Signs warning of the upcoming bend or advising motorists to slow down may prevent those unfamiliar with this stretch of road to slow down in anticipation of the bend.
- III. Tony Peake, an Assistant Engineer with the Waikato District Council also issued a report in relation to Mr Kerr's accident. This report concluded that:

“... advanced curve warning signage ... should be posted due to the severe downhill approach from the north increasing braking distance, the

continued crash record history at the site, the adjacent development in Pokeno potentially increasing Razorback Road ADTs (average daily traffic), and the low speed curve alignment.”

- IV. Recommendations for this signage were:
 - (a) Advance curve warning signage should be posted at each curve tangent.
 - (b) Curve chevron signs also posted on the northern downhill approach of the curve. A recommended maximum speed advisory should also be posted. This speed advisory has yet to be determined.
 - (c) A steep gradient slope sign should be posted before the downhill gradient commences and face southbound traffic.
 - (d) A solid white centreline should be applied on the crash curve.
- V. I agree with and endorse these recommendations.

COMMENTS OF CORONER BELL

- VI. I have since been advised by Waikato district council that all the above Recommendations have been installed. The appropriate speed advisory has been determined to be 45 and this is installed on both the advance warning and curve chevron signs.

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

Sudden unexpected death in infancy

Oti [2018] NZCorC 48 (27 June 2018)

CIRCUMSTANCES

Lucas Oti of 20 Aldersley Street, Richmond, Christchurch died on 15 May 2017 at his home. He was 19 weeks old. His death was a Sudden Unexplained Death in Infancy (SUDI).

On Sunday 14 May 2017 Lucas's mother, Vainetutai, gave Lucas a bottle of formula and tried to give him a pouch of food. He did not want the food which was unusual as he was usually a good feeder. After his bottle, he was put in his bouncer in the lounge where he fell asleep. He was then put to bed.

As the room in which Vainetutai slept was not large enough to fit both a bed and Lucas' cot, Lucas slept in a bed with his mother. On the night of 14 May 2017, Lucas was put to sleep in his usual position. He was on his side with his back against a large teddy bear that was on the bed. His head was resting on the bear's arm. He had a blanket underneath him and another blanket on top of him. His face was clear.

Vainetutai checked on Lucas a number of times during the evening and went to bed herself at 10.30pm. Vainetutai slept well away from Lucas across the bed as she had been drinking alcohol and was aware of the risks of being in bed with a baby.

Lucas woke up between midnight and 1am but went back to sleep, sucking his thumb. At 3am Vainetutai found that Lucas was not breathing and called for help. He was in the same position in which he was put to bed. Resuscitation was attempted before emergency services arrived but all resuscitation attempts were unsuccessful.

COMMENTS OF JUDGE D MARSHALL, CHIEF CORONER

- I. The cause of Lucas's death is unascertained. However, I note the Ministry of Health Guidelines for keeping babies between the age of 6 weeks and 6 months safe in bed. These are from the Ministry's web page and are set out below.

You can help to keep your baby safe in bed by:

- *making sure that your baby is in their own bed for every sleep (and in the same room as you or the person looking after them at night)*
- *making sure that your baby is on their back for every sleep*
- *having a smoke free home and car*
- *exclusively breastfeeding your baby to around 6 months of age and continuing to breastfeed them until 12 months of age*
- *immunising your baby on time.*

Make every sleep a safe sleep

Sudden unexpected death is a risk to babies until they are about 12 months old, but most deaths can be prevented. There are things that we can do to protect our babies. Although for some babies the cause of death is never found, most deaths happen when the babies are sleeping in an unsafe way.

Always follow these safe-sleep routines for your baby and your baby's bed.

Make sure that your baby is safe

To keep your baby safe while sleeping, make sure:

- *they always sleep on their back to keep their airways clear*
- *they are in their own bassinet, cot or other baby bed (eg, a pepi-pod® or wahakura)*

- free from adults or children who might accidentally suffocate them

- they are put back in their own bed after feeding
- don't fall asleep with them (to protect your back, feed your baby in a chair rather than in your bed)

- they have someone looking after them who is alert to their needs and free from alcohol or drugs

- they have clothing and bedding that keep them at a comfortable temperature – one more layer of clothing than you would wear is enough too many layers can make your baby hot and upset them

- they are in a room where the temperature is kept at 20°C.

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

Marjoribanks-Pita [2018] NZCorC 52 (19 June 2018)

CIRCUMSTANCES

Harlem Robin Marjoribanks-Pita of Waiuku died on 24 June 2015 at Waiuku Health Centre of Sudden Unexpected Death in Infancy occurring in a dangerous sleeping environment. He was eight months old when he died.

Harlem had been mildly ill in the days before his death; he had vomited a few times, was grizzly and did not have his usual appetite. On 24 June 2015, Harlem was put down on a cot mattress on the floor in the lounge of his home for a nap, next to his uncle, who was on a single mattress adjacent to the cot mattress. Harlem was

sleeping on his side with his back to his uncle. A kitten was also in his sleeping space. Photographs taken later that day suggest there were multiple blankets, pillows and soft toys across the two mattresses.

Around 2pm, Harlem's uncle woke, and found him not breathing and unresponsive. He started CPR and sought the assistance of his neighbours. Harlem was taken to the Waiuku Health Centre by his uncle and neighbour for immediate medical treatment. Despite multiple efforts to resuscitate, Harlem was declared dead at 2.45pm at the Waiuku Health Centre.

A post-mortem examination of Harlem confirmed that he was a well-developed and well-nourished child. Based on review of photographs and re-enactment evidence, it was commented that Harlem was in a dangerous sleeping environment for a child of his age. It was concluded that Harlem had an obstructed airway filled with gastric contents due to severe bronchitis, but that the most likely cause of Harlem's death was his airway becoming obstructed in the unsafe sleeping environment.

Harlem was a well-cared for and loved child. However, on 24 June 2015, Harlem was sleeping in an unsafe environment. This, unfortunately, contributed to his death.

RECOMMENDATIONS OF DEPUTY CHIEF CORONER H B SHORTLAND

- I. Harlem's death is a reminder of the need for safe sleeping environments and that we still have much to learn about SUDI death.

Considerable effort is being made in New Zealand to promote the message that every sleep for a baby should be a safe. 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 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 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.

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



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