



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

# Recommendations Recap

A summary of coronial recommendations and comments  
made between **1 January** and **30 June 2019**

# Coroners' recommendations and comments

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

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

The Office of the Chief Coroner maintains a public register of these recommendations and comments and publishes summaries of those which are not prohibited from being published by order of court or law. Recommendations Recap includes all those recommendations and comments which have been summarised and published. This edition includes 25 recommendations and/or comments issued by coroners between 1 January and 30 June 2019.

This issue also features a case study report on child drowning deaths in New Zealand. Key statistics relating to these deaths, an outline of the issues involved and the legal framework surrounding child drownings. It also has a summary of recent recommendations made by coroners following these deaths.

**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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# Recommendations and comments

## 1 January to 30 June 2019

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/>

### Alcohol-Related

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#### Ruffell [2019] NZCorC 25 (17 June 2019)

##### CIRCUMSTANCES

Hautehoro Ruffell, of Clarks Beach, died at 833 Kingseat Road, Kingseat on 3 March 2018 as a result of an acute alcohol intoxication.

On 2 March 2018, Mr Ruffell went to a party in Takanini. During the evening he became intoxicated and eventually became unresponsive although still breathing. He was carried to a mattress in the lounge as he could not walk. Later that night, the host of the party noticed that Mr Ruffell had urinated, defecated and vomited. He was then put on his side in case he vomited again. At about 1 am on 3 March 2018 Mr Ruffell was put into a car and driven to a relative's house. During the car ride he stopped breathing and despite resuscitation he could not be revived. Analysis of his blood found Mr Ruffell had a blood alcohol level of 462 milligrams per 100 millilitres. For comparison purposes, the legal blood alcohol limit for a New Zealand driver 20 years or older is 50 milligrams per 100 millilitres. The forensic pathologist found that due to his level of intoxication, Mr Ruffell was unable to protect his airways which led to the aspiration of his gastric contents. This would have contributed to his respiratory distress.

##### COMMENTS OF CHIEF CORONER MARSHALL

- I. Alcohol.org.nz provides the following advice to care for people who lose consciousness through drinking alcohol.
  - i. Call an ambulance as soon as possible
  - ii. Put the person in the recovery position
  - iii. Make sure they are breathing and their mouth is empty

iv. Don't ignore someone who is unconsciousness or vomiting

v. Don't leave someone alone, especially if they are unconscious.

- II. This case is a tragic reminder of the dangers of drinking too much alcohol. It also serves as a reminder of the steps that can be taken to protect someone who has had too much to drink.

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

## Long [2019] NZCorC 26 (21 June 2019)

### CIRCUMSTANCES

Deborah Jeanne Long collapsed while in a spa pool and died on 6 March 2019 at Te Wepu Intrepid Pod Retreats, French Farm, Banks Peninsula. The cause of death was a functional cardiovascular collapse due to alcohol intoxication and hot spa pool immersion in a context of hypertensive heart disease.

Ms Long was at the retreat with her partner, to celebrate his birthday. She had been drinking alcohol before getting into the spa pool and continued drinking while she was in it. Her partner heard glass smashing and turned to find Ms Long unresponsive in the pool. He pulled her out and ran for help. When emergency services attended, they confirmed that Ms Long had died. On analysis of the blood and urine samples, Ms Long was found to have had a blood alcohol level of 245 milligrams per 100 millilitres, almost five times the legal blood alcohol limit for a New Zealand driver 20 years old or over.

### COMMENTS OF CORONER TUTTON

- I. Dr Sage, the forensic pathologist, commented that collapse with sudden death or total immersion indistinguishable from drowning is a well-recognised risk of the use of hot tubs, particularly in the context of concurrent alcohol intoxication and underlying cardiovascular disease.
- II. I note the further comment of Dr Sage that there is some contention in literature from the United States as to whether or not treated hypertension is also a risk for cardiovascular collapse in these circumstances.
- III. Some spa pool suppliers advertise that spa pools may help lower blood pressure.
- IV. The extent to which the public is aware of the risks identified by Dr Sage, particularly in the face of advertising of the type referred to above, is unknown. Publication of the risks articulated by Dr Sage may assist to reduce the chances of further deaths occurring in circumstances similar to this in which Ms Long's death occurred.

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.

# Death in Custody

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## Braxton [2019] NZCorC 2 (11 January 2019)

### CIRCUMSTANCES

Jayde Melissa Braxton, 29 years old, died on 19 January 2016 at Christchurch Hospital. The cause of her death was blunt force head trauma sustained in a motor vehicle crash on 18 January 2016.

Ms Braxton had a long history of mental health issues, and at various times was subject to Compulsory Treatment Orders under the Mental Health (Compulsory Assessment and Treatment) Act 1992. At the time of her death, she was a voluntary patient at Hillmorton Hospital (run by Canterbury DHB).

Ms Braxton had requested a crisis admission to Hillmorton Hospital on 18 January 2016, as she was feeling unsafe, with an increased risk of suicide. Ms Braxton was given permission to leave the hospital that night but was not allowed to drive. Later that night, Ms Braxton left the hospital and was heard to accelerate away in her car. Police were called and were advised Ms Braxton was driving against medical advice.

Ms Braxton's car was found by two security guards shortly before midnight, crashed within a walkway tunnel that runs underneath the Brougham Street motorway. Ms Braxton was lying next to the car and taken to Christchurch Hospital, where she was found to have sustained an unsurvivable head injury.

### RECOMMENDATIONS OF CORONER TUTTON

- I. I make the following recommendations pursuant to s 57(3) of the Coroners Act 2006:
  - a. That, with the assistance of ethical and legal expertise, CDHB reviews its policies and expectations of clinical staff in situations where a clinical service user indicates serious violent or self-harm intent and where that person's ability to think clearly is likely impaired by staff administered medication.
  - b. That its (CDHB's) crisis plans include recorded agreement by the patient that his/her car keys will be handed in at the time of admission and not returned if the clinicians treating him/her deem it unsafe for him/her to drive.
- II. The CDHB has indicated that it accepts those recommendations.
- III. A copy of this Finding will be sent to the Ministry of Health for distribution to, and consideration by, all District Health Boards.

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.

## Tan [2019] NZCorC 8 (25 January 2019)

### CIRCUMSTANCES

On 3 November 2014, the body of Keen Yee Adam Tan (Adam) was found by members of the public lying on mudflats in the Henderson Creek, near the Central Park Drive overbridge, Henderson. It was determined that Mr Tan had died from environmental hypothermia.

On Friday 24 October, while visiting his close friend Lucas Hanson, Mr Hanson became concerned for Mr Tan's mental wellbeing. On Sunday 26 October Mr Tan arrived at Mr Hanson's house unexpectedly. Mr Hanson noticed immediately that Mr Tan was not himself and seemed "tranced". Mr Tan later commented to Mr Hanson that he thought he was living in a PlayStation game, and he became tense, hostile, and aggressive. Mr Hanson managed to convince Mr Tan that he needed some help. Accordingly, they drove to Mr Tan's home with a view to explaining to his parents that he was not well. After some discussion at the house Mr Hanson contacted the mental health crisis team. It was suggested that Mr Hanson bring Mr Tan to Waitakere Hospital for an assessment. Mr Tan agreed to go to hospital and requested Mr Hanson and his sister, Cindy, to come with him.

Adam was assessed by Mental Health Services at Waitakere Hospital and a compulsory assessment and treatment order was made under s 11 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. A security guard was placed outside Mr Tan's door as a precautionary measure. However, once it became clear that Mr Tan was willing to stay for an assessment, security was stood down. Adam was assessed at about 2am, and considered appropriate for inpatient treatment.

The inpatient mental health unit for Waitakere Hospital, Waiatarau, is not attached to the main hospital where this initial assessment took place. Accordingly, it was proposed that Mr Tan would be transported to Waiatarau in Nurse Markovina's car which was parked outside the ambulance bay, approximately six metres from the door. This was usual practice in the circumstances. In anticipation of the transfer Nurse Markovina organised a security guard to accompany her and Mr Tan. Mr Tan also knew that his family would be following so that they could see where he would be staying and could come and visit the next day.

At about 3am, Mr Tan, the security guard and Nurse Markovina walked down the corridor to the Ambulance bay. Mr Hanson, Cindy, and the rest of Mr Tan's family followed. Mr Hanson stated that as they walked to the exit Nurse Markovina dropped her phone. At that moment Mr Tan ran off, sprinting towards a fence, into the carpark and a nearby bush area. Mr Hanson took chase but by the time he got into the carpark he could no longer see Mr Tan due to the darkness.

Family members and the security guard also chased after Mr Tan – however, he was unable to be located. The police were called (attending at 3.39am) and a further search was undertaken around the hospital grounds involving the police, clinical staff, and family members, without success. The use of a police dog was considered but negated, mainly due to contamination by the amount of foot traffic in the area.

Mr Tan's family contacted the police later that morning (7.08am) to report him missing. They then emailed a photograph of Mr Tan to police, as well as his bank account details. The police appear to have made no active inquiries as to Mr Tan's whereabouts either on 27 or 28 October (although family members made contact with police on both days).



In the meantime, Mr Tan's family and friends conducted their own searches in the bush area and tracks behind the hospital. They also made a poster and put up a Facebook page. On 29 October the police requested Mr Tan's bank account details from his family (which had previously been provided by the family on 27 October). Other than this request, no substantive inquiries appear to have been made by police that day. From 31 October, air and ground searches were undertaken but were not successful.

Mr Tan's body was noticed by members of the public on 3 November, and was subsequently retrieved by the police.

An investigation into these events was undertaken by WDHB mental health services, involving two clinical directors of mental health services. The investigation concluded that Mr Tan's assessment, and the subsequent plan to transport him was appropriate. No recommendations were made.

Further independent advice was sought from Dr Clive Bensemann, an experienced Consultant Psychiatrist in adult mental health services. Dr Bensemann's conclusion was that Mr Tan's assessment and plans for transport were appropriate.

Detective Sergeant Mike Clubb provided a statement detailing police processes and guidelines relating to missing person files. The person taking the report of the missing person must make an initial risk assessment. If urgent action is required a supervisor must be notified, otherwise the file proceeds on a 'routine' basis. The missing person's report is entered into the police IT system at the earliest opportunity with all available information documented or attached electronically.

In the case of missing mental health patients, it is expected that police will establish whether the person is a threat to themselves or others. The level of police action will be determined on that basis. The policy does not indicate when a structured geographical search should be initiated. However, any such decision should be based on a cumulative subjective assessment of the circumstances and information particular to the missing person. At day three the file is subject to a review by a senior staff member who will assess and advise on further steps to be taken.

## **RECOMMENDATIONS OF CORONER MCDOWELL**

### *Police Search*

- I. The Missing Persons Guidelines require the police, in the case where a mental health patient is reported as missing, to consult a Duly Authorised Officer about:
  - a. The action to take
  - b. Whether a press release is needed
  - c. The level of police assistance required
  - d. Whether the patient is likely to suffer harm
  - e. Whether the patient is likely to harm other people or damage property
  - f. The DAO attending the location when it is believed a patient considered to be a threat can be located.
- II. Mr Tan's case has, in my view, highlighted a lack of documentation (and arguably formal process) about such consultation and assessment. I also note, that in the police evidence provided to the inquiry about missing persons with mental illness, there was an emphasis about risk of self-harm (suicide) or harm to others, with less recognition or acknowledgement that a person might be at risk because of an inability to care for themselves by reason of their mental illness.

- III. While having a policy about such matters is appropriate and obviously commendable, in my view a specific risk assessment tool/document for mental health patients reported missing could ease the process and ensure that relevant information is given in a timely manner to the police from mental health services, to inform their inquiry (and its level of priority).
- IV. Such document should include relevant collateral information, and the mental health services' own assessment of risk to that person (and/or others).

#### **Recommendation 1**

- V. I therefore recommend to the New Zealand Police, and the Waitemata District Health Board that they consider formulating a risk assessment document to ensure the exchange of information (including (among other things) risk of self, to others, or of self-care) which might better inform the steps, and the priority of such steps, to be undertaken by the Police in their investigation for the missing person. Such assessment/documentation should be undertaken by a suitably qualified person, and provided to the police at the earliest opportunity after the person has gone missing.
- VI. If such recommendation is adopted, this would potentially necessitate a change to the Missing Persons Policy currently used by police. It is suggested further, that the policy should reflect an expectation that the risk assessment document be obtained as soon as possible after the person has gone missing.

#### **Response to recommendation 1**

- VII. Both the New Zealand Police and the Waitemata District Health Board (WDHB) were invited to respond to the above recommendation before it was finalised.
- VIII. No response was received from the New Zealand Police.
- IX. Dr Greg Finucane, Clinical Director for the Adult Mental Health Service at WDHB, advised my inquiry that a meeting has been set up with the Police (to take place in February 2019) to reconsider the AWOL (absent without leave) process documentation. It appears there may be some discrepancies in expectations between the Mental Health Service and Police. This is considered an appropriate forum to agree on succinct but accurate risk documentation which can then guide a joint response, including escalation if the person remains missing.
- X. I commend WDHB and the Police for their efforts in this respect.
- XI. I do not propose to alter the recommendation, as it will assist in informing some of the issues to be discussed at the proposed meeting.

#### **Mental Health Services**

- XII. Dr Bensemman commented that, in some circumstances, a family member or friend might accompany a patient during transport. The presence of a trusted family member can reduce a person's anxiety and general distress, and therefore, may reduce the likelihood of acting in response to psychotic thinking. However, such arrangement is not always appropriate or practical. Dr Bensemman noted that Mr Tan's interaction with his friend (Mr Hanson) and some family members seemed helpful. Of course, it could not be predicted that having a family member or friend accompanying Mr Tan during transport would have reduced the likelihood of him acting as he did.

- XIII. I agree with Dr Bensemman's opinion in this respect, and simply drawn this matter to the DHB's attention for consideration in future situations; namely that clinicians should consider the potential benefits or family members accompanying a patient during transport in circumstances when it is considered safe and practical to do so.

## **Response**

- XIV. Dr Finucane also provided a response to the above paragraphs. He noted the Service's agreement that, in some circumstances, allowing a willing family member to accompany a patient on transfer may reduce distress and improve the quality of the process. This could be agreed on a case by case basis (and would depend on the state of the patient, risk to the patient, and risk to the family member and staff). It is proposed to add comment on this matter to the Duly Authorised Officer training and updates, as it is the DAO who manages the process of transfer or transportation.
- XV. I thank Dr Finucane for his response, and commend the actions proposed.

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

## **McDowell [2019] NZCorC 11 (12 February 2019)**

### **CIRCUMSTANCES**

Sergei Andrew McDowell, 21 years old, died at about 10.30 pm on 6 November 2015, after being struck by a vehicle while walking on State Highway 60 from Motueka to Nelson. Sergei was wearing dark clothing and was walking in the middle of the southbound lane. The driver of the vehicle had no opportunity to avoid hitting Sergei. Sergei suffered severe injuries as a result of the impact and died at the scene.

