



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

# Recommendations Recap

A summary of coronial recommendations and comments  
made between **1 October** and **31 December 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 24 recommendations and/or comments issued by coroners between 1 October and 31 December 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 October to 31 December 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/>

## Earthquake

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### Edgar [2018] NZCorC 94 (29 November 2018)

#### CIRCUMSTANCES

Albert Louis Edgar of Kaikoura died on 14 November 2016 at home as a result of his house collapsing during an earthquake.

Mr Edgar lived with his wife, and his mother, at the Elms Homestead. The building was a two-storey villa built in the 1870s. The homestead was in a fair condition, but there had been some cracking, possibly as a consequence of previous seismic activity in the area. In 2007, the Elms Homestead was registered as an historic site under the Historic Places Act 1993.

At 12.02am, on 14 November 2016, a magnitude 7.8 earthquake struck Waiiau, North Canterbury. Around 11.45pm, Mr and Mrs Edgar went to bed, and shortly after they felt the start of the earthquake. Mrs Edgar got up to check on her mother-in-law but got thrown sideways and was able to get out of the house, before the top storey collapsed. Mr Edgar's body was later found in the rubble. He was on his knees, with a lot of

rubble covering his back, which suggests he was struck while trying to escape through the bedroom door.

The cause of Mr Edgar's death was crush injuries to the head and chest as a result of the house collapsing in an earthquake.

#### COMMENTS OF CORONER ELLIOTT

- I. Given that the issue of assessment and strengthening of potentially earthquake prone buildings has been the subject of recommendations by the Canterbury Earthquakes Royal Commission, and that these have been considered by MBIE, I will not make any recommendations.

However, in order to highlight the ongoing risk of injury or death posed by older unreinforced masonry buildings in an earthquake, and noting the need for information and education referred to by MBIE in its Report, I make the following comments pursuant to section 57A of the Coroners Act 2006:

Louis Edgar died on 14 November 2016 due to injuries he sustained when the Elms Homestead collapsed in the 7.8M Kaikoura earthquake. The building was a two-storey bay villa constructed in the 1870s with unreinforced concrete.

Mr Edgar's death highlights the dangers associated with the collapse of old buildings in an earthquake. The failure of such buildings resulted in the deaths of 39 people in the earthquake in Christchurch on 22 February 2011.

People who use and occupy buildings constructed of unreinforced masonry face the risk of injury or death in a large earthquake.

It is therefore advisable that the owners of unreinforced masonry residential buildings obtain a structural assessment of earthquake risk and strengthen the building where necessary.

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

## Drugs (synthetic)

### Coleman-Fallen [2018] NZCorC 81 (31 October 2018)

#### CIRCUMSTANCES

Shannon Coleman-Fallen died during the night of 16 September 2017 at home in Rotorua from asphyxiation due to aspiration of gastric contents and positional asphyxia, antecedent to consumption of synthetic drugs.

Shannon lived in Rotorua. During the afternoon of 16 September 2017, he left home in a van with another resident of his home and purchased synthetic drugs. Shannon and the other resident consumed the drugs, and drank alcohol, at a local park. Both men

subsequently struggled to stay awake, and fell asleep. When the other resident woke up, he noted Shannon was facedown in the back of the van lying on some building items. He spoke to Shannon and received a groan in response. He drove back to their home and told Shannon he was going inside to sleep. Shannon groaned in reply.

The following morning, the other resident went out to the van where he found Shannon, still in the back of the van and in the same position as when he had left. Shannon was lying on his front and, when he was lifted, there was vomit and other material on Shannon's face. The Coroner considered that Shannon's drug consumption led to him being so incapacitated that when he vomited this resulted in him asphyxiating.

#### COMMENTS OF CORONER ROBB

- I. The dangers of consuming synthetic drugs include:
  - a. It is promoted or sold as a form of synthetic cannabis, but that there is no cannabis in the product.
  - b. The synthetic drug can be made to look like cannabis by using dried plant or other material but it is saturated in a synthetic drug not THC (tetrahydrocannabinol) the active ingredient in cannabis.
  - c. The pharmaceutical agents from which synthetic cannabis was developed were attempts to create new medications to treat spasms and epilepsy but were found to be unsuitable and were discarded. The nature of the synthetic drug is unknown to the purchaser and unknown or poorly understood by the manufactures/distributors in New Zealand.
  - d. The synthetic drugs, AMB-FUBINACA and 5F-ADB, have been the cause or contributing factor in a number of

deaths in both the Waikato/BOP , elsewhere in New Zealand, and overseas .

- e. The quantity and strength of AMB-FUBINACA and 5F-ADB is an unknown gamble which can have fatal consequences.
- f. Individuals who fall unconscious after consumption of synthetic drugs can die if they do not receive timely and appropriate medical assistance; dying from cardiac event induced by consumption of the drug, or as a result of being comatose and asphyxiating on their own vomit, or they may suffer an hypoxic brain injury.

#### **RECOMMENDATIONS ENDORSED BY CORONER ROBB**

- I. In order to prevent future deaths from synthetic cannabinoids Dr Quigley 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.
- II. 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.

- III. 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.

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

## **Motor vehicle**

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### **Cronwright [2018] NZCorC 77 (23 October 2018)**

#### **CIRCUMSTANCES**

Margaret Lynne Cronwright died on 17 October 2017 at Waihi of multiple non-survivable injuries to the head and chest, as a result of a motor vehicle crash.

Mrs Cronwright was travelling east on State Highway 2 towards Waihi and towing a caravan. At the same time, a truck was coming the other way with a trailer. The inquiry shows that she has failed to keep left while negotiating a gentle left curve, colliding with the oncoming truck and trailer.

Weather at the time was fine and the road surface was dry. There were strong gusty winds and visibility was good. The police specialist traffic crash investigation unit

conducted a report. They found the road and roadsides had adequate road markings but noted there was no barrier protection. There were no vehicle mechanical issues. There was no issue of speed and there was no alcohol involved in the crash. The post mortem found no evidence to suggest a prior medical event. The specialist crash analysis report suggests the causative factor to be fatigue and/or inattention.

As a result of the collision, Mrs Cronwright received critical injuries and died at the scene.

### **RECOMMENDATIONS OF CORONER WALLACE BAIN**

It is noted that the traffic crash unit has raised some issues. Those are repeated below and it is directed that these Findings be forwarded to the appropriate authorities.

- I. There be a review whether the open road speed limit is appropriate for this environment.
- II. Installation of a physical median barrier or audio tactile profiles (rumble strips) at the centre road.
- III. In-vehicle lane recognition system.
- IV. Continued education for drivers around the dangers of fatigue, inattentive or distractive driving.

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

## **Singh [2018] NZCorC 86 (14 November 2018)**

### **CIRCUMSTANCES**

Harjeet Singh died on Sunday 6 March 2016, at the scene of a motor vehicle crash on Mullins Road near Papakura, from multiple blunt force injuries, the most severe being to the right chest, sustained in that motor vehicle crash.

On 6 March 2016, shortly after 9.30pm, Mr Singh turned from Papakura Clevedon Road onto Mullins Road. There had been resealing work done on Mullins Road that day and there was loose gravel on the left hand side of the road that had not been swept away. The roadworks were routine maintenance being undertaken by a contractor for Auckland Transport (AT). The road markings had not been reinstated and the area was under a temporary traffic management plan. Temporary traffic signs indicating a speed limit of 30km/hr were not in place on the route that Mr Singh took to Mullins Road.

Mr Singh lost control of his vehicle when it came into contact with this gravel while navigating a moderate right hand bend. In his attempt to regain control, he overcorrected and the vehicle spun before leaving the road and careering through a wooden farm fence into a paddock. A fence railing had punctured the driver's side door and struck Mr Singh on his right side. It caused fatal injuries to Mr Singh.

### **COMMENTS OF CORONER GREIG**

- I. As this case illustrates, road works - even those deemed to be "low risk routine maintenance works" by those responsible for them - pose potential risks for road users and temporary traffic management arrangements that comply fully with the Code of Practice for Temporary Traffic Management (CoPTTM) are an essential part of road safety at all roadworks. Those responsible for traffic management plan approval must be satisfied that there are appropriate processes in place and that traffic

management plans for all jobs (large or smaller) are appropriate and compliant with CoPPTM. Those implementing such plans must do so in accordance with the plans.

- II. In light of the work undertaken by Auckland Transport following the crash, and the strengthened processes it now has in place, I do not consider recommendations are required following this inquiry.
- III. A copy of these findings will be sent to the Chief Executives of all local Councils in New Zealand to raise awareness of the issues identified in these findings.

## RESPONSE OF AUCKLAND TRANSPORT TO COMMENTS

- I. A copy of these findings and my comment that those responsible for traffic management plan approval must be satisfied that there are appropriate processes in place and that traffic management plans for all jobs (large or smaller) are appropriate and compliant with CoPPTM was provided to AT for response.

AT responded with further information about the arrangements it now has in place with regard to the self-approval processes for low-risk work sites.

Specifically:

- AT provided all three contractors who had self-approval status with an updated scope of delegation document which specified that only low risk works on roads under 65 kilometres per hour could be the subject of self approval;
- AT implemented additional ongoing monitoring of self-approved traffic management plans. In 2017, two of the three contractors with self-approval authority were required to undertake

corrective action to their processes and outcomes;

- A follow up review in 2018 resulted in one of the three self-approval contractors having their self-approval status withdrawn for the foreseeable future;
- AT continues to monitor the two remaining contractors with self-approval status.

AT's Manager of Walking, Cycling and Safety, Kathryn King, stated that as a result of the self-approval process being more rigorously monitored, all contractors are planning and preparing traffic management plans to a higher standard.

Ms King also advised that AT has a number of checks in place in its temporary traffic management processes in general to ensure temporary traffic management plans are appropriate and compliant with CoPPTM. She stated that more than 40% of the total traffic management plan applications for work within the Auckland Transport road network are initially returned to the applicant for revision.

Ms King stated that in terms of assessing whether AT is satisfied that contractors are meeting their obligations, its on-site audits reveal that around 70-80% of all worksites are usually found to be satisfactory (meaning that they meet all key requirements and have all necessary controls in place, albeit with the possibility of some minor non-critical fault).

Ms King also stated that AT is working at both a local and national level to improve education, competence and a focus on better planning in order to achieve ongoing improvement in the implementation and management of temporary traffic management.

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

# Gillanders-Ryan [2018] NZCorC 87 (20 November 2018)

## CIRCUMSTANCES

Malcolm Fergus Gillanders-Ryan of Broadlands Forest, Taupo, died on 12 April 2017 on Broadlands Road near Taupo of multiple injuries sustained in a motor vehicle collision.

Mr Gillanders-Ryan had been diagnosed with Alzheimer's dementia in February 2017. Following this diagnosis, he was informed that he should not be driving, and Police were informed. As Mr Gillanders-Ryan gave no indication that he was going to drive, he was given the opportunity to surrender his licence voluntarily, before his GP made a notification to the New Zealand Transport Authority (NZTA) under section 18 of the Land Transport Act 1998.

However, Mr Gillanders-Ryan did not stop driving. On 12 April 2017 he and his wife drove into Taupo to pick up Mr Gillanders-Ryan's Holden Utility vehicle from the panel beater. Mr Gillanders-Ryan drove this vehicle back towards his home, followed by his wife in her car, along Broadlands Road. Near the intersection of Broadlands Road with Centennial Drive, Mr Gillanders-Ryan crossed the centreline, into the path of an oncoming vehicle. Mr Gillanders-Ryan sustained extensive injuries and died at the scene.

