



OFFICE OF THE  
**CHIEF CORONER**  
OF NEW ZEALAND

# Recommendations Recap

A summary of coronial recommendations and comments  
made between **1 July** and **30 September 2018**

# Coroners' recommendations and comments

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

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

The Office of the Chief Coroner maintains a public register of these recommendations and comments and publishes summaries of those which are not prohibited from being published by order of court or law. Recommendations Recap includes all those recommendations and comments which have been summarised and published. This edition includes 20 recommendations and/or comments issued by coroners between 1 July and 30 September 2018.

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

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# All recommendations and Comments — 1 July to 30 September 2018

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

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

## Drowning

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### Child M [2018] NZCorC 56 (14 August 2018)

#### CIRCUMSTANCES

Child M died on 19 July 2017 at her home of drowning.

Child M was 23 months old and lived with her parents and siblings. While her father was at an appointment, she was left in the care of her siblings. The property where they lived had a pool in the backyard. It had a fence around it which had a self-closing gate, as is required by law.

Child M was found floating in the pool. It appears that Child M left the house via the back sliding door, which was open at the time. The evidence suggests Child M then entered the pool area via the gate which had not closed properly, and then either fell or made her way into the pool.

Police examined the pool gate closing mechanism and found that it was not closing properly. Child M's father stated that the gate would close properly when it was last used 6 months earlier. The pool had not been used in around 6 months and it is possible that it deteriorated over that time.

#### COMMENTS OF CORONER J P RYAN

- I. This death occurred because the self-closing mechanism on the pool gate failed to operate properly. It had been several months since the family had used the pool gate, and the mechanism may have deteriorated over that time. When the last person exited the pool enclosure, the pool gate did not close and lock properly, a fact which this person was probably unaware of.

#### RECOMMENDATIONS OF CORONER J P RYAN

To: Water Safety New Zealand

- I. That Water Safety New Zealand continue its efforts to educate the public on the need to:
  - a. check the self-closing and locking mechanism on their pool gate on a regular basis throughout the year to ensure that they are functioning properly; and
  - b. check that their pool gate is properly locked behind them on every occasion, rather than just trusting to the proper functioning of the self-closing and locking mechanism, and that the pool enclosure is thereby secure.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Child M, in the interests of decency. Any information likely to lead to the identification of the deceased, her family, others present at the home during the Child M's death, the name of their school, and the address where the death occurred are also prohibited from being published.

## Tiatia [2018] NZCorC 61 (19 July 2018)

### CIRCUMSTANCES

Chanel Rex Tiatia died on 1 March 2015 after falling into a blowhole at Fisherman's Rock Point at Paikea Bay in Waitakere.

On the afternoon of 28 February 2015, Mr Tiatia and his cousins arrived at Piha and walked to a cave, where they set up a camp. They spent some time fishing, eating, and drinking alcohol.

Around midnight, Mr Tiatia and some of his cousins walked around the rocks north of Piha towards Paikea Bay where there was a fishing spot. They had all been drinking earlier, but were wearing appropriate clothing and footwear as they crossed the rocks. The group were jumping across blowholes as they walked round the rocks.

Sometime between 1 and 2am on 1 March, the group was stopped by the incoming tide. They turned back. Approaching Fisherman's Rock Point, they came across a blowhole they had crossed earlier. At this point, Mr Tiatia slipped on the rocks and rolled into the blowhole, dropping a couple of metres into the water. His cousins tried to rescue him but were unable to. Although he could swim, Mr Tiatia was seen by his cousins to be floating face down, not moving in the water, immediately following his fall.

Emergency services retrieved Mr Tiatia's body that morning and confirmed that he had died.

### RECOMMENDATIONS ENDORSED BY CORONER B WINDLEY

- I. Water Safety New Zealand provides safety advice in relation to rock fishing that has relevant application in this case. I endorse the existing safety advice, which includes the following:
  - Wear a lifejacket
  - Pay particular attention to swell and tide information.
  - Never fish in exposed areas during rough or large seas
  - Spend at least ten minutes observing the sea conditions before approaching the rock ledge
  - Never turn your back on the sea
  - Pay attention to warning signs
  - Never fish from wet rocks where waves and spray have obviously been sweeping over them.

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

## Gomez-Lambertucci [2018] NZCorC 62 (24 August 2018)

### CIRCUMSTANCES

Maggie Gomez-Lambertucci died on 30 November 2017 at Ashburton of drowning.

Maggie was a much-loved 14-month-old. Her father was employed on a dairy farm and lived in a staff house. Some metres from the house, forming something of a roundabout in the driveway, was an ornamental pond. It was approximately two metres diameter and 240 millimetres in depth and was surrounded by shrubs of

various sizes. A brick pathway led through the shrubs to the pond. It was not fenced nor were there other means of preventing access to the pond.

Maggie, who had just started walking, went outside on the morning of 30 November. After approximately 3 minutes, Maggie's mother went outside and found her in the pond. She applied CPR and called for assistance. Unfortunately, Maggie could not be resuscitated.

#### COMMENTS OF CORONER D P ROBINSON

- I. This case is an absolute tragedy. In all other respects, Mrs Gomez-Lambertucci impresses as a caring and attentive mother. This tragedy was the result of a moment's inattention. The circumstances serve to highlight the need for vigilance, and that parents of young children should identify water features at residential properties and give consideration to the means by which such features can be made safe from enquiring youngsters.

In the case of a rental property such as this was, a landlord should give some thought to potential hazards if it is known that young children will be among the occupants.

The need for vigilance is perhaps highlighted by the report prepared by Water Safety New Zealand from 2012, which noted that 75 percent of all domestic and home pool fatalities (for children under five years of age) were aged two or under.

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

## Azmi [2018] NZCorC 63 (23 July 2018)

#### CIRCUMSTANCES

Abdul Azim Amzar Azmi died in Lake Karapiro on 26 February 2017 from drowning after he was surprised by a sudden drop in the lake and went out of his depth.

On 26 February 2017, around 11am, Mr Azmi and a friend cycled from Hamilton to Lake Karapiro. They arrived at Waikupe Landing in the afternoon, and the pair decided to go for a swim. Mr Azmi was not dressed for swimming and was not able to swim.

Initially, Mr Azmi paddled around in the lake, about 10 metres from the lake shore. About 10 – 15 metres from the shore at that location, the depth of Lake Karapiro drops from one metre to approximately six metres. After a few minutes, Mr Azmi's friend looked to the lake and saw Mr Azmi struggling with the water up to his nose. Before anyone could reach him, Mr Azmi became submerged in the water.

A search was launched immediately for Mr Azmi, but he could not be found. The following day, Mr Azmi's body was located in the lake.

#### RECOMMENDATIONS ENDORSED BY CORONER ROBB

- I. I consider that a contributing factor in Mr Azmi's death was his inability to swim. As he entered the water it was initially at a depth of only one metre which did not require him to be able to swim. The lack of water clarity prevented him from being able to see the sudden increase in water depth. As an individual unfamiliar with lakes and rivers in New Zealand he may not have appreciated that he would reach a depth over his head a short distance from the shore.