Sergei had significant involvement with the Mental Health and Other Drugs Service from 2014, he had prior admissions to the acute mental health unit and required supported accommodation. He was last seen by Dr King, the responsible clinician, on 2 November 2015 for a routine follow-up. At this appointment, Dr King records that there was no evidence of psychotic symptoms, there were no thoughts of self-harm or harm to others and no evidence of a major mood disorder. Consequently, there was no indication that Sergei required inpatient mental health care.

The service had previously provided Sergei with multiple attempts at supported accommodation but on many occasions his behaviour, related to his addiction issues, resulted in him being asked to leave. Sergei had burned his bridges with many of the accommodation providers in Nelson and, because of the particular combination of his mental illness coupled with his drinking problems, he was not welcome back to those establishments. He had found accommodation himself at the backpackers in Motueka. This highlights a gap in the services provided to such people. There is a lack of accommodation available for people with mental health illnesses and concurrent addiction issues.

### **RECOMMENDATIONS OF CORONER RYAN**

- I. Given the circumstances of this death, I consider that it is appropriate for a recommendation to be made. Specifically, Sergei was in a 'Catch-22' situation: the supported accommodation facilities provided by NMH would

not accept him because of his addiction issues, but he needed supported accommodation because of his underlying mental illness and to help him address his addiction issues.

- II. NMH was provided a copy of the proposed recommendation, and invited to provide a response on that subject. A response has been provided. NMH acknowledges that access to sustainable supported accommodation was a significant factor in Sergei's death and agrees that this is not an isolated issue and not peculiar to the area serviced by MMH. The response notes that there are limited examples in New Zealand of supported accommodation for clients with co-existing mental health and addiction issues.
- III. NMH informs that it is working with other agencies to address (inter alia) this issue. While stating that NMH does currently work with people with co-existing conditions, and that many of the contracted providers are also able to provide support to certain levels, there is a need to strengthen the ability to manage more complex presentations.
- IV. Based on the work NMH is currently doing in this area, I am invited to modify the proposed wording of my first recommendation to modify the directive "provide" with the phrase "work to strengthen the ability to provide". I am not inclined to do so. Sergei's death can be directly linked to the lack of supported accommodation for his co-existing conditions. If he did not suffer from alcohol addiction, then he would likely have been able to take advantage of supported accommodation due to his mental illness.
- V. I am concerned that if my recommendation is modified as suggested, this may have the effect of diminishing the urgency of the situation. The response from NMH reveals that this problem has not yet been resolved. Sergei's situation was not unique; it appears that there will currently be many others who have co-existing conditions and therefore will not be eligible for supported accommodation. It is in their interests that the proper urgency is placed on the need to rectify this situation to reduce the chances of further deaths occurring in similar circumstances.
- VI. Pursuant to section 57(3) of the Coroners Act 20016, I make the following recommendation:
  - (a) That the Nelson Marlborough District Health Board provide supported accommodation as required for mental health patients who currently are unable to access such accommodation due to alcohol or other drug addiction issues.
  - (b) Such accommodation should be able to support the patients with the alcohol or drug addiction rather than making it a pre-condition of acceptance to the accommodation that the patient first deal with that addiction issue.

## Gravatt [2019] NZCorC 14 (8 April 2019)

### CIRCUMSTANCES

Zachary Gravatt of Auckland, age 22, died on 8 July 2009 at Auckland City Hospital of Neisseria Meningitidis infection (Meningococcal Septicaemia – C strain).

On 8 July 2009, Zachary was assessed by his General Practitioner with flu-like symptoms. He was referred to Auckland City Hospital, arriving at 1.43 pm. Over the subsequent hours Zachary was triaged, assessed and attended to by several clinicians. His condition continued to decline despite treatment efforts, and he died at 7.15pm that night.

Zachary's case was initially investigated by Coroner Shortland, who proceeded to make his finding as a hearing on papers and concluded the inquiry in 2011.

In September 2016, Dr Gravatt (Zachary's father) received an anonymous, unsigned typewritten letter dated 29 August 2016. Dr Gravatt sent the letter to the Crown Law Office and asked the Solicitor-General to order a new Inquiry under s 97 of the Coroners Act 2006. The requirement for the discovery of new facts relating to the circumstances of Zachary's death was satisfied, and a second inquiry was ordered.

The issues to be determined by the second inquiry included the point of diagnosis of meningococcal disease, the prescribing of ceftriaxone (an antibiotic used to treat meningococcal disease), consultant contact and attendance, whether opportunities to increase/escalate treatment options were lost, and to what extent these would have increased Zachary's chances of survival.

## **RECOMMENDATIONS OF CORONER MCDOWELL**

### **To the Auckland District Health Board:**

Three staff members made records about Zachary's care which did not reach the formal clinical record.

- I. The accuracy of clinical notes, and that they are as complete as possible, is a cornerstone of clinical care. Clinical information about a patient's condition, or what was done or not done, should be copied into the clinical record from any private notes if it is information not otherwise in the clinical record.
- II. I therefore recommend to Auckland District Health Board that it consider the issues that have arisen about such notes, and that it consider implementing a policy or protocol in relation to the writing, storage and disclosure of such notes which protects the competing interests (not least the needs of the family).

### **To the Ministry of Health:**

- I. In recognition of these issues I proposed a recommendation to the Ministry of Health (the Ministry) that it consider forming a working group to develop a national antimicrobial guideline.
- II. The Ministry (through its Chief Medical Officer, Dr Andrew Simpson) provided a response to the proposed recommendation. It advised that work on improving antimicrobial stewardship has been underway since 2017 through the joint Ministry of Health and Ministry for Primary Industries Antimicrobial Resistance Action Plan and associated coordination groups. An important aspect has been to investigate the extent to which antimicrobial guidance is in existence and its consistency. This work has both identified the need for consistency alongside a need for regional variation to appropriately accommodate regional antimicrobial susceptibility profiles. Community focussed antimicrobial prescribing guidance has been disseminated to sector leaders. Propriety has also been given to support robust surveillance to understand resistance patterns across New Zealand, to communicate this information in a meaningful and timely manner to prescribers, and to facilitate incorporation into antimicrobial guidance where appropriate.
- III. It appears therefore that the issues raised in the course of this inquiry are, in part, being addressed by the Action Plan and associated coordination groups. I acknowledge and endorse this current work.
- IV. In light of the Ministry's actions, I therefore modify the recommendations:

That within its current Antimicrobial Action Plan and associated coordination groups, the Ministry continue to strive to achieve greater national consistency (appropriately accommodating regional antimicrobial susceptibility profiles) across current regional antimicrobial guidance.

Note: There exists a permanent non-publication order/name suppression order made by the Coroner in the last inquiry and confirmed by the High Court in relation to Dr R (referred to as such in the High Court decision of *Gravatt v the Coroners Court at Auckland and Auckland District Health Board* [2013] NZHC 390).

Note: Interim orders pursuant to s 74 are currently in place prohibiting making public the names of other medical professionals involved in the proceedings, and the content of the anonymous letter.

## Drowning

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### Slack [2019] NZCorC 22 (5 April 2017)

#### CIRCUMSTANCES

Ethan Slack of Kaikohe died on 5 April 2017 at 195 Mataraua Road, Kaikohe, of drowning.

Ethan was 1 year old and lived with his parents and three siblings at their home in Kaikohe, Northland. The home was on a large rural property, with a fenced swimming pool adjacent to the house. There was a shallow pond at the bottom of the lawn, about 30 metres from the house. The pond was not fenced from the rest of the property.

On the morning of 5 April 2017, it had been raining, and the pond was swollen. Ethan was at home with his mother and one sibling. At around 11.30 am, Ethan made his way outside. A few minutes later, Mrs Slack went to look for Ethan. Within a few minutes, she found Ethan face down in the pond.

Mrs Slack grabbed Ethan from the pond, placed him on the lawn and began resuscitation efforts. Mrs Slack's other child brought her cell phone, and she called emergency services. Resuscitation efforts were unsuccessful, and it was confirmed that Ethan had died.

#### COMMENTS OF CORONER MCDOWELL

- I. For a number of years, Water Safety New Zealand (WSNZ), in collaboration with Plunket, Tamariki Ora, and ACC, have campaigned for water safety relating to 'Under Fives' specifically. As part of this campaign, WSNZ published a list of eight key ways to keep babies and toddlers safe around water. Therein, it emphasises the importance of the message to keep young children within arms' reach around water, noting that it takes less than a minute for a child to drown, as well as to identify water hazards in and around the home and make such hazards safe by removing or isolating them.
- II. I endorse the general recommendations and strategies of Water Safety New Zealand, especially as they relate to making home water safe by removal or isolation of all potential water hazards.

- III. I consider it important to acknowledge that parental supervision will never be a perfect accident prevention strategy. There will always be occasions where a caregiver's attention is diverted, if even briefly, to attend to other matters (for example, another child). Moreover, it is well known that toddlers and young children are extremely unpredictable, easily distracted, constantly exploring, and can move quickly. They are naturally curious, and arguably water is an attraction. While not wishing to detract from the need to be vigilant with children around water, in the circumstances of this case it seems pertinent to emphasise the need for other, additional prevention strategies such as environmental protections. For example, there was a significant reduction in drownings following the legal requirement for pools to be fenced.
- IV. While it is noted that in 2018 there was a reduction in the number of children who drowned in the age group 1 – 4 years, between 2012 – 2016, 6.4% of deaths in this age group was by drowning. This was described by the Child Youth Mortality Review Committee as proportionally high.
- V. In the circumstances of this case, and noting the statistics regarding infant drowning, I suggest that targeted community messaging particularly regarding environmental prevention strategies may be warranted. If, for example, it is not possible to fence water hazards, then alternative environmental prevention could be considered such as childproof doorway gates, half doors or fenced play areas.
- VI. To that end I propose to forward a copy of this finding to Water Safe New Zealand, the Child Youth Mortality Review Committee, and Safekids NZ for those organisations to consider whether there should be such targeted messaging as part of their safety campaigns/drowning prevention analyses.

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

## Chen [2019] NZCorC 19 (16 May 2019)

### CIRCUMSTANCES

Haoran Chen aged 5 died at Torpedo Bay Wharf, Devonport on 11 November 2017 as a result of drowning.

Haoran was with his father and twin brother on Torpedo Bay Wharf, when he briefly became separated from them. He approached the right edge of the wharf and accidentally kicked the raised edge, which caused him to immediately fall in to the water.

Members of the public jumped in the water, but the tide was strong, and they could not keep hold of Haoran. The Coastguard found Haoran, but despite administering CPR, he was unable to be revived.

### COMMENTS OF CORONER BELL

- I. Haoran's death highlights how quickly tragedy can strike when young children who cannot swim are in the vicinity of water.

- II. I enquired of Auckland Council on whether railings should have been in place to prevent any further deaths such as Haoran's from occurring is required.
- III. I am in receipt of a report from Auckland Council who indicate that a regional resource consent is in force and the wharf structure is a Council asset. A visual assessment was carried out by the Council at the end of 2017 and concluded it was fit for purpose as a pedestrian wharf. Aside from routine maintenance no structural changes are proposed for the wharf in the future.
- IV. The Auckland Council referred me to the Building Code clause f4.3.1 which states  
*"Where people could fall 1 metre or more from an opening in the external envelope or floor of a building, or from a sudden change of level within or associated with a building, a barrier should be provided."*
- V. However, the above clause does not apply where *"a barrier would be incompatible with the intended use of an area."* The intended use for the wharf is for unrestricted public recreational use including the berthing of recreational vessels. Council would not expect the wharf platform to have barriers installed, because it is used for the berthing of vessels and the addition of barriers installed would be considered incompatible with use. Therefore, Auckland Council conclude that barriers or railings were not required on the wharf platform as they would be incompatible with intended use. Of note the jetty does have a barrier on its western side which complies with the requirements of the Building Code.
- VI. The Auckland Council advise that since Haoran's death, a lifebuoy has been installed at the southern end of the wharf for use by the public. Council has arranged for new signage to be installed on the wharf, which indicates the wharf is for pedestrian use only. The sign will be printed in English, Korean and Mandarin.
- VII. I note the steps the Council have taken. The sign would not have assisted in preventing Haoran's death, but the provision of a lifebuoy would have assisted those who bravely jumped in to attempt to save Haoran.
- VIII. Although a Coroner is advised to draw the circumstances of a death to public attention to avoid or reduce the chance of the occurrence of other deaths in similar circumstances in the future, it must be realised that activity such as walking on a wharf given the proximity to water must have potential dangers. People must take extra care and in particular parents need to be extremely vigilant when young children are near water.
- IX. I will not be making any recommendations in this matter as there have been many warnings to parents when supervising young children near water.

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



# Environmental

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## Mathieson [2019] NZCorC 7 (25 January 2019)

### CIRCUMSTANCES

On 29 July 2015, Ian Fullerton Mathieson, aged 79, was located by search and rescue personnel lying deceased in the open in a farm paddock at Monaghan Road in the Te Houka area of Balclutha. Mr Mathieson had been reported as missing seven days prior by his wife, Julie, after he failed to return to their Romahapa, Balclutha home on 22 July.

A report from Mr Mathieson's GP described him as "very fit", but that he had been getting more forgetful prior to his death. The GP believed he was developing dementia. Mrs Mathieson had voiced concerns regarding Mr Mathieson's mental acuity in June 2015.

On the evening of 22 July, Mr Mathieson attended the Clinton Lions Club meeting at Oak Tree Inn at Clinton. This is approximately 45 km from his home, a trip that would normally take about 30 minutes. Mr Mathieson is reported to have left sometime between 7 and 7.30 pm.

A man believed to be Mr Mathieson was seen between 7.30 and 8 pm on a farm property on Mill Road in the Kaihiku area, midway between Clinton and Mr Mathieson's home. The occupant at the address reported to Police that an elderly gentleman pulled into the driveway and asked directions to Romahapa. At about 8.30 pm, Mr Mathieson also spoke to an acquaintance, Stu Cowie, a few hundred metres from the property on Mill Road. There were no indications Mr Mathieson was lost or confused.

A car fitting the description of Mr Mathieson's was seen between 10.30 and 11 pm driving slowly along State Highway 1 in the Mill Road area. Mrs Mathieson called Police at about 1.20 am and reported her husband as missing.

Mr Mathieson's car was located on 23 July, stuck in mud in a paddock at the end of Carterhope Road, Kaihiku. The search for him extended from this area, and took six days by land and air. His body was discovered on 29 July.

The Coroner identified two issues in the inquiry; first, whether there were missed opportunities for intervention prior to Mr Mathieson's death, and second, whether the SAR effort was appropriately conducted in a manner that maximised opportunities to locate Mr Mathieson within the survival timeframe.