## RECOMMENDATIONS OF CORONER M ROBB

- I. Under section 18 of the Land Transport Act 1998 medical practitioners have an obligation to report to the NZTA any patient considered no longer fit to operate a motor vehicle, but only if the medical practitioner has formed the view that the patient would drive despite being told not to.

The reason for a direction not to drive is because the patient poses a risk on the road if

driving, be it a risk to themselves or to anybody else driving, riding, or otherwise on the road. It is difficult for a doctor to know whether a patient's assurances that they will not drive can be relied on. The removal of the ability to drive is a significant loss of independence and may be the subject of promises made that are subsequently not kept. The relationship between doctor and patient is an important one, and the prospect of this relationship being damaged by reporting to NZTA has been submitted to me as an important consideration. I acknowledge the importance of that relationship. I also consider the difficult position that family members are placed in when it falls to them to prevent a loved one from driving, rather than the NZTA ensuring that a licence is revoked or suspended.

The approach that Lakes DHB now take, to notify NZTA whenever a direction not to drive has been made, is a pragmatic approach, and an approach would trigger the NZTA to take steps, and prevent the responsibility resting solely on family members to prevent the individual from driving.

In my view, the obligation under section 18 should be formally changed to that effect.

## RESPONSE OF MINISTRY OF TRANSPORT IN CONSULTATION WITH THE NEW ZEALAND TRANSPORT AGENCY

- I. The Ministry of Transport acknowledges that under section 18 of the Land Transport Act 1998, medical practitioners are only required to inform the NZ Transport Agency if they believe that a licence holder will continue to operate a motor vehicle after being advised that they should surrender their licence because of a mental or physical condition.

The Ministry of Transport has accepted your recommendation that changes to section 18 of the Act could potentially have a beneficial

impact on road safety. A change in the obligations under the Act could provide clarity of medical practitioners' responsibilities and could reduce the burden on family members to restrain individuals who have been notified by a medical practitioner not to drive.

I have asked this proposal be investigated as part of the Ministry's review of the transport regulatory regime which is currently planned to begin in 2019. This would allow the Ministry to review the potential safety impacts of any changes, as well as consider any costs or unintended consequence of a change.

## **RESPONSE OF THE ROYAL NEW ZEALAND COLLEGE OF GENERAL PRACTITIONERS**

- II. Please pass on our condolences to the family of Mr Gillanders-Ryan.

Senior College Staff, including two medical members, discussed the provisional findings at a 'triage' meeting... We are very conscious that telling a patient they are unfit to drive can have a negative impact on the doctor-patient relationship. This can be further exacerbated when the doctor then reports the patient as unfit to drive to the NZTA. In such circumstances, GPs rely on the guidance provided by NZTA and find it useful to have the process and thresholds documented formally. Such documentation makes it easier for both doctor and patient to understand what is required. Should reporting to the NZTA become mandatory, we would expect the resources provided to GPs would also need to be updated – and that this will be done in such a way to make clear that the GP's decision is based on clear criteria, and that they are required to report their decision to the NZTA.

Until such a time as NZTA advice is updated, GPs will continue to follow the current guidance.

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

## **Holland [2018] NZCorC 90 (21 November 2018)**

### **CIRCUMSTANCES**

George Bernard Holland died on 6 August 2017 at the scene of a motor vehicle crash on the Wye River Bridge, State Highway 63 in Marlborough, from a traumatic head injury sustained in the crash.

On 5 August 2017, Mr Holland and three associates were travelling to Murchison. His associates were drinking in the car, and all four continued drinking when they reached the address in Murchison. It is believed Mr Holland had consumed about 12 cans of beer over about six hours. Later that night, following an altercation at the address, Mr Holland and his associates decided to leave.

One of the young men, Mr van Asch, recalls waiting for approximately two hours until he considered he was sober enough to drive Mr Holland's ute to the main road where they were then met by two of their friends who would be sober drivers. Mr Holland did not wish to leave his ute unattended by the road and appeared determined to drive. An argument ensued, as Mr Holland's associates considered he was quite drunk and did not want him to drive. However, despite a concerted effort, Mr Holland refused to leave his vehicle. As a compromise, it was agreed that he would follow their car to Lake Rotoiti, at which point they would check how he was. However, Mr Holland soon overtook them and travelled ahead.

Leslie Kemp was driving a truck along State Highway 63 toward the Wye River Bridge at 1.40am. He had the right of way as cars approaching from the opposite direction are subject to a well signposted 'Give Way' condition. As Mr Kemp approached the bridge, he noticed a car

approaching from the opposite direction. Mr Kemp, having the right of way, continued onto the bridge. However, the oncoming car, Mr Holland's ute, failed to give way and continued onto the bridge. Mr Kemp recalls a front on collision and subsequent fire. Mr Kemp and his passenger retreated to a safe area as Mr Holland's ute was crushed and on fire.

## COMMENTS OF CORONER ROBINSON

- I. Mr Holland's death could have been prevented by adhering to the restrictive blood alcohol laws that apply to young persons for the safety of road users. Even when sober, Mr Holland showed a disregard for the rules intended to ensure his safety and that of those around him in that he consumed alcohol as he drove the country road to the Murchison property.

He consumed alcohol to excess while at the "boys night" and no doubt made the decision to drive while his judgment was impaired by the excess consumption of alcohol and the use of illicit drugs.

While Mr van Asch and others are to be commended for their attempts to stop Mr Holland from driving, it is apparent that the group had little knowledge of the effects of alcohol. Mr van Asch in particular appeared to believe that he would have been sober enough to drive through having waited "a couple of hours" before driving. Ms Drummond commented that Mr Holland "physically appeared to be fine", which I infer to be a suggestion that he did not overtly appear to be intoxicated or affected by drugs.

In a previous finding I noted:<sup>1</sup>

[55] It bears repeating that the general population has no ability to reliably assess whether they or others around them are affected by alcohol such that they should not be driving.

Those who would drive having consumed alcohol, and those around them need to be disabused of the notion that people have an ability to accurately assess whether someone who has consumed alcohol is "okay to drive" (or more to the point whether they are under the legal limit).

As I go on to discuss below, (and contrary to popular belief) people do not have an ability to judge a person's level of intoxication accurately enough to decide if they are fit to drive.

*Effects of even low levels of alcohol consumption on driving risk*

The alcohol limits for drivers are set at a low level recognising that that drivers put themselves and other road users at risk when driving in the 251 to 400mcg of alcohol per litre of breath range (51 to 80mg per 100ml of blood) because their cognitive and driving abilities are impaired.<sup>2</sup>

<sup>1</sup> *Inquiry into the death of Donald Robert Morighan* (Coroners Court, Dunedin, CSU 2015-DUN-397, 20 September 2017).

<sup>2</sup> Land Transport Amendment Bill 2014, Explanatory Note at 1.

Data specific to New Zealand reflects overseas experience<sup>3</sup> that the relative risk of a fatal accident increases even at low blood alcohol concentrations. The table below sets out the relative risk (i.e. the number of times more likely an alcohol impaired driver is to be involved in a fatality than a sober driver) against a reference point of a sober driver aged 30+ driving with one passenger at night.<sup>4</sup> (figure omitted – see finding)

While the table speaks for itself, it is worth noting that even a driver at exactly the blood alcohol limit (of 50mg/100ml and therefore driving legally), driving in the most favourable scenario (aged 30+ with one passenger) is almost 6 times more likely to have a fatal crash than someone with a blood alcohol of zero.

*Can people judge if someone is “okay to drive”?*

Some publications identify signs and symptoms of intoxication by

reference to blood alcohol concentrations. Even apparently minor effects such as altered mood involving increased feelings of wellbeing or friendliness can be symptomatic of a blood alcohol level in excess of the legal limit.<sup>5</sup>

In one study, the researcher found that the only observable signs of intoxication for a blood alcohol concentration in the range 61 – 80 mg/100ml (i.e. above the New Zealand drink driving limit) were the presence of alcohol on the subject’s breath and the person swaying when undertaking Romberg’s test (a somewhat specialised examination similar to a compulsory impairment test administered by police to drivers who are suspected of being under the influence of drugs).<sup>6</sup>

That notwithstanding, the presence of breath alcohol is not a reliable indicator. One study found that only 33% of those who had a blood alcohol concentration in the range 61 – 80 mg/100ml had a detectable odour of alcohol

<sup>3</sup> Brick and Erickson *Intoxication Is Not Always Visible: An Unrecognised Prevention Challenge*, 33(9) *Alcoholism: Clinical and Experimental Research*, September 2009, pp 1489 – 1507.

<sup>4</sup> Keall, M.D, Frith, W.J and Patterson, T.L. (2004) *The Influence of Alcohol, Age and the Number of Passengers on the Night-Time Risk of Driver Injury in New Zealand*. *Accident Analysis and Prevention*, 36(1), 49-61 at 57.

<sup>5</sup> <http://www.alcohol.org.nz/alcohol-its-effects/about-alcohol/blood-alcohol-levels>, (last accessed 20 July 2017).

See also Table 126.1 Brust, J. C. M. (2015). *Alcoholism in Louis* (Ed.), *Merritt’s Neurology* (13th ed.). Wolters Kluwer.

<sup>6</sup> Widmark, *Principles and Application of Medicolegal Alcohol Determination* (1981), Biomedical Publications, Davis CA at 115 cited in Brick and Erickson *Intoxication Is Not Always Visible: An Unrecognised Prevention Challenge*, 33(9) *Alcoholism: Clinical and Experimental Research*, September 2009, pp 1489 – 1507

on their breath.<sup>7</sup> In another more recent study, breath alcohol was detectable (by police) in only 60% of instances where the blood alcohol concentration was 80 mg/100ml or less.<sup>8</sup>

Indeed determining whether one is safe to drive by reference to how the person feels or by their physical appearance or behaviour is fraught with difficulty. Firstly the effects of alcohol on an individual depends on many factors including gender, age, weight, overall health and habituation.<sup>9</sup>

Secondly, even experienced health professionals cannot accurately relate the signs and symptoms of alcohol consumption to particular blood alcohol concentrations.<sup>10</sup> It is therefore ridiculous for individuals to assume (as often occurs) that they are able to assess an ability

to drive lawfully. Any judgment must surely be worse when the person making the assessment has themselves consumed alcohol.

New Zealand and overseas studies confirm that those who have consumed alcohol (even with relatively low blood alcohol concentrations) underestimate the amount of alcohol they have consumed, and cannot determine the level of their intoxication.<sup>11</sup>

In my view, if any effects of the consumption of alcohol are noticeable (even if minor) it is likely that the person is above the legal limit. That is only conclusion that can properly be drawn from the research that has been conducted in this area.

Researchers have noted:<sup>12</sup>

<sup>7</sup> Widmark, *Principles and Application of Medicolegal Alcohol Determination* (1981), Biomedical Publications, Davis CA at 115, cited in Brick and Ericksen *Intoxication Is Not Always Visible: An Unrecognised Prevention Challenge*, 33(9) *Alcoholism: Clinical and Experimental Research*, September 2009, pp 1489 – 1507

<sup>8</sup> Moskowitz H, Burns M, Ferguson S (1999) *Police Officers' Detection of Breath Odors From Alcohol Ingestion*. *Accid Anal Prev* 31:175–180.

