

# Recommendations recap

A summary of coronial recommendations and comments  
made between 1 July 2016 and 31 December 2016

Issue 12



OFFICE OF  
THE CHIEF CORONER  

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OF NEW ZEALAND



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

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

This issue features 60 recent coronial cases where recommendations were made. Final findings were released by a coroner between 1 July 2016 and 31 December 2016.

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

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

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

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## Recommendations

Adverse Effects or Reactions to Medical/Surgical Care	
<b>Case Number</b> <b>CSU-2014-AUK-001227</b>	<b>Catch Phrases</b> Chronic Lymphocytic Leukaemia, chemo-immunotherapy treatment, liver function tests, Hepatitis B, acute liver failure <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/60.html">http://www.nzlii.org/nz/cases/NZCorC/2016/60.html</a> <b>Response</b> N/A
<b>Case Number</b> <b>CSU-2014-CCH-000498</b>	<b>Catch Phrases</b> Multiple organ system failure, bedsores, cerebral palsy, cerebral event, surgical debridement <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/61.html">http://www.nzlii.org/nz/cases/NZCorC/2016/61.html</a> <b>Response</b> N/A
<b>Case Number</b> <b>CSU-2015-PNO-000568</b>	<b>Catch Phrases</b> Dilated Cardiomyopathy, stress, anxiety, Amitriptyline, Seroquel, shortness of breath, enlarged heart, pleural effusion, idiopathic <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/106.html">http://www.nzlii.org/nz/cases/NZCorC/2016/106.html</a> <b>Response from Royal Australian and New Zealand College of Psychiatrists</b> See link above
<b>Case Number</b> <b>CSU-2015-CCH-000617</b>	<b>Catch Phrases</b> Post-operative bowel obstruction, fauculent vomiting and aspiration, stomal prolapsed, hypoxic brain injury, short-term memory loss <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/107.html">http://www.nzlii.org/nz/cases/NZCorC/2016/107.html</a> <b>Response</b> N/A
<b>Case Number</b> <b>CSU-2015-WGN-000260</b>	<b>Catch Phrases</b> Hepatic failure, prostate cancer, Flutamide, Hepatotoxicity, liver failure, encephalopathy <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/113.html">http://www.nzlii.org/nz/cases/NZCorC/2016/113.html</a> <b>Response from Urological Society of Australia and New Zealand and Centre for Adverse Reactions Monitoring</b> See link above

Choking	
<b>Case Number</b> CSU-2015-CCH-000363	<b>Catch Phrases</b> Choking, Down Syndrome, upper airway obstruction, Magill forceps, Eating and Drinking Difficulties Screening Tool (see Health Care Issues for further cases involving Choking) <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/67.html">http://www.nzlii.org/nz/cases/NZCorC/2016/67.html</a> <b>Response</b> N/A
Deaths in Custody	
<b>Case Number</b> CSU-2013-CCH-000209	<b>Catch Phrases</b> Self-inflicted, suicide risk assessment, prison  <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/52.html">http://www.nzlii.org/nz/cases/NZCorC/2016/52.html</a> <b>Response from the Department of Corrections</b> See link above
<b>Case Number</b> CSU-2014-AUK-000626	<b>Catch Phrases</b> Self-inflicted, welfare monitoring, At Risk Unit, MedTech notes, Auckland Regional Forensic Psychiatric Service <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/86.html">http://www.nzlii.org/nz/cases/NZCorC/2016/86.html</a> <b>Response from National Office</b> Response pending
<b>Case Number</b> CSU-2016-CCH-000231	<b>Catch Phrases</b> Acute Myocardial Infarct, heart attack, congestive cardiac failure, natural causes, comprehensive assessment, audit tool, documentation standards <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/105.html">http://www.nzlii.org/nz/cases/NZCorC/2016/105.html</a> <b>Response from Department of Corrections</b> Response pending
Drugs/Alcohol/Substance-related	
<b>Case Number</b> CSU-2015-CCH-000361	<b>Catch Phrases</b> Naloxone, Emergency Department, methadone, overdose, senior practitioner, review patient competence <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/62.html">http://www.nzlii.org/nz/cases/NZCorC/2016/62.html</a> <b>Response from Canterbury District Health Board</b> Response pending

<b>Case Number</b> CSU-2013-AUK-000622	<b>Catch Phrases</b> Lorazepam, alcohol intoxication, quetiapine, psychiatric assessment
	<b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/104.html">http://www.nzlii.org/nz/cases/NZCorC/2016/104.html</a>
	<b>Response from Waitemata District Health Board</b> See above link
<b>Fire-related</b>	
<b>Case Number</b> CSU-2014-PNO-000496 CSU-2014-PNO-000496	<b>Catch Phrases</b> Accidental fire, cigarette, smoking material, smoke alarms without battery, smoking in bed
	<b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/77.html">http://www.nzlii.org/nz/cases/NZCorC/2016/77.html</a> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/78.html">http://www.nzlii.org/nz/cases/NZCorC/2016/78.html</a>
	<b>Response from New Zealand Fire Service</b> Response pending
<b>Health Care Issues</b>	
<b>Case Number</b> CSU-2016-ROT-000044	<b>Catch Phrases</b> Warfarin, International Normalised Ratio, Tachycardic, Hypotensive
	<b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/51.html">http://www.nzlii.org/nz/cases/NZCorC/2016/51.html</a>
	<b>Response from Mainstreet Pharmacy and Taupo Medical Care</b> See link above
<b>Case Number</b> CSU-2015-AUK-001148	<b>Catch Phrases</b> Abdominal pain, constipation, laparotomy, Hartman's procedure, colostomy, laxatives
	<b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/54.html">http://www.nzlii.org/nz/cases/NZCorC/2016/54.html</a>
	<b>Response from Palms Aged Care Facility and Palms Health</b> See link above
<b>Case Number</b> CSU-2014-PNO-000058	<b>Catch Phrases</b> Choking, intellectual disability
	<b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/70.html">http://www.nzlii.org/nz/cases/NZCorC/2016/70.html</a>
	<b>Response</b> N/A

## Homicide/Interpersonal Violence

<b>Case Number</b> CSU-2014-DUN-000124	<b>Catch Phrases</b> Stab wounds, training in risk assessments, Ministry of Health guidelines for the assessment and management of people at risk of suicide
	<b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/74.html">http://www.nzlii.org/nz/cases/NZCorC/2016/74.html</a>
	<b>Response from Southern District Health Board</b> See link above

## Labour or Pregnancy Related

<b>Case Number</b> CSU-2014-AUK-000257	<b>Catch Phrases</b> Perinatal asphyxia, congenital pneumonia, amnionitis, infection, birthing pool, water birth, placenta policy, Lead Maternity Carer, Water for Labour and Birth Policy, birth pack
	<b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/89.html">http://www.nzlii.org/nz/cases/NZCorC/2016/89.html</a>
	<b>Response from Waitemata District Health Board</b> See link above

## Mental Health Issues

<b>Case Number</b> CSU-2014-HAS-000236	<b>Catch Phrases</b> Mental Health Compulsory Assessment and Treatment Order, St John Ambulance, stepped into road, truck, medication support service
	<b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/115.html">http://www.nzlii.org/nz/cases/NZCorC/2016/115.html</a>
	<b>Response from Hawkes Bay District Health Board</b> Response pending

## Recreational/Leisure Activities

<b>Case Number</b> CSU-2013-AUK-000862	<b>Catch Phrases</b> Blunt trauma, subdural haematoma, rugby, brain injury, testing for suspected head injury, education programme
	<b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/63.html">http://www.nzlii.org/nz/cases/NZCorC/2016/63.html</a>
	<b>Response</b> N/A

<b>Case Number</b> CSU-2013-AUK-000862	<b>Catch Phrases</b> Blunt force head injury, subdural haematoma, rugby, rain injury, history of head injuries, blue card system, RugbySmart Programme, concussions, <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/81.html">http://www.nzlii.org/nz/cases/NZCorC/2016/81.html</a> <b>Response</b> N/A
<b>Self-inflicted</b>	
<b>Case Number</b> CSU-2014-CCH-0737	<b>Catch Phrases</b> New Zealand Police, Self Harm leaflets, Ministry of Health Healthline <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/55.html">http://www.nzlii.org/nz/cases/NZCorC/2016/55.html</a> <b>Response from the Commissioner of New Zealand Police</b> See link above
<b>Case Number</b> CSU-2016-AUK-000192	<b>Catch Phrases</b> The Health Information Privacy Code 1994, disclosure of confidential information to family members, overriding patient privacy, prevent serious threat to life or health, Assessment and Management of People at Risk of Suicide Guidelines, no legal onus on GP to refer to Mental Health Services <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/59.html">http://www.nzlii.org/nz/cases/NZCorC/2016/59.html</a> <b>Response</b> N/A
<b>Case Number</b> CSU-2013-AUK-000407	<b>Catch Phrases</b> Acute Mental Health Unit, Te Whetu Tawera, Family participation philosophy, Auckland District Health Board <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/57.html">http://www.nzlii.org/nz/cases/NZCorC/2016/57.html</a> <b>Response from Auckland District Health Board</b> See link above
<b>Case Number</b> CSU-2013-CCH-0623	<b>Catch Phrases</b> Management plans, Crisis services, Peer review, hand over, <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/58.html">http://www.nzlii.org/nz/cases/NZCorC/2016/58.html</a> <b>Response</b> N/A