The Waipa District Council was provided with the draft finding in respect of Mr Azmi's death, and this led to Council discussions and the following advice being provided to the Inquiry, which I endorse.

“... Council is currently working with key internal members of staff to develop a (potentially multilingual) signage graphic as a depth drop warning to all reserve users. Further, staff have identified that the use of complimentary ‘in-water’ buoys would make the depth drop point more easily identifiable to reserve users already in the water. To this end, the Waikato Regional Council has kindly offered assistance to identify a supplier for the buoys and an internal resource to deploy the buoys on our behalf.”

The council further advises me that they are working towards having the signage and buoys in place by November 2018.

I acknowledge the efforts that the Waipa District Council have undertaken to reduce the risk of deaths in similar circumstances. In light of the council’s proposal for warning signage and positional buoys I make no further comment or recommendation.

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

## Lesoa [2018] NZCorC 68 (14 September 2018)

### CIRCUMSTANCES

Lemalufaitoaga (Lemalu) Eneliko Lesoa died on 2 April 2015 in the Manukau Harbour from drowning in the sea when his boat rolled over whilst crossing the Manukau Bar.

On 2 April 2015 at 5am, Mr Lesoa launched his 18 foot fibreglass runabout from the Mangere Bridge boat ramp to go out fishing for the day with a friend outside Manukau Heads. Two others joined the fishing

expedition in a second boat a few hours later. Mr Lesoa and his friend were both wearing life jackets all day.

Around 4.30pm, the group finished fishing for the day, and decided to return to the boat ramp. The tide was starting to turn, and the waves were getting stronger.

After about an hour, the two boats reached the Manukau Bar. Mr Lesoa did not notify Maritime radio or Coastguard of his intention to cross the bar. As Mr Lesoa’s boat was crossing the bar, it was caught by a large breaking swell and capsized. Mr Lesoa and his friend were thrown into the water. His friend surfaced with the aid of the lifejacket and was rescued by the other boat. A ‘May Day’ call was made to advise authorities of the incident. The friends in the second boat searched for Mr Lesoa without success.

Mr Lesoa’s body was found on 18 April 2015 at the water’s edge of the Kingswood Terrace Reserve in Hillsborough.

### COMMENTS OF CORONER GREIG

- I. An important lesson from Mr Lesoa’s untimely death is that crossing a bar can be dangerous and that skippers need to be well prepared and mindful of the risks. Maritime NZ has advised that all bars should be treated with respect - that there is no such thing as a “safe bar”.
- II. Although Manukau Bar is considered particularly challenging because of its size and complexity, Maritime NZ has advised that it does not have any key safety messages specific to the Manukau Bar. Rather, the information it provides on the Maritime NZ website, including its recommendations and the Code of Practice for bar crossings apply particularly to skippers wishing to cross the Manukau Bar.

### RECOMMENDATIONS OF CORONER GREIG

I. that skippers of recreational boats familiarise themselves with the information and advice provided on the Maritime NZ website in relation to bar crossings, including:

- general advice at <https://www.maritimenz.govt.nz/recreational/safety/crossing-the-bar.asp>;
- and
- the Maritime NZ National Code of Practice for Bar Crossing Boat Notice – 10/2001 November <https://www.maritimenz.govt.nz/commercial/safety/safety-updates/marine-notices/documents/mnz-boat-notice-102001-november.pdf>

prior to undertaking any bar crossing.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Mr Lesoa entered into evidence upon the grounds of personal privacy and decency.

## De Jong [2018] NZCorC 72 (5 September 2018)

### CIRCUMSTANCES

Rachael Louise De Jong died on 6 February 2017 at Taupo of drowning.

At about 11am on 6 February 2017, Rachael De Jong had gone to Aratiatia Dam, near Taupo, with 6 others. They were swimming in an area of the Waikato River, known as the Aratiatia Rapids, when the dam flood gates were opened at the scheduled time of 12pm.

The Aratiatia Rapids form part of the Dam spillway. The Aratiatia Rapids are a popular tourist attraction and the Dam is required to open four times a day during summer as a “tourist spill”. Before the opening of the Dam, a siren would warn at regular intervals.

Members of the group that Rachael was with had heard the siren before the Dam was opened. After it opened,

rapids approached the group. Some of the group who were on a small rock in the middle of the rapids were swept downstream. Rachael attempted to help another member of her group by jumping into the water. Sadly, she drowned.

### COMMENTS OF CORONER WALLACE BAIN

I. This is indeed a tragic accident. The Court agrees with Rachael’s father, Mr Kevin De Jong, that this Inquest is not to apportion blame as no one meant this to happen, but it is to try and help prevent another tragedy.

The authorities in charge of the area have taken significant steps with signage and blocking access.

II. In the Court’s view, matters could go further with more explicit signage, consideration to trying to have swimming prohibited and making that very clear.

III. Also, there could be a physical check of the area before water is released and the use of a drone could be considered. Mercury advises that this is being considered, but they need to look at the practicalities of it.

These are comments on the basis of the evidence before the Court.

### RECOMMENDATIONS OF CORONER WALLACE BAIN

To: the Minister of Conservation; Mercury Energy; Department of Conservation; and Waikato Regional Council

The Court **strongly recommends**:

I. That the appropriate groups associated with the administration of the Aratiatia Dam Rapids and surrounding scenic reserve, which appear to the Court to be Mercury Energy, Department of Conservation and the Waikato Regional Council, urgently meet to consider how to

implement a total prohibition on swimming in the area whilst “tourist spills” continue.

It is noted from the submissions that this recommendation is strongly supported.

It is clear to the Court, that a tragedy similar to this is likely to occur in the future despite the presence of signs and sirens and other measures. If the group that were caught on this occasion were not able to sense the imminent danger with all that was then in place, then it is clearly possible that this could occur again, especially as it is a tourist area.

- II. That consideration be given to whether legislative change is necessary to enable a total prohibition of swimming in the area.
- III. That consideration also be given to implementing a system of inspection of the area before any “tourist spills” are released. That may well involve new technology in the use of a drone.

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

## Motor-vehicle

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### Scott [2018] NZCorC 58 (9 July 2018)

#### CIRCUMSTANCES

Alethea Maureen Scott died on 29 April 2016 at Christchurch Hospital from complications of multiple traumatic injuries sustained when she was struck by a motorcycle while attempting to cross State Highway 6 on 14 April 2016.

On the evening of 14 April 2016, Mrs Scott and her husband were attempting to cross to the seaward side of State Highway 6 near the intersection with Bay View Road. Mr and Mrs Scott were unwise to attempt to cross where and when they did. Their failure to identify oncoming traffic in the north and southbound lanes was likely due to inadvertence, and perhaps light conditions affecting their view.

She was struck by an oncoming motorcycle at or about the fog line at the edge of the northbound lane. The motorcyclist was unable to avoid the collision. No means of avoiding the collision were reasonably available to him and there was no evidence of inattention on his part.

Mrs Scott suffered several injuries and was transported to Nelson Hospital. She was later transferred to Christchurch Hospital given the seriousness of her injuries where she later died due to the complications of the multiple injuries sustained in the collision.