### COMMENTS OF CORONER WINDLEY

- I. I have considered whether there were any errors or failings in the lead up to Mr Mathieson's death and in the course of the SAR effort that warrant comment or recommendations to reduce the chances of future deaths in similar circumstances.
- II. I am satisfied that Mr Mathieson's death was a tragic accident that resulted from the interplay of his underlying medical conditions, in particular onset of early dementia and diabetes, and the environment in which he found himself. I do not consider any comments or recommendations, pursuant to sections 57 and 57A of the Coroners Act 2006 are indicated.

III. I note however that Police have independently reflected on the SAR effort and identified a number learnings and recommendations which I consider will contribute to the effectiveness of future SAR efforts. While many are administrative in nature, the lessons learned and recommendations include:

- (a) Each team member should be issued with a GPS to capture areas searched;
- (b) Task sheets should be issued with clear instructions and GPS coordinates and a map with area of search highlighted when the team is debriefed their GPS units are downloaded and printed out on a map which is attached to the task debrief form. Any areas that need another look are identified and any clues are placed onto the found item register etc;
- (c) When briefing teams mention that any foreign object in an open type area needs to be investigated;
- (d) Training to be given on best practice for handling a vehicle when it is located to prevent compromise of a possible sign cut or dog track.

IV. I endorse these recommendations.

V. I also invited the Secretariat of the New Zealand Search and Rescue Council to comment on the extent technology (such as SARTrack) is currently used to aid in mapping areas and tracks so that there is greater assurance of comprehensive search coverage. Mr Ferner, the Secretariat Manager, advised:

- The use of searcher tracking/recording technologies and their subsequent utility to provide (some level of) assurance of search area coverage is very much considered best practice and as such is strongly encouraged.
- I'm also informed that these technologies are increasingly available to search teams and individuals throughout the country but are not yet ubiquitous.
- In some areas the local availability of the technologies is limited as is the ability/competence of the IMTs to use it effectively.
- LandSAR groups will typically fundraise locally for such technologies and Police SAR squad access is determined by Area/District budget prioritisation.
- Overall it appears to be an uneven but steadily improving picture

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

# Fire

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## Cameron [2019] NZCorC 20 (17 May 2019)

### CIRCUMSTANCES

Steve Ian Cameron of Christchurch died on 26 April 2017 at Middlemore Hospital, Auckland of sepsis resulting from the burns suffered in a fire at Mr Cameron's garage.

Mr Cameron lived with flatmates in Christchurch. The garage was used as storage and a workshop, as Mr Cameron worked on cars and motorbikes. It contained paint, oil and other petroleum-based products, solvents, spray cans, butane cans, a number of a 5 L methylated spirits containers and an LPG cylinder. Included in the items stored in the garage were tools, trays of CRC, black powder (gunpowder), shells and shot. There was no working smoke alarm in the garage.

Mr Cameron also used the garage as a sleepout on occasion. He slept in the garage on the night of 10 April 2017, as his bedroom was being used by guests. In the morning Mr Cameron was seen running out of the garage through a "wall of fire" by his flatmates. He suffered burns to more than half his body.

Fire Service investigators determined that the fire was most likely caused by Mr Cameron smoking in bed. The fire then rapidly developed due to the existence of the volatile organic compounds, which resulted in canisters of flammable products exploding.

### RECOMMENDATIONS OF CORONER ROBINSON

- VI. I recommend that publicity be given to the circumstances of this fire to provide a warning as to the potential consequences of:
- a. using a garage as accommodation; and
  - b. storing of volatile organic compounds in an area intended for sleeping / occupation.

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

## Parle [2019] NZCorC 23 (22 May 2019)

### CIRCUMSTANCES

Rosalind Parle of Orewa, Auckland died on 5 January 2016 at Middlemore Hospital of multi-organ failure due to thermal injuries.

Ms Parle was at home when a fire broke out around 4:30pm on 4 January 2016. Emergency services were called by a neighbour. The Fire Service located Ms Parle in her bedroom on the floor. Her bedroom was next to the garage. Ms Parle was removed from the house and provided with emergency treatment before being transported to Middlemore

Hospital in a critical condition. Despite intensive medical efforts, Ms Parle developed multi-organ failure and died the following day.

The area of origin of the fire was determined to be the garage. The point of origin was identified as the left middle of the couch near Ms Parle's ashtray. The Fire Service concluded that a discarded cigarette landed on the surface of the couch and had ignited the material covering. An ignition source was not located, meaning it was most likely consumed by the fire. The circumstances of the fire were accidental.

The remains of two smoke alarms were found in the fire debris in the hallway of the house. Ms Parle's friend, Mr Nordstrand, stated to Police that he had bought batteries for Ms Parle's smoke alarms a year before the fire, but she asked him to take them out because she didn't like the beeping noise they made. Mr Nordstrand reluctantly removed the batteries.

#### COMMENTS OF CORONER MCDOWELL

- I. I do not consider that there are any recommendations which need to be made in this inquiry. The dangers of smoking inside are well known in our community, and the importance of having working smoking alarms has been the subject of consistent publicity campaigns.
- II. In this respect 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. Optimum smoke detection is provided by hard-wired and interconnected smoke alarms. However, in the event that alarms cannot be hard-wired, long-life photoelectric smoke alarms which have a 10 year battery life are recommended [see [https://fireandemergency.nz/at-home/smoke-alarms /](https://fireandemergency.nz/at-home/smoke-alarms/)].
- III. Properly placed, functional smoke alarms can save lives.

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

## Medical Equipment

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### Lee, J [2019] NZCorC 3 (22 January 2019)

#### CIRCUMSTANCES

Jane Mansfield Lee died overnight on 1-2 October 2018 at her home address of 216 Waikiekie Road, Thames, from positional asphyxia after her head and neck became entrapped within the metal hoop of a bed lever.

Mrs Lee was 74 years old and had numerous health issues. She had limited eyesight, balance issues, and used a walker to move around her home.

Mrs Lee went to bed sometime between 7 - 7:30 p.m. on 1 October 2018. No disturbance was heard overnight, but at about 12:45 a.m. her husband went into her bedroom to check on her. He found her on the floor with her bedclothes wrapped around her, tangled within the bed lever. A table and chair next to her bed had been knocked over. An attending paramedic described finding Mrs Lee wrapped up in blankets, suspended slightly off the bed, with her head caught between the metal hoop of a bed lever.

The pathologist's report identified Mrs Lee's death as possibly due to suffocation/asphyxiation. The Coroner found Mrs Lee's death to be the result of her head and neck being wedged between the metal hoop of the bed lever, thereby causing her to asphyxiate.

The Coroner noted that there had been two other recent deaths that were the result of the use of the type of bed lever used by Mrs Lee. An inquest into these deaths was heard on 29 November 2018. The Court heard that a basic bed lever, of the design provided to Mrs Lee, is Band One disability equipment – it is purchased in bulk and immediately available. Band Two equipment, such as a three-bar bed lever which has no risk of head entrapment, is more expensive and therefore less readily available.

#### COMMENTS OF CORONER ROBB

- I. In accordance with section 57B of the Coroners Act I was required to provide a copy of my Draft Findings and recommendations to any person or organisation to whom a recommendation or comment is directed, and to allow an opportunity to respond to any recommendation prior to these Findings being finalised. The Draft Finding and recommendations be provided to: the Ministry of Health, Enable, Accessable, ACC, and all District Health Boards.
- II. I also directed that the Draft Finding be provided to the manufacturers and suppliers of bed levers that I am aware of (Tas-Tech and Multifit), in order to alert those companies of this coronial inquiry, and to provide them with an opportunity of responding to the draft Finding and/or providing me with any additional evidence that may assist me in this coronial inquiry.
- III. I also granted a request from Medsafe to be provided with a copy of the Draft Finding.
- IV. I received responses from Bay of Plenty DHB, Enable New Zealand, the Ministry of Health, and a joint response from Multifit Hospital Supplies Ltd and Tas-Tech Services Ltd.
- V. The response from Enable highlighted the consultation that has already been engaged in between Enable, Accessable and the Ministry of Health. I have adjusted this Finding to incorporate the additional information and corrections as provided to me in those responses. Below I set out some relevant additional information provided to me by Enable for completeness:
  - a. Enable New Zealand provides disability equipment via a contracted service on behalf of the Ministry of Health (MOH). The equipment is for clients who are assessed by DHB health professionals (Assessors) as requiring long-term support due to a disability. In order to access the equipment, clients must meet MOH eligibility criteria. Enable New Zealand is not a MOH entity but operates as a division of Midland Central DHB. Enable New Zealand provides their service for all regions south of the Bombay Hills. A separate entity, "Accessable", provides the equivalent disability equipment service for the Auckland and

Northland regions. While Enable is an operating division of the Central DHB, Accessable is a privately-owned entity.

- b. Accessable provides ACC with disability equipment.
- c. Quoting directly from the response received from Enable New Zealand:

*“Following the Draft Findings, Enable New Zealand, in conjunction with Accessable and the MOH, immediately ceased purchasing or issuing these basic bed levers due to the comments that Assessors were not undertaking risk assessments (or aware of the risks), and your recommendations. This was effective from 11 December 2018.*

*Enable New Zealand has also added the mattress strap to the item, which was available to be ordered previously but rarely requested by Assessors. The strap will be sent with every hoop bed lever from now on.”*

- VI. The MOH confirmed the advice set out above from Enable New Zealand and in addition explained:

*the “basic loop bed lever” has been removed from the Band 1 equipment list and has been replaced with bed lever options which include a central bar preventing entrapment. No recall of the basic loop bed levers has been issued but over time as the basic loop bed levers are returned to providers they will be withdrawn from the equipment pool. “The single loop bed lever will still be available from Band 2 where there is appropriate rationale provided by the assessor”.*

- VII. I acknowledge the comprehensive and helpful response that I received from Enable. I also acknowledge the immediate and comprehensive steps that Enable, in conjunction with Accessable, and the MOH, has undertaken to address the concerns that I raised in this Finding.
- VIII. I have determined that Mrs Lee’s death was caused or contributed to, by the design of the bed lever that she was provided with. While she had used the bed lever without incident for a period, ultimately, through her health frailties her head became entrapped within the metal loop of the bed lever and she asphyxiated.
- IX. Providing bed levers that have no risk of head entrapment, such as three-bar/safe rail bed levers would reduce, if not remove, the risk of death in circumstances similar to those encountered by Mrs Lee, Mr Lee, and Mr Carter. Ensuring that the bed lever has a mattress strap attached to the wooden base, would ensure that an individual could not fall between the bed lever and the mattress and thereby be subject to positional asphyxiation.
- X. A joint response from the manufacturers of bed levers in New Zealand, Multifit Hospital Supplies Ltd and Tas-Tech Services Ltd, suggested the “three-bar bed lever” be specified as “Three-bar Bed Lever with Cord and Cleat or their equivalent where the gap between the vertical bars of the bed lever handle is less than 85 millimetres but more than 60 millimetres”. I was advised that this spacing would allow an individual to place their hand between the bars in order to hold onto the bars for leverage, but would minimise the risk of mechanical compression of the neck where a person’s head may roll between the gap between the bed and the Bed Lever Handle. The “Cord and Cleat” allows the bed lever to be strapped onto the mattress preventing a gap occurring between the mattress and the bed lever. Both Multifit and Tas-Tech Three-bar Bed Levers incorporate these safety features.
- XI. I am grateful for the advice received from the manufacturers, and the efforts that they have undertaken to ensure that their equipment is used safely. They advised me that they have updated their Fitting Instructions, Risk

Assessment Guidelines, and have uploaded “Fitting Instruction Videos” on their websites. They have also ensured that a laminated label on each bed lever base explains the fitting instructions for the bed lever.

## RECOMMENDATIONS OF CORONER ROBB

- I. No patients, be it through a District Health Board or ACC, be provided with a metal hoop bed lever that carries the risk of head entrapment.
- II. ‘Three-bar Bed Levers, with Cord and Cleat, where the gap between the vertical bars of the bed lever handle is less than 85 millimetres but more than 60 millimetres’, or their equivalent, be categorised as Band One medical equipment.
- III. Bed levers that carry the risk of head entrapment be removed from any MOH equipment band.
- IV. That District Health Boards and ACC replace existing metal hoop bed levers with, ‘Three-bar Bed Levers, with Cord and Cleat, where the gap between the vertical bars of the bed lever handle is less than 85 millimetres but more than 60 millimetres’, or their equivalent.

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.

## Lee, C [2019] NZCorC 4 (22 January 2019)

### CIRCUMSTANCES

Colin Walter Lee died on 28 June 2017 at his home address of 228 Te Tumu Road, Te Puke, from positional asphyxia while using a bed lever, antecedent to hypoglycaemia.

Mr Lee was 84 years old and had numerous health issues. In late April 2017, he fell and fractured his right arm, and following a home assessment was provided with a bed lever to assist him to get in and out of his bed. He wished to remain at home, and received some home care assistance from Enliven.

On the morning of 28 June 2017, his wife went into his bedroom and found him unresponsive. Investigations revealed that, during the early hours of that morning his head and neck had become wedged within the metal hoop of the bed lever, and he had asphyxiated. The pathologist supposed that Mr Lee had likely misread his symptoms of hypoglycaemia causing him to inject insulin, further dropping his blood sugar. In his subsequent state of disorientation, he had become entangled in the metal hoop of the bed lever.

The Coroner noted that there had been two other recent deaths that were the result of the use of the type of bed lever used by Mr Lee. An inquest into these deaths was heard on 29 November 2018. The Court heard that a basic bed lever, of the design provided to Mr Lee, is Band One disability equipment – it is purchased in bulk and immediately available. Band Two equipment, such as a three-bar bed lever which has no risk of head entrapment, is more expensive and therefore less readily available.