<b>Case Number</b> CSU-2015-DUN-000136	<b>Catch Phrases</b> Compulsory Treatment Order, Discharge Policy, Risk Assessments, Did-Not-Attend Policy, Information Sharing <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/64.html">http://www.nzlii.org/nz/cases/NZCorC/2016/64.html</a> <b>Response from Southern District Health Board</b> See link above
<b>Case Number</b> CSU-2014-AUK-000661	<b>Catch Phrases</b> Threaten suicide, short suicide prevention training courses, <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/69.html">http://www.nzlii.org/nz/cases/NZCorC/2016/69.html</a> <b>Response</b> N/A
<b>Case Number</b> CSU-2014-PNO-000171	<b>Catch Phrases</b> Known risk factors, Mental Health Services, Intention <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/71.html">http://www.nzlii.org/nz/cases/NZCorC/2016/71.html</a> <b>Response</b> N/A
<b>Case Number</b> CSU-2015-WGN-000418	<b>Catch Phrases</b> Referral, Initial Review, Specialist Maternal Mental Health Services, delays <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/73.html">http://www.nzlii.org/nz/cases/NZCorC/2016/73.html</a> <b>Response from CCDHB</b> Response pending
<b>Case Number</b> CSU-2014-DUN-000125	<b>Catch Phrases</b> Training in Risk Assessments, Suicidal Intent, Recent diagnoses, Chronic Illness <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/92.html">http://www.nzlii.org/nz/cases/NZCorC/2016/92.html</a> <b>Response from Southern District Health Board</b> N/A
<b>Case Number</b> CSU-2014-WGN-000266	<b>Catch Phrases</b> Liquid, First Presentation, Testing, Poisoning <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/75.html">http://www.nzlii.org/nz/cases/NZCorC/2016/75.html</a> <b>Response</b> N/A

<b>Case Number</b> CSU-2015-DUN-000002	<b>Catch Phrases</b> CYF, Family Whanau Agreements, Social Worker, CYF Practice Guidance, Suicide Risk Indicators, Government Reforms <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/112.html">http://www.nzlii.org/nz/cases/NZCorC/2016/112.html</a> <b>Response from Child Youth and Family</b> Response pending
<b>Sudden Unexpected Death in Infancy (SUDI)</b>	
<b>Case Number</b> CSU-2015-AUK-888	<b>Catch Phrases</b> Unsafe sleeping environment, probable accidental asphyxia, probable suffocation, car seat <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/83.html">http://www.nzlii.org/nz/cases/NZCorC/2016/83.html</a> <b>Response</b> N/A
<b>Case Number</b> CSU-2014-AUK-001173	<b>Catch Phrases</b> Unsafe sleeping environment, acute haemophilus influenza bronchopneumonia, bed sharing, co-sleeping <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/84.html">http://www.nzlii.org/nz/cases/NZCorC/2016/84.html</a> <b>Response</b> N/A
<b>Case Number</b> CSU-2015-AUK-000894	<b>Catch Phrases</b> Unascertained causes <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/88.html">http://www.nzlii.org/nz/cases/NZCorC/2016/88.html</a> <b>Response</b> N/A
<b>Transport-related</b>	
<b>Case Number</b> CSU-2014-CCH-000690	<b>Catch Phrases</b> Van, crush asphyxia, severe pulmonary and cerebral fat embolism, Ischaemic heart disease, chronic obstructive respiratory disease <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/68.html">http://www.nzlii.org/nz/cases/NZCorC/2016/68.html</a> <b>Response from New Zealand Transport Agency</b> See link above

<p><b>Case Number</b>  <b>CSU-2014-ROT-000451</b>  <b>CSU-2014-ROT-000452</b></p>	<p><b>Catch Phrases</b>  Traumatic brain injury, school trip, outdoor education excursion, hiking, driver fatigue, drowsiness,</p> <p><b>Link to Summary and Recommendations</b>  <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/72.html">http://www.nzlii.org/nz/cases/NZCorC/2016/72.html</a>  <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/91.html">http://www.nzlii.org/nz/cases/NZCorC/2016/91.html</a></p> <p><b>Response from Ministry of Education</b>  See above link</p>
<p><b>Case Number</b>  <b>CSU-2014-CCH-000364</b></p>	<p><b>Catch Phrases</b>  Train level crossing, recording and collating information, sun</p> <p><b>Link to Summary and Recommendations</b>  <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/80.html">http://www.nzlii.org/nz/cases/NZCorC/2016/80.html</a></p> <p><b>Responses from Road Controlling Authorities</b>  See above link</p>
<p><b>Case Number</b>  <b>CSU-2015-HAS-000216</b></p>	<p><b>Catch Phrases</b>  Cyclist, pedestrian, intersection, Esplanade Trail, safe area, signage, underpass</p> <p><b>Link to Summary and Recommendations</b>  <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/56.html">http://www.nzlii.org/nz/cases/NZCorC/2016/56.html</a></p> <p><b>Response from the New Zealand Transport Association</b>  See link above</p>
<p><b>Case Number</b>  <b>CSU-2016-HAM-000016</b></p>	<p><b>Catch Phrases</b>  Motorcycle, excessive speed, obstructed view, trees and plants, blind spot, no U-turn sign</p> <p><b>Link to Summary and Recommendations</b>  <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/65.html">http://www.nzlii.org/nz/cases/NZCorC/2016/65.html</a></p> <p><b>Response from Hamilton City Council</b>  See link above</p>
<p><b>Case Number</b>  <b>CSU-2016-WHG-000012</b></p>	<p><b>Catch Phrases</b>  Blunt trauma to head, motor vehicle accident, quad motorcycle, quad bike, safety helmets, guard rail</p> <p><b>Link to Summary and Recommendations</b>  <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/82.html">http://www.nzlii.org/nz/cases/NZCorC/2016/82.html</a></p> <p><b>Response from Kaipara District Council</b>  See link above</p>
<p><b>Case Number</b>  <b>CSU-2016-WGN-000073</b></p>	<p><b>Catch Phrases</b>  Severe Head Injury, Quad bike, Safety Helmets, Tyres, Lack of Experience, Rough Terrain, Steep Bank</p> <p><b>Link to Summary and Recommendations</b>  <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/109.html">http://www.nzlii.org/nz/cases/NZCorC/2016/109.html</a></p> <p><b>Response from Worksafe New Zealand and New Zealand Transport Agency</b>  See link above</p>

<b>Case Number</b> CSU-2016-PNO-000245	<b>Catch Phrases</b> Overtuned tractor, farm work, Holder A12, chest injuries, abdominal injuries, capacity tank, non-standard tyres <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/111.html">http://www.nzlii.org/nz/cases/NZCorC/2016/111.html</a> <b>Response from Federated Farmers</b> Received
<b>Case Number</b> CSU-2014-PNO-000405	<b>Catch Phrases</b> Tension pneumothorax, spinal and chest injuries, modified mountain bike, unapproved cycle helmet, motorised bicycle, engine <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/85.html">http://www.nzlii.org/nz/cases/NZCorC/2016/85.html</a> <b>Response from Ministry of Transport</b> See link above
<b>Case Number</b> CSU-2014-AUK-001538	<b>Catch Phrases</b> Severe Traumatic Brain Injury, Motor Vehicle Accident, Toddler, Driveway, Struck by Vehicle, Rollover, <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/114.html">http://www.nzlii.org/nz/cases/NZCorC/2016/114.html</a> <b>Response from Safekids Aotearoa</b> See link above
<b>Water-related (General)</b>	
<b>Case Number</b> CSU-2015-HAM-000556 CSU-2015-HAM-000557	<b>Catch Phrases</b> Drowning, Surf, Ruapuke Beach, Swim, Undertow, Cross Current, <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/66.html">http://www.nzlii.org/nz/cases/NZCorC/2016/66.html</a> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/90.html">http://www.nzlii.org/nz/cases/NZCorC/2016/90.html</a> <b>Response</b> N/A
<b>Case Number</b> CSU-2015-HAS-000049	<b>Catch Phrases</b> Drowning, swim failure, wharf, sea conditions, ladder, jumping, Tolaga Bay <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/87.html">http://www.nzlii.org/nz/cases/NZCorC/2016/87.html</a> <b>Response from Gisborne District Council</b> Response Pending
<b>Case Number</b> CSU-2015-WGN-000547	<b>Catch Phrases</b> Drowning, Diving, Red Rocks, Regulator <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/95.html">http://www.nzlii.org/nz/cases/NZCorC/2016/95.html</a> <b>Response</b> N/A

<b>Case Number</b> CSU-2014-WHG-000216	<b>Catch Phrases</b> Diving, Waikuku Beach, Pulmonary Barotrauma, Cerebral Gas Embolism, Rapid Ascent <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/108.html">http://www.nzlii.org/nz/cases/NZCorC/2016/108.html</a> <b>Response</b> N/A
<b>Work-related (Agriculture)</b>	
<b>Case Number</b> CSU-2013-ROT-000253	<b>Catch Phrases</b> Forestry accident, logging accident, high energy impact, forestry operator, Independent Forestry Safety Review, Work Place Safety Legislation, <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/96.html">http://www.nzlii.org/nz/cases/NZCorC/2016/96.html</a> <b>Response</b> N/A
<b>Case Number</b> CSU-2013-HAM-000059	<b>Catch Phrases</b> Forestry accident, intra-cranial injuries, blunt force trauma, rope breakage, Independent Forestry Safety Review, Work Place Safety Legislation, <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/98.html">http://www.nzlii.org/nz/cases/NZCorC/2016/98.html</a> <b>Response</b> N/A
<b>Case Number</b> CSU-2014-AUK-000257	<b>Catch Phrases</b> Forestry accident, head injury, crush injury, blunt trauma, Independent Forestry Safety Review, Work Place Safety Legislation, <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/99.html">http://www.nzlii.org/nz/cases/NZCorC/2016/99.html</a> <b>Response</b> N/A
<b>Case Number</b> CSU-2012-ROT-000214	<b>Catch Phrases</b> Forestry accident, crush injury, falling tree, Independent Forestry Safety Review, Work Place Safety Legislation, <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/100.html">http://www.nzlii.org/nz/cases/NZCorC/2016/100.html</a> <b>Response</b> N/A
<b>Case Number</b> CSU-2012-ROT-000081	<b>Catch Phrases</b> Forestry accident, spine fracture, severe blunt force trauma, Independent Forestry Safety Review, Work Place Safety Legislation <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/101.html">http://www.nzlii.org/nz/cases/NZCorC/2016/101.html</a> <b>Response</b> N/A

<b>Case Number</b> CSU-2012-ROT-000289	<b>Catch Phrases</b> Forestry accident, multiple injuries, tree felling, Independent Forestry Safety Review, Work Place Safety Legislation <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/102.html">http://www.nzlii.org/nz/cases/NZCorC/2016/102.html</a> <b>Response</b> N/A
<b>Case Number</b> CSU-2012-ROT-000119	<b>Catch Phrases</b> Forestry accident, head injury, spinal injury, logging, Independent Forestry Safety Review, Work Place Safety Legislation <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/103.html">http://www.nzlii.org/nz/cases/NZCorC/2016/103.html</a> <b>Response</b> N/A
<b>Case Number</b> CSU-2013-ROT-000402	<b>Catch Phrases</b> Forestry accident, Fractured Cervical Spine, Blunt Force Trauma, Independent Forestry Safety Review, Work Place Safety Legislation <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/97.html">http://www.nzlii.org/nz/cases/NZCorC/2016/97.html</a> <b>Response</b> N/A
<b>Work-related (Other)</b>	
<b>Case Number</b> CSU-2012-CCH-000708	<b>Catch Phrases</b> Vessel, Noxious gases, forepeak tank, drowning <b>Link to Summary and Recommendations</b> <a href="http://www.nzlii.org/nz/cases/NZCorC/2016/53.html">http://www.nzlii.org/nz/cases/NZCorC/2016/53.html</a> <b>Response</b> N/A

## Case study: Self-Inflicted deaths

In New Zealand, suicide continues to be a significant health and social problem. Last year, approximately 579 New Zealanders took their lives.

