Recommendations recap

A summary of coronial recommendations and comments made between **1 July 2017** and **31 December 2017**

Issue **14**

OFFICE OF
THE CHIEF CORONER
OF NEW ZEALAND

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

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

This issue features **51** recent coronial cases where recommendations were made. Final findings were released by a coroner between **1 July 2017** and **31 December 2017**.

This issue also features a case study report on deaths related to **Sudden Unexplained Death in Infancy (SUDI)**, key statistics relating to these deaths, an outline of the issues involved and the legal framework surrounding SUDI. It also has a summary of recommendations made by coroners following these deaths.

Disclaimer: The overview of coronial findings detailed within this publication has 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 formal reference is intended.

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 detailed in 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.

We would like to thank Professor Edwin Mitchell of the University of Auckland for his assistance with the case study.

Contents

Recommendations

Accidental	
Case Number	**Catch Phrases**
CSU-2015-CCH-413	Carbon monoxide poisoning, car left running, garage, ventilation
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/38.html
	Response
	N/A[1]
Case Number	**Catch Phrases**
CSU-2015-CCH-415	Carbon monoxide poisoning, car left running, garage, ventilation
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/39.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2015-CCH-416	Carbon monoxide poisoning, car left running, garage, ventilation
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/40.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2015-CCH-414	Carbon monoxide poisoning, car left running, garage, ventilation
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/41.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2016-CCH-265	Fall down embankment, in care, lack of barriers, car parking area, layby, gorge
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/63.html
	Response
	N/A

[1] Where N/A appears, it means a response was not received – there is no obligation on a party named in recommendations to respond to those recommendations.

Case Number	Catch Phrases
CSU-2016-CCH-156	Carbon monoxide poisoning, garage, retirement village, airtightness
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/68.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2015-WHG-17	Electrocution, motor camp, campground power box, residual current devices
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/77.html
	Response
	N/A
Adverse Effects or Reactions to Medical/Surgical Care	
Case Number	**Catch Phrases**
CSU-2016-DUN-385	Orolingual oedema, thrombolysis, stroke, aphasia
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/78.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2014-CCH-684	Internal bleeding, duodenal ulcer, diclofenac, NSAIDs
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/79.html
	Response
	N/A
Alcohol and Drug-related	
Case Number	**Catch Phrases**
CSU-2015-WHG-3	Respiratory suppression, blood alcohol, sleep, alcohol toxicity
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/29.html
	Response
	N/A

Case Number	Catch Phrases
CSU-2013-CCH-605	Alcoholic liver disease, Community Alcohol and Drug Services, hospital care, liver failure, emergency department discharge
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/43.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2016-ROT-215	Hypoxic brain injury, cardiac arrest, drug and aerosol consumption, mental health, addiction
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/53.html
	Response
	N/A
Aviation Accident	
Case Number	**Catch Phrases**
CSU-2014-PNO-595	Helicopter accident, aerial spray operation, electrical wires, fog, hazard map
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/42.html
	Response
	N/A
Domestic Violence/Homicide	
Case Number	**Catch Phrases**
CSU-2015-ROT-302	Domestic abuse, criminal conviction, violent, multiple injuries, child
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/76.html
	Response
	N/A
Recreational/Leisure Activities	
Case Number	**Catch Phrases**
CSU-2015-HAM-531	Shot put, traumatic brain injury, respiratory failure
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/35.html
	Response
	N/A

Case Number **CSU-2016-CCH-10**	**Catch Phrases**
	Hiking, fall, multiple injuries
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/50.html
	Response
	N/A
Case Number **CSU-2016-CCH-85**	**Catch Phrases**
	Mountaineering, fall, spine injury
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/52.html
	Response
	N/A
Case Number **CSU-2016-CCH-706**	**Catch Phrases**
	Hunting, fall, Fox Glacier, terrain
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/58.html
	Response
	N/A
Case Number **CSU-2016-DUN-415**	**Catch Phrases**
	Climbing, fall, Mt Aspiring, loose rock, ropes
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/60.html
	Response
	N/A
Case Number **CSU-2017-HAS-36**	**Catch Phrases**
	Mountain biking, fall, helmet, track
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/69.html
	Response
	N/A

Self-inflicted	
Case Number	**Catch Phrases**
CSU-2015-CCH-579	Suicide, mental health assessment
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/33.html
	Responses
	N/A
Case Number	**Catch Phrases**
CSU-2014-DUN-386	Suicide, primary care, mental health
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/44.html
	Responses
	N/A
Case Number	**Catch Phrases**
CSU-2013-WGN-259	Suicide, youth, mental health
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/47.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2013-HAS-248	Suicide, youth, family
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/62.html
	Responses
	N/A
Case Number	**Catch Phrases**
CSU-2014-AUK-1127	Suicide, death in custody, prison
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/64.html
	Response
	N/A

Case Number	Catch Phrases
CSU-2017-CCH-203	Suicide, seeking help
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/72.html
	Responses
	N/A
Case Number	**Catch Phrases**
CSU-2016-HAM-311	Suicide, relationship, anti-depressants, counselling
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/73.html
	Responses
	N/A
SUDI	
Case Number	**Catch Phrases**
CSU-2016-HAM-58	Positional asphyxia, porta-cot
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/34.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2014-HAS-220	Co-sleeping, thermal stress
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/59.html
	Response
	N/A
Transport-related	
Case Number	**Catch Phrases**
CSU-2015-CCH-794	Motorcycle accident, head injuries
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/30.html
	Response
	N/A

Case Number **CSU-2016-WGN-405**	**Catch Phrases** Car crash, spinal cord injury **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2017/32.html **Response from NZTA** Response from NZTA at link above
Case Number **CSU-2014-WGN-426**	**Catch Phrases** Bicycle crash, traumatic brain injury **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2017/36.html **Response** N/A
Case Number **CSU-2015-DUN-81**	**Catch Phrases** Car crash, intersection, rib and sternum fractures, seatbelt **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2017/37.html **Response** N/A
Case Number **CSU-2016-CCH-350**	**Catch Phrases** Impact injuries, thrown from vehicle, seatbelt, failure to navigate corner, single vehicle crash **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2017/49.html **Response** N/A
Case Number **CSU-2015-DUN-397**	**Catch Phrases** Car crash, thrown from vehicle, seatbelt, single vehicle crash **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2017/51.html **Response from NZTA** Response from NZTA at link above
Case Number **CSU-2013-CCH-152**	**Catch Phrases** Truck, stationary vehicle, medical event, black-out, driver licensing **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2017/55.html **Response** N/A

Case Number **CSU-2016-CCH-413**	**Catch Phrases**
	Car crash, speeding, thrown from vehicle, alcohol
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/56.html
	Response
	N/A
Case Number **CSU-2016-CCH-414**	**Catch Phrases**
	Car crash, cycling, trailer
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/57.html
	Response
	N/A
Case Number **CSU-2015-ROT-124**	**Catch Phrases**
	Single car crash, alcohol, cannabis, Police chase, modified vehicle, drifting
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/61.html
	Response from NZTA
	Response from NZTA at link above
Case Number **CSU-2016-CCH-110**	**Catch Phrases**
	Cycle, train, crossing, barriers, footpath
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/67.html
	Response
	N/A
Water Related	
Case Number **CSU-2015-DUN-61**	**Catch Phrases**
	Drowning, kayak, lagoon, fishing
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/28.html
	Response
	N/A