<sup>9</sup> “At plasma concentrations in well excess of 100mg/100ml experienced alcohol drinkers may not appear intoxicated to very experienced observers. However this appearance of sobriety does not translate to safe operation of a motor vehicle... in which case very low plasma alcohol concentrations produce impaired performance”: Sullivan JB,

Hauptman M, Bronstein AC (1987) *Lack of Observable Intoxication in Humans With High Plasma Alcoholic Concentrations*. *J Forensic Sci* 32:1660–1665.

<sup>10</sup> Olsen et al *Relationship Between Blood Alcohol Concentration and Observable Symptoms of Intoxication in Patients Presenting to an Emergency Department* (2013) *Alcohol and Alcoholism* at 346, 48(4) at 386-389.

<sup>11</sup> Charlton and Starkey (2013) *Driver Risk from Blood Alcohol Levels Between 50mg/100ml and 80mg/100ml – New Zealand Transport Agency Report 541*.

<sup>12</sup> Brick and Ericksen *Intoxication Is Not Always Visible: An Unrecognised Prevention Challenge*, 33(9) *Alcoholism: Clinical and Experimental Research*, September 2009, pp 1489 – 1507 at 1504.

Two conclusions having direct implications for prevention specialists are apparent as a result of this review: (i) the lack of visible signs of alcohol intoxication is no guarantee that the drinking driver is not impaired and (ii) if signs of visible intoxication (i.e., trouble walking, speech impairment, impaired cognition or affect, or other signs of intoxication) are present, the person is probably (more likely than not) intoxicated well in excess of the legal definition for driving while intoxicated and is at significantly increased risk for a fatal crash or injury. Better training of alcohol beverage servers and social hosts, and **broader public awareness of the relationship between BAC, visible intoxication, obvious intoxication, and risk for a motor vehicle crash should be part of future prevention strategies.**

Most importantly, drivers who drink but do not show signs of visible intoxication may have BACs that exceed the current legal definition for intoxicated driving, and may be at high risk for injury to themselves and others.

(emphasis added).

That aside, those involved were aged under 20 and were subject to a zero-alcohol level. Waiting two hours to “sober up” after having consumed a dozen cans of beer was naïve at best.

Much concern has been expressed of late as to New Zealand’s increasing road toll. Ultimately the safety of road users comes down to the decision-making of individuals. Mr Holland’s death, and untold others like it, could have been prevented by individuals applying common sense.

In the absence of individuals making responsible decisions around alcohol use and adhering to restrictions imposed to protect them and their communities, it is incumbent on the State to further restrict access to alcohol.

Regrettably the opportunity afforded by development of the Sale and Supply of Alcohol Act 2012 was missed and key measures known to reduce alcohol harm to those in Mr Holland’s demographic did not form part of the legislation.

Given Mr Holland’s age it is appropriate in the circumstances of this case to reflect on research around the effects of changing minimum purchasing / drinking ages and road safety.

Two papers document the experience in the United States where the drinking age was lowered in many states in the early 1970s before being raised to 21 by 1987 in response to Federal law limiting Federal highway funding for States with lower ages.

In *Reviews of Evidence Regarding Interventions to Reduce Alcohol Impaired Driving*<sup>13</sup> the authors undertook systematic reviews of the research on

<sup>13</sup> Shults et al *Reviews of Evidence regarding Interventions to Reduce Alcohol Impaired Driving* Am J Prev Med 2001; 21 at 66.

the effectiveness of a range of interventions. Strong evidence was found for raising the Minimum Legal Drinking Age (“MLDA”) being an effective intervention to reduce alcohol-related harm from motor vehicle crashes. Most of the changes assessed were from 18 to 21 years or vice versa. Of the analysis, the authors stated:<sup>14</sup>

These results suggest that changes to the MLDA result in changes of roughly 10% to 16% in alcohol-related crash outcomes for the targeted age groups, decreasing when the MLDA is raised, and increasing when it is lowered. These effects were consistent over follow-up times ranging from 7 to 108 months.

The authors concluded:<sup>15</sup>

... there is strong evidence that MLDA laws, particularly those that set the MLDA at age 21, are effective in preventing alcohol-related crashes and associated injuries.

The second publication, *Effects of Minimum Drinking Age Laws: Review and Analyses of the Literature from 1960 to 2000* concluded that:<sup>16</sup>

The preponderance of evidence indicates there is an inverse relationship between the MLDA and two outcome measures: alcohol consumption and traffic crashes.

<sup>14</sup> Shults et al *Reviews of Evidence regarding Interventions to Reduce Alcohol Impaired Driving* Am J Prev Med 2001; 21 at 73.

<sup>15</sup> Shults et al *Reviews of Evidence regarding Interventions to Reduce Alcohol Impaired Driving* Am J Prev Med 2001; 21 at 75.

The drinking age was lowered in New Zealand in December 1999. The effects of that have been assessed. In *Minimum Purchasing Age for Alcohol and Traffic Crash Injuries Among 15 to 19 Year Olds in New Zealand* the authors examined the immediate effects of the lowering of the drinking age.<sup>17</sup>

In their introductory remarks, the authors refer to the research of Shults et al (summarised above), noting:

In the review of 17 studies from States that raised the minimum legal drinking age, Shults et al estimated average reductions in underage crash involvements of 16%. In addition to the consistent inverse relationship between the minimum legal drinking age and traffic crash involvement across jurisdictions are observations of reduced heavy drinking in those exposed to a lowered minimum legal drinking age and research showing that stricter enforcement of the minimum legal drinking age is associated with greater reduction of harm.

**No traffic safety policy, with the possible exception of motorcycle safety helmets, has more evidence for its effectiveness than do the minimum legal drinking age laws.**

(Footnotes omitted, emphasis added).

<sup>16</sup> Wagenaar et al *Effects of Minimum Drinking Age Laws: Review and Analyses of the Literature from 1960 to 2000* Journal of Studies on Alcohol Supplement No 14, 2002 at 206 and 213.

<sup>17</sup> Kypri et al *American Journal of Public Health* January 2006, Vol 96, No 1 at 126.

The study analysed the four-year periods before and after the reduction in the drinking age and concluded that:<sup>18</sup>

Significantly more alcohol-involved crashes occurred amongst 15 to 19 year olds than would have occurred had the purchase age not been reduced to 18 years. The effect size for 18 to 19 years is remarkable given the legal exceptions to the pre-1999 law and its poor enforcement.

Two studies then followed, analysing the longer-term effects of the lowering of the minimum purchase age on traffic crash injuries in the target age range.

The authors of *Long-Term Impact on Alcohol-Involved Crashes of Lowering the Minimum Purchase Age in New Zealand* examined data from the period 1994-2010.<sup>19</sup> After noting the increase in alcohol involved crashes amongst drivers aged 15-19 in short-term studies after the 1999 Amendment, the learned authors stated:<sup>20</sup>

Our findings indicated that lowering the minimum purchase age in New Zealand has had a long-term impact on drivers experiencing alcohol-involved crashes among of the age group directly affected: those aged 18 to 19 years. Although the odds of a driver aged 18 to 19 years

experiencing an alcohol-involved crash resulting in an injury or fatalities were similar to the odds of the age control group before the law change, the odds became significantly higher following the law change. The main effect was found in the short term (2000-2005); however, the higher odds were maintained in the long-term (2006-2010).

The authors concluded stating:<sup>21</sup>

The lowering of the purchase age in 1999 was associated with a long-term impact on alcohol involved crashes amongst drivers directly affected: those aged 18 to 19 years. We found the main increase in the odds of experiencing an alcohol-involve crash for drivers aged 18 to 19 years directly following the law change compared with the age control group, but the increased odds was maintained long term. Raising the minimum purchase age for alcohol in New Zealand would be an appropriate public health intervention.

The final study, *Long-Term Effects of Lowering the Alcohol Minimum Purchasing Age on Traffic Crash Injury Rates in New Zealand*<sup>22</sup> drew on the Shults et al paper discussed above.

<sup>18</sup> Kypri et al American Journal of Public Health January 2006, Vol 96, No 1 at 126. See also NZLC R114 *Alcohol in our lives: Curbing the harm* at 16.15.

<sup>19</sup> Huckle et al *Long-Term Effects of Lowering the Alcohol Minimum Purchasing Age on Traffic Crash Injury Rates in New Zealand* American Journal of Public Health in June 2014, Vol 104, No 6 at 1087.

<sup>20</sup> Huckle et al *Long-Term Effects of Lowering the Alcohol Minimum Purchasing Age on Traffic Crash Injury Rates in*

*New Zealand* American Journal of Public Health in June 2014, Vol 104, No 6 at 1090.

<sup>21</sup> Huckle et al *Long-Term Effects of Lowering the Alcohol Minimum Purchasing Age on Traffic Crash Injury Rates in New Zealand* American Journal of Public Health in June 2014, Vol 104, No 6 at 1090.

<sup>22</sup> Kypri et al *Long-Term Effects of Lowering the Alcohol Minimum Purchasing Age on Traffic Crash Injury Rates in New Zealand* Drug and Alcohol Review (March 2017), 36, 178-185.

The key finding (largely consistent with that of Huckle et al though adopting a different methodology) was that reducing the alcohol minimum purchasing age was followed by long-term increases in the incidence of traffic injury attributable to 15 to 19-year-old alcohol impaired drivers.

There appears to be incontrovertible evidence of a direct link between the lowering of the alcohol purchasing age in 1999 and an increase in the incidence of injury and fatal accidents involving alcohol impaired drivers aged 15-19 years.

The permissible alcohol level for drivers aged under 20 was lowered to 0 in 2011. Information from the commencement of that Amendment was not within the dataset reviewed for the purposes of the last two cited studies.

While the effect of that Amendment has not (to my knowledge) been the subject of detailed analysis, I do note that the total crashes affecting 15 to 19-year-olds where alcohol was a factor increased from 102 in the 2014 to 134 in 2015, and from 101 in 2016 to 142 in 2017.

An increase in the minimum purchasing age is justifiable by considering alcohol related harm in other contexts. For example, a 2014 study examining the period to 2011 found that the lowering of the minimum alcohol purchasing age increased weekend assaults resulting in hospitalisation among young males aged 15 to 19 years.<sup>23</sup>

Moreover, long term adverse effects have been identified resulting from adolescent drinking including two- to

threefold increase in the odds of binge drinking, drink driving, alcohol-related problems and alcohol dependence in adulthood.<sup>24</sup>

The research which I have attempted to summarise supports the raising of the minimum purchase age, consistent with the recommendations of the Law Commission in 2010:<sup>25</sup>

16.6 However, one of the interventions with the greatest evidence of effectiveness is increasing the minimum purchase or drinking age. Raising the purchase age has been found to reduce harmful consumption and a range of harms, including drink driving, car crashes, injuries and deaths, and other health and social harms. The reduction in harm benefits older and younger cohorts as well as the group directly affected by the law change.

...

16.14 It seems clear that, along with other policy and societal changes, reducing the minimum age for purchasing alcohol from 20 to 18 years in 1999 contributed to **increased** alcohol-related harm to young people in New Zealand.