## COMMENTS OF CORONER ROBB

- I. In accordance with section 57B of the Coroners Act I was required to provide a copy of my Draft Findings and recommendations to any person or organisation to whom a recommendation or comment is directed, and to allow an opportunity to respond to any recommendation prior to these Findings being finalised. The Draft Finding and recommendations be provided to: the Ministry of Health, Enable, Accessable, ACC, and all District Health Boards.
- II. I also directed that the Draft Finding be provided to the manufacturers and suppliers of bed levers that I am aware of (Tas-Tech and Multifit), in order to alert those companies of this coronial inquiry, and to provide them with an opportunity of responding to the draft Finding and/or providing me with any additional evidence that may assist me in this coronial inquiry.
- III. I also granted a request from Medsafe to be provided with a copy of the Draft Finding.
- IV. I received responses from Bay of Plenty DHB, Enable New Zealand, the Ministry of Health, and a joint response from Multifit Hospital Supplies Ltd and Tas-Tech Services Ltd.
- V. The response from Enable highlighted the consultation that has already been engaged in between Enable, Accessable and the Ministry of Health. I have adjusted this Finding to incorporate the additional information and corrections as provided to me in those responses. Below I set out some relevant additional information provided to me by Enable for completeness:
  - a. Enable New Zealand provides disability equipment via a contracted service on behalf of the Ministry of Health (MOH). The equipment is for clients who are assessed by DHB health professionals (Assessors) as requiring long-term support due to a disability. In order to access the equipment, clients must meet MOH eligibility criteria. Enable New Zealand is not a MOH entity but operates as a division of Midland Central DHB. Enable New Zealand provides their service for all regions south of the Bombay Hills. A separate entity, "Accessable", provides the equivalent disability equipment service for the Auckland and Northland regions. While Enable is an operating division of the Central DHB, Accessable is a privately-owned entity.
  - b. Accessable provides ACC with disability equipment.
  - c. Quoting directly from the response received from Enable New Zealand:

*"Following the Draft Findings, Enable New Zealand, in conjunction with Accessable and the MOH, immediately ceased purchasing or issuing these basic bed levers due to the comments that Assessors were not undertaking risk assessments (or aware of the risks), and your recommendations. This was effective from 11 December 2018.*

*Enable New Zealand has also added the mattress strap to the item, which was available to be ordered previously but rarely requested by Assessors. The strap will be sent with every hoop bed lever from now on."*
- VI. The MOH confirmed the advice set out above from Enable New Zealand and in addition explained:



*the “basic loop bed lever” has been removed from the Band 1 equipment list and has been replaced with bed lever options which include a central bar preventing entrapment. No recall of the basic loop bed levers has been issued but over time as the basic loop bed levers are returned to providers they will be withdrawn from the equipment pool. “The single loop bed lever will still be available from Band 2 where there is appropriate rationale provided by the assessor”.*

- VII. I acknowledge the comprehensive and helpful response that I received from Enable. I also acknowledge the immediate and comprehensive steps that Enable, in conjunction with Accessable, and the MOH, has undertaken to address the concerns that I raised in this Finding.
- VIII. I have determined that the design of the bed lever contributed to Mr Lee’s death. While he had used the bed lever without incident for a period, ultimately, through his health frailties his head became entrapped within the metal loop of the bed lever and he asphyxiated.
- IX. Providing bed levers that have no risk of head entrapment, such as three-bar/safe rail bed levers would reduce, if not remove, the risk of death in circumstances similar to those encountered by Mr Lee, Mrs Lee, and Mr Carter. Ensuring that the bed lever has a mattress strap attached to the wooden base, would ensure that an individual could not fall between the bed lever and the mattress and thereby be subject to positional asphyxiation.
- X. A joint response from the manufacturers of bed levers in New Zealand, Multifit Hospital Supplies Ltd and Tas-Tech Services Ltd, suggested the “three-bar bed lever” be specified as “Three-bar Bed Lever with Cord and Cleat or their equivalent where the gap between the vertical bars of the bed lever handle is less than 85 millimetres but more than 60 millimetres”. I was advised that this spacing would allow an individual to place their hand between the bars in order to hold onto the bars for leverage, but would minimise the risk of mechanical compression of the neck where a person’s head may roll between the gap between the bed and the Bed Lever Handle. The “Cord and Cleat” allows the bed lever to be strapped onto the mattress preventing a gap occurring between the mattress and the bed lever. Both Multifit and Tas-Tech Three-bar Bed Levers incorporate these safety features.
- XI. I am grateful for the advice received from the manufacturers, and the efforts that they have undertaken to ensure that their equipment is used safely. They advised me that they have updated their Fitting Instructions, Risk Assessment Guidelines, and have uploaded “Fitting Instruction Videos” on their websites. They have also ensured that a laminated label on each bed lever base explains the fitting instructions for the bed lever.

## **RECOMMENDATIONS OF CORONER ROBB**

- I. No patients, be it through a District Health Board or ACC, be provided with a metal hoop bed lever that carries the risk of head entrapment.
- II. ‘Three-bar Bed Levers, with Cord and Cleat, where the gap between the vertical bars of the bed lever handle is less than 85 millimetres but more than 60 millimetres’, or their equivalent, be categorised as Band One medical equipment.
- III. Bed levers that carry the risk of head entrapment be removed from any MOH equipment band.

- IV. That District Health Boards and ACC replace existing metal hoop bed levers with, 'Three-bar Bed Levers, with Cord and Cleat, where the gap between the vertical bars of the bed lever handle is less than 85 millimetres but more than 60 millimetres', or their equivalent.

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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### Taylor [2019] NZCorC 9 (29 January 2019)

#### CIRCUMSTANCES

Barry Michael Taylor died on 1 February 2018, at the scene of a motor vehicle crash on Campion Road, Palmerston North, from head injuries following a crash between the tractor he was driving and a utility vehicle.

On 1 February 2018, a utility vehicle, travelling along Campion Road, came up behind Mr Taylor in his tractor. As the utility vehicle moved to the right of the tractor, with the intention of overtaking it, Mr Taylor commenced a right-hand turn into a farm gateway and the tractor and the utility vehicle collided. Mr Taylor was thrown from the tractor and suffered fatal injuries.

A crash investigator noted the tractor was equipped with what appeared to be a safety frame to protect the driver and that frame was not crushed by the impact. It also had a safety belt but that did not appear to have been used by Mr Taylor and may have been inoperative.

#### COMMENTS OF CORONER SCOTT

- I. Sadly, I record here that the photographic evidence of the tractor recorded and contained in the Police Crash Investigation Report shows a largely undamaged roll-protection cage over the driver's position on the tractor. Therefore, I conclude that had Mr Taylor been wearing a seatbelt – which was available but may have been inoperative – he would probably have survived the crash.
- II. I record here that earlier this year I undertook a Finding on the Papers relating to a car and tractor collision on a rural roadway north of Palmerston North where the circumstances were almost identical to the ones here including sadly, that the driver of the tractor died as a result of injuries sustained in that crash.
- III. Whilst I do not suggest that two swallows make a summer (as the saying goes) and that two similar crashes do not establish a definite pattern the similarity concerns and disturbs me. I would hope that some publicity would be given to this decision in the hope and expectation that by doing so a readership of farming people and for that matter motorist who use rural roads may be warned about the potential danger which can result from farm vehicles turning right across a rural roadway when the way is not clear.

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.

## Jaggard [2019] NZCorC 15 (23 March 2017)

### CIRCUMSTANCES

Cyril Walter Jaggard died on 23 March 2017 at Otumoetai, Tauranga, as a result of a ruptured aorta sustained after he was struck by a motor vehicle. He was seen walking with a walking stick prior to the accident. Mr Jaggard was using the pedestrian crossing and was clearly visible.

The driver of the vehicle Mr Jaggard was hit by simply did not see him. While she was familiar with her vehicle and with the route that she was driving on, she was distracted by other traffic near the intersection at the time. She was clearly at fault in this accident.

### COMMENTS OF CORONER BAIN

- I. This is a terrible accident. The Jaggard family has compiled a very detailed email where they raise a number of issues relating to the traffic flows and the area where this accident occurred. In short, they refer to the complexity of the intersection. The fact that a full-sized bus travels the route and the intersection is small with very little road controls. The bus reduces visibility. They raise issues such as the crossing being close to the intersection and the supermarket access. The traffic can quickly appear. With an aging population, the intersection does not take account of people that may be slower to cross the road. They raise the issue of no 'give-way' or 'stop' signs on Vale Street and no safe place for pedestrians to stop in the middle of the road to ensure it is safe to cross. They recommend that 'give-way' signs be installed, there be added a safety space for crossing and the placement of the pedestrian crossing be considered.
- II. The Court directs this email be referred to the local council and the relevant roading authorities for the matters raised by the family to be considered and that they communicate directly with them.

Note: An order under section 74 of the Coroners Act 2006 prohibits, in the interests of decency or personal privacy, the publication of photographs of the deceased, as well as the addresses, telephone numbers and e-mail addresses (where applicable) of persons who have provided signed statements in evidence.

## Blance [2019] NZCorC 16 (7 May 2019)

### CIRCUMSTANCES

Kaye Marie Blance of Westport died on 3 May 2015 at 877 Wilsons Lead Road, Cape Foulwind, Westport of positional asphyxia due to a quad bike crash.

Mrs Blance was employed as a dairy farm assistant by Landcorp Farming Ltd at the Tram Road Dairy Unit. Mrs Blance had undertaken quad bike training as part of her employment.

On 3 May 2015, Mrs Blance began work at 5:00am. She completed some tasks then worked with her supervisor, Mr van der Weyden, until around 10am. They discussed other tasks for the day and Mr van der Weyden observed that Mrs Blance was in good spirits, although very tired as she had attended a concert the previous night and had three hours sleep. Mr van der Weyden was occupied until around 2:15pm when he noticed that one of Mrs Blance's tasks had not been completed. He followed Mrs Blance's quad bike tracks to an earth topped culvert located between two paddocks and found the overturned quad bike in the creek bed adjacent to the culvert crossing. Mrs Blance was lying face down on the ground directly under the quad bike with her lower half of her body in the creek water. Emergency services attended and Mrs Blance was confirmed to be deceased.

Mrs Blance's death was the second quad bike-related fatality at the Tram Road Dairy Unit. Another employee died in November 2010 from crush asphyxia as a result of a quad bike and trailer rollover.

#### COMMENTS OF CORONER WINDLEY

- I. The risk of harm associated with quad bike use has been well documented and coroners have for many years made recommendations aimed at reducing preventable quad bike related deaths.
- II. There is no simple or singular fix. A multi-faceted approach is necessary to achieve any real and sustained reduction in preventable quad bike related serious injuries and deaths in New Zealand.
- III. I am satisfied that the numerous changes Landcorp made following and in response to Mrs Blance's death have enhanced the safety of their employees who utilise quad bikes in the course of their employment, and the wider safety culture of the company.
- IV. As Mrs Blance's case demonstrates, individual companies and employers are currently shouldering the major responsibility for determining what quad-bike risk minimisation looks like in their particular workplace. New Zealand government agencies and industry bodies must provide leadership in this space, and actively look for and consider options and innovations that have the potential to enhance quad bike safety at a national level.
- V. WorkSafe advises that vehicles on farms (such as quad bikes) will continue to be an area of focus and are part of a new cross-sector harm prevention initiative focussing on vehicles used for work.
- VI. WorkSafe has agreed that a coordinated approach is necessary and reports it has well connected and effective relationships with MBIE, ACC, and agriculture industry bodies, who are "actively working together in what is, in effect, a working party." ACC advises it is committed to continue working with WorkSafe and MBIE and other relevant government agencies and industry bodies to promote measures to reduce the incidence and severity of personal injuries and improve quad bike safety. Federated Farmers also acknowledges its role "as part of a multi-faceted suite of solutions."
- VII. Whether any of the approaches under consideration by the ACCC are appropriate for New Zealand is outside the scope of my inquiry. The ACCC inquiry does however provide a real opportunity to draw on international safety

expertise, innovation and best practice and apply it to a New Zealand context. WorkSafe advise that the lessons it has learned from the ACCC's findings so far have contributed to the initiatives described above.

- VIII. Whether the imminent Policy Clarification on CPDs from WorkSafe, a possible small-medium sized business subsidy to incentivise OPD uptake, and any ultimate regulatory reform under MBIE's Health and Safety at Work Act 2015 regulatory reform programme, is enough to effect a real reduction in current levels of preventable quad bike deaths remains to be seen. Given these initiatives relate to quad bike use in workplaces, whether there is likely to be any positive impact on quad bike safety outside of workplaces is unclear. As it currently stands, New Zealand's approach falls well short of that which has been recommended by the ACCC in terms of introducing a mandatory safety standard.

#### RECOMMENDATIONS OF CORONER WINDLEY

- I. On the evidence before my inquiry it is impossible to know whether a mandatory safety standard requiring fitment of an OPD to the Honda quad bike Mrs Blance was riding on 3 May 2015 may have improved her outcome, all that can be said is that it may have. On that basis, I consider the following recommendation pursuant to section 57A of the Coroners Act 2006 is indicated.
- II. The responses received to my provisional Finding suggest there is a level of existing coordinated effort between relevant government agencies and industry bodies. I endorse that coordination and recommend that:
  - a. A cross-sector working party with participation from WorkSafe, MBIE, ACC, and other relevant industry bodies such as Federated Farmers, collectively review the work undertaken by the ACCC, its recommended new safety standard, and give timely consideration to whether New Zealand ought to follow suit to reduce the chances of preventable quad bike deaths.

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

## Mildon [2019] NZCorC 17 (7 May 2019)

#### CIRCUMSTANCES

Leslie Trevor Mildon of Napier died on 27 August 2017 at Hawkes Bay Regional Hospital of subdural haemorrhage, sustained in a motor vehicle crash. Mr Mildon lived in Napier with his wife, Jennifer. He was retired and physically active, with good mobility and a love for the outdoors.

On 26 August 2017, Mr Mildon, aged 81, lost control of his vehicle on State Highway 2, while travelling from Napier to Wairoa. As Mr Mildon approached a corner near the intersection of Matahorua Road, his vehicle left the road and travelled 80 m down a bank into a ditch. After approximately an hour, Mr Mildon was able to remove himself from the vehicle, make his way back to the road, and alert a passer-by, who called an ambulance.

Mr Mildon was taken to hospital. His condition deteriorated, and he died the following morning as a result of injuries sustained in the crash. The crash likely occurred because Mr Mildon failed to slow down sufficiently to safely negotiate the bend; however, he was not travelling in excess of the speed limit.

#### **RECOMMENDATIONS OF CORONER RYAN**

- I. That the appropriate roading authority consider erecting an Armco barrier or similar protective system on the bend where this crash occurred, to prevent any other vehicles (travelling north) leaving the road and crashing down the bank.

## **Schutt [2019] NZCorC 27 (27 June 2019)**

#### **CIRCUMSTANCES**

Bradley James Schutt of Far North district died on 26 May 2016 on State Highway 10 near Puketona from severe head injuries sustained in a motor vehicle collision.

On the evening of 25 May 2016, Mr Schutt joined his work colleagues for drinks. In the early morning of 26 May 2016 his car was travelling on State Highway 10 southwards from Kerikeri towards the intersection at Te Ahu Road, Puketona, when it crossed the centre line, returned to the southbound lane then left the tarseal (on the left-hand side). At the junction of the gravel and the tarseal his car flipped side over side before stopping back on the tarseal in the southbound lane. Mr Schutt, who was not wearing a seatbelt, was ejected from the car during the rollover and was found 19.8m south of the vehicle.

The primary causative factor of Mr Schutt's crash was the loss of control of his vehicle. More likely than not the presence of alcohol also contributed to the crash, as Mr Schutt's blood alcohol level was more than four times the legal limit, and likely impaired his ability to control the vehicle. The presence of THC and tiredness may also have been contributing factors.

#### **RECOMMENDATIONS ENDORSED BY CORONER MCDOWELL**

- I. In his report Senior Constable Hawthorn suggested three general roading improvements:
  - a. To install a raised Armco barrier near the edge of the roadway to prevent vehicles going onto the loose gravel shoulder;
  - b. To install an Audio Tactile Proof (ATP - a rumble strip) across the traffic lane before corners with a speed advisory, to arouse fatigued drivers; and
  - c. To install continuous ATP (a rumble strip) on the centre lines before and through corners with a speed advisory to alert drivers to move to their correct lane.

