OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments made between **1 July and 30 September 2022**

Office of the Chief Coroner | 2022 (3)

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 37 findings with recommendations and/or comments issued by Coroners between 1 July and 30 September 2022.

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Recommendations and comments

1 July to 30 September 2022

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

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

Aviation

Charlton et al [2022] NZCorC 109 (29 July 2022)

CIRCUMSTANCES

Cynthia Charlton, Nigel Charlton, Josephine Gibson, Sovannmony Leang, Andrew Virco, Katherine Walker and Mitchell Gameren (who was the pilot), died in a helicopter crash at Fox Glacier on the West Coast of New Zealand on 21 November 2015 of injuries sustained in the crash.

On 21 November 2015, an Airbus Helicopters AS350 ("Squirrel") helicopter, operated by James Patrick Scott, was conducting flights out of the operator's base near Fox Glacier town. The weather conditions that morning had caused the cancellation and postponement of several flights.

Mr Gameren decided that the weather had improved enough to conduct a scenic flight with passengers to the head of the Fox Glacier valley. At 9:45am the helicopter departed with Mr Gameren and six passengers on board for an expected 20-minute flight. The weather was cloudy and changeable as the flight departed. Weather permitting, the flight was to include a snow landing on Chancellor Shelf above the glacier. Mr Gameren spoke with the pilot of another helicopter flying in the neighbouring Franz Josef Glacier valley.

The helicopter was reported overdue at 10:15am. The subsequent search located the wreckage of the helicopter. It had crashed onto the glacier just below Chancellor Shelf. There were no survivors, no witnesses to the crash and no onboard recorder.

Images obtained from some passengers' cameras helped to trace the approximate track of the helicopter. The helicopter had first landed on Chancellor Shelf and the passengers got out and walked in the snow. It was snowing at the time and cloud was coming and going. There was no recorded evidence of the helicopter's flight path after it departed Chancellor Shelf.

The Transport Accident Investigation Commission (TAIC) found it unlikely that a mechanical failure with the helicopter was a factor in the accident. Although not all of the wreckage was recovered, an examination of the recovered components (including all the dynamic assemblies) revealed no pre-existing failure.

TAIC advised that it was very likely that when the helicopter took off from Chancellor Shelf, it struck the glacier surface with a high forward speed and a high rate of descent, with the engine delivering power.

TAIC considered possible contributing factors to the crash and concluded:

(a) It is unlikely that the pilot was medically incapacitated or that his performance was impaired in some way.

(b) It is unlikely that the helicopter encountered 'servo transparency.'

(c) The all-up weight of the helicopter exceeded the maximum allowable internal weight limit throughout the flight.

(d) It is very unlikely that any engine-related issue contributed to the accident.

(e) It is virtually certain that the helicopter was not in 'vortex ring state' when it crashed.

(f) The weather conditions on the day were unstable and unsuitable for conducting a scenic flight. The localised weather conditions in the area were very likely to have been frequently below the minimum criteria required by Civil Aviation Rules.

(g) It is very likely that when the helicopter took off from Chancellor Shelf and descended down the valley, the pilot's perception of the helicopter's height above the terrain was affected by one or more of the following: cloud, precipitation, flat light conditions, condensation on the front windscreen.

(h) In the absence of other identifiable causative factors, it is very likely that the helicopter struck the glacier due to the pilot losing awareness of the helicopter's height about the glacier until it was too late to avoid a collision.

TAIC found that Mr Gameren had not been properly trained and did not have the appropriate level of experience expected under the operator's categorisation scheme for a senior pilot in this type of operation. The operator's system for training its pilots was ill-defined and did not comply fully with the Civil Aviation Rules. The training system also did not have sufficient oversight by designated senior persons, which is why Mr Gameren was assigned roles and responsibilities without having had proper training and experience.

The Civil Aviation Authority laid charges against James Patrick Scott and Aviation Manual Development (2009) Limited under the Health and Safety in Employment Act 1992. Guilty pleas were entered on 17 May 2019 and the defendants were sentenced. Although the defendants admitted breaches of the Health and Safety in Employment Act 1992, they did not admit that these breaches were causative of the crash.