#### COMMENTS OF CORONER D P ROBINSON

- I. During the hearing I expressed some surprise that the Serious Crash Unit was not required to attend accidents involving serious injury. Attendance was only mandatory in relation to fatal accidents. Police may wish to reflect on the existing policy, noting the preference for the “best evidence” to be available, whether that be for criminal, or other jurisdictions. As this matter has demonstrated there is always the potential for a significant degree of variation between the evidence of eyewitnesses to the same event.

Some confusion appeared to exist as to the understanding by police of ambulance “status codes”. To the extent that such codes are relied upon by police in determining whether to involve the Serious Crash Unit, such codes should be properly understood. Mrs Scott was assessed as “status two”, recognising a condition posing a potential threat to life. The initial decision making around Serious Crash Unit involvement appears to have been based on an assumption that the injuries were survivable.

Of the witnesses who saw, or were involved in the collision, only Mr West was taken back to the scene. That appears to have been due to circumstances beyond Senior Constable Burbery's control. Certainly the fact that Mr Scott was not afforded the opportunity to return to the scene earlier was a source of much frustration. His presence at the scene could have allowed Senior Constable Burbery to report more comprehensively by assessing the route taken as reported by Mr Scott and such other matters as the point of impact, and his perception of the position of the approaching traffic. It would also have been appropriate for Mrs Scott, Mr Grant and Mr De La Cour to have been given the opportunity to identify the relevant points for the analyst.

It cannot be definitively said that the attendance of such witnesses at the scene would have influenced the analyst's findings, but it would least have given him an opportunity to be as fully informed as possible when reaching conclusions as to the likely scenario.

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

## **Edwards-Rendell [2018] NZCorC 67 (28 August 2018)**

### **CIRCUMSTANCES**

Te Mana Mauri Moroni Edwards-Rendell of Paeroa died on 19 May 2017 at Waerenga Road, Waerenga of a transection of his upper cervical spine as a result of fracture and dislocation of his C1/C2 vertebrae sustained in a motor vehicle collision.

At around 3:50 p.m. on 19 May 2017 Te Mana was a passenger, seated in the rear of a vehicle in a child car seat. The vehicle he was in was travelling west on Waerenga Road, Waerenga, when it crossed the centre

line and into the path of a vehicle travelling east on the same road. A head-on collision occurred between the two vehicles which resulted in Te Mana suffering fatal injuries and he died at the scene.

The car was being driven by Te Mana's father, Jay Ikinofu-Edwards. He was found to have THC, the active ingredient of cannabis, and methamphetamine in his blood. Those drugs, in combination with fatigue, were the likely cause of him driving on the wrong side of the road. He was prosecuted for causing Te Mana's death by driving carelessly while under the influence of a drug.

Te Mana was 10 months old and positioned in a forward-facing child seat. The child car seat was buckled in but not anchored. The injuries sustained by Te Mana were transection of his upper cervical spine as a result of fracture and dislocation of his C1/C2 vertebrae. These injuries resulted from Te Mana's head being thrown forward in the sudden impact of a head-on collision. Child car seats that are configured to be rear facing enables the impact of such a collision on a child's head and neck to be mitigated by the car seat providing a support and barrier to the forward momentum suffered by a child's head and neck in a collision.

The New Zealand Transport Agency (NZTA) recommend that any child under nine kilograms or under one year of age be seated in a rear facing child car seat. This is not currently a legal requirement.

### **RECOMMENDATIONS OF CORONER M ROBB**

The writer of the Serious Crash Unit report identified the causes and contributing factors in the collision and as a consequence, Te Mana's death, which support the making of a number of recommendations. I accept and adopt the recommendations set out below:

- I. Continued education and enforcement in respect of the dangers of driving while distracted and/or fatigued and while under the influence of drugs, and
- II. Continued education on the NZTA recommendation that infants under nine kilograms in weight or younger than 12 months

of age be secured in rearward facing child car seats.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Te Mana Mauri Moroni Edwards-Rendell, following his death, in the interests of decency.

## Zehner [2018] NZCorC 71 (28 August 2018)

### CIRCUMSTANCES

Arnold Alfred Zehner of Germany died on 11 December 2017 at Tauweru, Masterton of head injuries sustained in a motorcycle incident.

Mr Zehner was a 35-year-old German citizen and resident. He was holidaying in New Zealand at the time of his death. In the morning of 11 December 2017, he borrowed a motorcycle from a couple who were staying in a motor camp where he was staying. He began riding along the Highway between Castlepoint and Masterton.

There was a collision between Mr Zehner, on the motorcycle and a truck travelling in the opposite direction. Mr Zehner was travelling on the wrong side of the road and collided with the truck after a corner. Sergeant Peter Sowter conducted a serious crash investigation. No faults with the truck or the motorcycle contributed to the collision and a number of reasons were postulated for why Mr Zehner was travelling in the wrong lane. The collision was likely caused by Mr Zehner's unfamiliarity with driving in the left lane in New Zealand, and that he reverted to driving in the right lane, as was correct in Germany.

### RECOMMENDATIONS ENDORSED BY CORONER T SCOTT

- I. Sergeant Sowter made a recommendation and I endorse that. His recommendation was that lane arrows should be painted on either side of intersections or accesses to

rest areas, viewing points and other tourist destinations and at one lane bridges likely to be used by tourists. He said that these arrows were common on State Highway 2 in the Wairarapa – where Masterton and Castlepoint are situated. I can confirm this having recently driven between Palmerston North and Masterton. Sergeant Sowter however said that as far as he was aware there were no such lane marking painted on the Masterton Castlepoint Road. He referred to these markings as relatively cheap and already extensively used throughout New Zealand.

The purpose of lane markings – directional arrows painted in the lane and in the direction of travel are to remind overseas visitors who come from a right-hand drive jurisdiction that they are required to drive on the left-hand side of roadways in New Zealand.

## Carrie [2018] NZCorC 75 (27 September 2018)

### CIRCUMSTANCES

Jacqueline Bridget Carrie of Tangimoana died on 15 December 2017 at the intersection of Tangimoana Road and Taylor Road, Tangimoana of multiple injuries sustained in a motor vehicle crash.

The intersection of Taylor Road and Tangimoana Road was controlled by a 'give way' sign. Mrs Carrie's car was struck by another vehicle as she pulled out from Taylor Road on to Tangimoana Road. Neither vehicle was speeding, nor was alcohol involved. There was no clear indication as to why Mrs Carrie pulled out in front of the other vehicle.

### RECOMMENDATIONS OF CORONER T SCOTT

- I. Jacqueline's family has suggested that give way signage should be replaced with stop signage. My first thoughts about this were that

such a recommendation would not achieve much. I thought this because a give way sign did require Jacqueline to stop to yield the right away to Scott's vehicle and therefore in reality the signage whether it is a stop or a give way was essentially the same.

On further reflection however, I accept that – although some drivers do not stop for stop signs – the presence of a stop sign rather than a give way sign would probably cause most drivers to stop and it would definitely be an indication that very special care needed to be taken at the intersection.