- II. These suggested roading improvements were notified to the New Zealand Transport Agency (NZTA, the Agency responsible for this section of road) for its comments.
- III. In relation to the installation of an Armco barrier the NZTA advised that between 2010 and 2011 the road safety barrier system was extended southwards from the Waitangi Bridge (which was south of the where the crash occurred). It advised that the barrier system was unable to be extended further due to land accessibility. It is not clear from the NZTA's response whether extension northwards from the Waitangi Bridge (where the crash occurred) was also constrained by land accessibility.
- IV. The NZTA recognises the potential safety benefits of a rumble strip (ATP) and has advised that the installation of ATP markings will be reconsidered on this road corridor during the annual crash reduction studies in June/July 2019. However, there are policies in operation which prevent the installation of such strips within 100m of dwellings. Also in 2018, 200mm as opposed to 150m wide white edge lines were installed on the road in the vicinity of the crash, in response to crashes that involved alcohol impaired drivers.
- V. In relation to the suggestion of a rumble strip on the centre line before and through corners with a speed advisory the NZTA noted that current Land Transport rules required centre line markings to be white dashed lines. I have inferred that, accordingly, rumble strips in the manner proposed are not permitted by those rules.
- VI. The NZTA assured the inquiry that the implementation of markings at the crash location or on the wider corridor will be given consideration as part of the programmed crash reduction studies. There will be a focus on prioritising those corridors where most benefit can be initially gained, with wider implementation ongoing and subject to budgetary constraints.
- VII. I am satisfied from the NZTA's response that it will be considering road safety improvements in the area during its annual crash reduction studies over the next month. I propose to forward a copy of this finding to the NZTA for it to consider as part of the deliberations on road safety improvements. I do not propose to formalise Senior Constable Hawthorn's suggestions as coronial recommendations, in the context of the NZTA's current work in relation to this area.
- VIII. No further comments or recommendations are called for. I am satisfied that the message not to drink and drive, as well as to wear one's seatbelt are messages that regularly publicised and known within our community.

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

# Self-Inflicted

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## Chapman [2019] NZCorC 12 (18 February 2019)

### CIRCUMSTANCES

David Ian Chapman, a labourer, died on 20 August 2015. The coroner found his death was self-inflicted. He had a history of alcoholism and mental health struggles.

### RECOMMENDATIONS ENDORSED BY CORONER TUTTON

- I. In the provisional opinion it was recommended that SCDHB implement professional supervision for clinical staff working in the area of alcohol and other drugs services. SCDHB confirmed that it has since implemented weekly professional peer supervision for the Alcohol and Drug Service. I recommend that SCDHB report back to HDC, within six months of the date of this report, on the outcome of the actions it has undertaken to complete, including:
  - a. The findings and actions taken as a result of SCDHB's independent review of the assessment, care, and treatment of clients with dual diagnosis; and
  - b. The progress in implementing new terms of reference for Complex Case Conferences that set out, amongst other things, lines of responsibility for decision-making and requirements for minutes to be taken.
- II. I also recommend that SCDHB undertake the following actions and report back to HDC within six months of the date of this report:
  - a. Assess its mental health and addiction services with reference to Dr McMinn's comments about strengths-based practice to identify service improvements, and obtain input from family/whānau and consumer representatives in that assessment. The assessment should include consideration of consumer and family/whānau engagement in care planning and ensuring that implementation of improvements identified by the assessment can be monitored.
  - b. Review its policies and procedures in relation to boundary setting (including sexual safety for staff); professional supervision; incident reporting; discharge from the service; client engagement; and changing case workers, with reference to findings from this decision.
  - c. Review orientation for new staff to ensure that they are provided with training and appropriate supervision in relation to the policies in (b) above, including knowledge of escalation pathways when issues arise.
- III. I recommend that SCDHB take account of the findings of this report in finalising the terms of reference for its external audit of its mental health and addiction service, and report back to HDC with confirmation of this within three weeks of the date of this report.

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.



Note: Pursuant to section 71 of the Coroners Act 2006, without the authority of a coroner, publication of any particulars of Mr Chapman'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.

## Tuapawa-Rapana [2019] NZCorC 21 (20 May 2019)

### CIRCUMSTANCES

Thompson Frederick Pererika Tuapawa-Rapana died on 13 August 2017 of self-inflicted injuries in circumstances amounting to suicide.

Mr Taupawa-Rapana had been having relationship problems with his partner. On the night of his death, he had been arguing with his partner before going out drinking with friends. The argument continued over text messages and included threats of suicide.

### COMMENTS OF CORONER ROBINSON

- I. I urge persons who become aware of someone expressing suicide intent or taking steps to end their lives, to call emergency services as soon as possible. Such a call may maximise an opportunity for survival.

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death. Pursuant to section 71(3)(b) of the Act, the death may be described as a suicide.

An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs which show the deceased in the interests of decency and personal privacy.

## Sudden Unexpected Death in Infancy (SUDI)

Sudden Unexpected death in Infancy (SUDI) is an ongoing issue in New Zealand and Coroners continue to endorse the advice of the Ministry of Health. SUDI findings are also referred to the agencies responsible for SUDI prevention strategies. There were 11 SUDI findings released this quarter, many containing the following advice:

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.

In addition, the following cases included further comment from the Coroner on SUDI.

## Carpenter [2019] NZCorC 1 (7 January 2019)

### CIRCUMSTANCES

Dallas Josh Carpenter died on 17 August 2015 at 48c Beatrice Street from cardiorespiratory arrest in the context of sudden infant death syndrome (SIDS).

On 17 August 2015, Dallas' father, Mr Carpenter, fell asleep on a couch at the family's home, with Dallas' head cradled on his shoulder. When Mr Carpenter woke up, he noticed Dallas was white, cold and floppy. Despite CPR being performed, Dallas could not be revived.

### COMMENTS OF CORONER TUTTON

- I. I note the information available in relation to recommended safe sleeping practices published by various agencies and organisations. By way of example, the Ministry of Health has information, including the following, on its website:

#### **Make every sleep a safe sleep**

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

Always follow these safe-sleep routines

#### ***Make sure that your baby is safe***

To keep your baby safe while sleeping, make sure:

- they always sleep on their back to keep their airways clear
- they are in their own bassinet, cot or other baby bed (eg a pēpi-pod® or wahakura) – free from adults or children who might accidentally suffocate them
- they are put back in their own bed after feeding – don't fall asleep with them (to protect your back, feed your baby in a chair rather than in your bed)
- they have someone looking after them who is alert to their needs and free from alcohol or drugs
- they have clothing and bedding that keep them at a comfortable temperature – one more layer of clothing than you would wear is enough; too many layers can make your baby hot and upset them
- they are in a room where the temperature is kept at 20°C.

You can check that your baby is warm but not too hot by feeling the back of their neck or their tummy (under the clothes). Baby should feel warm, but not hot or cold. Your baby will be comfortable when their hands and feet are a bit colder than their body.

#### ***Make sure that your baby's bed is safe***

Baby's bed is safe when:

- it has a firm and flat mattress to keep your baby's airways open
- there are no gaps between the bed frame and the mattress that could trap or wedge your baby
- the gaps between the bars of baby's cot are between 50 mm and 95 mm – try to get one with the gaps closer to 50 mm if you can.
- there is nothing in the bed that might cover your baby's face, lift their head or choke them – no pillows, toys, loose bedding, bumper pads or necklaces (include amber beads and 'teething' necklaces)
- baby is in the same room as you or the person looking after them at night for their first 6 months of life.

It is never safe to put your baby to sleep in an adult bed, on a couch or on a chair. If you choose to sleep in bed with your baby, put them in their own baby bed beside you – for example, a pēpi-pod® or wahakura. This will help to reduce the risk of your baby suffocating while they are asleep. Information about using a pēpi-pod® or wahakura is available online; see the Whakawhetu and Pēpi-Pod® Sleep Space Programme websites.

Car seats and capsules protect your baby when travelling in the car. Don't use them as a cot or bassinet. Car seats and capsules are not safe for your baby to sleep in when you are at home or at your destination.

If you don't have a baby bed, talk to your nurse. If you are on a low income, you may be able to get a Special Needs Grant from Work and Income to buy a bed. See the Work and Income website or call 0800 559 009.

- II. There have been a number of recommendations and comments made by coroners focussed on the issue of safe sleep. Given this, I do not consider that it is necessary to repeat safe sleep recommendations in this finding. However, a copy of these findings will be sent to the Ministry of Health, the Child Youth Mortality Review Committee and Change For Our Children, all organisations actively involved in working to strengthen and make consistent the safe sleeping message.

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.

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

### CIRCUMSTANCES

Airon Mhel Orquijo died on 13 February 2017 at Starship Children's Hospital, Auckland from accidental asphyxiation in circumstances that can be regarded as a SUDI (Sudden Unexpected Death in Infancy).

Airon slept at home with his parents overnight on 11 February 2017. Between 8 and 8:30am on 12 February, Mr Orquijo checked on Airon. Airon was not breathing and his head was hyperextended on the edge of the bed. It appeared he had fallen into a space between the mattress and the wall and become trapped. Airon was transported to Starship Children's Hospital in a critical condition. Airon's heart had stopped on multiple occasions and tests showed hypoxic ischaemic

injury. Airon began to develop multiorgan failure by the morning of 13 February. The decision was made to withdraw his life support and he subsequently died

#### COMMENTS OF DEPUTY CHIEF CORONER SHORTLAND

- I. Airon's death is a reminder of the need for safe sleeping environments and the importance of continuing to learn about SUDI deaths.
- II. Considerable effort is being made in New Zealand to promote the message that every sleep for a baby should be a safe. That is for every sleep, babies up to one year of age should be put to sleep on their backs, in their own sleeping space (a firm, flat surface with no pillow) with their face clear.
- III. The challenge is to ensure the safe sleep message, and what research shows safe sleep means for baby, is clear to all parents and caregivers. It must also be delivered in a way that is understood, and the importance of the message appreciated.
- IV. Nevertheless, a copy of these findings will be sent to the Ministry of Health, the Child Youth Mortality Review Committee, Hāpai te Hauora, and Change for our Children – all organisations actively involved in working to strengthen and make consistent the safe sleep message.

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.

## Synthetic Drugs

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### Tangimama [2019] NZCorC 13 (13 March 2019)

#### CIRCUMSTANCES

Rua Tangimama died on 27 June 2018 at Tokoroa from acute pulmonary oedema, left ventricular failure, and ischaemic heart disease. However, as noted by the pathologist, the presence of synthetic cannabis in the blood could have been a significant provoking factor in the cause of Mr Tangimama's death.

Mr Tangimama was 47-years-old and resided at a motor camp in Tokoroa with his partner. Sometime during the afternoon of the 27 June 2018, Mr Tangimama and his partner smoked synthetic cannabis together before falling asleep. At approximately 8.30pm, his partner woke to find Mr Tangimama lying on the floor of the caravan. She did not disturb Mr Tangimama and she left to visit with her brother, who also resides at the campsite. She returned fifteen minutes later and tried to wake him but he was unresponsive. She ran back to get her brother to help and they called an ambulance, but Mr Tangimama never regained consciousness.

#### COMMENTS OF CORONER BAIN

- I. The dangers of consuming synthetic drugs include:
  - It is promoted or sold as a form of synthetic cannabis, but that there is no cannabis in the product.

- 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.
- 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.
- 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.
- The quantity and strength of AMB-FUBINACA and 5F-ADB is an unknown gamble which can have fatal consequences.
- 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 a hypoxic brain injury.

#### RECOMMENDATIONS ENDORSED BY CORONER BAIN

- I. Due to the circumstances and cause of this death, I concur with the recommendations made by Coroner Matenga, in reliance on the expert evidence of Dr Quigley, in the coronial inquiry into the death of McAllister, CSU-2017-HAM-000336.
  1. *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.*
  2. *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.*
  3. *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.*

- II. Dr Quigley is a vocational specialist in Emergency Medicine, he has completed additional studies in clinical toxicology and conducted research in forensic toxicology. He is a recognised expert in emergency management and treatment of drug and alcohol presentations.
- III. I endorse Dr Quigley's advice.

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.

## Pitman [2019] NZCorC 18 (16 May 2019)

### CIRCUMSTANCES

Memphis Edward Pereki Pitman died at 44 Lynwood Road, New Lynn, Auckland, on 10 November 2017 due to complications of acute synthetic cannabis intoxication, particularly of the drug AMB-FUBINACA.

After suffering a head injury in Australia, Mr Pitman began hearing voices. As a result, Mr Pitman used various drugs to help him cope including cocaine, ecstasy, MDMA and methamphetamine, as well as having inhaled petrol on at least one occasion. While in New Zealand, he used synthetic cannabis regularly, which led to a number of concerning incidents, including being taken into police custody.

### RECOMMENDATIONS ENDORSED BY CORONER BELL

- I. Memphis was aware that consuming synthetic cannabis products could endanger his life. He had significant levels of interaction with mental health and addiction services to address his use of drugs and the underlying reasons why he used them. However, despite the efforts of those caring for him, Memphis continued to use synthetic cannabis products. Unfortunately, his continued consumption of synthetic cannabis has resulted in his death.
- II. The dangers of consuming synthetic drugs include:
- III. It is promoted or sold as a form of synthetic cannabis, but there is no cannabis in the product.
- IV. 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.
- V. 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.
- VI. 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.
- VII. The quantity and strength of AMB-FUBINACA and 5F-ADB is an unknown gamble which can have fatal consequences.

- VIII. 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.
- IX. Due to the circumstances and cause of this death I repeat and adopt the recommendations made by Coroner Matenga in reliance on the expert evidence of Dr Quigley in the coronial inquiry into the death of *McAllister*, CSU-2017-HAM-000336:
- a. *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.*
  - b. *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.*
  - c. *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.*
  - d. *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 call taker who answers the emergency call for help will provide assistance. Do not delay.*
- X. Dr Quigley is a vocational specialist in Emergency Medicine, he has completed additional studies in clinical toxicology and conducted research in forensic toxicology. He is a recognised expert in emergency management and treatment of drug and alcohol presentations.
- XI. I endorse Dr Quigley's advice.

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

# Workplace

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## Newton [2019] NZCorC 24 (29 May 2019)

### CIRCUMSTANCES

Jason Shaun Newton of Christchurch died on 12 February 2016 at Forklifts NZ, 167 Waterloo Road, Hornby, Christchurch of blunt force trauma to his head as a result of being struck by a truck's tailgate.

The cause of the accident was that Mr Newton walked under the raised tailgate just before he was struck, having come from the vicinity of the workshop. When he walked under the raised tailgate, Mr Newton did not realise that it was dangerous in that area. It was dangerous because, due to a misunderstanding, his co-worker released the stop on the passenger's side. For reasons which have not been established, the stop on the driver's side also released. The tailgate fell and struck Mr Newton.