An inquest took place on the basis that the Coroner would adopt the TAIC conclusions about the cause of the crash. These conclusions formed the basis of possible comments and recommendations.

COMMENTS AND RECOMMENDATIONS OF CORONER ELLIOTT

I. I make the following comments and recommendations pursuant to section 57[1] of the Coroners Act 2006:

Calculation of passenger weight on helicopters

II. I recommend that the Ministry of Transport provides advice to the Minister of Transport about the possible amendment of rule 135.303 of the Civil Aviation Rules as follows:

(a) Subject to paragraphs (b), (c), and (d), a holder of an air operator certificate must ensure that for every air operation conducted under the authority of the certificate (except those in which immediate danger to life prevents compliance with this rule), the weights of the following items that are carried on the aircraft are established:

(1) the total weight of passengers:

(2) the total weight of crew members:

(3) the total weight of goods and baggage.

(b) The total weight of passengers (excluding their carry-on baggage (if any)) must be determined by using ~~only 1 of the following~~:

~~(1)~~ the actual weight of every passenger:

~~(2) a standard weight for every passenger that is established by the certificate holder and detailed in the certificate holder's exposition:~~

~~(3) a weight that is declared by the passenger plus an additional 4 kg for every passenger.~~

(c) The total weight of crew members (excluding their carry-on baggage (if any)) must be established by using—

~~(1)~~ the actual weight of every crew member; ~~or~~

~~(2) a standard weight for every crew member that is established by the certificate holder and detailed in the certificate holder's exposition.~~

(d) The total weight of goods and baggage must be determined by using—

(1) the actual weight of the goods and baggage; or

(2) for commercial transport operations operating from a remote aerodrome where it is not practicable to establish the actual weight of the goods and baggage, the certificate holder must establish procedures to enable the pilot-in-command to assess the weight of the goods and baggage.

[1] In its pre-July 2016 form.

~~(e) A certificate holder who intends to establish a standard weight to be detailed in the certificate holder's exposition for use under paragraphs (b)(2) or (c)(2) must establish the respective standard weight in accordance with a survey programme that is acceptable to the Director.~~

~~(f) A certificate holder who intends to use declared weights for passengers under paragraph (b)(3), or standard weights for passengers under paragraph (b)(2) or for crew members under paragraph (c)(2) must establish procedures that are acceptable to the Director to ensure that, if the weight of a passenger or crew member is clearly greater than the declared weight or standard weight being used, a weight that is more representative of the actual weight of the person is used.~~

~~(g) A certificate holder who uses a passenger declared weight under paragraph (b)(3) must ensure that the passenger is not encouraged to declare a weight that is less than the passenger's actual weight.~~

Webcams

III. I make the following comment:

Webcams are a very powerful aid to decision-making and a valuable training tool. Helicopter operators who conduct air operations in alpine environments should, where it is possible and permissible to do so, install webcams at locations selected to provide information to pilots.

HDFM

IV. I recommend that the Ministry of Transport provides advice to the Minister of Transport about possible amendment to the Rules to require those operating helicopters under Part 135 to use Helicopter Flight Data Management in a form acceptable to the Director of Civil Aviation.

Pilot categorisation system

V. I recommend that the Ministry of Transport provides advice to the Minister of Transport about possible amendment to the Rules such that Part 135 operators are required to implement a pilot categorisation system as part of their Safety Management Systems. This should define the parameters of the air operations which pilots are, by virtue of their training and experience, entitled to undertake for that operator.

Approach to flight in variable conditions

VI. I make the following comment:

Helicopter pilots should adopt a conservative approach when deciding whether to fly in conditions which may fluctuate below weather minima.

Condensation

VII. I make the following comment:

Helicopter pilots should be aware of the possibility of condensation on the windscreen of helicopters when passengers enter the helicopter in cold conditions and should not take off until demisters have taken full effect.

CAA monitoring of Part 135 operators

VIII. I recommend that the Ministry of Transport provides advice to the Minister of Transport about possible amendment to the Rules to include the following requirements for Part 135 operators:

a. Operators should regularly engage an independent auditor to assess their compliance with regulatory and health and safety obligations.

b. Operators should be required to provide the auditor's reports to CAA.