16.15 There was a significant increase in hospital presentations of intoxicated people aged under 20 in the year following the law change. **There have been increases in the trends for rates of prosecutions for excess**

<sup>23</sup> Kypri et al, *Effects of Lowering the Minimum Alcohol Purchasing Age on Weekend Assaults Resulting in Hospitalisation in New Zealand* American Journal of Public Health 2014 Aug 104(8):1396-401.

<sup>24</sup> Silins et al *Adverse Adult Consequences of Different Alcohol Use Patterns in Adolescence: An Integrative Analysis of Data to Age 30 Years from Four Australasian Cohorts* Addiction · May 2018

<sup>25</sup> NZLC R114 *Alcohol in our lives: Curbing the harm.*

**breath alcohol, road traffic crashes involving alcohol, and fatal road traffic crashes involving alcohol among several youth cohorts in the years after 1999. The increase in alcohol-related crashes among 15 to 19 year olds was higher relative to older age groups in the four years following the law change, and the higher rate of increase in road traffic crashes among the younger age group has continued since.** Similarly, as shown in chapter 3, hospital admissions that are wholly attributable to alcohol peak dramatically between the ages of 15 and 29.

(footnotes omitted, emphasis added).

Of particular note is the comment of the Law Commission after citing a Police submission as to perceived increases in alcohol related offending by youth since the minimum purchase age was lowered:

16.17 Although it is difficult to reach conclusions about trends in the absence of regular, comparable surveys, we might expect these increases in harm given the evidence of changes in the drinking patterns of young people over this period.

The New Zealand studies I have cited above appear to be good evidence of the continuation of the trend of increased harm amongst 15 – 19 year olds attributable to the reduced minimum purchase age. In my view, it

<sup>26</sup> Shults et al *Reviews of Evidence regarding Interventions to Reduce Alcohol Impaired Driving* Am J Prev Med 2001; 21 at 75 - 78.

<sup>27</sup> Whiting Moyne *Auckland Transport: Road Safety Business Improvement Review* (February 2018) at 35.

underscores the Law Commission's 2010 recommendation:

16.33 There is good evidence that increasing the minimum purchase age will be an effective and cost-effective method of helping to achieve the objectives relating to youth drinking.

16.34 We recommend the purchase age be increased to 20 years with no exceptions. We also recommend the necessary changes to related offences to reflect the new recommended purchase age.

Finally, there is the matter of enforcement.

The zero-alcohol level introduced in 2011 is of limited utility without adequate enforcement. Random breath alcohol tests are a key tool in ensuring compliance with the prescribed alcohol limits and is known to be an effective means of reducing drink-driving harm.<sup>26</sup> Breath testing has reduced from a high in 2013/14 of 3,013,272.<sup>27</sup>

I note that the Government expectation appears to be that police perform fewer random breath tests in the 2018/2019 financial year compared to 2017/18:<sup>28</sup> (figure omitted – see finding)

There is evidence of recent decreased levels of traffic enforcement in Auckland being linked with increasing incidents of alcohol related crashes causing injury and death in that centre:<sup>29</sup> (figure omitted – see finding)

<sup>28</sup> The Estimates of Appropriations 2018/19 - Justice Sector B 5 Vol 7 at 133 (accessible at <https://treasury.govt.nz/sites/default/files/2018-05/est18-v7-police.pdf>, last accessed 11 July 2018).

<sup>29</sup> Whiting Moyne *Auckland Transport: Road Safety Business Improvement Review* (February 2018) at 31.

The graph above illustrates the progressive rapid increases in DSI [death and serious injury] throughout 2017 reflecting, among other matters, the negative deterrence impact of a reduced road police enforcement presence in Auckland. The dose/response relationship between good quality police enforcement and impacts on levels of related non-compliance fatalities is always very strong and quite rapid. This effect unfortunately has been evident in the DSI outcomes for Auckland in 2017.

A media report of the above study records the author's view of the link between decreased random breath tests and increased alcohol related harm:<sup>30</sup>

Whiting Moyne president Eric Howard said there was a very clear link between the number of breath tests administered and drink-driving incidents.

"When we're talking about stopping drink-driving there's two different ways of deterring people – general and specific deterrence. Random breath tests fall into that general category," he said.

"The fact is as the rates of random breath testing lowered in Auckland, alcohol-related fatalities and injuries increased, [and] the road policing resources for Auckland were reduced significantly."

## RECOMMENDATIONS OF CORONER ROBINSON

To: the Minister of Transport; Minister of Police; Minister of Justice; and Minister of Health

- I. I recommend to the Ministers of Transport, Police, Justice and Health that the Sale and Supply of Alcohol Act 2012 be amended to provide that the minimum purchase age for

alcohol to 20 (with no exceptions) on the basis of the research cited herein.

## RESPONSES TO RECOMMENDATIONS

My draft recommendations were directed to the Ministers of Transport, Police and Health pursuant to section 57B Coroners Act 2006. I received the following responses:

- I. Hon Stuart Nash (Minister of Police) - the Minister noted that the Sale and Supply of Alcohol Act 2012 is administered by the Ministry of Justice and that my recommendation ought to be directed to that Minister (which it subsequently was). As to matters of enforcement the Minister noted:

*I note that the provisional findings also make comment about the reduced number of random breath tests proposed for 2018/19, and the decreased levels of traffic enforcement in Auckland (paragraphs 75 to 79).*

*The Commissioner of Police has informed me that the number of dedicated road policing staff was reinstated to 1070 across New Zealand in July 2018. A proportion of the staff have been deployed in Auckland. This gives Police the ability to significantly impact on road safety, including preventing drink-driving.*

*The decreased breath testing numbers that are projected for the 2018/19 year reflect Police's commitment to targeting breath testing*

<sup>30</sup> <https://www.stuff.co.nz/national/104062781/drinkdriving-on-the-rise-as-random-breath-tests-fall>.

*to high-risk times and places, rather than focusing solely on high-volume checkpoints. I expect the targeted approach to be more effective in preventing harm on our roads.*

- II. Hon Phil Twyford (Minister of Transport) - the Minister advised that the matters raised by my findings fell within the responsibilities of Hon James Shaw, Acting Associate Minister of Transport and that my draft findings had been referred to Mr Shaw's office. No substantive response was received from the Associate Minister.
- III. Hon Dr David Clark (Minister of Health) - the Minister noted my comments.
- IV. Hon Andrew Little (Minister of Justice) - no reply received.

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

## **Kumar [2018] NZCorC 99 (17 December 2018)**

### **CIRCUMSTANCES**

Raj Kumar of Hamilton died on 7 September 2017 on State Highway 1, Huntly, after he was struck by a truck.

Mr Kumar was 33 years of age and had moved from India to New Zealand to work. He owned his own business and worked as a representative for a security company. Mr Kumar did not suffer from any significant physical or mental health issues.

On 7 September 2017, Mr Kumar had parked his vehicle on Hakanoa Street in Huntly, just a short walk from the main shopping area. As Mr Kumar stepped out to cross

State Highway 1, a truck was travelling in the southbound lane approaching him. The driver saw Mr Kumar was looking to his left, rather than towards the oncoming truck. Mr Kumar stepped out into the path of the truck and was killed.

The cause of Mr Kumar's death was severe head and chest injuries resulting from being hit by a truck.

### **RECOMMENDATIONS OF CORONER ROBB**

- I. Coroner Robb considered that the addition of a pedestrian overbridge would have ensured that Mr Kumar was not walking across State Highway 1. Additionally, road markings indicating the direction of traffic may also have led Mr Kumar to look in the correct direction for oncoming traffic.
- II. Coroner Robb adopted the suggestions made by NZTA in their response to his proposed recommendations. Coroner Robb recommended that:
  - a. "look right" markings be placed on the footpath within the traffic island approaching the southbound traffic lane;
  - b. "look for cars" signage be directed at the pedestrian crossing in the lone of sight for pedestrians crossing the road.

### **RESPONSE OF THE NEW ZEALAND TRANSPORT AGENCY**

- i) *The addition of a pedestrian overbridge*

There are currently no plans to build a pedestrian overbridge in this location. There is an existing pedestrian overbridge across State Highway 1 at Huntly 500 metres south of the crossing point where Mr Kumar died,

between Glasgow Street and Shand Lane. We note that Mr Kumar was walking from Hakanoa Street to the Huntly shopping area, if he had used this (*existing*) bridge it would have been a similar walking distance.

- ii) *Markings are placed on State Highway 1 in the vicinity of the pedestrian traffic islands, to indicate the direction of travel of vehicles on each lane of the highway.*

Painted arrows are used on roads at intersections, one lane bridges, and at locations that foreign drivers frequently visit. Painted arrows are not widely used throughout New Zealand because they can be a hazard to motorcyclists in wet conditions, and to repaint the arrows requires implementing a 30 km/h temporary speed limit with stop/go traffic control. It is not common practice to paint arrows at pedestrian crossings, and that in this case Mr Kumar was not looking at the road surface where the arrows would be painted.

We believe it would be a better outcome to install “look right” markings on the footpath within the traffic island approaching the southbound traffic lane. We will also install “look for cars” signs at this pedestrian crossing. These signs will have the same effect as the “look for trains” signs currently used on the adjacent railway pedestrian crossing, and they will be in the line of sight for pedestrians crossing the road. We aim to have these markings and signs installed within the next three months.

In addition to this, the Transport Agency is currently constructing the Huntly section of the Waikato Expressway. This project consists of constructing 15 km of Expressway that will by-pass Huntly significantly increasing the safety of Huntly’s urban area. This project is expected to be open to traffic in early 2020. It is predicted that approximately 70 percent of the vehicles currently travelling through Huntly will instead travel on the Waikato Expressway.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken during the course of the investigation, and the name of the truck driver, in the interests of decency as this outweighs the public interest in the publication of that evidence.

## Self-inflicted

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### Antipas [2018] NZCorC 76 (11 October 2018)

#### CIRCUMSTANCES

Jonathan Joshua Jude Antipas died of self-inflicted injuries.

#### COMMENTS OF CORONER J P RYAN

- I. I acknowledge the improvements implemented by the Department of Corrections to policies and processes at Rimutaka Prison to reduce the chances of further deaths occurring in similar circumstances. However, I consider that the following recommendation if implemented will strengthen the policy covering circumstances when a formal risk assessment

must be undertaken, and therefore reduce the chance of a formal risk assessment not being performed in circumstances when it should be.

## RECOMMENDATIONS OF CORONER J P RYAN

To: the Chief Executive, Department of Corrections

- I. That consideration be given to amending the Prison Operation Manual to reflect the need for a mandatory formal at-risk assessment whenever staff are reliably informed that a prisoner has voiced suicidal ideation.

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

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

## Hutchens [2018] NZCorC 91 (26 November 2018)

### CIRCUMSTANCES

Timothy Patrick Hutchens died between 9 and 10 March 2017 at his home in Auckland of self-inflicted injuries in circumstances amounting to suicide.

Mr Hutchens had a history of mental health issues including depression and possible intermittent paranoia in the setting of relationship break-ups. He received counselling and was prescribed a trial of fluoxetine (anti-depressant) for several months. On 17 December 2015 Mr Hutchens was referred to the Taylor Centre for an urgent psychiatric assessment following concerns from his family about his mental health. On assessment, his

doctor described Mr Hutchens as guarded and reluctant to engage. He was reported to have paranoid delusions with limited insight. He disclosed possibly hearing unusual sounds but no clear auditory hallucinations were reported. Mr Hutchens was given the diagnosis of psychosis possibly induced by illicit drug use in the setting of relationship stressors. He was encouraged to avoid illicit drugs and alcohol and to start treatment with risperidone (an anti-psychotic medication), however he resisted the advice to take medication and remained symptomatic. On 19 December 2015, he was placed under the Mental Health Act 1992 on a community order with supervised treatment of risperidone.