### Self-inflicted deaths at a glance

For coroners, where a death is self-inflicted, the main issue to determine is whether the person intended to take their own life, knowing the probable consequences of their actions. That is, was the death a suicide?

The standard of proof, or threshold, that needs to be met before a coroner can be satisfied that something has been proven, is on the balance of probabilities. In order to justify a finding of suicide, the act of intentional self-harm requires a degree of proof in keeping with the seriousness of the allegation of suicide. This is consistent with the principle that the graver the allegation, the clearer, more cogent and more exacting the evidence must be.<sup>1</sup> Accordingly, the coroner must be satisfied that there is clear evidence from which an intention to end one's life can be inferred. The fact that an accident is not established does not mean that suicide is established, and suicide must not be presumed merely because it seems on the face of it to be a likely explanation.

### Notes

Care needs to be taken when interpreting and reporting figures relating to suicide. The data includes all active cases before coroners where intent has yet to be established. Therefore, some deaths provisionally classified as suicides may later be determined not to be suicides. In addition, the report relates to the financial year, starting 1 July and ending 30 June and the population analysis is based on estimated resident population of New Zealand as calculated by Statistics New Zealand.

### Provisional suicide death and rate per 100,000 population, by gender 2007-16

In 2015-16, 579 deaths were classified as suicides, which is the highest number of suicides in New Zealand since the government began recording statistics on suicides in 2007-08. This is a rate of 12.33 suicide deaths per 100,000 population, which is the third highest rate recorded. Approximately 71% of suicide deaths were male. The number of female suicide deaths rose from 136 to 170, which is the highest number of female suicide deaths recorded in New Zealand.

Year	Male		Female		Gender Rate (M:F)	Total	
	Number	Rate	Number	Rate		Number	Rate
2007/08	405	19.35	135	6.20	3.00:1	540	12.2
2008/09	394	18.61	137	6.23	2.87:1	531	12.04
2009/10	401	18.7	140	6.29	2.85:1	541	12.26
2010/11	419	19.36	139	6.2	3.01:1	558	12.65
2011/12	405	18.58	142	6.3	2.85:1	547	12.34
2012/13	388	17.63	153	6.76	2.54:1	541	12.1
2013/14	385	17.5	144	6.26	2.67:1	529	11.73
2014/15	428	18.96	136	5.81	3.14:1	564	12.27
2015/16	409	17.71	170	7.13	2.41:1	579	12.33

<sup>1</sup> *Anderson v Blashiki* [1993] 2 VR 89; *The Secretary of the Department of Health and Community Services v Gurrick* [1995] 2 VR 69.

### Provisional suicide deaths reported to the Coroner by age and gender, 2015-16

Since 2007, male suicide rates in New Zealand have been consistently higher than female suicide rates, which was the case again in 2015-16. The highest rate of male suicides was for those aged 25-29, while the highest rate of female suicides were for those aged 20-24 and 40-44.

Age Group (years)	Males		Females		Total	
	Number	Rate	Number	Rate	Number	Rate
10-14	5	3.32	3	2.09	8	2.72
15-19	34	20.75	17	11.00	51	16.02
20-24	40	21.96	20	12.00	60	17.20
25-29	54	31.80	12	7.13	66	19.51
30-34	35	24.17	13	8.43	48	16.06
35-39	30	22.41	17	11.71	47	16.84
40-44	32	22.23	20	12.69	52	17.25
45-49	38	25.00	19	11.42	57	17.90
50-54	37	24.15	11	6.72	48	15.15
55-59	30	20.94	11	7.20	41	13.85
60-64	27	21.66	9	6.80	36	14.01
65-69	16	14.03	6	5.03	22	9.43
70-74	8	9.77	4	4.54	12	7.06
75-79	10	16.70	6	8.81	16	12.50
80-84	8	21.24	1	2.15	9	10.70
85 +	5	15.97	1	1.93	6	7.23
<b>Total</b>	409	17.71	170	7.13	579	12.33

### Provisional suicide rates by ethnic group, 2007-16

In 2015-16, the rate of suicide for Māori was 21.57 per 100,000 population. This is the highest rate among all ethnicities in New Zealand. There were 129 suicides by Māori, accounting for 22% of all suicide deaths in this country. Asian people accounted for 7%, Pacific people accounted for 4% and people identifying their ethnicity as 'Other' accounted for 67%.

It is important to note that the small number of some ethnic groups means rates are variable and it is difficult to draw conclusion or trends from the data.

Year	Asian		Māori		Pacific		Other		Total
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	
2007/08	21	5.93	87	15.39	24	9.05	408	13.26	540
2008/09	10	2.82	95	16.81	26	9.81	400	13	531
2009/10	22	6.21	105	18.58	31	11.69	383	12.45	541
2010/11	19	5.36	101	17.87	22	8.3	416	13.52	558
2011/12	19	5.36	132	23.34	31	11.69	365	11.24	547
2012/13	28	7.9	105	18.58	24	9.05	384	12.48	541
2013/14	22	4.67	108	18.06	26	8.81	373	12.96	529
2014/15	16	3.4	130	21.74	27	9.15	391	13.58	564
2015/16	39	8.28	129	21.57	24	8.13	387	13.44	579



## Background

The statistical data gathered in this study involve all active cases before coroners where intent has yet to be established. Therefore, some deaths provisionally classified as suicides may later be determined not to be suicides.

The case study is limited to cases where coroners have made specified recommendations or comments pursuant to section 57 of the Coroners Act 2006.

Following are 20 coronial findings involving self-inflicted deaths where coroners have made such recommendations or comments.

## Coroners Amendment Act 2006

### Restrictions on making public the details of self-inflicted deaths

Before the Amendment Act came into force on 22 July 2016, there were restrictions on publishing information about self-inflicted deaths. The Amendment Act narrows the reporting restrictions but continues the prohibition on reporting:

- a. the method of any suspected method of the self-inflicted death; or
- b. any detail (for example, the place of death) that suggests the method or any suspected method of the self-inflicted death; or
- c. a description of the death as a suicide.<sup>2</sup>

Section 71 aims to reduce any risk that people will attempt to copy the behaviour, to protect privacy and to minimise the impact on families. However, media reports are permitted to describe a death as a 'suspected suicide' prior to the coroner's findings being delivered. The new amendment has also introduced increased financial penalties for breaching the restrictions under section 71.

A person can apply to the Chief Coroner for an exemption from all or any of the restrictions in section 71(2). The Chief Coroner may grant an application for an exemption if satisfied that the exemption does not present an undue risk of copycat behaviour and that any risk is outweighed by other considerations that make it desirable, in the public interest, to allow the publication of the details. In light of the recent changes, the Chief Coroner has the assistance of a suicide and media expert panel in deciding whether to grant an exemption, pursuant to section 116A of the Act.

## Themes in coronial recommendations and comments on self-inflicted deaths

Several coronial recommendations have called for a more holistic approach to cases that involve mental health. On 6 May 2016, Coroner na Nagara recommended to the Hawke's Bay District Health Board and the Ministry of Health that:

- I. A coordinator is appointed to set up a multi-agency platform for the reporting and coordination of response to young persons whose situations are such that the possibility or risk of suicide is maximised. This could include children and young persons living in homes where domestic violence is common, where alcohol and drug use and abuse are common, where the child or young person is consistently in disciplinary trouble at school, where the child or young person is coming to the attention of police.
- II. Such a response includes short, medium and long term actions, clarity about who is going to do what, and what to do should the situation change or if an action is not followed through. The response should also attend to the requirements of the child and the social system around the child.
- III. The coordinator be funded by the DHB, and operate in a similar way as the CAFS/MHS High Complex Needs User coordinator.
- IV. Sufficient funding is provided to enable the implementation of this recommendation.

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<sup>2</sup> Coroners Act 2006, s71.

- V. In the event that the Hawke's Bay Regional Children's Team, when implemented, is able to assume the responsibilities of the coordinator, the coordinator's role is devolved to that Team.<sup>3</sup>

Coronial findings have also referred to the actions family and friends can take. In one of Coroner Greig's findings, she recommended that:

There are key things to bear in mind. The first is that if someone expresses thoughts and feelings about suicide take them seriously. Urge the person to obtain help and if you are concerned, get help immediately, by contacting a doctor or mental health service. If you need to, call emergency services on 111. If the person is feeling unsafe, or you think they are at high risk, do not leave them alone. People in this situation need someone with them.<sup>4</sup>

Chief Coroner Judge Marshall has also commented that:

Research shows there are known risk factors for suicide. These include a recent relationship break-up, recent engagement with the police and/or mental health services and unemployment.<sup>5</sup> People who threaten suicide often go on to commit suicide, even if they deny an intention to follow through with the threat.<sup>6</sup>

Other recommendations and comments on self-inflicted deaths include:

- endorsing reviews and recommendations made by institutions
- recommending the reviews of policies, procedures and facilities
- encouraging multi-agency cooperation
- calling for better management of personal information and mental health history
- referring to the need for information sharing between families and health professionals
- suggesting more agency and community support
- highlighting the dangers of recreational drugs and cautioning the use of prescription drugs
- commenting on the need for more recognition of the triggers and stress factors, and
- advising of suicide prevention training courses.