Case Number	Catch Phrases
CSU-2014-CCH-739	Arterial gas embolism, diving, lung injury
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/31.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2016-CCH-215	Drowning, surf-cast fishing, river mouth, waves
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/45.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2016-CCH-786	Drowning, scuba diving, unascertained
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/48.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2016-CCH-9	Drowning, endurance running, river crossing, group training
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/65.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2015-HAS-20	Drowning, riptides, heavy surf
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/70.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2015-HAS-22	Drowning, riptides, heavy surf
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/71.html
	Response
	N/A

Case Number	Catch Phrases
CSU-2014-HAM-172	Drowning, dive training, visibility, equipment
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/74.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2015-WHG-1	Drowning, signage, remote, underwater current, waves
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/75.html
	Response
	N/A
Workplace/Farming	
Case Number	**Catch Phrases**
CSU-2015-CCH-151	Torso crush injury, truck mishap, roll-over
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/27.html
	Response
	N/A
Case Number	**Catch Phrases**
CSU-2016-CCH-575	Tractor, run over, farming, walking beside tractor
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/66.html
	Response
	N/A
Unascertained	
Case Number	**Catch Phrases**
CSU-2015-DUN-349	Presumed choking, running while eating, child
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2017/54.html
	Response
	N/A

Case study: Sudden Unexplained Death in Infancy (SUDI)

SUDI describes the death of an infant (typically under the age of one year) in their sleep, which is initially in unexplained or unexpected circumstances. The SUDI categorisation therefore includes both Sudden Infant Death Syndrome (SIDS) and subsequently explained fatal sleep accidents.[2] The first edition of the Coronial *Recommendations Recap* in 2011 highlighted this issue and the Coronial response to it via comments and recommendations pursuant to section 57(3) of the Coroners Act 2006.[3]

In New Zealand, children continue to die in circumstances described as SUDI. This case study reflects on recent SUDI trends in New Zealand, particularly in relation to recent Coronial comments and recommendations (from 2012 onwards) to raise awareness of SUDI risks and reduce the rate of SUDI nationwide.

SUDI at a glance

Every year, approximately between 40 and 60 infants die in circumstances of SUDI in New Zealand. It is a leading cause of death among New Zealand's children.[4] Despite overall decreasing SUDI rates since the 1990s, our rates have remained among the highest in the world, with a rate at least twice that of the lowest rate countries (Japan and the Netherlands).[5] Of particular note is that the incidence of SUDI in Māori infants is twice that of the general population.[6]

Three of the biggest SUDI risk factors are maternal smoking during pregnancy, the infant being placed on their front or side to sleep, and sharing a bed with the infant (often this occurs with parents or other family members).[7] These factors are all avoidable.

Reflection on SUDI statistics helps to identify the main risks and hazards, and the ways in which these can be mitigated, so that New Zealand SUDI rate can be further reduced.

Notes

Care needs to be taken when interpreting and reporting on figures relating to SUDI included in this report to ensure accuracy and appropriate recognition of statistical artefacts. The data gathered in this study contains active cases before coroners that involve deaths in circumstances which appear to fit the SUDI criteria, so the numbers and charts below are provisional. The definition of SUDI used includes

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[2] RY Moon and others "SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleeping environment" (2011) 128(5) Pediatrics 1341 at 1342.

[3] Recommendations Recap: Issue 1 (1 October – 31 December 2011), available at: https://coronialservices.justice.govt.nz/findings-and-recommendations/recommendations-recap/

[4] Child and Youth Mortality Review Committee *Sudden unexpected death in infancy (SUDI): Special report* (Wellington, June 2017) at 3. The report can be accessed at: https://www.hqsc.govt.nz/our-programmes/mrc/cymrc/publications-and-resources/

[5] Fern Hauck and Kawai Tanabe "International Trends in Sudden Infant Death Syndrome and Other Sudden Unexpected Deaths in Infancy: Need for Better Diagnostic Standardization" (2010) 6(1) Curr Pediatr Rev 95 at 100-101.

[6] EA Mitchell and others "The combination of bed sharing and maternal smoking leads to a greatly increased risk of sudden unexpected death in infancy: the New Zealand SUDI Nationwide Case Control Study" (2017) 130(1456) NZMJ 52 at 53.

[7] EA Mitchell and others (2017), above n 6, at 60.

unexplained deaths of infants during sleep, smothering or asphyxiation during sleep, and SIDS, but excludes deaths from natural causes and subsequently identified illnesses.

Please note:

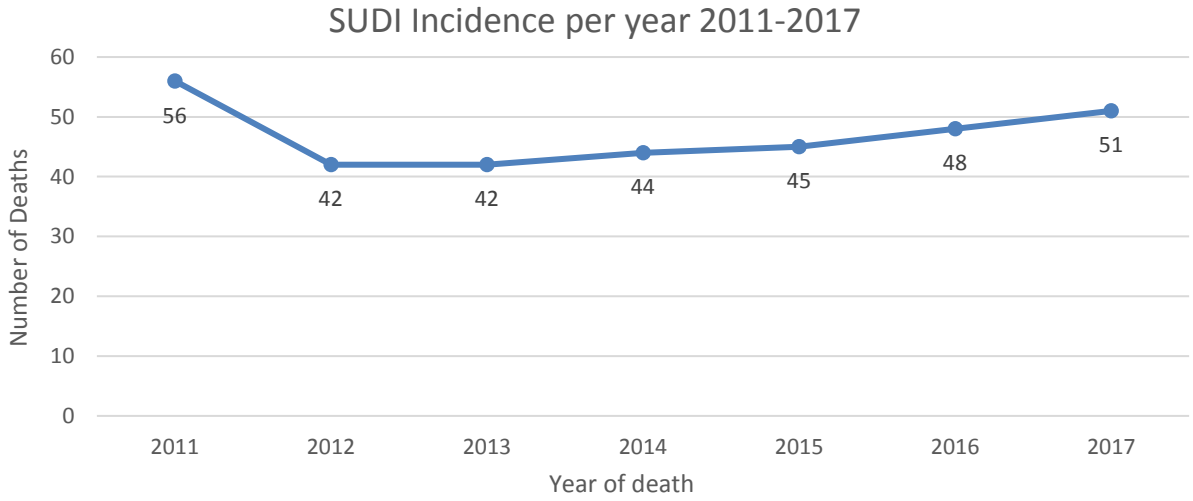
- Years are measured from 1 January to 31 December.
- Statistics use internal coronial data and may differ from other official data.
- 94 cases are still active/before a coroner.
- The following deaths are excluded from the data:
  I. All natural causes deaths such as underlying cardiac failure or fatal asthma attack;
  II. Deaths of infants with explainable cause;
  III. Deaths of infants where the cause of death could not be ascertained but the circumstances of death do not fit the SUDI profile (eg while the infant is awake or where they were choking prior to death).