Mr Hutchens' last contact with the Taylor Centre was with his therapist on 1 March 2017. Throughout the period of his care, he had stopped taking his medication but had agreed to restart it. He engaged well in his last appointment with his therapist and agreed to a follow-up session on 14 March 2017.

Mr Hutchens' was found dead at his home on 10 March 2017.

### COMMENTS OF CORONER DEBRA BELL

- I. I am aware of the publicity Mr Hutchens' death has received and the campaign message that "no one thinks any less of you for taking medication". I reiterate *that message*:

*"If you are suffering a mental illness, no one thinks less of you for sharing your thoughts. No one thinks less of you for taking medicine and no one thinks less of you for dealing with a mental illness. Just talk about it."*

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

Note: Pursuant to section 71 of the Coroners Act 2006, no person may make public a particular of the death other than the name, address and occupation of the person concerned, and the fact that a coroner has found the death to be self-inflicted, without a coroner's authority or permission.

## McKelvey [2018] NZCorC 93 (28 November 2018)

### CIRCUMSTANCES

Jessica Marie McKelvey of Palmerston North died of self-inflicted injuries.

### COMMENTS OF CORONER J P RYAN

- I. I endorse the recommendations contained in the [Serious Event Review] report, and note that Dr Westerlund confirms that these recommendations have been implemented. Consequently, there is no need for recommendations relating to two clinicians being required to perform assessments of persons in custody who are at risk, nor for those clinicians to obtain the full mental health history from the DHB prior to performing the assessment.
- II. Counsel for New Zealand Police has helpfully provided submissions on recommendations designed to improve the robustness of the briefing of clinicians who attend at Police Stations to assess the mental health state of a person in custody.

### RECOMMENDATIONS ENDORSED BY CORONER J P RYAN

To: The Commissioner of Police and all District Health Boards who provide mental health services

- I. That New Zealand Police and District Health Boards review their processes involving the briefing of clinicians who attend at Police Stations to perform mental health state examinations for persons in custody to formalise that process to ensure that all documentation relevant to the prisoner/patient is completed, handed to, and discussed with, the clinician during the briefing and prior to the assessment.  
  
To: The Commissioner of Police
- II. When Police complete the prisoner evaluation process by electronic means, the custody officer completing this process must complete the Duly Authorised Officer (DAO) pane of the processing section in all cases. Where no assessment by a mental health clinician/DAO is required, the officer would complete that section with 'N/A' to show that the section had been considered.
- III. To show that the custody officer has considered certain critical matters, the following comments sections should be mandatory fields:
  - a. Under the influence of alcohol or drugs
  - b. Behaviour
  - c. Signs or history of suicidality
  - d. Mental health risks
- IV. In cases where a mental health clinician/DAO is required to attend to assess a person in custody, the custody processing procedure computer application should:
  - a. Require the custody officer to complete a field showing that the clinician/DAO has been contacted by Police and to record what has been communicated to the clinician/DAO by Police.

- b. Prompt the system to print two copies of the evaluation form when information is entered into the DAO pane, one copy for the clinician/DAO and one signed by the clinician/DAO to be stored with the charge sheet documents.
  - c. Endorse on the evaluation form a section to be completed by the custody officer confirming that a copy of the evaluation was handed to the clinician/DAO, the name of the clinician/DAO, the date and time of the handover, the fact that the information was discussed, and the name and identification number of the custody officer. The signature of the clinician/DAO on that form would be an acknowledgement of receipt of the evaluation form.
- V. That New Zealand Police provide to mental health clinicians/DAOs called to assess an at-risk person in custody a record of family harm incidents pertaining to that person, to assist them in their assessment and formulation of a care plan.

**Rationale:**

- (a). This death indicates that the briefing process was informal and ad hoc. To a great extent, it depended on a discussion between the Police and the clinician. This provides an opportunity for the situation to arise where vital information is not provided to the clinician, and it is unclear exactly what was discussed. In this particular case, it is unclear what verbal information was passed to [the nurse assessing Jessica], and the passage of time meant that recollections were compromised. However, it is clear that the clinician did not have all of the information before commencing her examination of

Jessica. If she had had that information, it would have impacted on her assessment of Jessica.

- (b). The purpose of these recommendations is to ensure that clinicians who attend at a Police Station to perform a mental health state assessment of a person in custody have all of the relevant information gathered by Police in relation to that person, and have discussed that information with Police prior to commencing the examination of the patient.

Note: Orders under section 74 of the Coroners Act 2006 prohibit the publication of photographs of Ms McKelvey following her death, in the interests of decency; the name, and any particulars likely to lead to the identification of Ms McKelvey's partner, in the interests of justice and personal privacy; and, the name, or any particulars likely to lead to the identification of the nurse who assessed Ms McKelvey at the Police station, in the interests of justice, public order and personal privacy. This does not include the name of the service which the nurse worked for as it has already been published.

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

## Taylor [2018] NZCorC 98 (10 December 2018)

### CIRCUMSTANCES

Dr Michael John Taylor of Selwyn Village Retirement Home, Auckland died of self-inflicted injuries.

## COMMENTS OF CORONER K H GREIG

- I. The evidence I have received from AlarmNZ and Selwyn shows that both companies are used to many ('the vast majority') of Selwyn's independent residents' call point activations being false alarms or non-urgent matters. AlarmNZ also perceives that many of the calls it responds to are from "Selwyn residents suffering various levels of dementia," notwithstanding that the call activation service is for people living independently.

Whilst non-urgent matters and false alarms may be frustrating, the purpose of the service<sup>31</sup> is to allow residents the reassurance of being able to activate the alarm if they need urgent help, knowing that help will be forthcoming if they need urgent help or have an emergency. This means, as this case illustrates, that every call activation must be taken seriously as a potential emergency and must be properly assessed to establish exactly why the alarm has been activated. Such assessments should be done skilfully and not be coloured by a filter of scepticism or belief that the call is likely to be non-urgent and/or made by someone with dementia or who is otherwise "confused". If the call taker is unable to assess whether urgent help is required, after proper inquiries have been made, a robust process needs to be in place to ensure Selwyn staff respond promptly to assess for themselves.

## RECOMMENDATIONS OF CORONER K H GREIG

To: The Selwyn Foundation and AlarmNZ [revised after receiving their response to proposed recommendations]

- I. That the Selwyn Foundation and AlarmNZ further reassess whether they have sufficiently robust protocols, policies and processes in place to ensure that all call activations from Selwyn's independent living residents are managed appropriately and safely - including that:
  - a. both organisations have a shared understanding as to the circumstances in which it is appropriate for AlarmNZ to call emergency services and those situations in which it is not appropriate to do so (and the reasons for this).
- II. That AlarmNZ conducts ongoing training of phone operators to ensure all phone operators have the appropriate skills to manage call activations from Selwyn's independent living residents – specifically that they are trained to be able to elicit, to the extent possible, sufficient and appropriate information from callers on the reasons for the call activation and to accurately convey information about the alarm event to the onsite Selwyn responder (and, where relevant, to the 111 call taker).
- III. That the Selwyn Foundation formalises its practice of responding to an alarm activation within fifteen minutes by incorporating this response time into formal policy, and that it ensures that it has sufficient staff both during the day and at night to respond within the expected timeframes to notifications from AlarmNZ of call activations.

<sup>31</sup> The evidence is that the Occupation Licence for Independent Living Apartment provides for a 24-hour monitored emergency call system.

## RESPONSE OF SELWYN FOUNDATION

- I. The Selwyn Foundation responded that:
  - it conducted a review in 2016, and that it is continuing to monitor the alarm responses;
  - it has amended its internal policies and procedures to ensure the emergency services are notified as a matter of default should any alarm activation not be ruled out as a non-urgent issue;
  - its practice is to respond to an alarm activation within fifteen minutes.

## RESPONSE OF ALARMNZ

- II. AlarmNZ responded that:
  - It has made improvements to the training and response of its staff;
  - AlarmNZ is a call monitoring service not an ambulance despatch service and staff do not make medical determinations nor do they provide advice – their role is only to convey the alarm event to the onsite Selwyn responder and AlarmNZ will only call 111 if there is a confirmed medical incident in progress – otherwise the event has to be passed on to the onsite responder to assess. It noted that the 111 service often requires onsite information before emergency services are despatched.

AlarmNZ suggested that the system could be improved if:

“The 111 Services formally register 24/7 alarm monitoring centres, (currently adhoc) audit/grade them and issue an operation license as this would give certainty that 2<sup>nd</sup> hand calls made by people like Mr Fletcher are passed on to the 111 service with a measure of assurity and confidence and not subject to levels of scrutiny that requires a higher degree investigation on request of the service [sic]”.

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

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

## Drowning

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### Cooper [2018] NZCorC 82 (5 November 2018)

#### CIRCUMSTANCES

Jade Rangī Cooper died between 17 and 18 October 2015 at the Aparima River, Riverton of accidental drowning.

Jade was 24 years old at the time of his death. At about 9.20pm on 17 October 2015, Jade, his father and grandfather arrived at the Aparima River Bridge after having been drinking alcohol. Jade ran ahead and had jumped into the river. His father and grandfather, when they arrived about halfway across the bridge, found Jade’s clothes. They did not see him jump into the water.

Jade’s body was not found until the next morning on 18 October. He had drowned.

Police noted that the Aparima river was in full flood. It had discoloured water and a number of trees and debris in its current. Jade’s blood alcohol level indicated that he was heavily intoxicated at the time of his death.

## COMMENTS OF CORONER B WINDLEY

- I. My inquiry finds that Jade's exposure to risk when he decided to jump off the Aparima Bridge was significantly increased by his intoxication, the condition of the river, and the fact it was dark.

I consider Water Safety New Zealand safety advice in relation to river swimming to have relevant application in the circumstances I have established in this case. This includes advice to exercise extreme caution regarding river levels, particularly following inclement weather, and not to mix swimming with alcohol.

I endorse this existing safety advice, and do not consider that there are any further comments or recommendations which I can make, pursuant to section 57 of the Coroners Act 2006, that could reduce the chances of further deaths occurring in similar circumstances.

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

## Gardner [2018] NZCorC 84 (8 November 2018)

### CIRCUMSTANCES

Ben Simon Gardner of Cromwell died on 10 December 2016 in the Kawarau River, Bannockburn of drowning.

On 10 December 2016, Mr Gardner went with his partner, his partner's parents and their five-year-old niece to the Kawarau River near the Bannockburn Inlet. The group had not been to the Bannockburn Inlet before.

A swimming pontoon is in the river. Mr Gardner said he was going to go out to the pontoon and thought he would be able to walk out to it. As his partner's parents' niece wanted to go with him, he put her on his back and asked her to hold on tight. Halfway to the pontoon, Mr Gardner called out that the bottom of the river had 'disappeared' and that he 'could not feel it'. Mr Gardner called for help. His partner's father swam out and got his niece, however, he could not rescue Mr Gardner. Mr Gardner drowned.