## Key organisations

### **Ministry of Health**

There is great effort being put into suicide prevention, including the Ministry of Health's recently launched suicide prevention toolkit for District Health Boards and the trial Suicide Mortality Review Committee. This change aims to start a more open discussion of the reality of suicide in New Zealand. For more information, visit <http://www.health.govt.nz/our-work/mental-health-and-addictions/working-prevent-suicide>

### **Clinical Advisory Services Aotearoa (CASA)**

CASA has a model of working alongside groups and organisations that acknowledges the strengths both parties bring to the relationship. Their kaupapa is to share their clinical expertise through training, supervision, support and consultancy. They place particular emphasis on the delivery of effective suicide prevention and postvention services to organisations and communities. For more information, visit [www.casa.org.nz](http://www.casa.org.nz)

### **New Zealand Police - Iwi Liaison Officer and Māori Wardens**

Iwi Liaison Officers operate at a community level and concentrate on improving relationships between Police and Māori. Police work closely with Safer Community Councils and Māori Wardens, especially

<sup>3</sup> Re Ngatuere [2016] NZCorC 39; Staples [2016] NZCorC 40; Karangaroa-McKenzie [2016] NZCorC 41; Whaanga [2016] NZCorC 42

<sup>4</sup> Re Bergh [2011] NZCorC 149

<sup>5</sup> See Suicide Mortality Review Committee Feasibility Study 2014-2015, Health and Quality Safety Commission New Zealand

<sup>6</sup> Re Fitzgerald [2016] NZCorC 71

in the areas of youth suicide prevention, applying the national drug policy and working to improve road safety. For more information, visit [www.police.govt.nz/about-us/maori-police/iwi-liaison-officers](http://www.police.govt.nz/about-us/maori-police/iwi-liaison-officers)

### ***Child, Youth and Family Services (CYFS)***

CYFS work closely with families to help them find their own solutions, so they can deal with their problems, make the changes they need so their children will be safe and well cared for and achieve their goals for the family. For more information, visit [www.cyf.govt.nz/keeping-kids-safe/index.html](http://www.cyf.govt.nz/keeping-kids-safe/index.html)

### ***Lifeline Aotearoa***

Lifeline provides counselling to those in need 24 hours a day, 7 days a week counselling and support. They also provide a 24/7 confidential and free telephone counselling and support service for those who may be thinking about suicide, or for those who are concerned about friends or whānau. The helpline is staffed by highly experienced helpline counsellors with training in suicide prevention and intervention. For more information, visit [www.lifeline.org.nz](http://www.lifeline.org.nz)

## **Further Reading:**

### ***The Vulnerable Children Act 2014***

The Vulnerable Children Act 2014 aims to protect those children who are vulnerable and do not fall within the ambit of other laws protecting children. The Act implements 2 key requirements for the education sector. These are to safety check all those who work regularly with children and whose work is paid (or unpaid as part of an educational or vocational training course); and to have child protection policies in place.

The new requirements of the Act apply to early childhood education services, ngā kōhanga reo and playgroups (services), schools and kura (schools) because they have direct contact with children, as well as some people or organisations contracted by them. Schools must now have their child protection policies in place which will help to assist children's physical and mental wellbeing.

## Recommendations made by New Zealand coroners

**CASE** Bergh [2011] NZCorC 149

**CASE NUMBER** CSU-2010-AUK-000486

**DATE OF FINDINGS** 15 September 2011

### CIRCUMSTANCES

Willem Johannes Bergh, late of Hillsborough, Auckland, died at his home on 9 April 2010 from self-inflicted injuries.

### RECOMMENDATIONS MADE BY CORONER K GREIG

In this case, the issue of how best to deal with a person talking of taking their own life requires comment. This is not a circumstance most people are faced with. Knowing how best to respond if confronted with such a situation is important.

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

### COMMENTS MADE BY CORONER K GREIG

Having had regard to Mr Bergh's characteristics and the circumstances of his death, I consider that permitting publication of the cause and circumstances of his death is not likely to be detrimental to public safety. I consider that it is in the public interest to allow publication of this finding which contains information that may assist to prevent deaths in similar circumstances in future.

Accordingly, I permit this finding to be made public. The restrictions set out in s72 of the Coroners Act 2006 do not apply.

**CASE** McVey [2011] NZCorC 172

**CASE NUMBER** CSU-2011-WGN-000186

**DATE OF FINDINGS** 14 December 2011

### CIRCUMSTANCES

James Andrew McVey, late of Hataitai, Wellington, died at Houghton Bay, Wellington on the 21st of April 2011, of self-inflicted injuries.

### RECOMMENDATIONS MADE BY CORONER SMITH

To the Mayor and Councillors, Wellington City Council

- It is recommended that the Council investigate the construction of a short protective fence section to the layby lookout area at Houghton Bay, such fence to impede the public gaining access to a cliff face but not to restrict the public's view from the lookout itself.

**CASE** Barriball [2012] NZCorC 63

**CASE NUMBER** CSU-2010-DUN-000364

**DATE OF FINDINGS** 30 April 2012

#### CIRCUMSTANCES

Richard John Barriball of Milburn, a remand prisoner, died at Otago Corrections Facility (OCF), Narrowdale Road, Milburn, South Otago on the morning of 9 October 2010, in circumstances indicative of suicide. He was facing multiple stressors with a history of drug addiction and had a recent operation on his arm which caused chronic pain.

His family expressed concerns about a failure in care and protection offered at OCF and a failure to provide appropriate medical support. In particular, Mr Barriball's family was concerned with failures by OCF to administer prescribed medication that had been prescribed by his GP at the appropriate times. In particular Tramadol, a drug he had been prescribed, was not administered to him when it ought to have been due to staff shortages.

A toxicology test at autopsy determined that he had consumed cannabis, probably in the period immediately prior to his death. Notes left by him confirmed his mental fragility, although the fact that he was depressed was well recognised by his family. His sister had telephoned the prison in reference to family concerns about his mental state. Concerns had also been expressed through the prison chaplaincy service to the effect that he was vulnerable. These concerns had not been recorded or acted upon by OCF.

#### COMMENTS MADE BY CORONER D CRERAR

I am in no doubt as to the professionalism and good faith of [the doctors treating Mr Barriball] but, in the environment that exists at OCF, their ability to provide appropriate care is compromised if medications are not dispensed as instructed or if the doctors do not receive information that a prisoner's presentation has changed.

The disappointment which I share with the family of Richard Barriball is that information relating to his mental state was made available to OCF by a telephone call from a family member. Whether the family member knew the severity of the mental state faced by her brother is unclear but at least she passed this information on to OCF management. It is a matter of regret that this information was not recorded, disseminated and acted upon.

I similarly heard of concerns expressed through the prison chaplaincy service to the effect that Richard Barriball was vulnerable. Unfortunately there appears to have been no gathering of this intelligence and arranging for it to be transferred to the OCF Health Centre.

The fact that Richard Barriball had consumed cannabis, probably in the period immediately prior to his death, and almost certainly since his admission to OCF, also remains of concern. The submission of counsel for Corrections is recorded. It is accepted that the possession, and use, of the drug cannabis at OCF is unusual as well as being illegal. The contribution of cannabis to his state of mind will never be able to be accurately measured. I am advised that cannabis can variously be either a stimulant or a depressant and, when taken in conjunction with other drugs, it may have been a significant contributor to his mental state.

The damaged arm was creating chronic pain. A mix of medications prescribed by his GP to combat this pain would appear to have been working moderately well when he was admitted to OCF. A trial of other pain relief must not have been as effective as he had hoped. Of particular concern is the fact that the most effective pain relief, Tramadol, was prescribed but was unable to be delivered due to 'staff shortages'.

The Legislation governing care of prisoners in custody is s 75 Corrections Act 2004:

**Medical treatment and standard of health care.**

A prisoner is entitled to receive medical treatment that is reasonably necessary.

The standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public.

When I consider the facts of the death of Richard Barriball, against the statutory provisions, I must find that, in particular, the time of delivery of appropriate pain relief medication was not the same as the time of delivery which would have been achievable in the community.

**RECOMMENDATIONS MADE BY CORONER D CRERAR**

I recommend that a copy of this Finding be forwarded to the Chief Executive, Department of Corrections. The causes of the death and the circumstances of the death of Richard Barriball have shown suboptimal care by OCF in 2 respects:

- the failure by OCF to provide delivery of prescribed pain relief at a time deemed most appropriate by the clinicians, and
- two communications were made, by family and to or by the chaplaincy, expressing concerns to OCF as to the mental status of Richard Barriball. This intelligence was not collected, recorded, reported or acted upon.

**CASE** Luke [2012] NZCorC 80

**CASE NUMBER** CSU-2010-DUN-000364

**DATE OF FINDINGS** 30 April 2012

**CIRCUMSTANCES**

Hurikino Dennis Luke, a remand prisoner, died at Te Ahuhu Unit, Christchurch Men's Prison, on 10 January 2011. His death was self-inflicted with the intention of ending his life. After being arrested Mr Luke was assessed while in police custody. Although he had a suicide alert in the police system from 2006, he was not considered to be at risk. The information was not sent to the prison receiving office or watch-house psychiatric nurse who had access to Mr Luke's psychiatric records from 2006.

Mr Luke was remanded in custody and, when he arrived at Christchurch Men's Prison, he underwent a risk assessment which did not identify any concerns regarding his safety. His communications with Corrections officers and fellow prisoners also gave no concern for his safety. Following the September 2010 earthquake, there was a temporary reclassification that allowed the Te Ahuhu Unit to hold remand prisoners and other prisoners. Mr Luke was placed in a single occupant cell in a low-security unit.

During the night of the 10th of January, Correction officers did the normal routine check of the prisoners by using their torches to look into the cell windows. This is to check to see if there was a body on the bed and nothing untoward happening. Three of these prisoner cell and location checks were performed that night at regular 2-hour intervals. In the morning on 11th January, Mr Luke was found deceased in his cell.