A provision of a stop sign at this intersection might add a very small amount of time to a journey along Taylor Road but such an inconvenience is of no significance when compared with the possibility of saving a life or saving someone from extreme harm or financial cost.

I have therefore recommended to the local authority – The Manawatu District Council and to the New Zealand Land Transport Association that a consideration be given to replacing the give way signage at the intersection with stop signage – and the Council has agreed to do so.

On 16 August 2017 Andrew Brian McAllister was with some associates at 18 Fairview Terrace, Taupo. After smoking synthetic cannabis Mr McAllister collapsed onto the floor of the dining room. As this was not an unusual occurrence, Mr McAllister was not immediately attended to by his associates, as he was expected to recover. When it was realised that Mr McAllister was not recovering, emergency services were called.

Mr McAllister was not breathing. He was revived and transported to Taupo Hospital. After being stabilised, Mr McAllister was transferred to Waikato Hospital. Mr McAllister did not recover consciousness and continued to deteriorate. He died at Waikato Hospital on 17 August 2017.

Post-mortem toxicology testing revealed the presence of the synthetic cannabinoids, AMB-FUBINACA and 5F-ADB, in Mr McAllister's blood, along with alcohol, rocuronium, lignocaine and acetone.

#### COMMENTS OF CORONER G MATENGA

- I. In order to prevent future deaths from synthetic cannabinoids Dr Quigley [an expert appointed to assist the coroner] suggested that an all-encompassing harm reduction approach which reduces demand, supply and easy access to treatment for those seeking assistance should be developed. He cautioned that any recommendations on increasing enforcement, targets manufacture, trafficking and supply, while not overly penalising users as this can create a barrier to those seeking medical attention, even in cases of emergency. I agree with Dr Quigley, however I am unable to make any recommendations in this regard, as I have not heard any evidence. I am aware however, that Coroner McDowell is conducting a joint inquiry into deaths from synthetic cannabis which occurred in Auckland. I will refer this suggestion to Coroner McDowell to consider in the course of her joint inquiry. No recommendations will be made by me.

## Drugs

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### McAllister [2018] NZCorC 57 (4 July 2018)

#### CIRCUMSTANCES

Andrew Brian McAllister of Taupo died on 17 August 2017 at Waikato Hospital, Hamilton of severe hypoxic brain injury following a cardiac arrhythmia. The cardiac arrhythmia was caused by the consumption of synthetic cannabis products. Ethanol intoxication was a contributing factor

Dr Quigley submitted that efforts should be made to inform users of synthetic cannabis, their families and associates, of the dangers of synthetic cannabinoids and the need to get help immediately if someone collapses. I agree.

Dr Quigley's advice for the families or associates of synthetic cannabis users was that if a person who has used synthetic cannabis collapses, that person should be immediately shaken to attempt to rouse that person. If the person rouses, that person should then be placed in the recovery position and a call for help should be made. If the person does not rouse, then call for help and commence chest compressions. The calltaker who answers the emergency call for help will provide assistance. Do not delay.

I endorse Dr Quigley's advice.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Mr McAlister following his death in the interests of decency. Also prohibited are the names and identifying particulars of all witnesses who gave evidence at the inquest, except for Detective Sergeant Andrew Livingstone, Dr Paul Quigley and Mr McAlister's mother, on the grounds of personal privacy and in the interests of justice.

## Cooney [2018] NZCorC 59 (16 July 2018)

### CIRCUMSTANCES

Trevor Thomas Cooney died between 18 and 19 June 2015 at his home at Flat 12, 141 Kaikorai Valley Road, Dunedin from the effects of carbon monoxide poisoning due to a faulty portable gas heater.

On 18 June 2015, Mr Cooney's landlord, Mr Bruce Johnson, went to Mr Cooney's address to collect his rent. Mr Cooney was aware he was coming but did not answer

the door when he knocked. Mr Johnson found Mr Cooney lying on his bed and appeared to be sleeping. He walked over to him, yelled out and touched his leg, which was warm. The room was also warm. Mr Johnson left and said he did not think much about it because it was normal behaviour for Mr Cooney.

The following day, Mr Johnson returned to Mr Cooney's address, with Ms Johnson, and knocked on the door again. Ms Johnson noticed an overpowering smell of gas.

Mr and Ms Johnson and another resident went inside and saw Mr Cooney lying on his bed. Mr Johnson said Mr Cooney was in the same position as on the previous morning, and in the same clothes. The Johnsons called emergency services and turned off a portable gas heater.

The gas heater was assessed and it was shown to have a faulty thermoelectric flame failure device rectifier, which caused the gas to flow with or without a flame, as well as always burning on full heat.

### COMMENTS OF CORONER A TUTTON

- I. Energy Safety is the government agency responsible for providing an effective investigation, compliance, enforcement, and conformance regime for achieving electrical and gas safety outcomes.

On its website, Energy Safety records the need for special care when using portable, unflued gas heaters, and lists a number of instructions for their safe use. Among those are the following:

- a. **Test your connections (cabinet heaters):** After securely connecting a new or refilled cylinder, apply soapy water to the cylinder connections and turn on the cylinder. If bubbles appear you have a leak. Close the valve and either call an LPG service agent or take the heater to the agent; and

- b. **Get a check-up:** Get your heater checked and serviced before winter every year by a service agent so you know it is in a safe condition for winter.

Such steps may have revealed the fault in the heater used by Mr Cooney and thereby prevented his death.

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

## Elmes [2018] NZCorC 69 (19 September 2018)

### CIRCUMSTANCES

Grant Phillip Elmes of Highland Park, Auckland died on 6 March 2018 at his home of toxic megacolon on a background of clozapine use.

Mr Elmes had been diagnosed with schizophrenia and he had been prescribed clozapine which was effective in controlling it. Mr Elmes doctor had contact with him usually four times a year. His doctor would discuss clozapine's potential side-effects at these consultations. He would ask his patients about constipation and always advise them that, if they had problems lasting more than two to three days, they should seek medical advice. Mr Elmes did not report signs of serious complications during these consultations.

On 5 March 2018, Mr Elmes complained of a sore stomach. He also had diarrhoea and was vomiting in the morning. His condition worsened and he collapsed. Emergency services were called but he was unable to be revived. A post-mortem examination of Mr Elmes revealed that he had toxic megacolon and that, by

excluding other causes, the underlying cause of the toxic megacolon may be due to the use of clozapine.

### COMMENTS OF CHIEF CORONER, JUDGE D MARSHALL

- I. A New Zealand study<sup>1</sup> (the study) reported that for every thousand patients treated with clozapine, 300 to 600 will suffer constipation and at least four will develop serious gastrointestinal complications (including ileus, bowel obstruction, bowel ischaemia or necrosis), from which one will die. The study refers to this side-effect spectrum as "clozapine induced gastrointestinal hyper motility" (CIGH).