## COMMENTS OF CORONER ELLIOTT

- I. Mr Gardner's death highlights the importance of being vigilant about the dangers of swimming, especially in unfamiliar waters.

The Water Safety New Zealand website advises that natural swimming areas such as rivers and lakes are constantly changing. This means that those intending to swim should always check the depth of the water to ensure that they are not swimming beyond their comfort zone or capabilities, especially if bringing children into the water.

I have recommended the erection of warning signs in the area.

## RECOMMENDATIONS OF CORONER ELLIOTT

To: Crown Property and the Central Otago District Council

- I. That signs should be erected in prominent locations on the shore in the vicinity of the pontoon in the Kawarau River, Bannockburn, where Ben Simon Gardner died on 10 December 2016, warning of the water depth, the presence of weeds, the risks associated with swimming in the area and the need to supervise children.

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

## Wu [2018] NZCorC 100 (20 December 2018)

### CIRCUMSTANCES

Zhiliu Wu died on 22 November 2015 at Uretiti Beach, Waipu of drowning.

Mr Wu and his family and friends went to Uretiti Beach, Waipu on 22 November 2015 for a day of swimming and crab fishing. Mr Wu went out in the sea in a small inflatable dinghy. He was wearing a wetsuit but had left his life jacket on the beach. Mr Wu could swim but he was not a good swimmer.

While Mr Wu was out at sea, the weather changed, and he began to be blown out to sea. Witnesses recall seeing him paddling hard to try and get back to shore. When he was about one kilometre off shore, witnesses lost sight of him and recall seeing the dinghy blowing freely across the sea, without Mr Wu on it. Mr Wu drowned and his body was later recovered.

### RECOMMENDATIONS ENDORSED BY CORONER H B SHORTLAND

- I. In response to other deaths in nearly identical situations, I have previously endorsed safety initiatives and recommendations around crab fishing.<sup>32</sup> These initiatives and

recommendations apply both specifically to Uretiti Beach, and more generally.

In December 2015, signage was installed at major entry points to Uretiti and Ruakaka beaches. That year, there were also safety campaigns, volunteer beach patrols, and information pamphlets distributed in an effort to increase awareness of the dangers and help educate people about safe crab fishing.

These measures appear to have been successful, as there have been no further deaths while crab fishing at Uretiti beach, since Mr Wu's death.<sup>33</sup> Nevertheless, it is important that these safety messages remain at the forefront of people's minds, and consequently, I reiterate and endorse the following general recommendations of Surf Lifesaving New Zealand and Dr Kevin Moran:<sup>34</sup>

- Life jackets and wetsuits should be worn while crab fishing;
- A roving surveillance team along the beach at busy periods can reaffirm safety messages;
- Fishers (especially males) should be conscious of their tendency to overestimate their ability and underestimate the risks in the water; and
- Signage warning of the risks and dangers at beaches should be

<sup>32</sup> Inquest into the death of Heng Li, CSU-2014-WHG-000292, 21 December 2015.

<sup>33</sup> The Findings into the death of Heng Li, CSU-2014-WHG-000292, 21 December 2015 were released

around this same time, and endorsed these efforts and recommendations.

<sup>34</sup> From the Inquest into the death of Heng Li, CSU-2014-WHG-000292, 21 December 2015.

maintained in a variety of recognisable languages.

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

## Fall

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### Freeman [2018] NZCorC 92 (28 November 2018)

#### CIRCUMSTANCES

Joyce Freeman died in Mossbrae Residential Home and Hospital, Mosgiel on 12 May 2016. The cause of her death was bronchopneumonia due to fractures of the cervical spine as a result of a fall. Dementia was found to be a contributing factor.

Mrs Freeman, aged 94, was a resident of Mossbrae Residential Home and Hospital in Mosgiel. On 5 May 2016, she was found on the floor in her room and the next day she was taken to Dunedin Hospital where she was found to have fractures of her 1<sup>st</sup> and 2<sup>nd</sup> cervical vertebrae and a dislocation of her 6<sup>th</sup> and 7<sup>th</sup> cervical vertebrae. Following discussions with spinal surgeons and her family, a decision was made not to operate and instead provide palliative care. She was transferred back to Mossbrae Hospital on 11 May 2016 where she died on 12 May at 3.15 pm.

Mrs Freeman had regular falls risk assessments at Mossbrae. A care plan was in place, which included falls prevention strategies. It states that Mrs Freeman was very anxious about falling and unsteady on her feet, requiring the following to transfer: two people to assist; a frame; a lifting/walking belt; and a sling hoist, or standing hoist. It also provided that “bedside restraints are to be in place when Joyce is in or on her bed – to be reviewed

3/12 at Clinical Review.” Her falls risk was reviewed every three months.

On the afternoon of 5 May 2016, Mrs Freeman had been hoist transferred to her chair and a blanket was placed over her legs as usual. Her bell was within reach and her overbed table was in front of her. At about 3 pm she was found on the floor of her room.

A report from the staff who found her shows that her fall was not witnessed. She was found “wedged up against the open door in the doorway to her room”. She was on her right-hand side. She was manoeuvred into a position where she could be clinically assessed before she was hoisted from the floor into her bed, using a sling hoist.

Mrs Freeman had a painful right arm, a bump and graze on the top of her forehead, and a painful neck. She told staff that she had been leaning over to pick something off the floor, which staff thought was likely one of her tissues or hankies. She was checked for injury and complained of a sore head and neck. She was given analgesia and Dr Bulow and her family were contacted.

Dr Bulow told staff that he would visit the next morning which he did. He found her to have a bruise on the left forehead, a clearly sore arm and all her neck movements were sore. Her face was swollen generally and her speech was slurry. He was concerned that she had a neck injury and concussion. After discussion with her family, Mrs Freeman was transferred to Dunedin Hospital.

Mrs Freeman was investigated and found to have significant fractures involving the cervical spine. The following morning the orthopaedic surgeons reviewed her and consulted with a spinal surgeon. Due to Mrs Freeman’s background of significant osteoporosis, her age, cognitive impairment, lack of mobility normally, and history of frequent falls, it was considered that operative management would not be appropriate. The spinal surgeon also advised that surgery would be difficult, with a high rate of failure and an extremely high chance of Mrs Freeman not surviving it.

A discussion was had between the Orthopaedic team, the Medicine for the Elderly Team and family members. A plan was put in place, in association with her GP to try to get her back into Mossbrae and keep her comfortable with an understanding that there was a high risk that she would not survive her injuries.

## RECOMMENDATIONS OF CORONER JOHNSON

To: Mossbrae Residential Home and Hospital

- I. Mossbrae advised me that Mrs Freeman had restraints to prevent her falling out of bed and that after her fall on 5 May 2016 her falls prevention strategies were updated to include a lap belt when she was in a chair.

I recommend to Mossbrae that if it has not already done so, to consider the use lap belts for other residents who are left unattended and out of sight in armchairs and are a significant falls risk. The use of a lap belts would of course need to be balanced against the fact that a lap belt is a restraint and curtails a person's freedom. My recommendation is therefore only to consider the use of these in residents who are at risk of the sort of fall that Mrs Freeman had and have the sort of cognitive and physical limitations that she had. I do not consider this recommendation to in any way take the place of regular sightings of these vulnerable residents.

## Reid [2018] NZCorC 95 (3 December 2018)

### CIRCUMSTANCES

Justin Noel Colin Reid of Palmerston North died on 6 November 2017 at Palmerston North Hospital of a severe traumatic brain injury.

Justin was 8 years old and lived with his family. On 4 November, Justin had been playing at a local primary school with his brother and a friend. They were on the

roof of a classroom, having climbed up a structure attached to one of the classroom walls.

Justin walked over the roof of a walkway between two classrooms. It was made of sheets of polycarbonate roofing material. As Justin walked up toward the apex of the roof, he fell through a sheet of polycarbonate onto the concrete approximately four metres below.

Justin's hit his head on the concrete and went unconscious. An ambulance transported him to Palmerston North Hospital. Investigations showed that Justin had suffered a severe traumatic brain injury with no chance for survival.

The failure of the roofing material to bear Justin's weight and the fact that Justin was on the roof were both causative factors in his death. Given his age, it is likely that Justin did not appreciate the risk of walking on the polycarbonate roofing material.

## RECOMMENDATIONS OF CORONER J P RYAN

To: The Office of the Minister of Education

- I. That the Ministry of Education consider the appropriateness of utilising roofing material on any structure on school grounds which may shatter or break if walked upon; and if such roofing material is to be utilised, then what measures can be implemented to mitigate the risk of young people falling through those roofs.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photos of Justin, following his death, in the interests of decency.

## Pellett [2018] NZCorC 96 (5 December 2018)

### CIRCUMSTANCES

Nicola Pellett died in Christchurch Hospital Intensive Care Unit on 11 August 2015. The cause of death was a high energy impact head injury (diffuse traumatic axonal injury Grade 3) resulting from a fall from a horse. Her death was accidental.

Mrs Pellett was an experienced equestrian, who had been riding since she was 8 years old. She was a competitive dressage rider who schooled and trained her own horses at the family property, and coached young riders through the local Pony Club. In return for her coaching, Eyreton Pony Club granted her ground user rights to their grounds at Mandeville Sports Grounds. Mrs Pellett was conscientious about safety, always wearing a helmet, boots, and suitable clothing when riding.

Mandeville Sports Grounds is a large section of land that is operated by the Mandeville Sports Club (MSC), and has multiple sports operating in various areas of the property. At this time, Mandeville Sports Club was having work done on the property in preparation for an upcoming event. Part of this included fencing work that was being done across the grounds. MSC had arranged two quotes, and had eventually accepted a quote by Paul Addie, of Addie Contracting Limited (ACL).

There was some confusion about when Mr Addie was to begin the work, due to a lack of communication between Mr Addie and MSC. Nevertheless, on Wednesday 5 August, Mr Addie arrived at the site late in the afternoon, and arranged supplies and began preliminary work in order to build fences in earnest the following day. On Wednesday 5 August, Mr Addie sited a horse rider in the 'Back Paddock' that he was beginning to put a new fence in, but he continued with his work without alerting them to the hazards. Mr Addie mounted a guide wire for the fence in the 'Back Paddock', and left it tensioned overnight, close to ground level, with spray paint 'dazzle'

every six metres to indicate the location of the fence posts and increase visibility of the line.

Neither MSC nor ACL took any steps to limit access to the worksites, nor was there any signage in place indicating the work that Mr Addie was undertaking or the hazards that went with it. MSC did not communicate these hazards, or that work was being undertaken on site with any of the affected members of affiliated clubs. MSC did not communicate the publicly accessible nature of the site to Mr Addie, nor did they seek a Health and Safety plan from ACL or any information that detailed the order in which Mr Addie intended to carry out the fencing work.

On Thursday 6 August, Mrs Pellett and a friend went riding together at the Mandeville Sports Grounds. As they rode together across the 'Back Paddock', Mrs Pellett's horse came into contact with the fencing guide wire that Mr Addie had left unattended the previous day. Mrs Pellett was found lying on the ground with her horse standing beside her. Mrs Pellett was taken to hospital unresponsive and it was discovered that she had suffered an unsurvivable head injury. Five days later, life support was removed, and she died at 7.35 pm on 11 August 2015.