**COMMENTS MADE BY CORONER R G MCELREA**

There is a need for review of the prisoner cell and location check policy, as highlighted by the Chief Ombudsman, to better ensure the welfare of the prisoners. The first issue is whether the recent change in policy as to the frequency of prisoner cell and location checks is appropriate given the requirements of the Corrections Act 2004 to ensure the safe custody and welfare of prisoners.<sup>7</sup> The second issue is whether prisoner cell and location checks should be limited to establishing the prisoner's presence in the cell subject to nothing being noticeably untoward (as would appear to be

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<sup>7</sup> The new policy reduces the number of checks from every two hours after lock up, to two times, one between general lock-up and the other randomly determined by central control between the hours of 11pm and 6am.

the practice at Christchurch Men's Prison), or whether the checks should establish the prisoner's well-being (as presently expressed in the Prison Service Operations Manual).

As highlighted in the evidence, the Te Ahuhu Unit was constructed in recent times and has an obvious design feature which can lead to self-harm. The evidence shows that for 'low-risk' prisoners, not only from a security perspective but from a self-harm perspective, there are benefits in this type of 'hut' accommodation. The minimisation of ligature points is referred to in the department's facilities standards for new facilities.<sup>8[2]</sup>

This case highlights that an assessment of being not at risk of self-harm (which applied to the newly-imprisoned Hurikino Luke) does not equate to that prisoner being at low risk of self-harm. As Mr Rushton has stated, usually only a prisoner who is 'towards the pathway of being released' is placed in a 'hut' unit. Prison authorities in such circumstances have had the opportunity of observing a prisoner over a period of time. In this case, the prisoner was in the early period of imprisonment and was only placed in the unit because of exigencies arising from the Canterbury earthquakes.

The evidence indicates that although historical information concerning a prisoner's at-risk status is taken into account when known, the main emphasis is on how the prisoner presents at the assessment. Although unlikely to have been a factor in the death of Hurikino Luke, Christchurch Men's Prison's non-compliance with the relevant standard from the Prison Service Operations Manual that prisoner cell and location checks be carried out at irregular intervals is an issue highlighted by this inquest.

#### RECOMMENDATIONS MADE BY CORONER R G MCELREA

To the Chief Executive, Department of Corrections

- That the prisoner cell and location check policy be reviewed to better ensure the welfare of the prisoners.
- That taking account of the department's facilities standards, the design of new cell facilities should avoid exposed piping.
- That consideration be given to only prisoners considered at low risk of self-harm and who are 'towards the pathway of being released' be placed in low-security units with design features such as exposed piping.
- That policy concerning a prisoner's at-risk status in New Zealand prisons is reviewed as regards the weight to be placed on historical at-risk information relating to the prisoner.

To: Manager, Christchurch Men's Prison

- That Christchurch Men's Prison reviews its procedures to ensure prisoner cell and location checks are carried out at irregular intervals.<sup>9</sup>

Note: Section 71 of the Coroners Act 2006 applies in this case: I consider that the making public of these Findings is unlikely to be detrimental to public safety and because I consider that the public interest is served by publication of these Findings. In authorising publication above, I take account of the evidence that prisoners placed in 'hut' units are in usual circumstances those 'towards the pathway of being released' where there has been opportunity to consider the prisoner's history in custody from a risk of self-harm perspective. From a public safety perspective the risk of 'copycat' suicides is therefore minimised.

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<sup>8</sup> Mr Brown advises the aim of such standards is to ensure that all new facilities provide for best practice, for functional and operational purposes. 'This includes the minimisation of ligature points' - letter 20 June 2012.

<sup>9</sup> Mr Brown advises that the adherence by custodial staff to the prisoner cell and location check policy is monitored on a monthly basis by 'Prison Services Quality and Business Improvement team'. He states that the results for Christchurch Men's Prison over the last 6 months provide assurance that these checks are being undertaken on a random and irregular basis. – letter 20 June 2012.

**CASE** Krystal [2013] NZCorC 121  
**CASE NUMBER** CSU-2008-AUK-000695  
**DATE OF FINDINGS** 09 May 2013

## CIRCUMSTANCES

Krystal late of Auckland died, aged 12 years, between 12 and 13 September 2008 at her home of self-inflicted injuries.

At the time of her death, Krystal was in the custody of Child Youth and Family (CYF), and was, along with her sister, living with a Barnardos caregiver in Auckland. Previously she and 7 of her siblings had been in the care of Ngaphui Iwi Social Service (NISS) approved caregivers in Kaikohe. In August 2008, during a contact visit, Krystal disclosed to her parents that she had been sexually abused by one of her caregivers. Her parents told her CYF social worker, who passed the information on to NISS. Contrary to protocol, NISS informed the caregivers of the allegation while the children were still living with them. Krystal was confronted by her female carer about the allegations, which severely distressed her, as they had had a long-standing and close relationship.

For several reasons, including her despondency on the day of her removal from Kaikohe, Krystal was believed to be at risk of self-harm, and provided with therapeutic support on arriving in Auckland. She was screened for psychological distress and suicide risk, but the screen was misapplied and her total score was recorded as 3, though it was in fact 11. If a child has a total score higher than 4, a referral for further assessment is to be made but because of the misapplication, Krystal was not referred for further support.

She had an evidential interview of the subject of her sexual abuse, after which no counselling was organised by CYF. Nonetheless, the girls settled in well to their placement in Auckland. On the night of her death, Krystal had an argument with her sister regarding pocket money, which escalated into a physical confrontation. The girls were sent to their rooms and told if such behaviour were to continue, they would not be allowed to stay. The next morning, Krystal's sister found her deceased of self-inflicted injuries.

Krystal had been through significant upheaval, including the separation from her siblings and the loss of her relationship with her long-time female carer. The fact that her caregivers in Kaikohe were informed of the allegation while she still lived with them was not acceptable child-centred practice, and the ensuing confrontation had a significant impact on her mental health up until her death. She also was suffering from the psychological impact involved in pursuing her allegation of sexual abuse.

In the review undertaken by the Office of the Chief Social Worker, it was said that no counselling was organised after Krystal's evidential interview in order to preserve the integrity of the criminal process, before a subsequent interview. This was not part of any relevant policy in place at the time.

The misapplication of the screening test meant that Krystal lost a key opportunity for further intervention and support, including exploration of her risk of suicide. The social worker who applied the test has undergone further training in it and test scores are now calculated by computer, eliminating the risk of human error.

Though her caregivers in Auckland were provided with her care plan, they were not informed of the timeframe of her alleged sexual abuse, nor did they know that she had had an evidential interview on the subject or that she had undergone any screening for psychological distress. CYF conceded that the care plan did not meet the acceptable standard. It was not clear whose responsibility it was to keep the plan up-to-date.



## COMMENTS OF CORONER M MCDOWELL

I consider that Krystal's case is a tragic reminder to frontline social workers, and those involved in the immediate care of children, of the requirement to be child, rather than process-focused. That is, there needed to be an overall assessment of Krystal's situation and what she was experiencing. However, I am satisfied that learning has been taken from the management of her case, and that steps have been taken to improve the frontline response.

The quality of the care plans in this case fell below standards, and was possibly not assisted by the ability of individual social workers to circumvent the CYRAS system (the information case note system). Evidence was given at Inquest, that it was possible for social workers to save care plans to their own computer hard drives – meaning that, unless the care plans were uploaded to CYRAS, access to updated plans was not available to anybody else working on the case. There was evidence also that the care plan document in the CYRAS system was not particularly user-friendly.

While I accept that it is policy not to withhold support/counselling services to a child who is involved in an evidential interview process, I am concerned (on the basis of evidence at the inquest) that there is an impression for some social workers that such counselling/support should not be offered for fear that it may compromise the criminal process.

## RECOMMENDATIONS OF CORONER M MCDOWELL

To Child Youth and Family

That it consider:

- reviewing the format of the care plan to facilitate, in a user-friendly way, its timely and comprehensive completion
- undertaking regular audits of existing care plans to ensure that they are up-to-date and accessible on CYRAS
- taking steps to ensure that all staff are regularly reminded of the importance of care plans (particularly in relation to information-sharing with caregivers) and their appropriate completion and updating, and
- implementing a checklist along similar lines as exists for Barnardos to ensure that full information is provided at least verbally to caregivers
- that, in consultation with the New Zealand Police, it clarifies the policy pertaining to the provision of support/counselling to children involved in the Evidential Interview Process, and that it takes steps to ensure that frontline staff have knowledge of that policy.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of several particulars of these proceedings, including the manner in which Krystal took her own life, the names of Krystal's siblings and any information that may lead to their identification, including Krystal's surname, and the names of various social workers and caregivers.

## RESPONSE FROM MINISTRY OF SOCIAL DEVELOPMENT (MSD) TO RECOMMENDATIONS MADE BY CORONER MORAG MCDOWELL RE THE DEATH OF KRYSTAL

Note: An order under section 74 of the Coroners Act 2006, prohibits the publication of several particulars of these proceedings, including the manner in which Krystal took her own life, the names of Krystal's siblings and any information that may lead to their identification, including Krystal's surname, and the names of various social workers and caregivers. The response has been adapted due to this prohibition order.

MSD provided the following response to Coroner McDowell's recommendations:

Inquest into the death of Krystal

I refer to your letter of 10 May 2013 in which you provided your findings in respect of the cause and circumstances of the death of Krystal. The Ministry was grateful for the opportunity to respond to your

comments in the provisional findings and has previously commented on a number of the issues highlighted.

The Ministry would like to update you about some key changes that have occurred within Child, Youth and Family's practice since Krystal's death. These advancements, as outlined below, have significantly strengthened our response to the complex cases facing our social workers. Gateway assessments have been rolled out nationally and these robust assessments consider a wide range of health and education needs for children and young people. As of July 2014, the service specifications for Gateway Assessments will more clearly set out the expectations that mental health will be a core part of these assessments and that all Gateway teams will have access to a Child and Adolescent Mental Health clinician.

Our new assessment framework, Tuituia, introduced in September 2013 provides social workers with a much clearer framework for analysing the complexity of these types of situations for children and young people and as such, helps to ensure visibility of issues that may impact on a child or young person's wellbeing in social work assessments. Child, Youth and Family are also currently looking at ways to reduce the complexity and duplication within our recording systems. The Assess, Plan, Implement and Review (APIR) project work is underway to develop a more integrated approach with our plans, including our Care Plans.