### RECOMMENDATIONS OF CORONER ELLIOTT

- I. I make the following recommendation pursuant to section 57 of the Coroners Act 2006:

When completing maintenance of mobile vehicle ramps on trucks or similar vehicles, a two-step approach should be considered:

1. Primarily, ensure that the ramp is restrained in place with the use of chains, or ratchet straps, or solid steel brace. Consideration should be given to locking these mechanisms out by way of a lock and tag system so that the person who put them on is the only person who can take them off.
2. Secondary physical support should also be applied to prevent the ramp from falling should the primary restraint fail. This could be as simple as parking the transporter close to a wall or positioning a forklift to provide additional support and fall protection. If this type of work is a regular occurrence the person or PCBU should consider manufacturing a bracing device for this purpose (which should be fit for purpose).

- II. I invite WorkSafe to advertise this recommendation within the relevant industries.

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



# Case Study: Child Drownings

This case study categorises a “child” as a person aged 0 – 10 years old.

Note: the statistics in this case study contain active cases before coroners that involve deaths in circumstances which appear to be drowning, so the numbers and charts below are provisional. Non-accidental drownings and drownings that occurred after a medical event have been excluded. Additionally, these statistics may vary from those held by other agencies such as Water Safety NZ due to recording methods and differences in coding of deaths.

## Legislation

This case study has been chosen following recent changes in legislation. As of 1 January 2017, the Fencing of Swimming Pools Act 1987 is no longer in effect, repealed by the Building (Pools) Amendment Act. This inserted new provisions into the Building Act 2004, creating Building Code clause F9.

The clause requires preventing unsupervised access by children under five years of age to residential pools, including with barriers around pools. The Building Act also requires pools to be inspected every three years to ensure they comply with the regulations, by territorial authorities or independently qualified pool inspectors.

### Clause F9: Means on restricting access to residential pools

#### *Objective*

**F9.1** The objective of this provision is to prevent injury or death to young children involving residential pools.

#### *Functional requirement*

**F9.2** Residential pools with a maximum depth of water of 400 mm or more that are filled or partly filled with water must have means of restricting access that prevents unsupervised access by a child under 5 years of age.

#### *Performance*

**F9.3.1** Residential pools must have or be provided with physical barriers that restrict access to the pool or the immediate pool area by unsupervised young children (i.e. under 5 years of age).

**F9.3.2** Barriers must either—

- (a) surround the pool (and may enclose the whole or part of the immediate pool area); or
- (b) in the case of a small heated pool, cover the pool itself.

**F9.3.3** A barrier surrounding a pool must have no permanent objects or projections on the outside that could assist children in negotiating the barrier.

Any gates must—

- (a) open away from the pool; and
- (b) not be able to be readily opened by children; and
- (c) automatically return to the closed position after use.

**F9.3.4** Where a building forms all or part of an immediate pool area barrier, —

- (a) doors between the building and the immediate pool area must not be able to be readily opened by children, and must either—
  - (i) emit an audible warning when the door is open; or
  - (ii) close automatically after use;
- (b) windows opening from a building into the immediate pool area must be constructed or positioned to restrict the passage of children.

**F9.3.5** Where a cover is provided as a barrier to a small heated pool, it must—

- (a) restrict the entry of children when closed; and
- (b) be able to withstand a reasonably foreseeable load; and
- (c) be able to be readily returned to the closed position; and
- (d) have signage indicating its child safety features.

#### ***Limits on application***

In the case of a small heated pool, the means of restricting access referred to in Performance F9.3.1 need only restrict access to the pool when the pool is not in use.

Performance F9.3.2(b) applies only to those small heated pools where the top surface of every wall of the pool is at all points not less than 760 mm above the adjacent floor or ground and the walls of the pool inhibit climbing.

Schedule 1 clause F9: inserted, on 1 January 2017, by section 20 of the Building (Pools) Amendment Act 2016 (2016 No 71).

# Coroners' obligations to investigate child drownings

Under the Coroners Act 2006, coroners have a legal responsibility to investigate deaths that are reportable unexpected deaths.<sup>1</sup> When a death is reported, a coroner is able to take several actions:

- If a death that has been reported to a coroner is being conducted by another investigating authority, the coroner may either postpone an inquiry into the death or adjourn an open inquiry.<sup>2</sup>
- If a death has resulted in criminal liability of any person, a coroner may postpone opening an inquiry or adjourn an open inquiry until the coroner is satisfied that the proceedings are finally concluded, or the person is no longer charged with the offence.<sup>3</sup>
- Where it is in the public interest, a coroner conducting an inquiry may refer the death concerned to another investigating authority to complete an investigation.<sup>4</sup>
- A coroner has the power to commission from another investigating authority any reports, medical or otherwise, the coroner thinks proper, or to request a copy of a report/investigation to be made available to a coroner.<sup>5</sup>

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

- An alternative investigation is not likely to go ahead; or
- An alternative investigation is going ahead but is unlikely to establish the matters that a coronial inquiry would establish; or
- To open or resume the inquiry will not prejudice the investigation or any person interested with it.

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

<sup>1</sup> Section 14.

<sup>2</sup> Section 69.

<sup>3</sup> Section 68.

<sup>4</sup> Section 119.

<sup>5</sup> Sections 118 and 120.

## Key organisations

### Water Safety New Zealand

Water Safety New Zealand (“WSNZ”) works with other safety sector organisations, individuals and the public to reduce the incidence of drowning and injury in Aotearoa. Its work contributes to the reduction in drownings. WSNZ is an association of members in the water safety sector with an elected board and recruited management and administration team.

WSNZ’s purpose is a simple one; to lead a change in New Zealand so people don’t drown. Its vision is that by 2025 more people in New Zealand respect the water and have the skills, knowledge and awareness to enjoy it safely. For more information, visit [www.watersafety.org.nz](http://www.watersafety.org.nz)

### Child and Youth Mortality Review Committee

The Child and Youth Mortality Review Committee (“CYMRC”) is a statutory committee which is accountable to the Health Quality and Safety Commission. CYMRC collects information for every New Zealand child and young person who dies.

CYMRC advises the Commission on how to reduce preventable deaths in children and young people in the following ways:

- Monitoring the number and types of deaths that occur among New Zealand children and young people over time;
- Providing education about how mortality reviews are useful;
- Encouraging the establishment and nationwide coordination of local child and youth mortality review groups;
- Interacting with community and organisational networks;
- Collecting information from all relevant sources that will identify ways to prevent deaths both locally and nationally;
- Conducting investigations into particular types of child and youth deaths;
- Producing an annual report for the Commission outlining data and making recommendations for actions that will reduce child and youth deaths in New Zealand; and
- Advocating for any improvement of health and social services for children and young people that will reduce deaths.

For more information, visit [www.hqsc.govt.nz/our-programmes/mrc/cymrc/](http://www.hqsc.govt.nz/our-programmes/mrc/cymrc/)

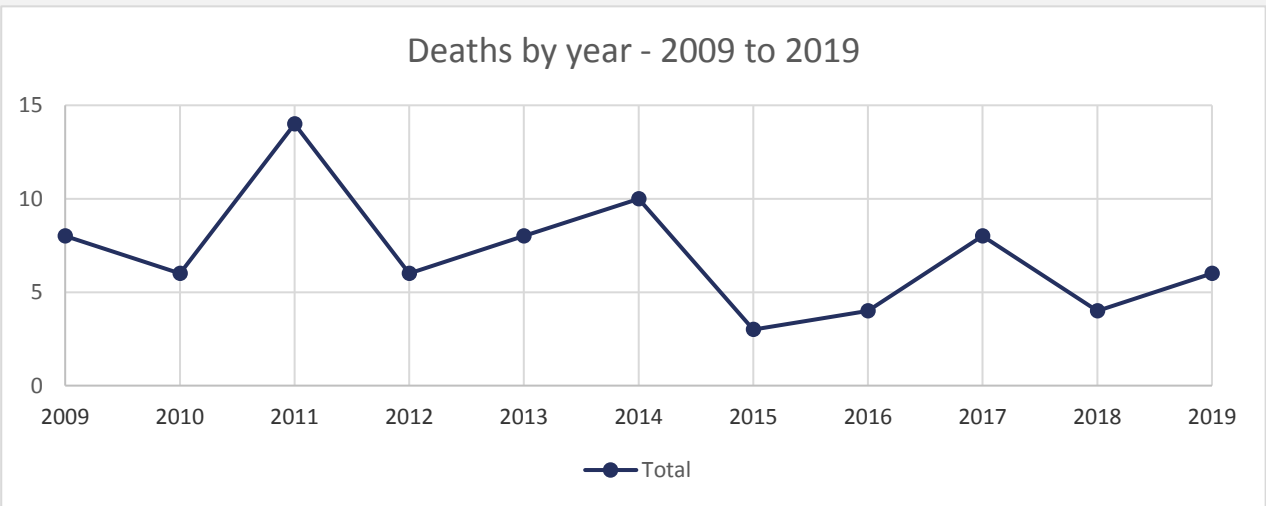
### Safekids Aotearoa

Safekids Aotearoa provides information, services and advice to government agencies, territorial authorities, Well Child providers, health professionals, private industry, media, educators and families. Safekids Aotearoa produce a number of reports on unintentional child deaths and injuries which can be accessed via the website: [www.safekids.nz](http://www.safekids.nz)

# Child drowning statistics

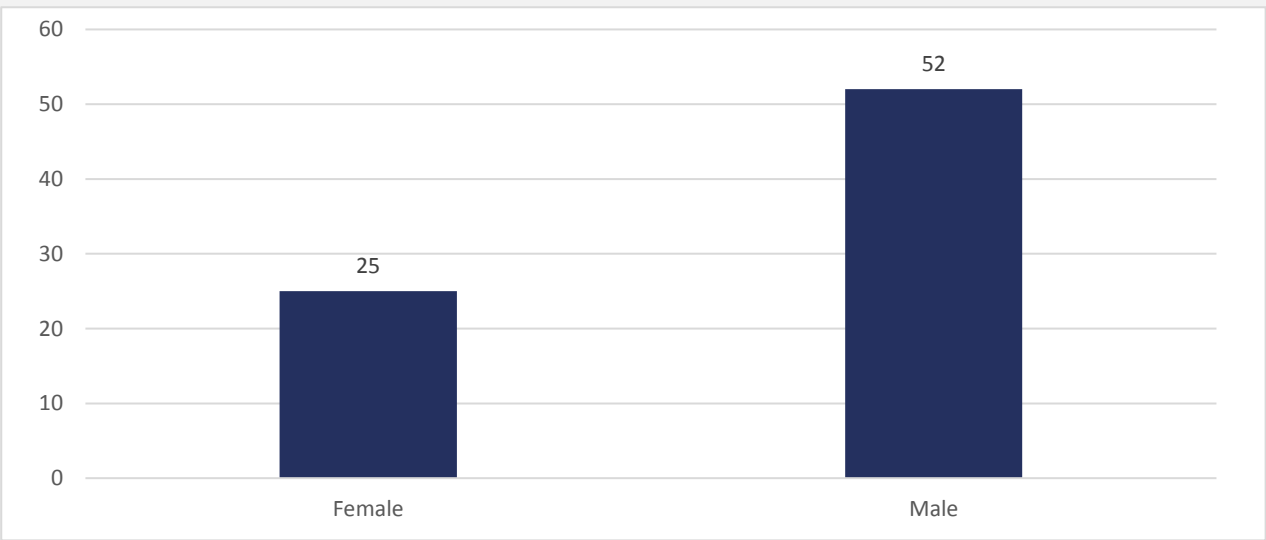
## Deaths by year

There is no identifiable pattern to child drowning deaths by year, partly due to the small sample size each year. This chart illustrates the numbers of children that have died by drowning in New Zealand in the past 10 years.



## Gender

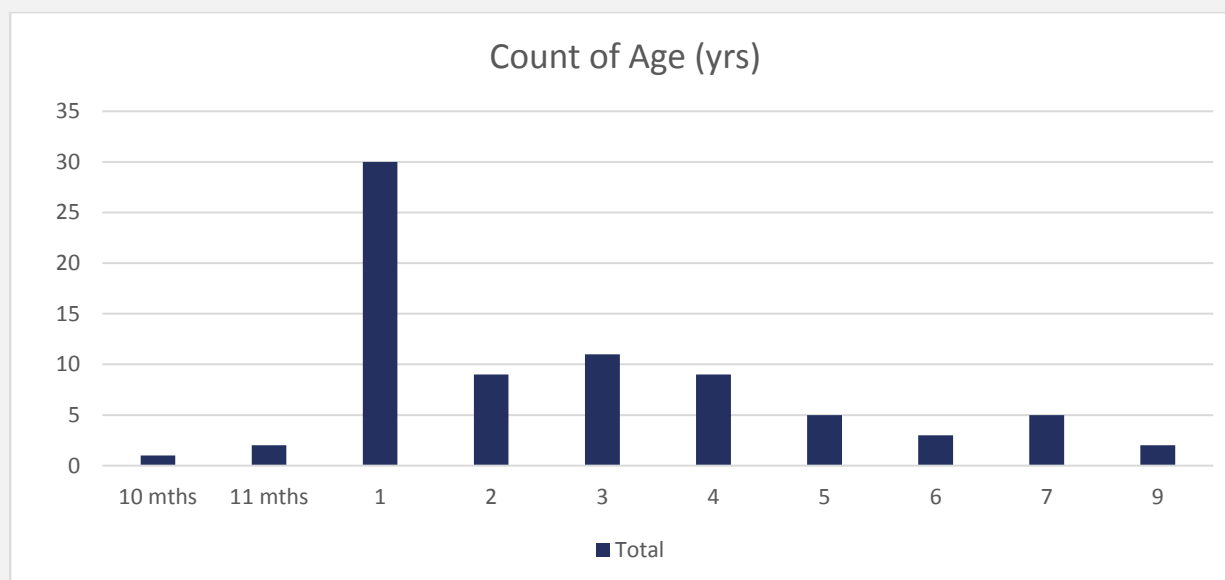
Child drownings are heavily male biased. Between 2009 and 2019, approximately two thirds of all child drownings were males. This ratio is consistent with global research into child drownings.<sup>6</sup>



<sup>6</sup> World Health Organization “World report on child injury prevention: Children and Drowning”

## Age

Children learn to walk or crawl unaided at age 1, so parental supervision becomes crucially important, but parents may also not be aware of the distance or speed at which their baby can move.



## Region of Death

The following table illustrates the regions in which deaths most commonly occur. These are based on the coronial regions due to data collection methods, rather than council or DHB regions. There may be several reasons for regional discrepancies, chief among them population, rural/urban makeup, and possibly differing council standards of inspections. Due to the small sample sizes, these are absolute rather than population-adjusted rates so major centres (such as Auckland) will demonstrate more deaths.