IX. If these amendments are adopted, I recommend that CAA uses these auditors' reports as a means to determine whether further investigation of an operator is warranted.

Reporting and auditing of weight data

X. I recommend that the Ministry of Transport provides advice to the Minister of Transport about possible amendment to rule 135.303 to include:

(e) a holder of an air operator certificate must ensure that records are maintained of the total weights of passengers, crew members and luggage for every air operation conducted under the authority of the certificate.

(f) a holder of an air operator certificate must furnish copies of records maintained under subsection (e) to the Civil Aviation Authority at intervals directed by the Director.

XI. If these amendments are adopted, I recommend that the Civil Aviation Authority audits the records obtained under the amended rule to determine whether investigation of an operator is warranted.

Pilot training

XII. I recommend that the Ministry of Transport provides advice to the Minister of Transport about possible amendment to Rule 135.553 as follows:

(a) Each holder of an air operator certificate shall establish a training programme to ensure that each of its crew members are trained and competent to perform their assigned duties.

(aa) A holder of an air operator certificate must ensure that each segment of the training programme includes a syllabus that is applicable to the certificate holder's operations and is acceptable to the Director.

(ab) For pilots operating in mountainous areas, the training programme should include training relating to mountain flying (including in relation to pilot- decision-making) and the risks associated with condensation.

(b) Each holder of an air operator certificate shall ensure that each crew member is trained in accordance with the training programme contained in the certificate holder's exposition.

(c) The holder of an air operator certificate shall ensure that its training programme is controlled by the certificate holder.

(d) The holder of an air operator certificate may—

(1) conduct the training programme; or

(2) contract with the holder of an aviation training organisation certificate issued under Part 141, to conduct the training programme where the Part 141 certificate authorises the holder to conduct that training; or

(3) for a training programme conducted outside New Zealand, contract with an organisation that meets an equivalent standard specified by Part 141.

Combe and Patterson-Gardner [2022] NZCorC 111 (1 August 2022)

CIRCUMSTANCES

Stephen Anthony Nicholson Combe, aged 43, died on 19 February 2015 in the Lochy Valley, near Queenstown as a result of injuries received in a helicopter accident.

James Louis Patterson-Gardner, aged 18, died on 19 February 2015 in the Lochy Valley, near Queenstown as a result of injuries received in a helicopter accident.

Steve was a very experienced and safety conscious helicopter pilot who worked for Over the Top Helicopters Limited, a business owned by James' mother, Louisa Patterson. James was a much-loved son who was about to start student life at the University of Sydney.

On 19 February 2015 Steve and James were returning from a training flight in a Robinson R44 helicopter (ZK-IPY). James was appropriately experienced and was at the controls of ZK-IPY as the helicopter flew down the Lochy Valley at 102 knots ground speed, at the end of a training flight.

Shortly after 1:40pm, the ZK-IPY experienced a main rotor blade divergence event. The rotor blade diverged from its normal plane and swung through the cabin, breaking the helicopter up in mid-air. It crashed into bush near the Lochy River. Steve and James were killed instantly.

The Transport Accident Investigation Commission (TAIC) investigated the crash and the Civil Aviation Authority (CAA) were advised of it.

Robinson Helicopters

Robinson helicopters are popular in New Zealand, possibly due to their price. The blade divergence phenomena is unique to Robinson helicopters due to the design of the rotor head. There are two main teetering twin blade designs, the "Bell-type" design, in which the blades are rigidly connected through a central hub, or the "Robinson-type" design, where each blade has its own flapping (coning) hinge in addition to the central teetering hinge. The Robinson rotor head

includes an additional hinge at each blade root, which allows the two blades not only to teeter, but to flap independently of each other. The blades are able to deflect upwards in response to lift forces, rotating along the path of a shallow cone as the blades are pulled outwards by much higher centrifugal forces. The blade root pivots are called “coning hinges”. As the blades flap through small angles around these hinges their centre of gravity shifts in a spanwise direction. The central hub pivot fitting can rock in response, which helps to ensure that the rotor stays dynamically balanced in normal flight. Adding the coning hinges to a twin blade teetering rotor head relieves stresses at the hub, which means that the rotor system can be lighter than that of rigidly connected rotor pairs. The coning hinges also add an additional degree of freedom of motion. The Robinson rotor head design means that when the blade teeters beyond its limits, the control of the pitch change links can be damaged. At extreme teeter angles, mechanical interference between the pitch link and pitch change horn fitting can induce very high stresses in the links, causing them to fail. This risk is where Robinson helicopters are potentially vulnerable.