SUDI Statistics

There was limited understanding and investigation of SUDI and its risk factors in New Zealand prior to the New Zealand Cot Death Study in 1987-1990, when over 200 infants each year were dying in circumstances amounting to SUDI.[8] Following the study's confirmation and identification of several specific risk factors, a far clearer picture of SUDI has emerged. Emphasis and additional funding in this area of mortality has led to more focused messaging, greater involvement of Police and health staff and the institution of SUDI liaison officers (who attend the scene of a suspected SUDI to gather information about how it has occurred). Consequent to the increased identification of risk factors and identification of vulnerable demographics, at present, there has been a reduction in SUDI to around 50 per year.

Provisional SUDI Incidences by year of death 2011-2017

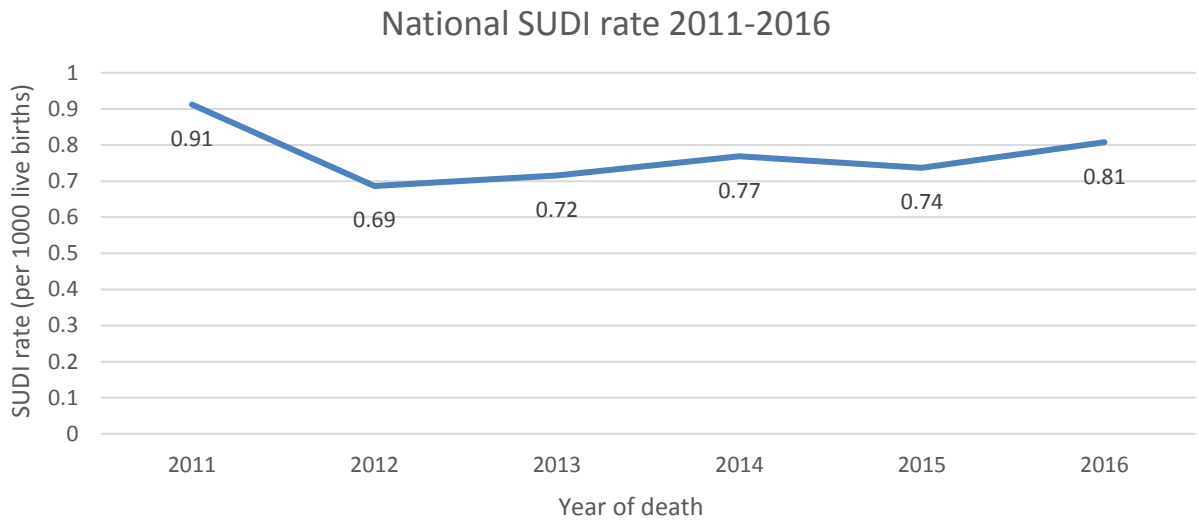
Internal coronial data displays a sharp downward trend in the number of SUDI from 2011 to 2012, followed by an upward trend of SUDI. This increase could indicate that messaging and campaigning (as part of the National SUDI Prevention Programme launched in 2011) was successful in reducing the SUDI rate, as historical figures are approximately at or above the 2011 level. However, we are again seeing a slow rise in the rate of SUDI deaths nationally.



[8] EA Mitchell and Peter Blair "SIDS prevention: 3000 lives saved but we can do better" (2012) 125(1359) NZMJ 50 at 51.

Provisional SUDI Rate by year of death 2011-16

The following graph measures the rate of SUDI per 1000 live births. It displays a similar downward trend of SUDI from 2011 to 2012, followed by an upward trend of SUDI to 2016. This suggests that the rise in SUDI numbers is not solely due to increased births.[9]



Provisional Gender of SUDI victims reported to coroners 2011-2017

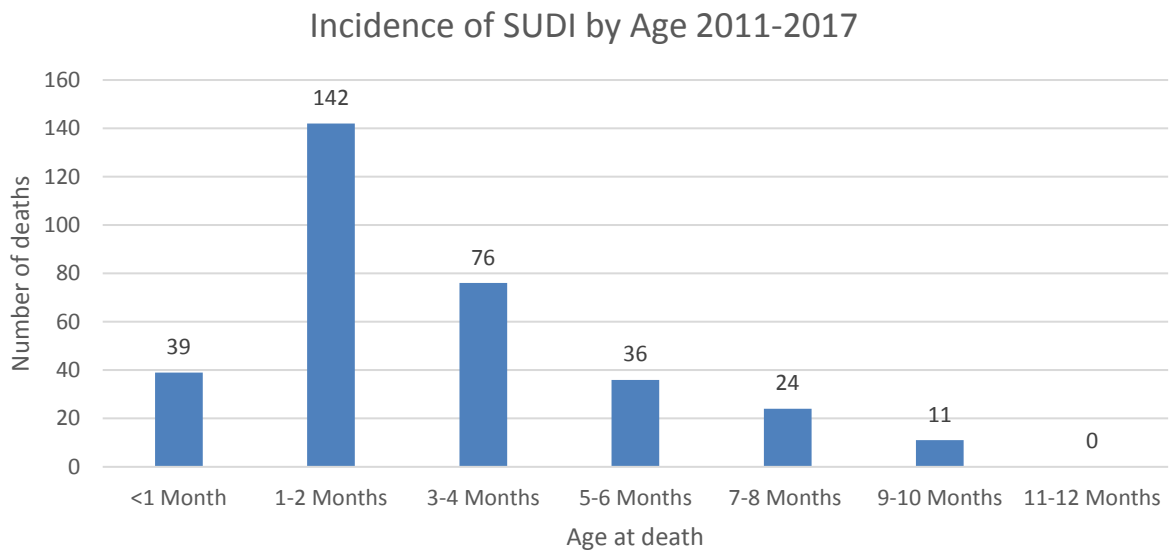
Internal coronial data shows that there is a higher incidence of SUDI among male infants. While New Zealand has a slightly higher ratio of male to female births in these years (StatsNZ data ≈1.04:1),[10] the ratio of male to female SUDI is disproportionately higher (≈1.43:1).

Gender	2011	2012	2013	2014	2015	2016	2017	Total
Female	21	17	17	17	21	20	23	**136**
Male	35	25	25	27	24	28	28	**192**
Total	56	42	42	44	45	48	51	**328**

Provisional Age of SUDI victims reported to coroners 2011-2017

The highest incidence of SUDI is between the ages of one to four months. Younger infants are more vulnerable to the effects of maternal smoking in pregnancy and bed sharing.[11] The SUDI rate drops significantly from four months of age. By 11 months, a child appears to be far less susceptible to SUDI, as there have been no deaths of children of this age or older reported in the past seven years.