**CASE** McDowall [2014] NZCorC 101

**CASE NUMBER** CSU-2012-CCH-000260

**DATE OF FINDINGS** 29 October 2014

#### CIRCUMSTANCES

Helen Grace McDowall of Christchurch died on 5 April 2012 at Christchurch Hospital of self-inflicted injuries. Ms McDowall had a major depressive disorder. She was admitted to an acute inpatient service under the control of Canterbury District Health Board (CDHB). While deficiencies were found in Ms McDowall's documentation, the coroner found no clear indication in the evidence that these deficiencies were causative of the final outcome.

#### COMMENTS OF CORONER R G MCELREA

To Canterbury District Health Board

The Root Cause Analysis carried out by CDHB identifies documentation was incomplete 'and this limits confidence that decisions taken were accompanied by an adequate account of the risk that Ms McDowall posed'. Further, 'instructions or requests for an upcoming shift were recorded in the Healthlinks Patient Information Management System, but were not acted on'.

[The Chief of Psychiatry at CDHB] said there is still some reliance on the paper-based records and 'work is being done' to provide appropriate technology to allow notes to be recorded in the file at point of contact.

#### RECOMMENDATIONS OF CORONER R G MCELREA

To Canterbury District Health Board

- I recommend to CDHB that the ongoing process of digitalising medical records be given emphasis to complete the process at an early date to remove the need for reliance on any hard-copy records such as day-to-day medical notes, in the assessment and treatment of a patient.

**CASE** Kraidy [2014] NZCorC 151  
**CASE NUMBER** CSU-2014-AUK-000809  
**DATE OF FINDINGS** 2 December 2014

#### CIRCUMSTANCES

Daroish Kraidy of Auckland died on 25 March 2014 when he took his own life. He died of multiple injuries he sustained after he flew his plane until it crashed into the sea. The precise place of death is unknown.

Mr Kraidy was an experienced pilot. He had a history of depression. In renewal applications for his medical certificate from the Civil Aviation Authority, he had answered 'no' to a question that concerned diagnosed depression.

The coroner found conclusive evidence that when Mr Kraidy took off in his plane, it was his intention not to return. The coroner gave authority to make public the circumstances of the death.

#### RECOMMENDATIONS OF CHIEF CORONER, JUDGE MACLEAN

It emerged in the course of the inquiry that Mental Health Services in Auckland District Health Board [(ADHB)] overlooked the obligation under s 27C of the Civil Aviation Act 1990 to notify CAA of pilots unfit to fly. The ADHB has acknowledged this and has advised that all ADHB staff employed medical practitioners will be notified regarding this obligation.

The relevant provisions are 'If a medical practitioner has reasonable grounds to believe that a person is a licence holder and is aware or has reasonable grounds to suspect that the licence holder has a medical condition that may interfere with the safe exercise of the privilege to which the licence holder's medical certificate relates, the medical practitioner must as soon as practicable... 'advise the director [of Civil Aviation] of the condition'.

As it is possible that this oversight could be an issue with Medical Practitioners employed by other District Health Boards, although I have no information about this, I will arrange for a copy of these findings to be sent to the Chief Medical Officers of all New Zealand District Health Boards to remind them of the provisions of s 27C of the Civil Aviation Act 1990. Also, for completeness, these findings will be sent to the NZ Medical Association to consider.

**CASE** Smaill [2015] NZCorC 94  
**CASE NUMBER** CSU-2014-DUN-000436  
**DATE OF FINDINGS** 14 October 2015

#### CIRCUMSTANCES

Erroll Calvin Smaill of Dunedin died on 7-8 November 2014 at Dunedin of self-inflicted means.

In late October 2014, Mr Smaill was seriously mentally unwell. His family were concerned for his health and found indications he was suicidal. They arranged for him to attend Dunedin Hospital. A psychiatrist there admitted him to Wakari Hospital as a voluntary patient. Mr Smaill was allowed to go home to collect clothes and belongings before his admission and, while he was there, he evaded his family members and went missing.

Some days later he was located and taken by family, Police, and Emergency Psychiatric Services (EPS) staff for assessment with EPS. Mr Smaill was assessed at EPS over 5-6 November 2014. While there, his family noticed him taking a 'real interest' in the windows to the unit and how they were secured. Due to Mr Smaill continuing to absent himself from his family, a psychiatrist prepared an application for compulsory treatment. Mr Smaill was taken to the secure unit of EPS. However, he was left alone for a short time and walked through an unsecured door to a kitchen where he escaped

through an unsecured window. Staff had not thought this was possible due to Mr Smaill's age and perceived level of fitness. EPS and the Police conducted searches. Mr Smaill was found dead on 8 November 2014.

The coroner considered that EPS staff provided Mr Smaill with an appropriate level of care. Mr Smaill's calm presentation, religious beliefs, and denial of suicidality contributed to Mr Smaill not being under constant observation. The major contributory factor to Mr Smaill's departure was the fact the window was not secure.

#### RECOMMENDATIONS OF CORONER D CRERAR

I adopt and endorse the recommendations of the Review of Care report:

- a. swipe card access to Emergency Psychiatric Services and duties office be reviewed
- b. the window in the kitchen at the secure unit needs to be provided with stays. (It is acknowledged that this has been completed on 27 November 2014)
- c. that consideration be given to CCTV cameras being provided for the Emergency Psychiatric Services building
- d. that the Authorised Leave guidelines provided by Emergency Psychiatric Services be reviewed.

#### RESPONSE OF THE SOUTHERN DISTRICT HEALTH BOARD

The Southern District Health Board Mental Health, Addictions and Intellectual Disability Service responded saying that recommendations (a), (c), and (d) had been completed and that recommendation (b) was in progress.

Note: Sections 71 and 74 of the Coroners Act 2006 prohibit the making public of particulars of this death. The coroner allowed reference to be made to the facts and circumstances of the death, specifically the fact that patient was able to leave a secure unit by means of an unsecured window. No names of doctors or EPS staff involved in the care of Mr Smaill may be made public. His mode of suicide cannot be made public.

**CASE** Houston [2015] NZCorC 101

**CASE NUMBER** CSU-2014-CCH-000119

**DATE OF FINDINGS** 19 October 2015

#### CIRCUMSTANCES

Geoffrey Houston, late of Spreydon, Christchurch died sometime between 1100 hours on 14 March and 0400 hours on 15 March 2014. His death was self-inflicted.

#### COMMENTS OF CORONER A TUTTON

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

Patients detained pursuant to the Mental Health (Compulsory Assessment and Treatment) Act 1992 form a particularly vulnerable group of society. Those caring for, treating and dealing with them assume a responsibility to ensure their wellbeing to the greatest extent possible. Such a responsibility will require appropriate processes. To ensure the effectiveness of those processes, they should be designed to include oversight, preferably supervisory, of all significant decisions.

These comments are directed to District Health Boards and New Zealand Police.

#### RECOMMENDATIONS OF CORONER A TUTTON

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

- That the CDHB requires a 'dual sign-off' process to be adopted for all Absent without Leave Police Notification forms completed in respect of a compulsory patient, whereby the form is completed by one registered nurse or doctor and checked and countersigned, by a supervisor if reasonably available, or otherwise by another registered nurse or doctor, before being sent to Police to ensure that all appropriate information is provided to Police.

This recommendation is directed to the Canterbury District Health Board Specialist Mental Health Services.

- That Police require that all Absent Without Leave Police Notification forms received in respect of a compulsory patient are referred immediately on receipt to a supervisor for appropriate coding and action.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Mr Houston by Police in the interests of personal privacy.

Note: Pursuant to section 71 of the Coroners Act 2006 no person may make public a particular of the death other than the name, address, and occupation of the person concerned, and the fact that a Coroner has found the death to be self-inflicted.

#### RESPONSE OF THE CANTERBURY DISTRICT HEALTH BOARD

The Canterbury District Health Board accepts the recommendation and is implementing the changes.

**CASE** Bestic [2015] NZCorC 106

**CASE NUMBER** CSU-2013-AUK-000773

**DATE OF FINDINGS** 03 November 2015

#### CIRCUMSTANCES

Kirstine Elizabeth Bestic of Auckland died between 2 and 4 July 2013 of self-inflicted means.

#### COMMENTS OF CORONER M A MCDOWELL

In response to Dr Nightingale's suggestion that it may be helpful to develop a mechanism to identify people whose frequency of presentation increases to ensure they have a more detailed review of their care, Waitemata District Health Board (WDHB) referred to the current practice of clinical review and discussion at team meetings and the detailed collaborative planning that is in place for clients with [Ms Bestic's condition]. The complexities that arise in relation to such clients would, in the DHB's submission, make it difficult to reduce to a policy. It is proposed that, alternatively, it would be more beneficial to utilise Ms Bestic's case as a learning tool in a formal education session with a view to looking at (among other things) her diagnosis, care and treatment and the interaction with family and friends.

I accept the submissions made by WDHB. I concur that it may be helpful for staff to identify key learning points from Ms Bestic's case. The s71 limitations on publication ... would not prevent the education session proposed. Having considered this proposal and the steps taken by the DHB to address issues arising from Ms Bestic's case, I do not propose to make any further recommendations or comments.

Note: Section 71 of the Coroners Act 2006 prohibits the making public a particular of the death other than the name, address, and occupation of the deceased, and the fact that the coroner has found the death to be self-inflicted.

**CASE** Ngatuere [2016] NZCorC 39; Staples [2016] NZCorC 40; Karangaroa-McKenzie [2016] NZCorC 41; Whaanga [2016] NZCorC 42

**CASE NUMBER** CSU-2013-HAS-000139; CSU-2013-HAS-000221; CSU-2013-HAS-000224; CSU-2014-HAS-000167

**DATE OF FINDINGS** 06 May 2016

## CIRCUMSTANCES

Lesha Ruben Ngatuere, Jahnaya Wikitoria Staples, Ebony Rose Karangaroa-McKenzie and Deichan Jarnika Teri Whaanga of Hastings, each aged 15 years old, died between July 2013 – August 2014 at Flaxmere of self-inflicted injuries. The following comments and recommendations relate to each of the deaths.

## COMMENTS OF CORONER NA NAGARA

With respect to comments that, in my opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which these deaths occurred, I reiterate the point made by Professor Collings in her report:

It should be noted that self-harm such as cutting, if it occurs in the context of other risk factors, should never be dismissed as ‘attention-seeking behaviour’, as it is actually a known risk factor for future suicide death. Furthermore, any suicide or frank suicide attempt where there is high potential for lethality should always be regarded as significantly increasing future risk, even at times when matters appear to be improving or stabilising.