Expert, Andrew McGregor, described the ability of the Robinson rotor blades to flap independently at the coning hinges as “undesirable” and “scary”. Mr McGregor noted three problems and issues with the Robinson helicopter and its rotor head design: Low-G flight and mast bumping/main rotor blade divergence; pilot control responses; and Loss of Control and main rotor blade divergence.

The Robinson Helicopter Company (RHC), based in Torrance, California, USA, is aware of the issues with its helicopters. No significant changes have ever been made to the design of the main rotor system. Instead, RHC prefers to issue Safety Notices and to provide pilot education, thus bringing the helicopter community’s attention to the limitations of its machines. Notably, none of the Safety Notices or Federal Aviation Authority (FAA) airworthiness directives suggest that light turbulence creates a risk.

The design of the Robinson rotor head makes the R44 (and the R22) particularly vulnerable to gusts, turbulence, and wind direction changes, even at relatively conservative speeds. Many areas in New Zealand are mountainous, and moderate to severe turbulence is likely. The Lochy Valley is a mountainous region which is susceptible to turbulence and changes in wind speed and direction. Therefore, under existing guidelines Robinson helicopters are vulnerable for much of the flying that is done in them in New Zealand.

In New Zealand, there have been 19 deaths in Robinson helicopters which TAIC have attributed to the rotor blade divergence/mast bumping problem. The CAA reported that the accident rates for both R22 and R44 helicopters have been trending down since 2010, which coincides with the introduction of certain safety notices.

Inquest

In any other type of helicopter, the accident would not have occurred in these circumstances. All parties agreed that ZK-IPY broke apart in mid-air after experiencing a main rotor blade divergence event. Ultimately, this inquest was about what caused the main rotor blade divergence.

The Coroner considered whether ZK-UPY spontaneously broke up while in flight. Mr McGregor opined that another contributing mechanism (other than low-G conditions, pilot inputs, or turbulence) caused the accident. The Coroner accepted that this was possible but noted the possibility was low.

The Coroner determined that the following factors did not contribute to the accident: mechanical fault, pilot behaviour and training, and a low-G flight sequence being deliberately initiated.

At the time of the accident, there was nothing to suggest that ZK-IPY was flown too fast. Steve and James were flying well within the recommendations and safety advice that was current at the time. However, the evidence indicated that the airspeed was likely too fast to be safe, because it increased the risk of a right roll and/or main rotor blade divergence during a low-G event, which can occur due to turbulence. In November 2016 RHC issued a safety alert recommending a maximum cruise speed of 110 KIAS (air speed) for Robinson helicopters. The Coroner opined that there are flaws in the design of the Robinson rotor head, which renders Robinson helicopters susceptible to issues such as turbulence, particularly when they are flown at any speed.

Undertaking the flight in a mountain valley increased the risk of sudden turbulence. This was a relevant factor to the cause of the accident. The information available to Steve at the time would not have suggested that the R44 was so prone to encountering risk in that terrain.

The Coroner concluded that, on the balance of probabilities, an abrupt change, or changes, in wind flow, or a gust, was encountered when ZK-IPY flew down the Lochy Valley. This turbulence affected the gravitational forces on the helicopter and exposed it to the risk of main rotor blade divergence.

Several studies have been undertaken in respect of Robinson helicopters which identified gaps in what is known about the aerodynamics of the machines, in particular, what is known about the causes and effects of main rotor blade divergence. The Coroner concluded that, until more research is done, which can give greater certainty regarding the cause of main rotor blade divergence, Robinson helicopters should not be flown over 70 knots in areas where moderate to severe turbulence is likely.