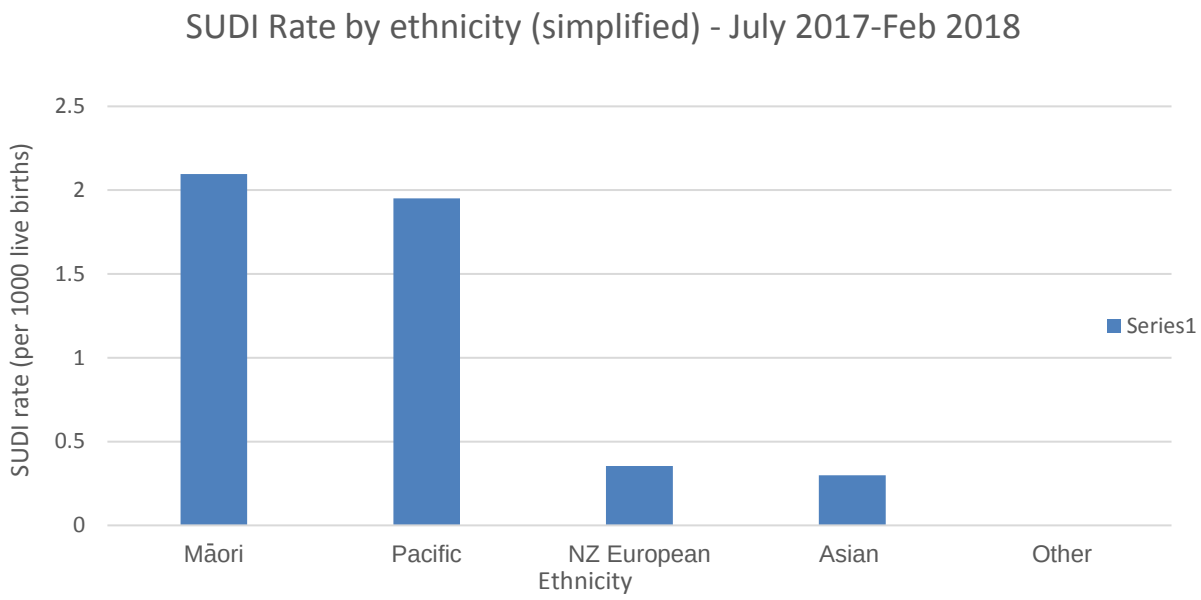
[9] Birth data for 2017 has not been made available by the Department of Internal Affairs
[10] Statistics New Zealand births data available at:
http://archive.stats.govt.nz/browse_for_stats/population/estimates_and_projections/pop-indicators.aspx
[11] EA Mitchell and others (2017), above n 6, at 59.



Provisional Ethnicity of SUDI victims reported to the coroner 2011-2017

Ethnicity	2011	2012	2013	2014	2015	2016	2017	2018 ytd	Total
Cook Island Māori	2	1	2	3	2	4	4		18
European[12]				2		3		1	6
Fijian						2			2
Fijian Indian		1							1
Filipino			1				2		3
Indian						2		1	3
Korean					1				1
NZ Māori	42	22	22	27	25	28	30	5	201
NZ European	8	12	10	5	6	6	8	4	59
Niuean				2			1		3
Pacific Island nfd		2		1	5		1		9
Rarotongan	1								1
Samoan	1	2	2		4	2	4	1	16
Somali	1								1
Tibetan			1						1
Tongan	1	2	3	4	1	1		1	13
Unknown			1		1		1		3
Total	56	42	42	44	45	48	51	13	**341**

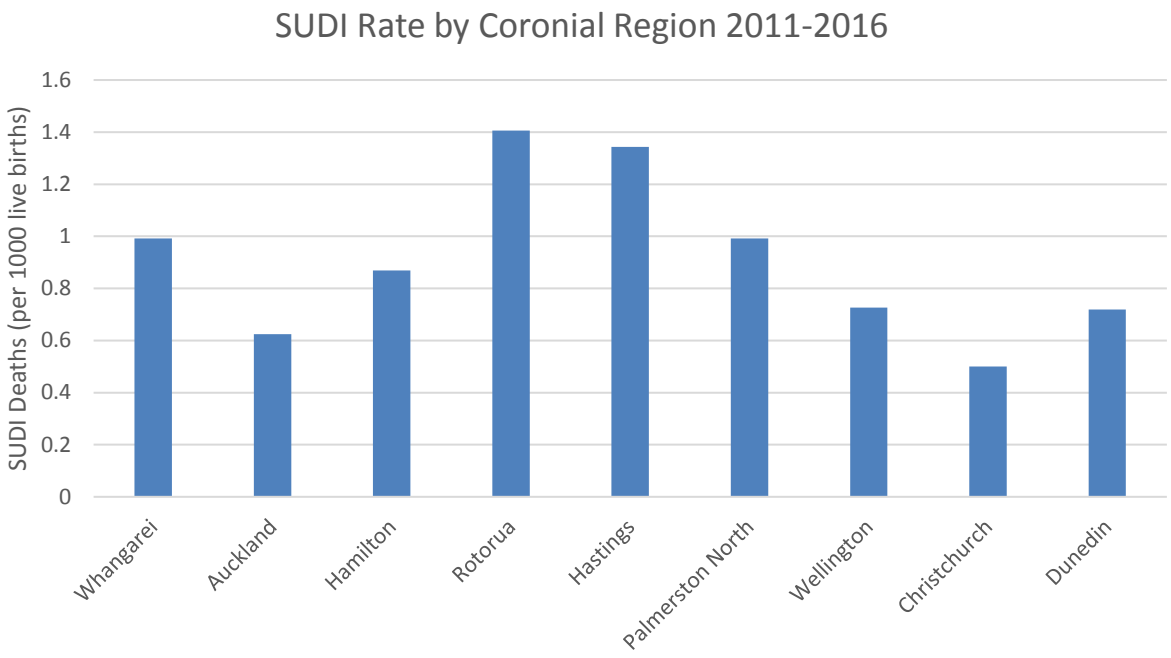
[12] No further detail given.



Provisional Location of SUDI reported to the coroner 2011-2017

The largest proportion of total deaths occurs in the Auckland coronial region, reflecting both the larger population size and the proportion of Māori and Pacific Island people who live there. However, the rates of SUDI, as displayed in the below charts, are disproportionately higher in the Rotorua and Hastings coronial regions and lower in the Auckland, Christchurch, Wellington and Dunedin coronial regions.