Key findings in the study are summarised as follows:

- (a). the passage of contents through the gastrointestinal tract (colonic transit times) took on average four times longer in clozapine treated patients than other people, with 80 percent of clozapine treated patients exhibiting clear hypo motility;
- (b). clozapine treated patients displayed this pattern of hypo motility independent of age, ethnicity, gender and duration of clozapine treatment;
- (c). Higher clozapine serum levels were associated with longer transit times;
- (d). subjective reporting of constipation symptoms had low sensitivity in predicting hypo motility.

<sup>1</sup> Every-Palmer, S., et al., Clozapine-treated Patients Have Marked Gastrointestinal Hypomotility, the Probable Basis of

Life threatening Gastrointestinal COMP..., EBIOMedicine (2016).

In a follow-up study<sup>2</sup>, the authors recommended that bowel function be carefully monitored in clozapine users and that prophylactic laxatives be considered for all clozapine users.

Dr Djurkov advises that he was familiar with the seriousness of gastrointestinal hypo motility caused by clozapine and its fatal complication of toxic megacolon. That is why the first question he asks when talking to a patient on clozapine is about constipation. He advises that he is also aware of the work of Dr Every-Palmer. His approach is not to prescribe stimulant laxatives routinely for patients on clozapine. The prescribing reference book "MIMS NZ" advises that stimulant laxatives are not to be used for prolonged periods as one of the adverse effects is atonic colon, meaning the large bowel become less active and slow and that potentially complicates the constipation.

In addition, toxic megacolon does not usually present with acute symptoms and before acute deterioration there are typically warning symptoms and signs for at least a few days, including change in bowel routine that should prompt medical assessment.

Dr Djurkov refers to the minutes of the Gastrointestinal Subcommittee of the Pharmacology and Therapeutics Advisory Committee held on 28 March 2017. The subcommittee recommended that the special authority criteria for macrogol 3350 be amended to include first-line use to prevent constipation in patients receiving clozapine with a high priority. He would consider using macrogol as prophylaxis given that there are

reports that it has been used long-term in disorders like Parkinson's disease.

CMDHB has reviewed its clozapine guideline for clinicians. The revised guideline requires prophylactic treatment with stimulant laxatives while a patient is on clozapine.

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

## Aviation

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### Letham [2018] NZCorC 65 (6 August 2018)

#### CIRCUMSTANCES

Benjamin Thomas Gould Letham died on 22 April 2017 at the Queenstown Primary School, when he became entrapped in his paraglider and fell to his death.

Mr Letham was 26-years old, and a highly skilled, capable, and talented commercial paraglider pilot. He had amassed well over 300 flight hours, and more than 2000 jumps, and had been working for a local paragliding company in Queenstown for three years.

On 22 April 2017, Mr Letham was rostered on duty. The morning was quiet and, in accordance with company policy, he was able to go off duty to undertake solo recreational flying. Mr Letham took off from a designated area on Bob's Peak above Queenstown, intending to land in the Queenstown Primary School grounds.

<sup>2</sup> Every-Palmer, S., et al, Clozapine Induced Gastrointestinal Hypomotility: A 22 year Bi-National Pharmacovigilance

Study of Serious or Fatal..., DOI10.1007/s40263-017-0448-6.

During his flight, Mr Letham undertook a number of 'infinity loops' – an aerobatic manoeuvre where the pilot rotates themselves and the canopy around a horizontal axis, as if somersaulting. Mr Letham successfully carried out seven loops, but on the eighth he lost momentum and fell into his paraglider's canopy. He became trapped in the canopy which caused it to collapse. Due to his proximity to the ground, Mr Letham could neither escape nor deploy a reserve parachute. Mr Letham died immediately from his injuries when he impacted on the ground.

### RECOMMENDATIONS OF CORONER D P ROBINSON

To: New Zealand Hang Gliding and Parachute Association

I adopt the recommendation of the Civil Aviation Authority:

1. Aerobatic flights should be conducted at a height above ground at which a pilot can manage an in-flight emergency and recover the aircraft. A pre-flight assessment of the manoeuvres to be carried out, and the amount to be conducted, could be discussed with peers to provide an objective risk assessment. During the manoeuvres, pilots need to maintain an appropriate level of situational awareness of their surroundings, to ensure a suitable safety margin is maintained.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs or videos on the grounds of personal privacy and decency.

## Andrews [2018] NZCorC 73 (24 September 2018)

### CIRCUMSTANCES

William Bruce Andrews of Te Anau died on 15 December 2013 at Gladeburn Valley, Fiordland of massive traumatic injuries sustained when the helicopter he was piloting crashed into mountainous terrain.

On 15 December 2013, Mr Andrews had been piloting a helicopter as part of his employment. He had been ferrying some passengers from Milford Sound Aerodrome to Rat Point. He departed at 3.48pm. During the flight, Mr Andrews had been radioed about an injured Department of Conservation worker that was needing to be picked up at Dumpling Hut. Mr Andrews landed at Rat Point at 4.46pm. At 4.55pm, he made a position and intentions radio call stating that he was in the Greenstone Valley heading to Dumpling Hut and that he was the only person on board the helicopter.

Mr Andrews colleagues had become worried when he had not returned around 5.30pm. A search was later commenced, and a crash site was located later in the night. The Civil Aviation Authority (CAA) investigated the helicopter crash. No faults with the helicopter were identified.

In the day of 15 December, Mr Andrews' colleagues had noticed he was limping and he had discussed with them that there was an issue with his leg and ankle. Experts were unable to determine whether Mr Andrews had suffered a mid-air ophthalmic event or transient ischaemic attack. Mr Andrews' leg and ankle pain, whether caused by a deep vein thrombosis without pulmonary embolism, or some other aetiology, may potentially have been sufficient to cause him acute discomfort and distraction while he was flying.

It could not be determined, retrospectively, whether Mr Andrews was eligible for the issue of an aviation medical certificate when he was last assessed, or whether he was medically fit to fly at the time of the crash. However, applying the low threshold for reporting medical conditions, his leg and ankle symptoms were likely sufficient to provide reasonable grounds to suspect a medical condition that had the potential to interfere with safe flying. On that basis, Mr Andrews would have been obligated to report the change to the Director of CAA as soon as was practicable, and refrain from piloting further flights until further investigation of his symptoms had been completed.

The meteorological conditions in Gladeburn Valley could not be reliably ascertained. The degree of cloud present

while Mr Andrews was flying there can only be speculated. There is evidence that Mr Andrews breached rules by flying less than the minimum flying height of 500 feet. This appears to include the last saddle crossed by Mr Andrews before the crash. However, it was not shown that Mr Andrews' conscious manner of operation of the helicopter within Gladeburn Valley contributed to the helicopter crash.

On the available evidence, it is impossible to discern whether the potential causative factors identified operated individually in isolation, or together in combination. Mr Andrews inadvertent entry into cloud cannot be elevated to the status of being the predominant cause.

### RECOMMENDATIONS OF CORONER B WINDLEY

To: The Director of the CAA and the Secretary for Transport

- I. The **Director of the CAA and the Secretary for Transport** ensure their respective agencies work collaboratively, and as a matter of priority, to:
  - a. continue the work begun by the CAA in developing, delivering and ensuring ready access to information and education for both medical practitioners and licence holders, which is capable of being easily understood and applied and makes clear the respective responsibilities, thresholds, and pathways for reporting under section 27C [of the Civil Aviation Act 1990];

<sup>3</sup> Medical Information Sheet 'You Must Advise the CAA' (MIS 004 2014 with a revision date of 12/2017) is available at <https://www.caa.govt.nz/medical/medical-home/> under the heading 'Reporting Changes in Medical Conditions'.