## RECOMMENDATIONS OF CORONER NA NAGARA

With respect to recommendations that, in my opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which these death occurred, I make the following recommendations:

To the Hawke’s Bay District Health Board and the Ministry of Health

It is recommended that:

- A coordinator is appointed to set up a multi-agency platform for the reporting and coordination of response to young persons whose situations are such that the possibility or risk of suicide is maximised. This could include children and young persons living in homes where domestic violence is common, where alcohol and drug use and abuse are common, where the child or young person is consistently in disciplinary trouble at school, where the child or young person is coming to the attention of police.
- Such a response includes short, medium and long-term actions, clarity about who is going to do what, and what to do should the situation change or if an action is not followed through. The response should also attend to the requirements of the child and the social system around the child.
- The coordinator be funded by the DHB, and operate in a similar way as the CAFS/MHS High Complex Needs User coordinator.
- Sufficient funding is provided to enable the implementation of this recommendation.
- In the event that the Hawke’s Bay Regional Children’s Team, when implemented, is able to assume the responsibilities of the coordinator, the coordinator’s role is devolved to that Team.

To the Hawke’s Bay District Health Board and the Ministry of Health

It is recommended that:

- The Hawke’s Bay District Health Board set up a whanau wellbeing facility in Flaxmere to provide a place for families and young people to drop in whenever they feel like the support and camaraderie of a community of people trying to live without alcohol, drugs, violence and abuse, or trying to change negative behaviours/family dynamics.

- The facility could be modelled on the Te Whare Manaaki facility in Palmerston North referred to in these findings, but need not be modelled exclusively on an alcohol and drug addiction recovery paradigm. Its development might usefully be informed by consultation with the community and potential users of the facility.
- Sufficient funding is provided to enable the implementation of this recommendation.
- If such a facility is a substantial duplication of programmes or facilities that exist already in Flaxmere itself, greater support and publicity should be given to these programmes or facilities so that families are aware of their existence and are supported to access them.

To the Minister of Justice and the Chief Executive of the Ministry of Justice<sup>10</sup>

It is recommended that:

- Relevant aspects of the Care of Children Act 2004 and administrative processes under that Act be reviewed with a view to:
  - Ensuring the automatic appointment of a Lawyer for Child in cases involving allegations of family violence.
  - Ensuring Judges have the power to direct counselling for children exposed to childhood trauma including exposure to family violence.

## PUBLICATION

Note: An order made under section 71(2) of the Coroners Act 2006 prohibits any person, without a coroner's authority, to make public any particular of these deaths other than the name, address and occupation of the persons concerned, and the fact I have found their deaths to have been self-inflicted.

## RESPONSE

Response from the Ministry of Health received on 6 October 2016 follows.

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<sup>10</sup> In their capacity as persons overseeing the Ministry responsible for administering the Care of Children Act 2004.

6 October 2016

Judge Deborah Marshall  
Chief Coroner  
Coronial Services Unit  
DX SX 10044  
**WELLINGTON 6011**

Dear Judge Marshall

**The late Lesha Ruben Ngatuere, Jahnaya Wikitoria Staples, Ebony Rose Karangaroa-McKenzie and Deichan Karnika Teri Whaanga**

Further to my letter of 28 July 2016, I have received a response from Dr Simon Shaw, Director of Mental Health at Hawkes Bay District Health Board (DHB) on the recommendations made by Coroner na Nagara in respect to her inquiry into the deaths of the four young people listed above.

Following the release of the Coroner's inquiry into the deaths of these four young people, the Hawkes Bay DHB has started a six-month project to investigate the recommendations relating to the DHB. I attach a copy of the terms of reference for your information. In addition, the role of the DHB's Suicide Prevention Coordinator has been increased to fulltime. I expect to receive a copy of the project team's findings next month.

I trust this information is helpful to you. Please do not hesitate to contact me, if I can be of any further assistance.

Yours sincerely



Dr John Crawshaw  
**Director of Mental Health**  
**Chief Advisor, Mental Health**



**CASE** Rogers [2016] NZCorC 52  
**CASE NUMBER** CSU-2013-CCH-000209  
**DATE OF FINDINGS** 12 July 2016

#### CIRCUMSTANCES

Adeline Kate Rogers of Templeton, Christchurch died on 20 April 2013 at Christchurch Women's Prison of a self-inflicted injury. Because Ms Rogers died in custody, a coroner was required under s80(a) of the Act to hold an inquest for the purposes of inquiry.

#### RECOMMENDATIONS OF CORONER A J TUTTON

To the Chief Executive of the Department of Corrections

The coroner makes the following recommendations, which in her opinion, may reduce the chances of the occurrence of other deaths in circumstances similar to those in which this death occurred.

- That management of the Christchurch Women's Prison undertakes a comprehensive review of the way in which information relevant to the management of risk is recorded and communicated to all staff.
- That training in suicide risk assessment for Corrections staff (including custodial staff) includes information on self reporting, its significance in terms of the overall risk assessment process and the following points relevant to it:
  - When assessing the weight to be attached to a denial of suicidal intent, the need to appreciate:
    - the heightened risk of suicide in the prison population generally, particularly among female prisoners
    - the significance of established risk factors such as a history of self harm, and
    - the frequency with which those asked about suicide will falsely deny an intention to suicide.

The coroner also made recommendations regarding risk assessments of suicide methods.

Note: An order under section 71 of the Coroners Act 2006 prohibits any person, without a coroner's authority, to make public any particulars of the death other than the name, address and occupation of the person concerned, and the fact that a Coroner has found the death to be self inflicted. A further order under section 74 of the Coroners Act 2006 prohibits the publication of the schematic diagram of Wing Two of Christchurch Women's Prison, the Wing Two muster list, and the name of the prisoner shown in paragraph 10 of the statement of CO Patricia Hutchison at page 55 of the final inquest bundle.

**CASE** Ra [2016] NZCorC 55  
**CASE NUMBER** CSU-2014-CCH-000737  
**DATE OF FINDINGS** 25 July 2016

#### CIRCUMSTANCES

Halil Hu Ra late of Rapahoe died on either the night of 17 December 2014 or the morning of 18 December 2014 at his home of self-inflicted injuries. Prior to his death, police had removed computers at the house when executing a search warrant.

#### RECOMMENDATIONS OF CORONER JOHNSON

The coroner proposed a number of recommendations in her preliminary findings, which was sent to the Commissioner of the New Zealand Police. A response was received from the Acting Commissioner of the New Zealand Police advising of changes that have been proposed and implemented. The coroner is satisfied the only recommendations she needs to make are as follows:

To the Commissioner of the New Zealand Police

The Self Harm section of the internal police guideline has been updated to include:

- Because electronic devices are likely to be seized as part of an investigation, ensure that the suspect, family/ whānau or support person are able to contact support services if necessary. This can be achieved by advising them to contact the 24/7 Ministry of Health Healthline (0800 611 116), to take the person to a hospital emergency department or by calling 111. This advice is contained in the leaflets ['Having Suicidal Thoughts?' and 'Are you worried someone is thinking of suicide?'].
- The Ministry of Health Healthline (0800 611 116) number is not included in the leaflet 'Having Suicidal Thoughts?' The advice to Police investigators that it is in both leaflets, should be amended.
- Police investigators should be advised that suspects who are now being given the 'Having Suicidal Thoughts?' leaflet need to also be given the Ministry of Health's Healthline number (0800 611 116) separately in writing.
- Both leaflets given out should be the up-to-date versions.

Note: Section 71 of the Coroners Act 2006 applies. This means that no particulars of Mr Ra's death can be published apart from his name, address and occupation and the fact that the coroner has found his death to be self inflicted. This restriction means that from a practical point of view, all that can be published is the fact of Mr Ra's death and the finding it was self inflicted.

#### RESPONSE

Response from the New Zealand Police received on 19 July 2016 follows.



19 July 2016

Coroner Johnson  
Coronial Services Unit Christchurch  
DX WX10073  
**CHRISTCHURCH**

Dear Coroner Johnson

**The Late Halil Hu RA**

Thank you for the opportunity to respond to your proposed recommendations regarding the circumstances leading to the tragic death of Mr Halil RA.

In your letter of 30<sup>th</sup> June 2016, you acknowledge the mental health and suicide awareness training that Police are currently undertaking. This training outlines risk factors and how to recognise, engage and respond to people who are experiencing mental distress, including suicidality.

Police recruits commenced mental health training in 2014, with 540 recruits having been trained so far. Training for current frontline staff has been developed in partnership with the University of Otago Medical School, which includes a comprehensive suicide awareness module. Six hundred Communication Centre staff are currently undertaking this training. All other frontline staff, including members of the Criminal Investigation Branch, will start this training in September 2016. If you would like to view the mental health e-learning training modules you are welcome to contact Inspector [REDACTED] who can send you an electronic link.

Additionally, all sworn police undertake custodial management and health risk awareness training which includes suicide awareness and recognising risk factors. Although this training is designed for the custodial setting, the messages in regard to police managing vulnerability has direct relevance to suicide prevention. This training is undertaken by frontline staff every 24 months.

Police mental health training has been designed to provide a number of platforms to build on the skills and knowledge Police require to respond appropriately to people who experience mental distress and connect them to the right support services and mental health expertise. Police have been careful to ensure that training does not attempt to make Police pseudo mental health workers, while recognising Police have a role to play in suicide prevention.

Proposed recommendation one relates to Police liaising with specialist mental health services about how to support Online Child Exploitation Agency New Zealand (OCEANZ) suspects, family/whanau and support people. The Police response to this recommendation is that Police training has been developed with the clinical expertise

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180 Molesworth Street, Thorndon, WELLINGTON  
Telephone: 64 4 474 9499 www.police.govt.nz

of the University of Otago Medical School, which includes suicide awareness and how to respond to varying levels of mental distress. Police are confident that the skills and knowledge being developed across all frontline staff, regarding suicide awareness, are transferrable to any situation involving the risk of suicide.