Coronial Region	2011	2012	2013	2014	2015	2016	2017	2018 ytd	Total
Whangarei	2	4	1	3	2	1	3	2	18
Auckland	13	6	15	14	17	18	17	4	104
Hamilton	4	6	4	5	5	7	3	0	34
Rotorua	15	3	2	5	5	2	7	0	39
Hastings	7	1	2	5	2	6	6	2	31
Palmerston North	3	4	4	4	5	7	4	1	32
Wellington	3	9	7	1	5	2	5	0	32
Christchurch	5	7	6	2	2	4	5	4	35
Dunedin	4	2	1	4	2	2	1	0	16
Total	56	42	42	43	45	49	51	13	**341**



Coroners' Obligation to Investigate SUDI Deaths

Under the Coroners Act 2006, coroners have a legal responsibility to investigate deaths that are reportable unexpected deaths.[13] By definition, the cause of a SUDI is unascertained and requires a coroner's determination as to what the cause and circumstances of the death were. When a suspected SUDI is reported, a coroner is able to take several actions:

- If a death that has been reported to a coroner is being conducted by another investigating authority, the coroner may either postpone an inquiry into the death, or adjourn an open inquiry.[14]
- If a death has resulted in criminal liability of any person, a coroner may postpone opening an inquiry or adjourn an open inquiry until the coroner is satisfied that the proceedings are finally concluded or the person is no longer charged with the offence.[15]
- Where it is in the public interest, a coroner conducting an inquiry may refer the death concerned to another investigating authority to complete an investigation.[16]
- A coroner has the power to commission from another investigating authority any reports, medical or otherwise, the coroner thinks proper[17] or to request a copy of a report/investigation to be made available to a coroner.[18]

After adjourning or postponing an inquiry, a coroner can open or resume it if they are satisfied that:

- an alternative investigation is not likely to go ahead; or
- an alternative investigation is going ahead but is unlikely to establish the matters that a coronial inquiry would establish; or

[13] Section 14.
[14] Section 69.
[15] Section 68.
[16] Section 119.
[17] Section 118.
[18] Section 120.

- to open or resume the inquiry will not prejudice the investigation or any person interested in it.

When a suspected SUDI is reported, a coroner has an obligation to inquire into the death with the support of other agencies. The purpose of this inquiry is to establish what happened and how a death of a similar kind can be prevented in the future. To this effect, coroners have often made recommendations which if implemented, would decrease the incidence of SUDI in New Zealand.

Key Organisations

Ministry of Health

The Ministry of Health is the predominant government body responsible for the management and development of New Zealand's health and disability system.[19] The Ministry is responsible for administering the New Zealand Health Strategy and for the allocation of funding, including to SUDI prevention programmes.[20]

Part of the Ministry's role is oversight of the National SUDI Prevention Programme and messaging related to SUDI. To increase co-ordination of messaging and services, the Ministry has tendered the national service contract for SUDI prevention to Hāpai te Hauora (Hāpai).

Hāpai te Hauora

Hāpai are a Māori public health organisation with the primary aims of increasing opportunities to enjoy good heath in the communities it serves, and for those communities to be sustained by healthy environments. Hāpai cite a strategic focus supported with evidence-based research in local and national communities to address health inequity.[21]

Hāpai hold four national service contracts, including for the National SUDI Prevention Co-ordination Service (NSPCS). This provides a centralised and integrated approach to SUDI prevention in New Zealand. They provide specialised workforce development programmes, and collate research and data. Under the SUDI prevention contract, Hāpai has stated it aims to reduce preventable deaths from SUDI to 0.1 in 1000 liveborn infants by 2025.[22]

The NSPCS will support the establishment, development, implementation and monitoring of SUDI prevention programmes delivered through four regional co-ordination services and all 20 District Health Boards.[23]

District Health Boards

District Health Boards (DHBs) throughout the country provide specialist medical and health services, including running hospital and regional health programmes. Medical professionals employed by DHBs (doctors, nurses and/or midwives) are often the initial point of contact for education following birth. This provides a good opportunity for educational messages to be passed on to the parent.

Child and Youth Mortality Review Committee

The Child and Youth Mortality Review Committee (CYMRC) is a statutory committee established by the Public Health and Disability Act 2000 to advise the Health Quality and Safety Commission. It is tasked with reducing preventable deaths of New Zealand children and young people from the first month of

[19] https://www.health.govt.nz/about-ministry
[20] https://www.health.govt.nz/new-zealand-health-system/overview-health-system/funding
[21] http://www.hapai.co.nz/content/who-hapai
[22] http://www.hapai.co.nz/content/who-hapai
[23] http://sudinationalcoordination.co.nz/welcome

their life until they are 24 years old.[24] The committee's reports carry considerable weight with decision-makers due to its expertise and independence. It has produced a number of reports referencing SUDI; its 2017 report is the first with SUDI as the sole focus.[25]

Plunket

Plunket is New Zealand's largest provider of support services for the development, health and wellbeing of children under five, seeing more than 90% of New Zealand newborns each year.[26] Plunket nurses provide education, parenting and health advice and support to families and whānau. An early home visit will take place within a few weeks following birth, and follow-up visits can then be arranged to ensure the infant is developing well.[27]

SUDI Liaisons

The SUDI liaison team work closely with Coronial Services, and fulfil two main roles. The first is the gathering and dispensation of information to and from families/whānau who have recently been affected by SUDI. The SUDI liaison team interview the family and may reconstruct the previous night's sleep (for instance, sleeping position and number of blankets or pillows) to gather information useful for the coronial inquiry. This also enables them to provide quality information for bereaved families/whānau about Coronial Service processes, identify health or other services that may be required by family/whānau, and ensure appropriate referral. The second role is the gathering of information and statistics to inform research on SUDI, in particular, the Nationwide SUDI Study.

Government Response to SUDI

In 2011, the Government allocated an additional $21.3 million over four years towards Well Child services. This included additional Plunket visits for high-risk families. This was part of a $54.5 million fund for maternity initiatives to improve safety and quality.[28] A commitment was made to provide up to three free well-child visits to 30% of new mothers with the highest level of assessed need in the postnatal period from four to nine weeks.[29]

The Ministry of Health has actively promoted safe sleep messages.[30] The focus now is on making sure this work reaches more people.

In August 2017, a national SUDI prevention programme was launched by the Government. This programme was supported by the investment into health in the 2017 Budget. The aim of this initiative is to "help reduce the overall rate of SUDI by 85% overall, and by 94% for Māori, by 2025. This [will] reduce the number of SUDI deaths from 44 to six".[31] Hāpai te Hauora provides this service. This programme targets two of the biggest risks for SUDI, namely being exposed to tobacco smoke during pregnancy, and having the infant share a bed.

While launching the programme, the then Minister of Health Jonathan Coleman stated:

> *It will better utilise innovative approaches to reduce smoking, include smoking cessation incentive programmes. From September we will be providing safe sleep*

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[24] https://www.hqsc.govt.nz/our-programmes/mrc/cymrc/
[25] Child and Youth Mortality Review, above n 4.
[26] https://www.plunket.org.nz/what-we-do/who-we-are/
[27] https://www.plunket.org.nz/what-we-do/what-we-offer/plunket-visits/well-child-tamariki-ora-schedule/
[28] https://www.beehive.govt.nz/release/22b-extra-boost-public-health-services
[29] https://treasury.govt.nz/sites/default/files/2018-02/b11-2097610.pdf
[30] https://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/helpful-advice-during-first-year/safe-sleep
[31] https://www.beehive.govt.nz/release/national-sudi-prevention-programme-launched

devices such as wahakura or pēpipods to families identified as needing them during the baby's first year of life.