- b. consider whether there is a case for statutory amendment to widen the scope of the reporting obligation under section 27C(3) to include optometrists;
- c. continue to progress the cost/benefit analysis of [Helicopter Flight Data Management] HFDM with a view to determining whether to mandate fitment of such in all helicopters pursuant to a rule amendment.

### RESPONSE TO RECOMMENDATIONS

Prior to finalising my recommendation, both the CAA and the Secretary for Transport were consulted in relation to the recommendations I proposed. The CAA, through its Chief Legal Counsel, advised it considered the recommendations appropriate in light of the evidence it heard at inquest. The CAA's Chief Legal Counsel also helpfully provided an update on various work relevant to the recommendations, which I reproduce (other than references to Appendices) below:

#### I. Recommendation as to s.27C of the Civil Aviation Act 1990

The CAA has, in response to the TAIC recommendation referred to in paragraph 233 of the Coroner's proposed recommendations, done the following:

1. A Medical Information Sheet, detailing reporting obligations under s.27C, has been published.<sup>3</sup>
2. A Medical Information Sheet for health professionals other than medical professionals has been completed and uploaded onto the CAA's website.<sup>4</sup> This complements an

<sup>4</sup> Medical Information Sheet 'Health Practitioner Obligations' (MIS 002b with a revision date of 02/2018) is available at <https://www.caa.govt.nz/medical/med-info-sheets-2/>. This MIS provides advice for health professionals (including optometrists) who have no statutory reporting

existing Medical Information Sheet for medical professionals;

3. The front page of the medical section of the CAA website has been updated to include a section titled "Reporting Changes or Concerns", with added links to relevant Medical Information Sheets;<sup>5</sup>
4. Information has been sent to District Health Boards, the Accident Compensation Corporation, various medical colleges (for example, the Royal Australasian College of Physicians) and medical associations (for example, the New Zealand Medical Association ("NZMA")) explaining the obligations under s.27C. As a result of that work, the NZMA published information on legal obligations affecting medical practitioners in its February 2018 newsletter.<sup>6</sup>
5. An "Issues Assessment" paper, reviewing current policy surrounding requirements to request and review GP notes has been prepared.

Other work, including the creation of a video explaining the s.27C obligations, intended for uploading to the CAA website and wider distribution, is currently underway.

## II. Recommendation as to s.27C(3)

Along with other aviation-related legislation, the Ministry of Transport has undertaken a review of the Civil Aviation Act 1990 to ensure that it is fit for purpose, given the significant changes within the public sector and aviation environment during the Act's lifespan. A Bill is currently being drafted to give effect to the policy decisions made as part of that review.

obligation but have concerns about a pilot or air traffic controller's medical condition which may compromise public safety.

<sup>5</sup> See <https://www.caa.govt.nz/medical/medical-home/>

The Ministry of Transport has considered the reporting provisions as part of its work on the Bill. However, I understand that the Ministry is not recommending any changes to this provision at this time. Interested parties will have a chance to make submissions on the Bill later in the process.

## III. Recommendation as to HFDM

The CAA has established a working group, comprising members of its Helicopter Flight Operations, Intelligence Safety and Regulatory Analysis, Airworthiness, Safety Investigation and Legal units. In addition, the Ministry of Transport is represented in the working group.

The working group has produced a project initiation document, which sets out the major tasks, objectives and risks of the project. Once the cost-benefit analysis is complete, it will be used to inform the development of options for promoting the use of HFDM devices in small helicopters. One of the options for achieving this outcome would be mandatory fitment under the Civil Aviation Rules.

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

<sup>6</sup> See

[https://www.nzma.org.nz/\\_\\_data/assets/pdf\\_file/0020/80039/vitalsigns905.pdf](https://www.nzma.org.nz/__data/assets/pdf_file/0020/80039/vitalsigns905.pdf)

# Self-inflicted

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## Adams [2018] NZCorC 60 (19 July 2018)

### CIRCUMSTANCES

Graham Adams of Christchurch died of self-inflicted injuries while on leave from Hillmorton Hospital.

### RECOMMENDATIONS OF CORONER D P ROBINSON

To: Canterbury District Health Board [CDHB]

- I. I recommend CDHB revise its procedures as to the granting of leave to provide for:
  - (a) Detention by a nurse (if necessary) following a request for leave in order that the patient be assessed by a clinician before the approval of leave;
  - (b) A process for the re-evaluation of leave decisions by a clinician to take into account matters occurring subsequent to the leave decision;
  - (c) Specific identification staff who may make a final decision as to leave (being suitable qualified and experienced to do so);
  - (d) Handover to the Crisis Resolution Team of patients granted leave, specific as to:
    - (i) Medication during leave;
    - (ii) Conditions of leave;
    - (iii) Involvement of family / friends;
    - (iv) Extent of contact by C R Team (i.e. time of first visit and frequency thereafter, extent and regulatory of telephone contact).

- (v) Follow up in the event of failed telephone contact

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

Note: Pursuant to section 71 of the Coroners Act 2006, without the authority of a coroner, publication of any particulars of Mr Adams' death, other than his name, address and occupation and the fact that his death has been found to have been self-inflicted is prohibited.

## Day [2018] NZCorC 66 (7 August 2018)

### CIRCUMSTANCES

Karen Michelle Day of Taneatua died on 9 October 2016 at Tauranga Hospital from self-inflicted injuries, in circumstances amounting to suicide.

On the evening of Monday, 26 September 2016, Karen Day left her home in Taneatua during a family dinner. She drove her vehicle to Whakatane where her husband, Barry Sykes, was staying with his mother. Barry and Karen had recently separated.

By about 9.50pm, Karen began sending text messages indicating that she was going to take her own life. Barry drove to the Whakatane Police Station, reported that Karen was suicidal and showed the police the text exchanges on his telephone. By that time, the police had received a report from Lifeline.

Karen had telephoned Lifeline at 8.45pm in a distressed state saying that she wanted to die, before ending the call. Lifeline had been unable to contact Karen by telephone afterwards which had led Lifeline to try and contact Karen's family and the police.

Karen engaged in multiple text messages with her son and daughter and other family members where she explained that she had made the decision to end her life despite their wishes that she not do so. At 11.15pm, she

said she was switching her phone off and no further telephone calls or text messages were responded to by Karen from that time.

Barry left the police station to search for Karen. Barry saw Karen, driving slowly towards him, before she recognised him and drove away at speed. Barry followed her until a police vehicle arrived and began following her.

Karen did not stop for the police sirens and flashing lights and road spikes were used to damage Karen's tyres eventually leading her to stop her vehicle. She was placed in a police vehicle.