ZK-IPY was not fitted with an in-flight data recorder, which would have provided invaluable evidence to TAIC and to the Coroner's inquiry about the cause and the sequence of the break-up. It is currently not a requirement in New Zealand for helicopters to be fitted with in-flight data recorders. One reason for the gaps in knowledge surrounding the cause of main rotor blade divergence events is that they are almost always so catastrophic that everyone on board is killed. The value of helicopter cockpit video recorder systems (CVRS) for understanding accidents and incidents, and for training pilots, is recognised across the industry. Mrs Patterson developed Eye in the Sky, a CVRS which stores intercom and radio communications as well as ambient sound on a SD card. The CAA has worked with Ms Patterson to facilitate technical standards for its fitment to a range of helicopters.

COMMENTS AND RECOMMENDATIONS OF CORONER CUNNINGHAME

I. Having considered the evidence and submissions in this inquiry, I make the following recommendations to the CAA and TAIC, as regulators and organisations that have powers in respect of, or influence over, the New Zealand aviation community and the use of Robinson helicopters:

   a. The CAA and TAIC work together with the Ministry of Transport and other stakeholders to explore pathways for achieving, or obtaining the results of, an analytical model study of the Robinson rotor blade system and associated control system.

   b. The CAA and its Director:

      i. Identify stakeholders and implement a programme of work in order to effect regulatory change to prohibit the Robinson helicopters being flown in New Zealand in forecast moderate or severe turbulence; and

ii. Identify stakeholders and implement a programme of work in order to effect regulatory change to restrict the VNE (Velocity Never Exceed) to 70 KIAS for Robinson helicopters in ordinary flight in mountainous zones in New Zealand (as defined by the AIP).

If the results of studies into the design and flight behaviour of Robinson helicopters result in the causes of main rotor blade divergence accidents being better understood, then either or both of these restrictions could be amended or rescinded.

c. CAA and TAIC seek the involvement of, and consult with, stakeholders including the Ministry of Transport, and prioritise implementing a programme of work with the aim of achieving mandatory CVRS in all helicopters in New Zealand.

II. I make the following recommendation to AvNZ [Aviation New Zealand]:

a. That AvNZ summarise relevant safety information about Robinson Helicopters, including these findings, the Prosolve report, the Hall-Jones affidavit and Mr McGregor's supplementary brief of evidence, and disseminate that summary to members of its NZHA division.

III. Recognising that the first three of these recommendations may not be quickly implemented, and that the results of further studies will not be known for some time, I also make two recommendations to pilots of Robinson helicopters, and the owners and operators of those machines. These recommendations are:

a. Do not fly Robinson helicopters in forecast moderate or severe turbulence;

b. Do not exceed 70 KIAS in Robinson helicopters in ordinary flight in mountainous zones (as defined by the AIP).

IV. Finally, to the owners and operators of all helicopters in New Zealand, I recommend that CVRS devices are installed as soon as reasonably practicable.

V. It is my hope that these recommendations and comments will mean that no other family will experience the loss of a loved one in a rotor blade divergence incident in a Robinson helicopter in this country.

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

a. in relation to Steve:

his wife's name and the names of their children; any photographs of Steve, his wife and their children which form part of the evidence or submissions given at the inquest, except for any photographs which were published prior to the inquest; photographs of the accident scene and the wreckage at the scene which form part of the evidence or submission given at the inquest, except for those photographs which have been published in the TAIC report or the TAIC addendum report; any information about Steve and/or his family's personal or domestic affairs including health, relationship, and financial information; any specific description of Steven's injuries beyond "internal injuries"; reports or documents produced in relation to Steve's death and the post-mortem examination of his body including Dr Anderson's report, the toxicology report, death certificate, laboratory results, property record sheets, and examination records; Steve's wife's application dated 10 June 2021 and her affidavit in support;

b. in relation to James:

any specific description of James' injuries beyond "internal injuries"; reports or documents produced in relation to James' death and the post-mortem examination of his body including Dr Anderson's report, the toxicology report, death certificate, laboratory results, property record sheets, and examination records; and any photographs that show James' body that are not covered by the above orders in the interests of decency and personal privacy.

Death in Custody

Nguyen [2022] NZCorC 124 (31/10/2022)

CIRCUMSTANCES

Anh Tuan Nguyen, aged 45, died on 14 September 2017 at Mount Eden Corrections Facility in Auckland in circumstances amounting to suicide.