A range of other evidence-based risk and protective factors will be incorporated into the national prevention programme. These include encouraging immunisation, breastfeeding, and sleeping baby on their back.

As part of this investment, in 2017, a further $2 million was put into the programme, taking its annual budget to $5.1 million.[32]

Themes in Coronial Recommendations and Comments on SUDI

Risk factors

While some SUDI risk factors, such as prematurity, are unavoidable, the bulk of SUDI cases present with risk factors that can be eliminated or mitigated. The following risk factors have been identified as some of the most crucial in ensuring an infant does not become a SUDI victim:

Co-sleeping

Co-sleeping or bed-sharing is the act of having an infant share a bed or sleeping space (such as a couch or mattress) with others, particularly adults. As a person is unaware of the movement of their body while asleep, and does not react as strongly to external stimuli, co-sleeping is a significant risk factor for SUDI and may result in the accidental asphyxiation of an infant.

Sleep environment and position

SUDI is much more likely when an infant is placed on their front or side to sleep than their back. This may be because these positions make the infant susceptible to obstruction of the airway and smothering by their mattress or other materials. Once an infant is in this position, they often do not have a suitably developed arousal reflex or the strength to move themselves to a more suitable, safer position.[33]

A second factor is the mattress they are put to sleep on. When an infant is put to sleep on an unsuitable mattress, particularly with a gap between the mattress and other object, such as a wall, there is a risk that the infant will become trapped in this gap and suffocate. A number of recent deaths that have been attributed to positional asphyxia highlight that an infant needs to be placed on a thin, firm mattress with no gaps.[34]

Smoke exposure

Antenatal smoke exposure significantly increases an infant's risk of SUDI. It is thought that this may impact on an infant's arousal mechanisms resulting in them being less likely to respond to external stimuli, including an inability to breathe. While the exact mechanism is unknown, the literature has demonstrated that when smoke exposure is combined with bed-sharing, an infant is at up to 32-times greater risk of SUDI.[35]

Temperature

Infants are unable to regulate their own body temperature. A safe and comfortable sleeping temperature for infants is 20°C with a single blanket. When the temperature is higher than this, or an infant has too

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[32] https://www.beehive.govt.nz/release/national-sudi-prevention-programme-launched

[33] Dennis Coon and John O Mitterer *Introduction to Psychology: Gateways to Mind and Behavior* (14th ed, Cengage Learning, Boston MA, 2015) at 177.

[34] Recent cases where infants died following becoming trapped between bed and mattress include: Thirkal [2013] NZCorC 116, Mamapomisa [2013] NZCorC 143, Buchanan [2016] NZCorC 1, Baby D [2016] NZCorC 29 and Makiri-Wi Thompson [2017] NZCorC 34.

[35] EA Mitchell and others (2017), above n 6, at 60.

many blankets on, due to a lack of ability to cool themselves down, the infant will overheat. This puts the infant at risk of thermal stress and potentially SUDI.

Safe sleeping advice

Coroners have promoted safe sleeping for a number of years. As mentioned above, attention was drawn to SUDI in 2011 in the first issue of the Recommendations Recap. Since then, coroners have focused on bringing to the attention of the Ministry of Health and the public the preventable nature of SUDI. They have sought to clarify and reinforce the safe sleeping message suggested by experts in this area, and which are proven to reduce the rates of SUDI and sleep death in infants.

The current advice repeats the message that every sleep for an infant should be a safe sleep. This means that, for every sleep, infants up to one year of age should:[36]

- be put to sleep on their backs
- be in their own sleeping space (a firm, flat and level surface with no pillow)
- have their face clear, so their breathing cannot become obstructed
- have someone looking after them who is alert to their needs and free from alcohol or drugs, and
- have clothing and bedding that keep them at a comfortable temperature (20°C ambient temperature).

Advice regarding how to make the infant sleeping space safe is also included on the Ministry of Health website.[37]

Make sure that your baby's bed is safe

Baby's bed is safe when:

- it has a firm and flat mattress to keep your baby's airways open
- there are no gaps between the bed frame and the mattress that could trap or wedge your baby
- the gaps between the bars of baby's cot are between 50mm and 95mm – try to get one with the gaps closer to 50mm if you can
- there is nothing in the bed that might cover your baby's face, lift their head or choke them – no pillows, toys, loose bedding, bumper pads or necklaces (including amber beads and 'teething' necklaces)
- baby has their feet close to the end of the bed so they can't burrow under the blankets
- baby is in the same room as you or the person looking after them at night for their first six months of life.

A lack of understanding and engagement with the advice surrounding these risk factors has been cited as a potential reason that SUDI continues to be a concern in New Zealand.[38] SUDI researchers have suggested that if the three main safe sleep messages (not co-sleeping, making sure the infant is sleeping on its back on a thin, firm mattress and ensuring the infant is not exposed to smoke) were consistently heeded, the rate of SUDI could be as low as seven deaths per year nationally.[39] However, as the fact scenarios continue to demonstrate, due to a number of factors, this advice is still not always heeded.

A large part of reducing these risk factors is education and raising awareness. A coroner's recommendations may be highlighted by the media who can then spread these messages.

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[36] https://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/first-6-weeks/keeping-baby-safe-bed-first-6-weeks

[37] https://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/first-6-weeks/keeping-baby-safe-bed-first-6-weeks

[38] Child Youth and Mortality Review Committee, above n 4, at 15.

[39] EA Mitchell and others (2017), above n 6, at 61.

Case example: Pēpi-pods and Wahakura

Coroners have supported the use of pēpi-pods and wahakura. Coroner Shortland was an early advocate of the approach of creating a separate sleeping space for the infant, and the use of wahakura, in his recommendations in the *Pene* inquiry.[40]

Infant safe sleeping devices such as pēpi-pods and wahakura are adapted beds for infants who are not yet able to roll themselves over. The benefit of these devices is that they allow the infant to be in close proximity to their parents (particularly as co-sleeping is a cultural custom for Māori) but also to be in their own environment, free from the risks of being smothered or trapped (such as between the mattress and the wall). These devices are also portable, ensuring that the infant can easily be monitored whilst it sleeps. Both the pēpi-pod and wahakura can be used on their own, or placed on an adult bed so the infant can sleep close to their parents.

A pēpi-pod is a plastic box with a well-fitting mattress in the bottom. As well as the sleep space, these devices are always provided with safe sleep messaging, which is also etched into the base of the pod. The current version of the pod has windows in the box to enable babies to open their eyes to familiar faces, and allow parents to see in whilst lying next to their infant. Ventilation slits allow for airflow near the infant's face. Etched onto the box are symbols encouraging parents to change the direction their infant's head is facing to prevent formation of a flat head. Further markings on the pod guide safe placement of adult bedding for when the pod is used on an adult bed.[41]

A Wahakura ("waha" meaning "to carry" and "kura" meaning "precious little object") is a traditional flax-woven basket which has been adapted to achieve the same effect: providing a safe sleeping space for the infant.