In response to the second and third proposed recommendations, Police training is expected to provide all staff with an appropriate ability to respond to a person experiencing mental distress and connect them to the support services they require. Additionally the standard covering report for all OCEANZ search warrants has been amended to provide more emphasis on the potential for a suspect to become suicidal. The updated covering report is attached with additions highlighted. The additions relating to recommendations two and three include:

- Instructions for Police to provide a leaflet which contains advice specifically to family/whanau and friends if they are worried about someone being suicidal. The leaflet provides a list of possible warning signs and what circumstances may lead to a person wanting to die by suicide, which includes reference to the possibility of court action and shame. The leaflet has been sourced from the Mental Health Foundation and also includes contact details, including phone numbers for a range of support services. The Mental Health Foundation brochure is provided to those supporting a suspect who is the subject of an OCEANZ investigation and the Ministry of Health brochure which was provided to Mr Ra's family, is given to suspects.
- Investigators are advised to ensure the suspect, family/whanau or support person have the ability to contact support services if their electronic communication devices are seized. This can be achieved by the suspect, family/whanau or support person using a range of support service phone numbers which are free of charge and are contained in both leaflets.

Police has considered proposed recommendation four, regarding a Family Liaison Officer being offered to support the suspect, family/whanau or support person. It is standard practice for investigators to provide their contact details to a suspect. However the assignment of a Family Liaison Officer is difficult because that person will not be available 24/7. Mental health services are the right service for the suspect, family/whanau or support person to directly access the advice and support they need. The amended instructions to the investigator contained in the OCEANZ covering report, alongside the leaflets being provided to the suspect, family/whanau or support person provide a clear pathway for people to access support services. This includes advice to call 111 in an emergency.

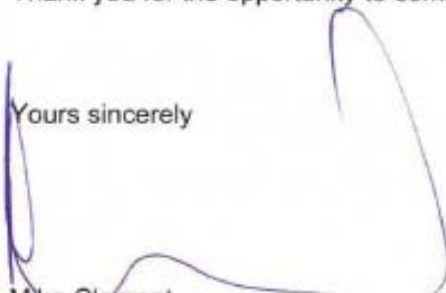
Police has also actively supported the Department of Health through the 2016 budget process where they have been successful in securing funding to establish a mental health triage service. This enables Police call takers in our emergency centres to link directly to mental health professions to ensure the correct inter-agency response to call for assistance.

An additional amendment has been made to the original content of the OCEANZ covering report regarding the investigator notifying family/whanau or a support person about Police being involved with the suspect. The amendment recognises the suspect's right to privacy and the need for the suspect to consent to any

disclosure of information, unless there are genuine concern for the suspect's wellbeing. Advice on how this can be managed by the investigator is outlined in the updated OCEANZ covering report.

Thank you for the opportunity to comment on your proposed recommendations.

Yours sincerely



Mike Clement  
Acting Commissioner of Police

**CASE** Fitzgerald [2016] NZCorC 71  
**CASE NUMBER** CSU-2014-PNO-000171  
**DATE OF FINDINGS** 6 October 2016

#### CIRCUMSTANCES

Edward Fitzgerald, late of no fixed abode, died on 14 April 2014 of self-inflicted injuries.

#### COMMENTS OF CHIEF CORONER D MARSHALL

Research shows there are known risk factors for suicide. These include a recent relationship break-up, recent engagement with the police and/or mental health services and unemployment.<sup>11</sup> People who threaten suicide often go on to commit suicide, even if they deny an intention to follow through with the threat.

Mr Fitzgerald was not perceived as being at high risk of suicide and he denied an intention to end his life. Sadly, his death is yet another confirmation of those known risk factors.

Notes: Sections 71 and 74 of the Coroners Act 2006 applies. The chief coroner prohibits making public without her authority any particulars of Mr Fitzgerald's death other than his name, address, and occupation and the fact that she has found his death to be self-inflicted. The chief coroner also prohibits the making public of any photographs of Mr Fitzgerald's entered into evidence by New Zealand Police in the interests of decency and personal privacy.

**CASE** Duncalfe [2016] NZCorC 73aa  
**CASE NUMBER** CSU-2015-WGN-000418  
**DATE OF FINDINGS** 12 October 2016

#### CIRCUMSTANCES

Amber Jane Duncalfe, a policy advisor, late of Wellington, died on 20 September 2015 of self-inflicted injuries.

#### COMMENTS OF CORONER J P RYAN

I would expect the Capital & Coast District Health Board (CCDHB), based on what has happened in this particular case, will review its processes with regard to actioning referrals to its Specialist Maternal Mental Health Services (SMMHS) to ensure that there are no undue delays in the initial review of referred clients.

This comment is made on the basis that, if the delay between the referral and the initial review of a referred client can be reduced, it is likely that the client will receive the required help and support in a more timely manner. This will be of benefit to the client and may reduce the prospect of further deaths occurring in similar circumstances.

Notes: Sections 71 and 74 of the Coroners Act 2006 applies. The coroner prohibits making public without his authority any particulars of Ms Duncalfe's death other than her name, address, and occupation and the fact that the coroner has found her death to be self-inflicted. The coroner also prohibits the making public of any photographs taken of Ms Duncalfe after death in the interests of decency.

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<sup>11</sup> Suicide Mortality Review Committee Feasibility Study 2014-2015, Health and Quality Safety Commission New Zealand.

**CASE** Tryselaar [2016] NZCorC 86  
**CASE NUMBER** CSU-2014-AUK-000626  
**DATE OF FINDINGS** 10 November 2016

#### CIRCUMSTANCES

Joshua Mark William Tryselaar died on 30 May 2014 at Paremoremo Prison, Auckland as a result of self-inflicted injuries.

#### RECOMMENDATIONS OF CORONER SHORTLAND

- National Office to review the recommendations made by the Inspectorate report prepared by Ms Louise MacDonald. Emphasis with respect to the prisoner welfare monitoring including mandatory welfare checks of prisoners who have been removed from the 'At Risk Unit' within a 7-day settling-in period in the residential unit.
- Further considerations given to making available to the Auckland Regional Forensic Psychiatric Service (ARFPS) access to the MedTech notes (prison medical notes) in addition to the HCC notes they already access.
- At inquest it was noted there is slow progress in making available to the ARFPS the prison medical notes in addition to the HCC notes from other correction facilities around Auckland. It would greatly assist the assessment process for serving prisoners, those in remand custody, and the management of prisoners, if all the available medical information was accessible by the ARFPS.

Note: Pursuant to s71 of the Coroners Act 2006, any particulars of Mr Tryselaar's death, other than his name, address, occupation and the fact that I have found his death to be self-inflicted, are prohibited from being made public. There is no restriction on reporting of efforts being made to prevent suicide and the risks thereof. This is not a case where authority to publish further particulars is warranted.

**CASE** Campbell [2016] NZCorC 93  
**CASE NUMBER** CSU-2011-WGN-000381  
**DATE OF FINDINGS** 21 November 2016

#### CIRCUMSTANCES

William Donald Campbell, of Porirua, died on 17 August 2011 at Porirua in circumstances that were self-inflicted. At the time of his death, Mr Campbell was subject to a compulsory treatment order.

#### COMMENTS OF CORONER RYAN

Ms Boyd, on behalf of the Campbell family, has invited me to make comments relating to the formulation of national guidelines for District Health Boards for dealing with vulnerable, mentally unwell persons and their families. In particular, she states that such guidelines could be expected to address communications with families and how to take these into account appropriately, reporting and management of risk factors, leave and leave conditions, and discharge, among other issues.

While the family's submission may have merit in its essence, I do not consider it is appropriate for me to make a recommendation to that effect based simply on the one case before me. I also question whether national guidelines, had they existed at the time of William's death as proposed, would have affected the outcome. The family contend that properly formulated guidelines would require DHB staff to take appropriate account of family's concerns. However, in my view, there is already a professional obligation on DHB staff to do that.

Notwithstanding this, I have included reference to the family's submission in this finding in the hope that the CCDHB, and any other DHBs which may read this finding, will consider whether national guidelines should be formulated as recommended by the family.

I endorse the recommendations contained in the SAER report which was issued following the investigation into William's death, and encourage the CCDHB to continue its efforts to implement those recommendations.

Ms Boyd also invited me to make a recommendation for the development of national guidelines by Police in relation to SAR operations and the proper eliciting of information from families of missing persons and the utilisation of such information.

Once again this suggestion may have some intrinsic merit, but it is not appropriate for me to make a recommendation along these lines. Section 57(3) of the Act restricts the making of recommendations or comments to those likely to reduce the chances of further deaths occurring in circumstances similar to those in which the death occurred. Any failings identified in William's case relating to the police search were not contributory to his death and therefore any recommendation to improve the search procedures or policies would fall outside the purview of this inquiry.

Nevertheless, I have included reference to this matter in this finding for the sake of New Zealand Police who no doubt are continually striving to improve their policies and processes.

## RECOMMENDATIONS OF CORONER RYAN

To Capital and Coast District Health Board

- That the CCDHB complete as a matter of urgency the work being done to institute a single document (or the electronic equivalent) encompassing all of the up-to-date information on a patient who is in an acute mental health ward, including (but not limited to) risk factors and management of those, leave status and conditions, for the purpose of assisting clinicians to quickly and easily understand the patient's mental health state, leave status and any attendant conditions.
- That the CCDHB consider requiring 2 staff members be involved when a patient is granted short unaccompanied leave, at least for the first time, to ensure that any safeguards or conditions put in place are adhered to.

## RATIONALE FOR RECOMMENDATIONS

These recommendations are based upon the finding that there was a misunderstanding by the primary nurse at the time of the arrangement for William's short unaccompanied leave (SUL) to Vailima, and a failure by the nurse to ensure the safeguard arrangement put in place by the multi-disciplinary team (MDT) relating to William's SUL to Vailima was implemented. As a result, William had an opportunity to leave the hospital grounds and end his life.

This failure was the result of human error, but in the context of fragmented documentation. Any process that is dependent on one person carries a significant inherent risk of failure. That risk can be mitigated by improved documentation which provides the primary nurse with all of the up-to-date information on a patient in one document. In addition, the introduction of a second person should reduce the chance of a similar error being made in future, as that second person will be checking that the proper procedure is followed.

Notes: Section 71 of the Coroners Act 2006 applies. This means that no particulars of Mr Campbell's death can be published apart from his name, address and occupation and the fact that the coroner has found his death to be self-inflicted. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Campbell following his death on the basis that it is in the interests of decency.



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