Mr Nguyen had a history of mental health issues, including schizophrenia, for which he was prescribed antipsychotic medication. He also abused methamphetamine which would lead to a psychotic relapse.

On 11 September 2017 Mr Nguyen was remanded in custody on charges relating to the manufacture of methamphetamine and transported to Mount Eden Corrections Facility (MECF). On arrival he was reviewed by a corrections officer but did not indicate a risk of self-harm or suicide. He was also reviewed by a nurse and told her that he stopped taking his medication in the last five to six days. He was referred for an initial health assessment the following day but could not attend due to a scheduled court appearance. He was then reviewed by a nurse on 13 September 2017 and indicated no thoughts of suicide or self-harm, although he was upset and crying because he was worried about his mother.

On the evening of 13 September 2017 Mr Nguyen and his cellmate were restricted to their cell (per MECA standard practice). At around 7pm, Mr Nguyen was crying and upset, as he was worried about his family and his sentence. During the course of the night, five 'Prisoner cell and location checks' were recorded as having been undertaken – at 6:12pm; 10:30pm; 1:15am; 4:10am and 6:19am.

On 14 September 2017 Mr Nguyen's cell mate woke up and discovered Mr Nguyen. He immediately alerted prison staff using the cell intercom at 6:18am. Master Control had control of the prison alarm system at that time, but the call was not answered. Mr Nguyen's cell mate said he kept pressing the alarm, at least "a hundred times".

At 7:43am control of the alarm system was transferred back to Alpha Unit at the request of a day shift officer who had just commenced his 8am shift. An officer answered the call at 7:47am. Two corrections officers and a nurse arrived outside Mr Nguyen's cell at 7:51am, and upon entering the cell Mr Nguyen was pronounced dead. The attending nurse concluded that Mr Nguyen had been dead for some time.

Following Mr Nguyen's death, an investigation was carried out by Inspectors of Corrections. In relation to the alarm call not being answered, the officer in charge of Master Control that day explained that the calls were not answered between

6am and 8am because the site was very busy at the time. The investigation inspectors concluded that staff did not follow processes, including the requirement that they answer all calls received via the intercom system, and that the delay in answering the call was unacceptable. The inspectors' report made a number of recommendations to the MECF Prison Director, the National Commissioner and the Deputy Chief Executive Service development. The Acting National Commissioner of Corrections accepted the factual findings and advised that all the recommendations made had been accepted.

The Coroner found that the delay in answering the call made by Mr Nguyen's cellmate was an egregious failure.

COMMENTS AND RECOMMENDATIONS OF CORONER GREIG

I. When an emergency occurs, a call bell is the only lifeline for a prisoner locked in a cell. The standard expected is that prison staff will respond promptly when a prisoner call bell is activated. That did not occur.

II. Following the investigation into Mr Nguyen's death by the Inspectors of Corrections which highlighted the importance of this issue and failure by Corrections staff to respond promptly to prisoner call bells on the night of Mr Nguyen's death, the Acting National Commissioner responded by advising that work would be undertaken promptly to create consistent Master Control cell call response protocols across the prison estate. To this end the Chief Custodial Officer and Custodial Practice Team were to work together to:

- Define and communicate practice protocols that support prison sites to determine urgent and important call events, from not important and non-urgent call events, and how these must be managed, including recording the final response outcome.
- Review and propose any technological solutions that can reduce or eliminate gaps within the system controls, for example, remove the ability to manually, or digitally subvert, snooze or otherwise ignore the 'system'.
- Further define and recommend any changes to practice protocols in response to technological improvements.

III. I **recommend** that:

IV. A review is undertaken by Ara Poutama Aotearoa (Department of Corrections) to:

1. Establish whether any of the commitments of the Acting National Commissioner in response to the matters raised in the report of the Investigation into the death of Anh Tuan Nguyen at Mount Eden Corrections Facility on 14 September 2017 by the Office of the Inspectorate, Department of Corrections require completion. Specifically, whether since August 2018:
    - New practice protocols that support prison sites to determine urgent and important call events, from not important and non-urgent call events, and how these must be managed, including recording the final response outcome have been developed and implemented across the prison estate.