Year	Whangarei	Auckland	Hamilton	Rotorua	Hastings	Palmerston North	Wellington	Christchurch	Dunedin	Total
2009	1	2	1		2	1				7
2010	1	1			1	2		1		6
2011	3	4	1	1	2	1			1	13
2012	1	2				1		1	1	6
2013	1	3		1	1				2	8
2014		1	2	2		1	1	1	2	10
2015	1				1	1				3
2016		4		1						5
2017	1	5			2			2		10
2018					1			1	1	3
2019		1	1	1				1	2	6
<b>Total</b>	<b>9</b>	<b>23</b>	<b>5</b>	<b>6</b>	<b>10</b>	<b>7</b>	<b>1</b>	<b>7</b>	<b>9</b>	<b>77</b>

## Circumstances of Death

International data shows that child drownings most often occur in water hazards that are in or near their homes. This trend proves true in New Zealand, with swimming pools showing the highest number of deaths, and bathtubs and ponds also common. The following table shows the incidence for each kind of hazard where a child has drowned from 2009-2019:

Location/Circumstances of Death	Number of Deaths
Swimming pool	15
Bathtub	7
River/Creek	7
Pond	6
Following motor vehicle crash	5
Beach/Mudflats	5
Farm pond	5
Wharf	3
Water feature	3
Following boating accident	3
Lake	3
Water park	2
Water trough	2
Farm trench	2
Open water tank	2
Small water container	2
Water hole	1
Inflatable pool	1
Stormwater drain	1
Spa pool	1

## Deaths in swimming pools

In New Zealand, swimming pools remain the most common location for children aged ten and under to drown, with 15 deaths occurring in a residential swimming pool in the selected period (19.5%). The most common factors in these deaths were a lack of supervision (even momentarily), a faulty or non-compliant gate or fence, and underestimation of the wandering ability of small children.

Out of these 15 deaths, the most common feature was that none were witnessed. In eight cases the deceased was playing with, or was left in the care of, older children. In at least eight cases there was an issue with either the barriers or the gate that meant it did not totally prevent a child from entering; often this included a faulty self-closing mechanism allowing the gate to remain open if not manually closed. Other trends included children wandering or being left alone for short periods by adults who believed the child was playing peacefully, or busy gatherings where it became easy to lose track of who was supervising the children.

Finally, in one tragic case, a child gained access to a pool through a dog door in a garage wall which formed one side of the pool enclosure. While this was usually blocked by a lawnmower, on this occasion the child had gained access to the

dog door by removing the lawnmower's catcher. He was being supervised by two adult family members who were both under the impression the child was with the other.

International research has demonstrated that the most effective way to prevent home pool drownings is through the installation of a four-sided barrier, such as a fence, that is not scalable by children, and has an automatically closing gate. This is a legal requirement included in the Fencing of Swimming Pools Act 1987, which was amended from 1 January 2017 and requires:

- Any home pool with walls less than 1.2m above the ground, with a depth of water of more than 40cm, be inaccessible to children via a physical barrier such as a gated fence, locked door or walls.
- Have no gaps where a child could get through.
- The owner of a home pool to notify the council of the pool's existence, or their intent to construct a pool.
- Gates must open outwards of the pool area, must shut and latch automatically, and have a latching device at least 1.2m high (if accessed through or over the gate) otherwise must be at least 1.5m high. The self-closing mechanism should be checked regularly to ensure it works as intended from both a wide-open and a narrower position.

The full legal requirements and duties can be found in the Fencing of Swimming Pools Act 1987 and ss 162A-E of the Building Act 2004.

## Key themes in Coronial recommendations

There appear to be three key factors that can greatly reduce child drowning deaths. The first is to proactively identify and recognise water hazards such as ponds, streams, pools and even troughs or buckets that can fill with water and are accessible to children. Action can then be taken to mitigate risk by fencing, draining, or removal of the hazard.

Second, active adult supervision is crucial. A recurring trend in child drownings is that the child has entered a water hazard either unseen or while being left in the company of other children. A child can drown in as little as an inch of water, and in under two minutes.<sup>7</sup> Further, many believe that the act of drowning is accompanied by panic, splashing or yelling but usually this is not the case. Signs to look out for include

**Gasping** – a drowning child is more focussed on simply trying to breath than to call for help.

**Bobbing** – where the child alternates between rising above the surface and sinking below.

**Lowered arms** – When trying to keep their head above the water, children will place their arms at the sides or try to push themselves up.

<sup>7</sup> <https://www.plunket.org.nz/your-child/safety/water-safety/keeping-your-child-safe-from-drowning/>



**Floating face down** – indicates the child has become unconscious and is a critical sign that a child is in need of urgent help.

Third, appropriate and functional fencing and gating of pools and spas – The findings considered in this analysis show a preponderance of deaths that have occurred due to a faulty gate or section of fencing which has allowed a child access to the water, in some cases these risks have been recognised but not remedied prior to the death. In one study of toddler drownings in domestic pools, it was found that there was not a single case out of 33 where a child drowned in a pool that was gated and fenced in accordance with Australian standards.<sup>8</sup> In cases where a child has escaped attention, preventing their ability to access a water hazard can save a life.

Child and Youth Mortality Review Committee gave this advice in their examination of drowning in under 25s in New Zealand:<sup>9</sup>

- All children under the age of three years should be constantly supervised in the bath by an adult.
- Children under the age of five years should not be left to supervise younger children in the bath
- All home pools need to be fenced in regulation with the Fencing of Swimming Pools Act 1987, with attention to ongoing compliance. Gates should never be propped open.
- Adults need to closely supervise toddlers while they are near any body of water.

The following advice is also promoted by the World Health Organization to reduce or prevent child drowning:<sup>10</sup>

- Drain unnecessary accumulations of water (e.g. baths, ponds, buckets).
- Build safe bridges and install piped water systems to reduce exposure to open bodies of water.
- Build and maintain 4-sided fencing around swimming pools.
- Wear a personal flotation device (e.g. life jacket) when on a boat.
- Cover wells and rainwater collection sites (e.g. cisterns, barrels) with heavy grills.
- Teach parents and caregivers basic life-saving and first aid skills and train the general community in cardiopulmonary resuscitation.

## Recommendations made by Coroners

The following is a full reproduction of the recommendations of Coroners made in child drowning cases from 2009-2018.

These are in addition to the 2019 recommendations made by Coroners in the Slack and Chen cases, referred to above in the 2019 recommendation summaries.

<sup>8</sup> Blum C, Shield J. Toddler drowning in domestic swimming pools *Injury Prevention* 2000;6:288-290.

<sup>9</sup> Child and Youth Mortality Review Committee "Circumstances surrounding drowning in those under 25 in New Zealand (1980-2002)"

<sup>10</sup> Above, n 2.

## **Frank [2009] NZCorC 39 (29 May 2009)**

Summer Kaylee Frank, an infant aged 3 years, died on 8 January 2009, at Skeet Road, Manaia, near Hawera, by drowning in an effluent pond on a dairy farm.

### **RECOMMENDATIONS OF CORONER SCOTT**

To: Federated Farmers

- I. That Federated Farmers revisit the Share Milking Agreement and provide that the Share- Milker's house must be fenced to a standard which will prevent young children from wandering from the house onto the farm.
- II. That the clause in the agreement be flagged as a significant clause in some way; i.e: by highlighting or bolding, or simply stating at the beginning that there are significant clauses and this is one of them.

To: The appropriate government department and appropriate farm workers union

- I. This decision will be referred to the above organisations, so that they can make submissions to the relevant authority regarding drafting legislation to provide for secure child-proof fencing around farm dwelling houses, and to include a mandatory measure for checking and policing of those fences; and that those organisations report back to me within 3 months and advise me of the steps that they intend to take to implement my recommendations.

### **RESPONSE FROM THE DEPARTMENT OF LABOUR**

27 August 2009

Mr Tim Scott  
Coroner, Palmerston North  
c/- Coronial Services Unit  
Private Bag 39819  
Wellington Mail Centre  
Lower Hutt 5045

11 SEP 2009  
2009TS-20

Department of Labour

TE TARI MAHI



Our ref: 09/87740

Dear Mr Scott

**Recommendation arising from the inquest into the death of Summer Kylee Frank at Kapuni on 8 January 2009 [CSU-2009-PNO-000020]**

This department was forwarded a copy of your 29 May 2009 report and certificate of findings into the death of Summer Kylee Frank.

We note that one of your recommendations was referral of your findings to "the appropriate department and to the appropriate farm workers union, so that those organisations can make submissions to the relevant authority regarding drafting legislation to provide for secure child-proof fencing around farm dwelling houses, and to include a mandatory measure for checking and policing of those fences".

You also requested that those organisations report back to you within three months and advise you of the steps they intend to take to implement your recommendations.

This letter is to advise you of the results of discussions between this department, the Department of Building and Housing and Federated Farmers. Each of these bodies has therefore reviewed the contents of this letter.

Collectively the three organisations have considered the potential application of legislation in relation to a drowning hazard such as that which led to the death of Summer Frank, and proposed a means of preventing such a death in the future.

Three pieces of legislation have been identified which could potentially apply:

- The Fencing of Swimming Pools Act 1987
- The Building Act 2004 and the Building Code
- The Health and Safety in Employment Act 1992

The Department of Labour is responsible for the Health and Safety in Employment Act 1992. The other two pieces of legislation are administered by the Department of Building and Housing.

In summary, the Department of Building and Housing considers that the issues raised in the report do not lend themselves to a regulatory solution under the Fencing of Swimming Pools Act or the Building Act (or any revised legislation).

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Additionally, the Department of Labour does not consider that drafting an amendment to, or creating regulations in accordance with, the Health and Safety in Employment Act 1992 would be an appropriate vehicle for requiring the child-proof fencing of homes on farms.

These views are discussed further below, and are consistent with those expressed by Federated Farmers.

#### *Legislative regime governing the fencing of swimming pools*

The purpose of the Fencing of Swimming Pools Act 1987 is to 'promote the safety of young children by requiring the fencing of certain swimming pools'. The Act does not apply to fencing of naturally occurring lakes or waterways. It also does not apply to man made lakes and dams (i.e. farm dams, duck shooting ponds, effluent ponds), unless they are:

- used "in association with" certain buildings, including houses or apartment buildings; and
- intended to be used for swimming.

The Department of Building and Housing noted that a Coroner's report in a 2004 case considered the drowning of a child in an ornamental pond. The pond was situated 72 metres from the house and this distance was considered to be in 'association with the house'. However, the law does not apply to a pond that is not intended for swimming, such as an effluent pond.

#### *Building Act 2004*

The Building Act 2004 and the Building Code (especially Clause F4 Safety from Falling) potentially have application in regard to fencing pools. The New Zealand Standard 8500:2006 'Safety Barriers and Fences around Swimming Pools, Spas and Hot Tubs' (the NZ Standard) provides details of fences that comply with the Fencing of Swimming Pools Act.

The Building Act relates to the regulation of building work. While the Building Code (Clause F4) does include a requirement for safety from falling, this provision is only in relation to buildings; that is, that they be constructed to reduce the likelihood of accidental fall within or from buildings. The Building Act and Code also require access to swimming pools to be restricted for children under 6 years of age, but this does not extend to effluent ponds or require houses to be fenced.

#### *Review of building legislation*

The Department of Building and Housing is currently reviewing the legislation and is proposing that the Fencing of Swimming Pools Act should be repealed once the child safety requirements around swimming pools have been incorporated into an amended Building Act 2004. This proposal is before Cabinet.

#### *Health and Safety in Employment Act 1992*

Because farms are workplaces they are covered by the Health and Safety in Employment Act. The Department of Labour considers that the hazards to children arising on farms are appropriately dealt with under that Act.

However, we do not support the mandatory fencing of farm houses as a matter of policy or for practical reasons.

The policy reason concerns the application of the HSE Act to "places of work" as distinct from homes. The Act's focus is on the prevention of harm through requiring employers and others to control hazards by imposing general duties, rather than prescribing the means of controlling them. There are cases where requirements are prescriptive, but in general, these are where a hazard arises from the workplace and is readily identifiable and controlled. So, for example, the department requires guards on tractor power take-offs, the guarding of milking machinery and other plant, but the situation is less clear with regard to streams and irrigation ditches, and natural hazards on farms.

It is however, arguable that silage pits or effluent ponds are workplace hazards that a farmer has an obligation to control in certain circumstances, such as where there is a foreseeable risk of young children accessing them.

The department's view is that child-proof fencing on farms is principally concerned with the restraint of a child in the home, rather than managing a particular hazard arising from the work activities of the farm. Regulations requiring the fencing of all farm houses would therefore be inconsistent with the purpose of the Act which is to control potential causes of harm in the workplace. Thus a requirement to control a hazard in a home may be ultra vires.

Additionally, the department does not usually inspect farms as workplaces and would be unable to enforce any such requirement without significant resource implications. Any such regulation is therefore likely to be unenforceable and ineffective.

#### *Proposed solution*

The Department of Labour's proposal is to work with Federated Farmers and the Agricultural Safety Council to provide education and guidance material to farm owners and employees to prevent children from falling victims to hazards such as effluent ponds. This approach has been discussed with those bodies, and they are in support of the proposal. There is further scope for involving the Accident Compensation Corporation.

The Department of Building and Housing also supports this approach, and has suggested that information in the NZ Standard in relation to how to construct appropriate child proof barriers may be a useful source to draw upon.

I hope this response is acceptable to you and if you would like further information please let me know.

Yours sincerely



Jim Murphy  
Workplace Health and Safety Policy Manager  
for Secretary of Labour

## Calvey [2009] NZCorC 80 (3 August 2009)

Corbyn Aston Calvey late of Paeroa died, aged 13 months, on 3 February 2009 at his home of drowning.

Corbyn was in the care of his grandmother and aunt, and for a brief time each woman mistakenly thought he was in the care of the other. In this unsupervised period Corbyn managed to climb through a dog door in the garage into the enclosed pool area in the back yard. When the women realised they did not know where Corbyn was, they searched and found him in the pool, face down. CPR was commenced immediately but Corbyn could not be revived.

The dog door was obscured by the catcher of a lawn mower, but Corbyn was able to unlatch it in order to climb through the door. He had been seen trying to climb through the door on a previous occasion.

### COMMENTS OF CORONER J P RYAN

- I. This death was preventable, although not readily foreseeable. Corbyn's family had taken significant steps to prevent Corbyn from gaining access to the pool area, and therefore no doubt considered that the area was safe. But there were still weaknesses in their precautions. I refer to the fact that Corbyn could gain access to the garage itself through an open side door, and then through the unlatched and open dog door to the pool area and then to the pool.

### RECOMMENDATIONS OF CORONER RYAN

- I. That all owners of properties with swimming pools ensure that any portal through which a child could gain access to the pool is appropriately fastened at all times.