Once Karen was placed in the police vehicle, she was asked a series of questions by the police officer and she confirmed that she was intent on ending her life and wished to be asleep forever. She inferred that she had not stopped for the flashing lights as she thought it was an ambulance pursuing her.

Karen was taken to the Whakatane Police Station and contact was made with the on-call mental health services, leading to the on-duty nurse attending at the police station and undertaking a mental health assessment of her. The nurse assessing Karen received only limited information to assess her. Further useful information, such as the content of the explicit text messages and of police notebooks, could potentially have been available from police and some would only have been available through the interview of Karen's family members.

Karen was unwilling to be voluntarily admitted into the Whakatane Hospital for mental health care, and a decision was made that Karen did not meet the criteria for compulsory treatment under the mental health legislation. She was taken home by her family just before 4 am. Family were advised how to care for her.

Karen was attended to the following day by a mental health nurse, and a further assessment was scheduled for the morning after but this did not occur due to an oversight. Karen's condition deteriorated and she was taken to Whakatane Hospital and later transferred to

Tauranga hospital. Despite medical efforts, her condition declined and she died.

#### COMMENTS OF CORONER M ROBB

- I. The task of assessing an individual with no prior mental health history in a time of crisis is difficult and is not capable of scientific mathematical determination. Individuals that are involved in direct contact with members of the public who are undergoing a crisis are involved in a difficult and taxing role which can have significant ramifications for members of the public. The role is also subject to retrospective analysis and criticism.

In analysing the circumstances of Karen's death and looking for any matter that may have reduced the risk of her death I understand that I have the benefit of a complete picture, the time to reflect and the benefit of drawing on a variety of sources of information and expert views.

An accurate mental health evaluation is dependent upon attaining and critically analysing the best available information. It is in the information gathering and sharing that I have identified the potential for improvements.

In identifying areas where information gathering and sharing can assist in a mental health crisis assessment I do not wish to discourage any professional from continuing in what I acknowledge is their important and difficult role.

- II. The police called for a psychiatric assessment of Karen but did not provide the attending nurse with information that may have assisted the nurse to carry out her assessment, and to better understand Karen's position and her resolve to commit suicide.

With no record of the text messages retained by the police nor provided to the

nurse, the detail of those recent communications from Karen could not be assessed by the nurse. With no copy of the arresting officer's notebook entry being provided to the nurse, the nurse was not made aware of Karen's confirmation to the police officer that she intended to commit suicide, wanted to be asleep forever, and was driving to escape what she thought was an ambulance.

- III. The information that Karen provided to [the nurse] about the events that led her to be in custody were inaccurate and misleading. Karen was a stranger to [the nurse], Karen's mental health history was not known to the nurse. Karen was upset in circumstances that were extraordinary for her. While the relationship between [the nurse] and Karen was important, there was a need to corroborate Karen's account. There was an opportunity to check Karen's account of the events, to check with family and the police whether Karen was telling the truth, or the complete truth about those events. That would have assisted in determining whether Karen and the account that she gave was reliable, and whether any assurances that Karen gave about ... keeping herself safe could be relied on.

The nurse could have asked family members to show her the text message exchanges with Karen. In that way, she could have evaluated for herself what was meant by the description that Karen was in "a dark place". Reading those text messages would have revealed the level of determination that Karen demonstrated in wanting to end her life. Reading those text messages would have revealed the fact that Karen was well aware of the love and support that she had from her family, and despite that "protective factor", she had made it clear that it was her decision to end her life and that her decision was firmly

made. That was a relevant consideration in determining if she was suffering from an abnormal state of mind, a disorder of mood or otherwise, and to better assess the risk that Karen posed to her own health or safety. Whether Karen's assurances that she was not at risk of self-harm could be relied on and whether her going home with her family was genuinely a protective factor could have been better evaluated if the nurse had more relevant information available to her.

A family may not appreciate the significance of the nature of the text messages but a mental health expert may detect a precise plan or firm intention to commit suicide despite protective factors, revealed in the text exchanges.

As earlier outlined, there is benefit in a three-source approach when assessing an individual in a psychiatric sense: looking to their previous psychiatric history if they had one; assessing the individual and the account that they give; and finally checking with other sources to determine whether the information conveyed by the individual was truthful or otherwise corroborated. Karen was a stranger to the mental health system and a stranger to [the nurse]. If Karen's account had been critically evaluated with a view to checking the accuracy of that information with other available sources, such as the family who were present and the information the police had available to them, it is possible that [the nurse] would have been more sceptical of what Karen told her and the assurances that she had been given.

If Karen had been assessed as requiring compulsory care in hospital that may have contributed to her chances of survival. However, I acknowledge as I have done

earlier, that even if Karen had been assessed as requiring compulsory care that may not have resulted in Karen receiving medical attention ... in time to save her life.

## RECOMMENDATIONS OF CORONER M ROBB

- I. To provide the best opportunity for an accurate assessment of an individual in custody at a police station, and to thereby reach the best determination as to whether compulsory mental health care or other medical treatment is appropriate in circumstances such as this, I recommend that:
  1. The police record in as much detail as possible all information provided by any family member or other interested party in respect of an individual suspected of being suicidal ...
  2. Where the police have called on the professional assistance of a service provider to undertake a mental health evaluation of an individual in their custody, that they provide as much detailed information as they have available to them about that individual and the circumstances that led them to be in custody.

In undertaking a mental health assessment, the information provided by the person being assessed be critically evaluated by reference to other sources of information, be it through the interview of family members, reviewing text messages, or seeking out information recorded by police officers directly involved with the individual.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Mrs Day, following her death, in the interests of decency.

Note: Pursuant to section 71 of the Coroners Act 2006, no person may make public the method or suspected

method of the self-inflicted death or any detail that suggests the method or any suspected method of death, without an exemption granted under section 71A or permission under section 72.

## Fall

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### Smith [2018] NZCorC 70 (24 August 2018)

#### CIRCUMSTANCES

Clinton Blake Smith died on 6 April 2017 at the Intensive Care Unit of Wellington Hospital of a traumatic brain injury caused by a fall while he was rock climbing.

On the morning of 3 April 2017, Mr Smith had travelled to the Charleston area on the West Coast of the South Island to rock climb. Mr Smith was climbing in a “free solo” manner. This meant he was climbing without ropes. And he was not wearing a helmet. While Mr Smith was climbing a cliff, he fell to the ground. He was transferred to Wellington Hospital where he later died.

Members of the Mountain Safety Council reviewed the incident. Their opinion was that it was not clear why Mr Smith fell while climbing, the area where he landed was hazardous as it was littered with boulders, that a helmet may have enabled Mr Smith to survive the fall, and that the use of a climbing rope would likely have prevented his death.

#### RECOMMENDATIONS ENDORSED BY CORONER D P ROBINSON

- I. I endorse the recommendation of the Mountain Safety Council [MSC]:

Free solo climbing is inherently dangerous and is not an activity that MSC would encourage people to participate in.

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

## Workplace

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### Brown [2018] NZCorC 74 (26 September 2018)

#### CIRCUMSTANCES

Douglas Russell Brown died on 1 March 2017 at Te Kauwhata of hypovolaemic shock due to traumatic abdominal injuries.