### COMMENTS OF CORONER JOHNSON

- I. Changes in legislation have addressed some of the factors that enabled the environment in which the present case arose to exist: principally the new Health and Safety at Work Act 2015. Under the 2015 Act, Persons Conducting Business or Undertakings are required to communicate with each other and ensure that they discharge their duties to site users, if necessary by communicating the site hazards and restricting access or using other measures as appropriate.

## RECOMMENDATIONS OF CORONER JOHNSON

To: Fencing Contractors Association of New Zealand

I do not intend to make recommendations which specifically address guide wires. Instead, I make two recommendations to the Fencing Contractors Association of New Zealand (FCANZ) to raise the awareness of fencing contractors of the hazards posed by guide wires and the steps that should be taken to mitigate these.

- I. I recommend that FCANZ publish an article, suitably anonymised, in their magazine 'Wired', and in their E-News which uses this accident as a case study to highlight the measures that could or should have been taken both broadly (with respect to health and safety and the communication between parties), and more narrowly (regarding the guide wire) in order to reduce the likelihood of a similar incident.
- II. I also recommend that FCANZ use its advisory role to develop and publish guidelines for fencing contractors, regarding fencing in public areas. At the discretion of FCANZ, these could cover good/best practice fencing for such an area, health and safety measures to be taken when working a public area like MSC, and any other pertinent matters FCANZ deems relevant. Once these guidelines are developed, they should be publicised to members through the two aforementioned FCANZ publications.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any evidence relating to Mr Addie's health, on the grounds of personal privacy and in the interests of justice.

## Fire

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### Theiventhiran [2018] NZCorC 78 (24 October 2018)

#### CIRCUMSTANCES

Umadhevi Theiventhiran of Flat Bush, Auckland died on 22 December 2016 at home of smoke inhalation and burns, due to a house fire.

On the night of 21 December 2016, Umadhevi and her family were at home. They had an evening meal, watched television, and then went to bed around 10pm. In the early hours of the morning on 22 December, a fire started in the house. A family member woke to find it moving up the stairs of their house. He called out to his family and escaped the house with another.

Fire and emergency services arrived, however, some other family members, including Umadhevi were found dead in the house. The origin of the fire was identified as being upholstered furniture and furnishings in the lounge room. Evidence suggested that a smouldering fire may have developed on the furniture or a floor rug. The cause of the fire could not be determined. Sometime after the fire, someone suggested, by anonymous letter, that the fire was arson. There was no evidence to support this allegation and police determined the fire to not be suspicious.

The remains of a single smoke alarm were recovered. The location of it was near the house's entry foyer on the ground floor, adjacent to the bedroom on that floor where the two family members who escaped the fire were sleeping.

#### COMMENTS OF CORONER S HERDSON

- I. By way of comment it is important to recognise one aspect highlighted by this case and already discussed in relation to detection and alarm

systems (the second actionable outcome set out in the Fire Investigation Report).

It is important to recognise the widely promoted public fire safety and protection messages, specifically in relation to smoke alarms. These messages have been reiterated in many public safety campaigns and information is widely available, for example, information contained on the relevant website which sets out clear information about smoke alarms: “Working Smoke Alarms Are Your Only Voice” [<https://fireandemergency.nz/>].

In the present case, the evidence shows there was a smoke alarm and that it activated. However, it was a single smoke alarm. The current safety information from Fire and Emergency New Zealand demonstrates that there should be a greater number of smoke alarms in such a domestic setting. For example, one alarm on each level as a minimum, with the recommendation that there is one alarm within, or near, each sleeping space. In some building and tenancy situations there are associated mandatory requirements [Residential Tenancies (Smoke Alarms and Insulations) Regulations. Smoke alarms are a requirement under New Zealand Building Code clause F7 Warning systems. The requirement is applicable to new homes and all existing homes undergoing building work].

Accordingly, the specific topic of smoke alarms has been reiterated by way of comment in order to support the actionable outcomes set out in the Fire Investigation Report, and also to highlight the existing public safety messages already available which point to the need for greater numbers of smoke alarms to be installed in domestic settings.

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

by police that show the deceased, in the interests of decency and personal privacy, and the name of the person who supplied police with the anonymous letter alleging that the fire was arson, in the interests of personal privacy.

## Roberts [2018] NZCorC 85 (9 November 2018)

### CIRCUMSTANCES

Stephen John Roberts of Auckland died on 10 June 2018 at home of soot and smoke inhalation and thermal injuries following an accidental house fire.

On 10 June 2018, a fire started in Mr Roberts home. His neighbours noticed the fire and called emergency services. It appeared that extensive renovations had been taking place inside the house, and the interior walls and ceilings were lined with a mixture of gypsum plasterboard and composite wood sheeting such as MDF board.

The investigation into the fire identified that the fire was caused by an unidentified electrical fault in the ceiling void in the area above the dining room table. The fire had spread rapidly and developed due to the wall linings. Mr Chopping of Chopping and Associates, electrical safety engineers, postulated that the electrical fault may have originated in a ceiling rose light fitting located above the dining room table, as evidence indicated that is where the fire burned for the longest time.

No smoke alarms were found, and no witnesses heard smoke alarms.

### COMMENTS OF CHIEF CORONER, JUDGE D MARSHALL

- I. Following receipt of Mr Chopping’s report, I asked him whether there were any suggestions he could make to improve the safety of the electrical fittings involved. He notes that

electrical installations do wear out over time and connections do fail which can lead to overheating and a fire in the surrounding building elements. He also notes that many homes are fitted with smoke detection devices but these are generally not installed in ceiling areas. He considers this would be an advantage but would not always be easy to maintain and the alarm would need to be audible throughout the premises.

Mr Chopping refers to changes in the Electricity Regulations which require mandatory residual current devices(RCD) protection to be installed on all new homes. These do provide some protection of the wiring within an installation and may prevent a fire developing, but not always. In addition, the new wiring rules for Australia and New Zealand require that arc fault detection devices (AFDDs) are on all power circuits in bedrooms of new homes. These devices pick up faults in wiring circuits and turn off power to the circuit involved. To provide for the safety of older properties, both RCDs and AFDDs can be installed in older homes.

In summary, Mr Chopping considers the introduction of smoke detection equipment in ceiling voids which are audible throughout the home would improve the chance of survival should a fire occur in a ceiling void. The fitting of RCDs and AFDDs would also greatly improve safety in homes

I agree with Mr Chopping that working smoke alarms should be standard in all houses. Given the other comments Mr Chopping has made, I will send a copy of this finding to the Ministry of Business, Innovation and Employment which provides policy and technical advice on building systems – including protection from fires.

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

## Medical condition

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### Andrew [2018] NZCorC 80 (26 October 2018)

#### CIRCUMSTANCES

Annmarie Andrew died at Auckland Hospital on 22 September 2015 of an acute myocardial infarction (heart attack) secondary to coronary artery atherosclerosis.

On 21 September 2015 Annmarie Andrew, aged 73 years, underwent urgent coronary angiography (the placement of stents in her coronary arteries) at Auckland Hospital, following a myocardial infarction (heart attack). She had been transferred there from North Shore Hospital earlier in the evening. Although the angiography proceeded without major incident, the blood flow within her coronary arteries failed to recover after the procedure, and she became profoundly hypotensive (had low blood pressure), with cardiogenic shock (shock due to the failure of the heart to pump). In light of Mrs Andrew's widespread coronary disease, extensive infarction, and her poor prognosis, further treatment and resuscitation efforts were not undertaken. She died in the presence of her husband at about 1.30am.

On 17 September, Mrs Andrew became ill with nausea and dry retching. On 18 September she also started to complain of having back pain near her left shoulder. On Saturday 19 September, Mrs Andrew was taken to North Shore Hospital by her husband. He was told her illness could be viral - "a urinary infection". Mrs Andrew was discharged home around lunchtime.

Because she had not recovered, Mr Andrew took his wife to the hospital again on Sunday 20 September in the

morning. More tests were conducted and she was again discharged home at lunchtime with a diagnosis of urinary infection. However, later that day Mrs Andrew was feeling worse, so Mr Andrew returned her to hospital for a third time. Mr Andrew described her as "...in agony with back pain". More tests were done, and eventually it was agreed that she would remain in hospital overnight. At 9.30pm, Mrs Andrew informed her husband that she would be having an electrocardiogram (ECG), and that she may be transferred to Auckland Hospital. Mr Andrew called North Shore Hospital at 11.30pm for an update and was advised that clinicians thought Mrs Andrew was having mild heart attacks, and that she was being transferred to Auckland.

The hospital has no record of Mrs Andrew presenting to the Emergency Department on 19 September. Moreover, the clinical notes from the subsequent consultations on 20 September do not reference the alleged 19 September presentation. There are no records of any tests taken or reported on 19 September, and no other evidence available at the hospital to indicate that Mrs Andrew was there on that day.

Mrs Andrew reported having had nausea for three days and vomiting after meals. She did not report diarrhoea, abdominal pain, urinary symptoms, cough or any other issues. The doctor was able to ascertain that she had been to her General Practitioner several times in the past for urinary tract infections. Mrs Andrew was also on an immunosuppressant medication for her arthritis, and had previously had gastro-intestinal bleeding related to non-steroidal anti-inflammatory drugs and aspirin use. When he examined her, the doctor found Mrs Andrew to be well with normal vital signs, a normal abdominal examination, and normal examination of her heart and lungs. Blood tests showed Mrs Andrew to have a normal white blood cell count, but her CRP (a marker of inflammation) was elevated. Mrs Andrew's urine test also showed high white blood cells, although no bacteria was seen. The doctor was suspicious that Mrs Andrew was suffering from a urinary tract infection. The absence of bacteria in her urine was attributed to a recent course of antibiotics.

Mrs Andrew was treated with an anti-nausea medication and given a script for antibiotics. After a period of observation in which her nausea settled, and she remained looking well and un-distressed, Mrs Andrew was discharged home. She was advised to return to the Emergency Department if she became symptomatic again, or her condition changed.

Mrs Andrew re-presented to the Emergency Department (ED) later that afternoon at about 5.10pm. By this time, she was complaining of severe back pain and associated nausea. She was initially triaged by nursing staff who recorded Mrs Andrew's vital signs and observations to be within normal limits. Further blood tests were also taken. Pain relief (paracetamol), anti-nausea medication, and fluids were prescribed by the ED registrar.

Mrs Andrews was eventually reviewed by a specialist in Emergency Medicine at approximately 8.50pm. In the intervening period, she had been under observation by nursing staff. The doctor noticed immediately that Mrs Andrew appeared restless. She had significant nausea, unwellness, some upper back and shoulder pain, and further vomiting after returning home earlier in the day. However, her vital signs were good and there were no prominent abnormal physical findings. The doctor was considering alternative diagnoses (as she did not believe Mrs Andrew had a urinary tract infection), and it was clear that Mrs Andrew needed to be admitted. Her condition was, at that time, not considered to be too serious. In anticipation that further testing was required, the doctor suggested to Mr Andrew that he go home.

In the context of Mrs Andrew's discomfort, and to be thorough, the doctor requested an ECG to rule out cardiovascular reasons for her discomfort. That returned the unexpected finding that Mrs Andrew had suffered a ST myocardial infarction – a heart attack (STEMI). She was moved immediately to the resuscitation room at 9.15pm, and referred to the general medicine and cardiology teams. A troponin test was undertaken on the blood taken from the morning to try and 'time' the heart attack. It showed an elevated troponin indicating that Mrs Andrew's heart attack had occurred prior to her first ED

visit (possibly 1 – 2 days earlier). Mrs Andrew was transferred to Auckland Hospital following further testing.