## Symes [2011] NZCorC 123 (5 October 2011)

Aisling Celine Symes, late of Massey, Auckland, an infant, drowned in a stormwater pipe near 51 Pomaria Street, Henderson, on or about 5 October 2009, she likely having stepped onto a displaced manhole cover lying in the driveway of 5 Longburn Road, Henderson, Auckland, and been tipped into the manhole below, following which she was swept down the pipe to a point where her body was caught by tree roots which had infiltrated and were obstructing the pipe

### RECOMMENDATIONS OF CORONER EVANS

TO: The Chief Executive Officer, Local Government New Zealand

- I. Building on the improvements effected by the Auckland Council in management of its stormwater infrastructure (and associated public risk), and having regard to the recommendations made to the Court by Mr Brian Kouvelis, consulting civil engineer (set out in paras [81] and [143] hereof), THAT Local Government New Zealand establishes a national body of guidelines and recommendations for adoption by all Territorial Local Authorities for the management of stormwater systems, including the steps needing to be taken in the interests of public safety; the levels of service required in respect of surcharging manholes; and the establishment of criteria for the fitting of safety grilles or other protective devices to manholes in existing and new stormwater networks.

- II. THAT consideration be given to the establishment of an Integrated Risk Management policy (similar to that developed by the Rotorua City Council) for adoption by Territorial Local Authorities, the purpose of which policy is to link infrastructure activity, asset management/planning and corporate risk management (each asset management plan to include a comprehensive risk register), through levels of service, to sound and effective community outcomes.
- III. THAT Local Government New Zealand convey to Territorial Local Authorities the following specific recommendations made by Mr Kouvelis, for consideration/action pending completion of Recommendations 1-2 hereof:
- (i) That Territorial Local Authorities take immediate steps to secure manhole covers or fit safety grilles to manholes which:
    - a. have been identified with a potential for surcharging through network modelling studies; and
    - b. to existing manhole covers with a known problem with surcharging as reported through existing stormwater operation and maintenance contracts and programmes
  - (ii) That a quality assurance loop be included in maintenance and operations contracts to ensure consistent effectiveness of work order, actions and intent
  - (iii) That key stormwater pipes within stormwater networks be fitted with telemetered sensors to monitor stormwater network performance and to enable rapid response to displaced manhole covers in areas at risk of surcharge within the stormwater network
  - (iv) That TLA call-centre complaints protocols include the issuing of a complaint number to complainants for future reference and follow-up
  - (v) That procedures for prioritising responses to notification of displaced manhole covers be reviewed
  - (vi) That procedures in terms of identifying problems in stormwater drainage networks following repeat complaints of manhole cover displacement in or around an area to be reviewed
  - (vii) That each TLA develops a robust system of identifying and ranking public safety risks around all manholes
  - (viii) That each TLA develops a public health and safety risk profile of all existing manholes according to level of service, depth and location.
- IV. It is directed that a copy of these Findings be sent to the Chief Executive Officer, Auckland Council; Chief Executive Officer, Local Government New Zealand; Chief Executive Officer, Ingenium; Chief Executive Officer, SOLGM and the Chief Executive Officer, Office of the Auditor General.



## **Vau [2011] NZCorC 125 (27 October 2011)**

Nylah Masae Faamanu Vau, of Manurewa, Auckland, died at the Waiwera Infinity Thermal Spa Resort, 21 Main Road, Waiwera, on 5 February 2011. The cause of death was accidental drowning.

### **COMMENTS OF CORONER RYAN**

- I. This death highlights again the need for parents to actively and closely supervise young children at swimming pools, even if the pool complex provides lifeguards. If there is a handover from one parent to the other of responsibility for such supervision, then it is imperative that each parent clearly understands who has that responsibility at any given time. Parents cannot and should not rely upon staff at a commercial pool complex to supervise their young children, as this is not usually the staff's responsibility.

## **Millar [2013] NZCorC 60 (11 April 2013)**

Astyn Millar, late of Whaharoa, died on 13 October 2011, aged four, at his grandparents' home, of drowning.

Astyn was staying at his grandparents' home with his mother and sister. In the afternoon of the day he died, he left the lounge where he had been playing with his sister. After a few minutes his mother went to look for him and discovered him at the bottom the swimming pool. She immediately pulled him from the pool and commenced CPR. Emergency services were called, but Astyn could not be revived.

The fencing of the pool did not comply with the Fencing of Swimming Pools Act 1987 (the Act) in many ways, but notably it was accessible through a back door that was not self-closing, did not open inwards, and had a latch that was less than 1.5 metres from the floor. Had the back door been compliant it is unlikely that Astyn would have been able to open it on his own.

The Waitakere City Council (now Auckland Council) did not know about the pool and had not inspected it. Astyn's grandparents believed the Council did know, and that an inspection would have been done before they had purchased the property.

The pool has since been back-filled with topsoil and is no longer required to be compliant with the Act.

The Auckland Council has taken steps to identify unknown, non-compliant pools, and educate the public on pool safety.

### **RECOMMENDATIONS OF CORONER MATENGA**

To: Auckland Council, Water Safe Auckland

- I. That the net of distribution of the pool safety pamphlets be widened to places such as supermarkets and other retail outlets where swimming pools and pool products are sold, thereby maximising the availability of the "pool safe" message.

## **Schuster [2013] NZCorC 163 (18 October 2013)**

Genesis Schuster late of Henderson, Auckland died, aged five years, on 29 March 2013 at Luckens Reserve, West Harbour, Auckland of drowning.



Genesis was a young boy with autism who did not communicate well and was known to run off from time-to-time. He was described as 'not understanding safety'. His family had arranged for him to wear a tracking device called 'WandaTrak Tracking System' (WandaTrak), used by Auckland Land Search and Rescue and New Zealand Police to search for people living with dementia or autism, as well as other groups of people, who regularly wander from their place of residence. On the day of his death he was celebrating his fifth birthday with his extended family at Luckens Reserve in West Harbour. He had been playing with the other children, but while the adults were cleaning the barbeque he wandered out of sight. His family members did not find him in their initial search and so contacted emergency services. He was eventually located by helicopter, lying on a mudflat area, having drowned. His WandaTrak device had been damaged and therefore was not emitting a signal.

The WandaTrak device had come free of the protective pendant with was encased to be worn in, and it is unclear how that happened. It had not been noted as appearing damaged earlier that day.

#### COMMENTS OF CORONER HERDSON

- I. Although the WandaTrak device was not operating in a manner that enabled Genesis to be located through that device in the particular circumstances of his situation, the use of WandaTrak devices should continue to be supported. The device and its associated WanderSearch programme appear to be a valuable aid in terms of locating missing persons and increase the chances of a more rapid search and rescue process, which may in turn prevent deaths of such missing persons occurring in the future.
- II. Search and Rescue staff of the New Zealand Police should continue to work with the manufacturer to improve the reliability of the WandaTrak technology and devices.

#### Waples [2014] NZCorC 138 (25 November 2014)

Violet Elisabeth Waples of Queenstown died on 6 August 2013 at Lake Wakatipu of drowning.

Violet was 2 years and 10 months old. She lived with her family on a property near Lake Wakatipu.

Violet and her mother were at their home. After playing outside, Violet's mother thought Violet had followed her indoors. When she went to check on Violet, she could not locate her. After a search Violet was found in the lake. Attempts to resuscitate Violet were unsuccessful.

#### COMMENTS OF CORONER MCELREA

To: Water Safety New Zealand as further support for the message that all infants need to be supervised around water.

- I. The inquest has highlighted the issues of parental responsibility of infants in the vicinity of water hazards. As stated by Water Safety New Zealand, all infants need to be supervised around water. Where supervision may be temporarily reduced such as in the home environment it is critical that doors and means of egress are closed and that access to the outside of the dwelling is not achievable.

#### Unwin [2014] NZCorC 139 (11 December 2014)

Charlie Aaron Unwin of Mandeville died on 12 June 2013 at his home address of drowning.

Charlie was a 22 ½ month old boy. He lived with his family on a farm where his father was employed. A trench was located in a paddock near the house where Charlie lived with his family. One end of the trench had filled with runoff water.

When Charlie's mother noticed he had not followed her inside the house, she searched for him. Charlie was located in the water in the trench. Attempts to resuscitate him failed.

#### **RECOMMENDATIONS OF CORONER CRERAR**

- I. I recommend that Work Safe investigate, in conjunction with [the property owner], to whom a copy of this Finding is being sent, the installation of a protective fence around the replacement rubbish trench dug on the property.
- II. I recommend that Water Safety New Zealand continue with its programme of providing appropriate advice for caregivers in relation to the absolute need for those in charge of infants who are at risk to take care of them when such children are exposed to a water hazard.

#### **Nath [2014] NZCorC 153 (4 June 2014)**

Irene Nath of Otapiri died on 14 January 2014 at her place of residence of drowning.

Irene was 22 months old. She lived with her family on a farm. Irene had been playing with family members. Her mother and sisters returned inside the house. Approximately 10 minutes later they looked for Irene. They could not locate her.

Irene was located in a pond in a paddock on the farm. Attempts to resuscitate her failed.

#### **RECOMMENDATIONS OF CORONER CRERAR**

- I. I draw to public attention the recommendations by Water Safety New Zealand. When in or near water, keep under fives within arm's reach (and line of sight) at all times.
- II. The obvious qualification to this recommendation, in the circumstances investigated during the Inquest Hearing, is that it was not considered by any that Irene Nath was in, or near, water.

#### **Paasi [2015] NZCorC 9 (23 February 2015)**

Sosaia Paluto Paasi and Tino Paea-I-Muli of Mangere died on 20 May 2012 at Manukau Harbour of drowning. Sosaia took his children out on a small boat he had purchased the previous day. There were no life jackets on board, the weather conditions were rough and the children could not swim. There was no bung in the boat and it began to sink. The boat then capsized and sank very quickly. Alcohol may have been a factor contributing to Sosaia's balance and judgment. Sosaia and Tino were not able to be rescued and their bodies were found on 21 May and 22 May respectively.

#### **COMMENTS OF CORONER GREIG**

- I. The circumstances of the deaths of Sosaia Paasi and his son Tino Paasi highlight the important issue of the use of appropriate life jackets or personal flotation devices at all times in small craft under six metres – which are vulnerable to capsizing, swamping in waves and taking on water, as well as people falling overboard.

- II. Auckland Council is to be commended for taking steps to strengthen the obligation to wear lifejackets with its new Auckland Council Navigation Safety Bylaw 2014 which requires everyone aboard a vessel under 6m in length to wear a lifejacket at all times unless the person in charge considers there would be no reduction in safety and expressly authorises it. Some water safety advocates consider the Auckland Council bylaw does not go far enough as discretion for removing life jackets is given to the skipper.
- III. Failure to wear lifejackets in small vessels that are prone to capsize has been identified by Maritime New Zealand as the main cause of death in boating accidents (Maritime New Zealand (2008) Boating Safety Strategy: 2007 Review of the New Zealand Pleasure Boat Safety Strategy Wellington, p72).
- IV. There has been ongoing public debate on the issue of the compulsory wearing of lifejackets on small boats and the issue of mandatory use of lifejackets (removing the discretion of the skipper) for all those in boats under 6 metres continues to be supported by many water safety bodies. There are vocal supporters both for maintaining the status quo and for legislative reform. The evidence to this inquiry suggests that there may be growing public confusion as to what the requirements currently are due to different requirements being introduced by different regional council bylaws.
- V. I am advised that there is currently work underway by Maritime New Zealand and the Ministry of Transport at the request of the Minister of Transport on the feasibility of a single national rule to govern the use of life jackets/personal flotation devices in relation to recreational craft and that it is anticipated that this work will be presented to the Minister soon.
- VI. In view of the consideration the Minister of Transport is soon to give to the issue, I direct that a copy of these findings be sent to the Minister to draw to his attention to the preventable deaths of Tino and Sosaia Paasi that occurred when neither was wearing a life jacket.

## **RECOMMENDATIONS OF CORONER GREIG**

To: Hon Simon Bridges. Minister of Transport

- I. I make the following recommendation for consideration by the Government:
  - a. That as part of the upcoming review of the regulation of the use of life jackets/personal flotation devices in recreational craft, consideration be given to whether occupants of vessels of six metres or less in length should be required to wear life jackets/personal flotation devices at all times whilst at sea.

I direct that a copy of this finding be sent to the Chief Executive Officer, Maritime New Zealand, the Chief Executive, Ministry of Transport, the Chief Executive, Water Safety New Zealand and the Chief Executive, Auckland Council.

## RESPONSE FROM THE NEW ZEALAND TRANSPORT AGENCY



### Office of Hon Craig Foss

**MP for Tūkituki**

Minister for Small Business

Minister of Statistics

Minister of Veterans' Affairs

Associate Minister of Immigration

Associate Minister of Transport

Ms Shama Sikora  
Coronial Case Manager  
Coronial Services Unit  
Auckland District Court  
65-69 Albert Street  
**AUCKLAND 1010**

**11 MAR 2015**

Dear Ms Sikora

Thank you for your letter of 24 February 2015 providing the Minister of Transport, Hon Simon Bridges, with Coroner Greig's final findings into the deaths of Tino Paasi and Sosaia Paasi in a boating accident on Manukau harbour. Your letter has been referred to me for reply, as this matter falls within my portfolio responsibilities.

At present, Maritime New Zealand is investigating the merits of possible changes to Maritime Rule Part 91: Navigational Safety, which includes requirements concerning the carriage and use of personal flotation devices on recreational vessels.

The Coroner's recommendation that consideration be given to requiring occupants of vessels of six metres or less in length to wear life jackets at all times while at sea is being considered as part of Maritime New Zealand's review. I am expecting Maritime New Zealand's advice in April this year.

Yours sincerely

Hon Craig Foss  
**Associate Minister of Transport**

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

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

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

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

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

### **COMMENTS OF CORONER J P RYAN**

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

### **RECOMMENDATIONS OF CORONER RYAN**

To: Water Safety New Zealand

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

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

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

Maggie was a much-loved 14-month-old. Her father was employed on a dairy farm and lived in a staff house. Some metres from the house, forming something of a roundabout in the driveway, was an ornamental pond. It was approximately two metres diameter and 240 millimetres in depth and was surrounded by shrubs of various sizes. A brick pathway led through the shrubs to the pond. It was not fenced nor were there other means of preventing access to the pond.

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

#### **COMMENTS OF CORONER ROBINSON**

- I. This case is an absolute tragedy. In all other respects, Mrs Gomez-Lambertucci impresses as a caring and attentive mother. This tragedy was the result of a moment's inattention. The circumstances serve to highlight the need for vigilance, and that parents of young children should identify water features at residential properties and give consideration to the means by which such features can be made safe from enquiring youngsters.
- II. In the case of a rental property such as this was, a landlord should give some thought to potential hazards if it is known that young children will be among the occupants.
- III. The need for vigilance is perhaps highlighted by the report prepared by Water Safety New Zealand from 2012, which noted that 75 percent of all domestic and home pool fatalities (for children under five years of age) were aged two or under.



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