At around five months, an infant will start to grow out of the pepi-pod or wahakura and at six months of age, the highest risk period of SUDI ends.[42] As infants also start to develop the ability to roll at this stage, they should be moved to a cot or bassinet. Midwife Natasha Rawiri advises: "Babies over the age of six months are more able to change position and have increased mobility; this presents the older baby with a different form of risk".[43]

Te Aka Oranga Waikawa Wahakura Wananga[44]

Te Aka Oranga Waikawa Wahakura Wananga is a programme that has introduced at Waitemata DHB. Pregnant Māori mothers-to-be are involved in a free one-day workshop. This workshop takes women through a process of weaving a bed/wahakura for their infant, whilst being informed of important messages about smoking, breastfeeding and safe sleep practices. It is anticipated that this will help spread Safe Sleep messages throughout Māori and wider communities as the program is based on a partnership model where participants have a responsibility to pass on safe sleep strategies to their whānau and friends.

To date this program has had a high level of engagement. Feedback from participants has been positive. Waitemata DHB are exploring working with community partners to take up the program and

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[40] A summary of the *Pene* finding may be accessed at http://www.nzlii.org/nz/cases/NZCorC/2008/53.html.
[41] http://www.changeforourchildren.nz/pepi_pod_programme/windows_upgrade
[42] http://www.manageme.org.nz/healthy-living/pregnancy/reducing-sudi/wahakura-pepi-pod/ See also coronial statistics above.
[43] "Pepi-pods for Edgecumbe whānau needing safe sleeping space for babies", Māori Television – Online News Rereātea, (online ed, New Zealand, 12 April 2017): https://www.Māoritelevision.com/news/regional/pepi-pods-edgecumbe-whanau-needing-safe-sleeping-space-babies
[44] http://2014.qualityaccounts.health.nz/quality-initiatives/patient-family-centred-care/stories/type/view/storyid/152; see also the CYMRC SUDI Report 2017 available at: https://www.hqsc.govt.nz/assets/CYMRC/Publications/CYMRC_SUDI_Report.pdf.

provide it to more communities. The cultural reframing of important and protective health messages was considered innovative and a critical part of the programme's success to date.[45]

The programme was submitted to the Waitemata DHB Health Excellence awards, where it was overall winner.[46]

Recommendations made by New Zealand coroners

The following collection of **40** coronial cases (ordered by date of finding) involves instances where a coroner made a significant SUDI recommendation. Repeated messages and recommendations of limited effect have not been included. The case study is limited to cases from 2012 and 2017 where the coroners have made specified recommendations or comments pursuant to section 57 of the Coroners Act 2006.

In addition to the discrete recommendations that have been made, SUDI findings are regularly provided to a number of relevant organisations including the Ministry of Health, the Child Youth Mortality Review Committee, and Change for our Children, to raise awareness and for ongoing data collection and analysis.

Public Health Messaging	
CASE Baby R **CASE NUMBER** 2010-ROT-000379 **DATE OF FINDINGS** 9 January 2012	**Recommendation Catch Phrases** Education, graphic nature, law change, explicit risks, Ministry of Health **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2012/199.html **Response** N/A
CASE Gear-Wood **CASE NUMBER** 2011-ROT-000258 **DATE OF FINDINGS** 17 February 2012	**Recommendation Catch Phrases** Co-sleeping, education, explicit risks, Ministry of Health **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2012/29.html **Response** N/A
CASE Baby L **CASE NUMBER** 2011-AUK-000157 **DATE OF FINDINGS** 11 October 2012	**Recommendation Catch Phrases** Hospitals, safe sleep practices, policies, bed sharing, health professionals, Ministry of Health, District Health Boards **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2012/131.html **Response** N/A

[45] http://www.waitematadhb.govt.nz/assets/Documents/health-reports/MaternityQSPAnnualReport2015.pdf
[46] http://www.waitematadhb.govt.nz/assets/Documents/health-reports/MaternityQSPAnnualReport2015.pdf

CASE Fraser **CASE NUMBER** 2011-DUN-000314 **DATE OF FINDINGS** 6 December 2012	**Recommendation Catch Phrases**
	Education, safe infant care, safe sleep, Moe Ora, Ministry of Health
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2012/157.html
	Response from Dr Kevin Woods, Director General of Health
	Response from Dr Woods at link above
CASE Edwards **CASE NUMBER** 2011-ROT-000008 **DATE OF FINDINGS** 30 January 2013	**Recommendation Catch Phrases**
	Preventable, risks, bed-sharing, educations, Ministry of Social Development
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2013/4.html
	Response
	N/A
CASE Baby A **CASE NUMBER** 2011-ROT-000277 **DATE OF FINDINGS** 1 May 2014	**Recommendation Catch Phrases**
	Risk factors, prone sleeping, research, Ministry of Health, education
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2014/63.html
	Response
	N/A
CASE Baby T **CASE NUMBER** 2012-ROT-000066 **DATE OF FINDINGS** 1 May 2014	**Recommendation Catch Phrases**
	Co-sleeping, wahakura, pēpi-pod, education, research, Whakawhitu programme, prone sleeping, Ministry of Health
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2014/64.html
	Response
	N/A
CASE Lapota **CASE NUMBER** 2014-AUK-000341 **DATE OF FINDINGS** 17 October 2014	**Recommendation Catch Phrases**
	Safe sleep messaging, education, Ministry of Health, Child Youth and Mortality Review Committee
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2014/99.html
	Response
	N/A
CASE McKee-Tuira **CASE NUMBER** 2013-AUK-001061 **DATE OF FINDINGS** 30 July 2015	**Recommendation Catch Phrases**
	Safe sleep messaging, risks, education
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2015/75.html
	Response
	N/A

Specific Risk Factors	
CASE McMurdo **CASE NUMBER** 2010-DUN-000348 **DATE OF FINDINGS** 25 May 2012	**Recommendation Catch Phrases** Overheating, ambient temperature, heat dissipation, Child and Youth Mortality Review Committee **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2012/69.html **Response** N/A
CASE Toki **CASE NUMBER** 2011-WGN-000520 **DATE OF FINDINGS** 15 August 2012	**Recommendation Catch Phrases** Overheating, thermal stress, sweat, electric blanket **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2012/204.html **Response** N/A
CASE Spice **CASE NUMBER** 2010-CCH-000865 **DATE OF FINDINGS** 11 July 2013	**Recommendation Catch Phrases** Co-sleeping, Ministry of Health, nose-breathing **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2013/99.html **Response** N/A
CASE Thirkell **CASE NUMBER** 2013-ROT-000090 **DATE OF FINDINGS** 5 September 2013	**Recommendation Catch Phrases** Prone sleeping position, mattress gap, sleeping environment **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2013/116.html **Response** N/A
CASE Mamapomisa **CASE NUMBER** 2012-CCH-000235 **DATE OF FINDINGS** 27 September 2013	**Recommendation Catch Phrases** Mattress gap **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2013/143.html **Response** N/A