The matter was referred to the Health and Disability Commissioner. Expert clinical advice was also sought from an Emergency Department Physician, Dr Louise Finnel. Both reached the conclusion that a diagnosis of urinary tract infection was tenuous. However, they agreed that Mrs Andrew presented atypically for someone experiencing a myocardial infarction. The STEMI diagnosis following ECG was a completely unexpected finding. It is accepted that making the diagnosis was a difficult one, particularly at the morning consultation, with the doctor and nurse being unaware of her current physical pain. The HDC expert concluded that the failure to suspect a diagnosis of cardiac syndrome, and therefore, to order further tests (a troponin/ECG), was not a significant departure from expected standards.

#### COMMENTS OF CORONER MCDOWELL

- I. Notwithstanding my conclusions that Mrs Andrew's diagnosis was difficult to make in the context of her symptoms, and that, it cannot be determined that for her, an earlier diagnosis would have made a difference to the outcome, it must be asked whether lessons can, nevertheless, be learned from Mrs Andrew's sad death.

Dr Finnel commented in her advice to me, that elderly patients often present to ED in an undifferentiated manner, making it difficult to pin down a diagnosis. They also tend to play down their symptoms not wanting to be a bother to anyone. At Middlemore Hospital there is, therefore, an informal, unwritten practice that elderly patients get ECGs as a matter of course – even if they present with a seemingly unrelated problem. She says further, that while it is not reasonable to make a blanket rule about who gets an ECG as part of their nursing assessment, it would not be unreasonable to recommend that an elderly patient, particularly immunosuppressed with non-specific symptoms should have a mid-stream urine test, ECG and

routine blood tests done as part of a diagnostic work up.

Dr Landman responded to this suggestion and noted that Mrs Andrew did have routine blood tests, and a mid-stream urine as part of her diagnostic work up. He did not believe that a blanket rule to screen all elderly patients with an ECG, was evidence-based practice. He did however, accept that, in the absence of an explanation for a patient's symptoms, in the group mentioned by Dr Finnel (immunosuppressed with non-specific symptoms) it would be entirely reasonable, and desirable to do an ECG to rule out myocardial infarction.

I do not consider that a formal recommendation is required in this matter. However, in light of Dr Finnel's comments, and the acceptance of those comments by Dr Landman, I consider there would be some benefit in utilising Mrs Andrew's case for teaching, and as a means of highlighting the diagnostic difficulties of acute coronary syndrome, presenting atypically. I therefore, suggest to Dr Landman that Mrs Andrew's case be discussed as part of formal learning within the Emergency Department – so as assessing clinicians can, in particular, be alerted to Dr Finnel's suggestion.

## Edmonds [2018] NZCorC 88 (21 November 2018)

### CIRCUMSTANCES

Bryan Joseph Edmonds of Whataroa died on 14 July 2017 at 290 Scally Road, Whataroa of a sudden cardiac death in the context of hypertrophic cardiomyopathy, being a death due to natural causes.

Mr Edmonds was a farmhand on the West Coast when, on 14 July, he was found by a workmate unresponsive and without a pulse in a farm paddock.

In July 2014, when admitted to Christchurch Hospital for appendicitis, Mr Edmonds had a couple of ECGs

performed which showed anomalous results and caused the anaesthetist to advise Mr Edmonds to follow up with his GP for further investigations. This was never done, and no referral was made by the Canterbury District Health Board (CDHB). The CDHB do not appear to have completed a discharge summary, and Mr Edmonds's GP practice was incorrect on his patient records.

In May 2015, Mr Edmonds reported to the Buller Medical Centre complaining of occasional blackouts, which were thought to perhaps be cardiac related. The doctor ordered a chest x-ray, but this does not appear to have been done. Although the GP at the Buller Medical Centre could have seen the ECGs done in 2014, they received no notification of the abnormal results, nor a discharge summary from the CDHB.

There was evidence of a lack of continuity of care from the CDHB which could have denied the GP relevant information when confronted with symptoms of cardiac origin in 2015. Although there are apparent shortcomings in the CDHB processes, these must be moderated by the fact that Mr Edmonds did not have the chest x-ray undertaken and did not follow up with his GP in 2015.

#### **RECOMMENDATIONS OF CORONER ROBINSON**

To: the Canterbury District Health Board

In the circumstances of this case, I recommend that the Canterbury District Health Board:

- I. review its procedures as to the identification of the medical practice with which the patient is enrolled. I note patient registration with GP practices is recorded by the Ministry of Health, and query whether DHB computer systems could access such data to reduce the potential for errors in data input when patients are admitted to hospital; and
- II. ensure that files relating to discharged patients are reviewed to ensure that discharge

summaries recording all clinical findings be sent to the correct general practitioner.

The Canterbury District Health Board has accepted both these recommendations and has provided details on improvements and initiatives that are currently underway or in place, which are consistent with these recommendations.

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

## **Forestry**

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### **Hinds [2018] NZCorC 83 (8 November 2018)**

#### **CIRCUMSTANCES**

Arthur William Hinds died on 23 September 2017 at 31 Boat Harbour Road, Whenuakite of exsanguination due to a tree-felling accident.

On the afternoon of 23 September, Mr Hinds was cutting a pine tree down on a steep embankment. He used his chainsaw and initially cut on the downhill side of the tree to make the tree fall down the slope. Mr Hinds then moved to the uphill slope and began to saw the tree to the point where it would fall down the slope.

However, the tree did not topple forward down the bank, but instead, part of the log split, and it tilted backwards up the slope towards Mr Hinds. Mr Hinds was struck by the log on his left leg and it came to rest upon him as it broke free of the stump.

## COMMENTS OF CORONER M ROBB

- I. The *Approved Code of Practice for Safety and Health in Arboriculture* outlines the method required to safely fell a large tree, and this is also detailed in *A Guide to Safety and Tree Felling and Cross Cutting*, first published by OSH in 1980 and reiterated in the *Approved Code of Practice for Safety and Health and Forestry Operations as published by MBIE/WorkSafe*.

I recommend those code of practice explanations to anyone who undertakes the task of felling a large tree. It is particularly important when felling a tree that is positioned on a slope.

### In words:

- i. Begin by cutting out a scarf (a wedge) in the direction where it is planned for the tree to fall.
- ii. The scarf should be at a depth of 1/4 to 1/3 of the tree diameter.
- iii. On the opposite side of the tree to the scarf cut the backcut. This should be a flat cut, i.e. no wedge/scarf. This backcut should not be at the same level as the scarf cut, it should instead be above the horizontal portion of the scarf cut.
- iv. The depth of both cuts (scarf cut and backcut) should leave a hingewood step of 10% of the tree's diameter.

**By way of diagram** the recommended approach is set-out on the following page: (figure omitted – see finding)

For each tree being felled an escape route shall be cleared on the safest side. (figure omitted – see finding)

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

## Sudden unexpected death in infancy

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### Yukich [2018] NZCorC 79 (25 October 2018)

#### CIRCUMSTANCES

Royal Prize Yukich died on 12 September 2015 at home of Sudden Unexplained Death in Infancy (SUDI).

Royal was a two-week old baby boy. He was born on 29 August 2015 two weeks early by a planned caesarean section as he was suffering from inter-uterine growth retardation. It was noted by an employee of the Ministry of Social Development that two of Royal's older siblings had been taken into the care of whanau groups. It was also noted in the post-mortem report that Royal appeared to be a well nourished and well cared for baby.

At home, Royal and his mother slept in the lounge as it was the warmest room in the house. Royal would not settle in the bassinette that had been set up for him on the first night at home. Since then, he was put to sleep in the double bed with his mother.

On the night of 11 September, Royal's mother put him to bed, and later went to sleep on the other side. When she woke at 5am, she noticed that he was not breathing and commenced CPR but Royal could not be saved.

## RECOMMENDATIONS OF CORONER D BELL

- I. In 2017 the New Zealand Medical Association published a paper addressing SUDI deaths. The paper states that although there has been “a major reduction in overall infant mortality, sudden unexpected death in infancy (SUDI) continues to be of concern in New Zealand, as the rate is high by international standards and is even higher in indigenous Māori.” The study found that the two major risk factors for SUDI are maternal smoking in pregnancy and bed sharing. Infants exposed to both of these risk factors were shown to be at far greater risk than children who are not exposed to either factor. The study concludes that SUDI mortality could be reduced to just 7 deaths a year in New Zealand. This is in stark contrast with the 137 SUDI deaths recorded for the 3-year period of the study (1 March 2012 – 28 February 2015) [Edwin A Mitchell and others “The combination of bed sharing and maternal smoking leads to a greatly increased risk of sudden and unexpected death in infancy: The New Zealand Nationwide Case Control Study” (2017) 130 NZMJ 52 at 52].

This study also showed that “the high rate of SIDS [sudden infant death syndrome] in Māori is based largely on the high prevalence of risk factors (especially smoking and bed sharing) in the Māori population.” [Ibid at 53].

In this study, almost half of the SUDI deaths considered involved both maternal smoking and bed sharing [Ibid at 58]. Low birth weight was also shown to be factor [Ibid at 59].

I have no information before me regarding whether or not [Royal’s mother] smoked tobacco during her pregnancy... We do know that Royal was sharing his bed with [his mother], and that he had a low birth weight.

Royal was a Māori baby, but as the study explains, the higher incidence of SUDI among Māori is a result of the increased prevalence of the risk factors and is not a result of being Māori per se.

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

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

## Gunshot

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### Farr [2018] NZCorC 89 (21 November 2018)

#### CIRCUMSTANCES

Paul Nicholas Farr of Lincoln, Christchurch, died on 6 June 2016 at his home of a gunshot wound to his chest.

Mr Farr was retired and lived with his wife, Ann Judson-Farr. Monday 6 June was a public holiday for Queen's Birthday. Mr Farr was doing jobs around the house and told Mrs Judson-Farr that he was going to shoot a sick chicken that afternoon so not to be alarmed if she heard a gunshot. A couple of minutes after she heard the gunshot, Mrs Judson-Farr went looking for her husband. He was lying face down on the gravel driveway, and when she turned him over she saw he had a gunshot wound in the middle of his chest.

A shotgun was located on top of furniture in the boot of the car. Family members told Police that Mr Farr owned a faulty gun, although it was unclear whether this was the same gun that had wounded Mr Farr. A forensic scientist concluded that the wound was not self-inflicted. Police were satisfied that no other person was involved in Mr Farr's death.

The cause of Mr Farr's death was determined to be an accidental gunshot wound to the chest.

#### **COMMENTS OF CORONER TUTTON**

- I. I do not consider that there are any recommendations which need to be made in this inquiry.

However, I take this opportunity to reiterate the importance of gun safety. I note especially that the New Zealand Police have published Seven Firearms Safety Rules, being:

1. Treat every firearm as loaded
2. Always point firearms in a safe direction
3. Load a firearm only when ready to fire
4. Identify your target beyond all doubt
5. Check your firing zone
6. Store firearms and ammunition safely
7. Avoid both alcohol and drugs when handling firearms.

Had these rules been adhered to, Mr Farr's tragic death could have been avoided.

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



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