On 1 March 2017, Robert Douglas Brown was working on a rural property with his farm worker erecting post and wire fencing. They were using a hydraulic post-rammer which was attached to a tractor by a three-point linkage. At the end of the day's work, and while setting up to complete the final post ramming, the hitch pin came loose at the upper linkage point of the post-rammer, which in turn led to the mast coming loose and striking Mr Brown causing him unsurvivable injuries. Worksafe New Zealand undertook an investigation of the events.

The uppermost linkage that failed on this occasion had been secured by a hitch pin with a 19-millimetre diameter. This pin was located at the scene. The diameter of the upper linkage point was 28 millimetres. The hitch pin appears to have vibrated free or otherwise come free of the upper linkage point leading to the mast of the post-rammer suddenly swinging violently free.

#### RECOMMENDATIONS ENDORSED BY CORONER M ROBB

- I. The Worksafe investigation report identified practical steps to prevent accidents of this nature occurring in the future. Those steps were:
  1. Ensuring that the correct sized hitch pins were fitted (i.e. hitch pins that were no

less than 75 percent of the diameter of the linkage point hole),

2. Ensuring the hitch pins were fitted with locking pins to prevent them from vibrating free,
3. Ensuring that pre-start inspections were carried out by those using the equipment to ensure that the correct sized hitch pins were in place and were properly secured by locking pins.

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

## Aged care

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### Russo [2018] NZCorC 64 (25 July 2018)

#### CIRCUMSTANCES

Georgina Audrey Russo died on 17 February 2017 at Trevellyn Rest Home and Village (Trevellyn), where she lived, from undetermined causes likely of a cardiac nature.

Georgina Audrey Russo was a resident at Trevellyn Rest Home and Village (Trevellyn) in February 2017. During the night of 16 February 2017, and the early morning of 17 February 2017, staff at the rest home entered Mrs Russo's room as part of their rounds. They found Mrs Russo sleeping each time.

Mrs Russo suffered from diabetes and each morning at around 6 a.m. her blood sugar levels were checked. When the registered nurse (RN), Michelle De Leon, checked on Mrs Russo just before 6 a.m. on 17 February 2017 she found Mrs Russo unresponsive.

The RN activated the emergency assistance alarm for some seconds but then turned the alarm off and made her way to the nurses' station to check Mrs Russo's personal file to review her Advance Directive Form. Mrs Russo had signed the form confirming that she was for resuscitation. No Healthcare Assistants (HCA) had actively answered the emergency alarm by attending Mrs Russo's room, one reason being the short duration of the sounding of the alarm, and the fact that alarms were on occasion accidentally activated and quickly cancelled. The RN left the nurses' station and returned to Mrs Russo's room. The RN made a 111 telephone call at 6:05:50 a.m., nearly 10 minutes after the emergency alarm had been activated and then deactivated. In that call, the RN stated that she was calling for confirmation of a death. She carried out CPR on Mrs Russo while she remained on the bed. CPR was then stopped and the RN left the room to undertake telephone calls to more senior members of staff and, in due course, to Mrs Russo's family.

The RN who had attended on Mrs Russo was on the telephone when ambulance staff arrived. The two ambulance officers were not able to gain immediate entry into Trevellyn, and once within the building were not able to immediately examine Mrs Russo in her room.

On examining Mrs Russo, the ambulance officers' evidence was that they found her still warm to the touch. They raised concerns with the nurse as to why CPR was not being continued through to the time when the ambulance arrived. The responses from the RN about that issue, the timing of when the CPR was undertaken, the timing of the 111 telephone call, and the content of the information conveyed in the 111 telephone call, troubled the ambulance officers.

The ambulance officers evaluated the available information and considered that CPR had been stopped 15 or more minutes prior to their physical examination of Mrs Russo, and that the CPR was of poor quality due to the CPR being undertaken on the bed rather than on a firm surface. A decision was made that further attempts to resuscitate Mrs Russo should not be undertaken.

## COMMENTS OF CORONER M ROBB

- I. I considered the emergency care that Mrs Russo was provided when she was found unresponsive at Trevellyn was inadequate in the following ways:
  1. Mrs Russo was for resuscitation, CPR should have been undertaken immediately.
  2. HCAs should have been utilised to confirm the resuscitation instructions while CPR was being undertaken.
  3. The resuscitation instructions, the use of red heart stickers, needed to be regularly checked or otherwise audited.
  4. The RN and the HCAs should have worked together as a team to ensure that CPR was carried out on the floor by obtaining available equipment for that purpose, and working together to move Mrs Russo from the bed onto the floor.
  5. The RN and HCAs should have managed the 111 telephone call to ensure that effective CPR was able to be continued during the 111 call.
  6. The 111 telephone call should have conveyed an emergency situation requiring urgent dispatch of an ambulance under lights and siren.
  7. Staff at Trevellyn should have worked as a team to ensure that ambulance staff were given immediate access into Trevellyn and to the patient.
  8. CPR should have been performed until ambulance staff arrived.

I determine that the emergency care afforded to Mrs Russo fell short of best practice and

resulted in a reduced prospect of her surviving and as such amounted to circumstances constituting a contributing factor in her death.

Despite the HCA witnesses that I heard from at the Inquest having many years of experience as HCAs, and some training in CPR, no HCA witness had actively participated in an emergency situation carrying out CPR.

#### **RECOMMENDATIONS OF CORONER M ROBB**

I. I recommend training in real-life situations requiring nursing staff and HCA staff at Trevellyn being involved in practical exercises to ensure that they work as a team in an emergency. In particular to ensure that each member of the team understands:

- The importance of regular auditing of the red heart sticker resuscitation advice to ensure that there is in-room advice on resuscitation. I consider that this would ideally be checked and marked off as part of the handover sheet provided between duty nurses at handover;
- The need for immediate CPR where an individual is for resuscitation;
- The need to carry out CPR on a hard, flat surface;
- How to undertake a 111 telephone call which conveys the correct information;
- The need for continuous CPR until the ambulance arrives.]

Role-play training where the staff are required to work as a team: conducting CPR; making the 111 call; ensuring access for ambulance staff; and arranging how a patient can be moved from the bed to the floor, is a relatively straightforward practical training exercise to establish and carry out on a regular basis.

I have received advice from Oceania that a change in process at handover has now taken place. I note their advice that all residents who are for resuscitation (be they hospital or otherwise) are now listed on the handover sheet provided between duty nurses, not just those that are in the hospital wing. As earlier indicated I have also been advised of ongoing staff training in the need for CPR to be performed on a flat surface where possible, and the use of equipment such as transfer sliding boards/sheets to move residents to the floor.

II. I understand that RN De Leon no longer works at Trevellyn but I recommend that she undertake refresher training in emergency situations to ensure that if she is in a senior role where she is required to instruct other staff she can manage her team to ensure that CPR is carried out immediately, that the correct information is conveyed in the 111 telephone call, that arrangements are put in place to ensure that the patient's CPR is undertaken on a hard flat surface and that this continues until ambulance staff arrive.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Mrs Russo, following her death, in the interests of decency.



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