CASE Jhanke **CASE NUMBER** 2013-PNO-000309 **DATE OF FINDINGS** 13 May 2015	**Recommendation Catch Phrases** Unsafe sleeping environment, co-sleeping, alcohol, education **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2015/38.html **Response** N/A
CASE Conmee-Evetts **CASE NUMBER** 2014-ROT-000351 **DATE OF FINDINGS** 21 January 2016	**Recommendation Catch Phrases** Risks, breastfeeding, alcohol, education, bed-sharing **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2016/8.html **Response** N/A
CASE Baby D **CASE NUMBER** 2014-PNO-000688 **DATE OF FINDINGS** 31 March 2016	**Recommendation Catch Phrases** Mattress gap, mattress depth, porta-cot **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2016/29.html **Response** N/A
CASE Makiri-Wi Thompson **CASE NUMBER** 2016-HAM-000058 **DATE OF FINDINGS** 14 July 2017	**Recommendation Catch Phrases** Cots, pēpi-pod, wahakura **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2017/34.html **Response** N/A
General Safe Sleep Advice	
CASE Baby T **CASE NUMBER** 2010-WHG-000181 **DATE OF FINDINGS** 28 May 2012	**Recommendation Catch Phrases** Unsafe sleeping arrangements, education and monitoring, safe sleeping principle, independent bed **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2012/73.html **Response** N/A

CASE Hayward **CASE NUMBER** 2011-HAM-000355 **DATE OF FINDINGS** 16 August 2013	**Recommendation Catch Phrases** Safe sleeping environment, risk factors **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2013/216.html **Response** N/A
CASE Wihongi **CASE NUMBER** 2011-WHG-000246 **DATE OF FINDINGS** 3 April 2014	**Recommendation Catch Phrases** Fatigue, adult bed, adult movement while asleep, positional asphyxia, alcohol **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2014/25.html **Response** N/A
CASE Ioata **CASE NUMBER** 2012-WGN-000174 **DATE OF FINDINGS** 7 April 2014	**Recommendation Catch Phrases** Unsafe sleeping environment, co-sleeping **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2014/28.html **Response** N/A
CASE Warren **CASE NUMBER** 2013-AUK-000937 **DATE OF FINDINGS** 17 August 2015	**Recommendation Catch Phrases** Sleep environment, bed-sharing, fatigue, Safe sleep messaging, education, risks, Ministry of Health, Change for our Children **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2015/70.html **Response** N/A
CASE Rihari **CASE NUMBER** 2013-AUK-001072 **DATE OF FINDINGS** 17 August 2015	**Recommendation Catch Phrases** Sleep environment, bed-sharing, pillows, Safe sleep messaging, education, risks, Ministry of Health, Change for our Children **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2015/71.html **Response** N/A
CASE Popata-Anderson **CASE NUMBER** 2014-AUK-000019 **DATE OF FINDINGS** 5 November 2015	**Recommendation Catch Phrases** Safe sleep messaging, education, risks, Ministry of Health, Change for our Children **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2015/107.html **Response from Change for our Children** Response from Change for our Children at link above

CASE Walden **CASE NUMBER** 2015-AUK-000094 **DATE OF FINDINGS** 27 November 2015	**Recommendation Catch Phrases** Safe sleep messaging, risks, wahakura, pēpi-pod, temperature, Ministry of Health advice **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2015/114.html **Response** N/A
CASE Palekotama **CASE NUMBER** 2014-AUK-000099 **DATE OF FINDINGS** 10 December 2015	**Recommendation Catch Phrases** Safe sleep messaging, education, risks, Ministry of Health, Child and Youth Mortality Review Committee, Change for our Children **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2015/121.html **Response** N/A
CASE Fehoko **CASE NUMBER** 2013-AUK-000246 **DATE OF FINDINGS** 14 December 2015	**Recommendation Catch Phrases** Safe sleep messaging, risks, wahakura, pēpi-pod, temperature, Ministry of Health advice **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2015/120.html **Response** N/A
CASE Buchanan **CASE NUMBER** 2014-CCH-000079 **DATE OF FINDINGS** 5 January 2016	**Recommendation Catch Phrases** Safe sleep messaging, risks, wahakura, pēpi-pod, temperature, Ministry of Health advice **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2016/1.html **Response** N/A
CASE Willis **CASE NUMBER** 2015-AUK-001426 **DATE OF FINDINGS** 22 February 2016	**Recommendation Catch Phrases** Safe sleep messaging, risks, wahakura, pēpi-pod, temperature, Ministry of Health advice **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2016/19.html **Response** N/A
CASE Tofa **CASE NUMBER** 2015-AUK-000888 **DATE OF FINDINGS** 31 October 2016	**Recommendation Catch Phrases** Safe sleep messaging, risks, wahakura, pēpi-pod, temperature, Ministry of Health advice **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2016/83.html **Response** N/A

CASE Latu **CASE NUMBER** 2014-AUK-001173 **DATE OF FINDINGS** 8 November 2016	**Recommendation Catch Phrases** Co-sleeping, safe sleep messaging, pēpi-pod, Ministry of Health, Child and Youth Mortality Review Committee, Change for our Children **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2016/84.html **Response** N/A
CASE Witeri **CASE NUMBER** 2014-HAS-000220 **DATE OF FINDINGS** 30 October 2017	**Recommendation Catch Phrases** Co-sleeping, risks, sleep environment, pēpi-pod, wahakura, overheating **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2017/59.html **Response** N/A
Specific and Targeted Recommendations	
CASE Vaimalu **CASE NUMBER** 2008-WGN-000028 **DATE OF FINDINGS** 3 April 2012	**Recommendation Catch Phrases** Doctor, history, more pro-active **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2012/37.html **Response** N/A
CASE Gerrard **CASE NUMBER** 2009-WGN-000163 **DATE OF FINDINGS** 28 June 2012	**Recommendation Catch Phrases** Prone sleeping, early childhood (Well Child) providers, early involvement **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2012/85.html **Response from Hon Tony Ryall, Minister of Health** Response from the Minster of Health at link above
CASE Baby Alexis **CASE NUMBER** 2011-CCH-000961 **DATE OF FINDINGS** 7 September 2012	**Recommendation Catch Phrases** Older baby, maintaining clear face, Child Youth and Family, Ministry of Social Development, additional education, caregivers **Link to Summary and Recommendations** http://www.nzlii.org/nz/cases/NZCorC/2012/140.html **Response** N/A

CASE Baby A **CASE NUMBER** 2012-HAM-000325 **DATE OF FINDINGS** 8 October 2012	**Recommendation Catch Phrases**
	Marae, safe sleeping practices, wahakura, pēpi-pod, shared sleeping environments
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2012/205.html
	Response
	N/A
CASE Neemia **CASE NUMBER** 2012-AUK-000815 **DATE OF FINDINGS** 3 November 2015	**Recommendation Catch Phrases**
	Supervision, policies, training, health practitioners, Counties Manukau District Health Board, postnatal observations, guidelines, education
	Link to Summary and Recommendations
	http://www.nzlii.org/nz/cases/NZCorC/2015/105.html
	Response
	N/A

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