- A review of technological solutions that can reduce or eliminate gaps within the system controls, for example, remove the ability to manually, or digitally subvert, snooze or otherwise ignore the 'system' has been completed.
- Any technological solutions proposed in such a review have been introduced.
- Any recommended changes to practice protocols have been introduced as a result of technological improvements.

2. Identify the timeframe in which any matters identified as not yet completed will be completed.
3. Establish the extent to which Master Control staff across the prison estate are currently complying with relevant operating standards in regard to response to cell alarms.

And, if non-compliance is found:

4. Establish whether the response required by the operating standards is possible for staff to achieve during periods identified as routinely 'busy' (for example during the hours of 6 am – 8 am) and, if it is not, to identify how this situation will be rectified so that prisoner call bells can be answered in a timely fashion.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of the body of Mr Nguyen entered into evidence in the interests of personal privacy and decency.

Drowning

Stewart [2022] NZCorC 107 (27 July 2022)

CIRCUMSTANCES

Jorja Ashley Stewart, aged 13, died on 2 July 2019 at 147 Dunstan Road, Alexandra of drowning as a result of butane induced unconsciousness ("huffing").

Jorja lived with her parents and older sister. She engaged in huffing on several occasions before her death. Jorja's friend said that they would do this until they experienced head spins. This would usually take four to five puffs. Jorja had also huffed on her own at least once prior to her death.

At around 4:30pm on 2 July 2019 Jorja took a bath, which she often did after school. At around 5pm Jorja's sister went to the bathroom to ask Jorja if she wanted to go for a bike ride. When Jorja did not respond her sister alerted their parents. Once Jorja's father unlocked the bathroom door, Jorja was found face down in the water. Her father and sister attempted resuscitation but despite their efforts paramedics who attended the scene confirmed Jorja had died. Toxicology results showed presence of butane in Jorja's blood.

COMMENTS AND RECOMMENDATIONS OF CORONER DUGGAL

I. The most commonly abused products in New Zealand are those that contain propane and butane or butane alone.[2] Inhaling such products, particularly when alone, can have fatal consequences.

II. The dangers of inhaling butane have been the subject of numerous coronial comments and recommendations. In 2012 the Chief Coroner's Recommendations Recap No. 2 comprised a case study report on deaths in New Zealand which related to butane inhalation (the Case Study).[3] The Case Study found that between 2000 and 2012, 63 people had died as a result of intentionally inhaling butane-based substances, of which 87% were under 24 years old with the youngest being 12 years old.

III. In July 2013, Coroner Johnson made recommendations following inquests into butane inhalation deaths of three young people from Christchurch.[4] Coroner Johnson recommended to the Interagency Committee on Drugs (IACD), the Department of the Prime Minister and Cabinet, the Minister of Social Development, and the Associate Minister of Health, to establish a well organised approach to butane (and other volatile substances) abuse as a priority.

IV. She also made recommendations to local councils, Safe Communities Foundation NZ, and to the Media Freedom Committee for a volatile substance awareness project for retailers.

V. In August 2013 the Child Youth Mortality Review Committee Special Report: Unintentional deaths from poisoning in young people[5] ("the Report") was released. The Report advocated for the development of a nationwide volatile substance abuse (VSA) evidence based prevention strategy to reduce access to and attractiveness of VSAs, improve screening and intervention for youth at risk, and raise awareness amongst peers, family and community.

VI. However, the Report suggested that caution should be taken with universal interventions to prevent VSA. It considered that a balance is needed to be struck between informing young people and the public of the dangers of VSA and inadvertently promoting its use in school-based education initiatives, the implementation of warning labels on products and media awareness campaigns.[6]

VII. The Report also suggested that legislation be changed to control the display and age of purchase for butane products and to strengthen retailer responsibility to be more aware of such products and more responsible in how they are displayed.[7]

VIII. I note that while there have been no legislative changes restricting the age of purchase for butane products in New Zealand, many hardware store suppliers have age restrictions and secured displays in place for spray can purchasing.

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[2] Office of the Chief Coroner of New Zealand Recommendations Recap A summary of coronial recommendations and comments made between 1 January–31 March 2012 (Ministry of Justice, Issue 2, 2012) at 3.
[3] At 1.
[4] *Inquest into the death of* Samuel John Gold, CSU-2010-CCH-000761, Coroner S P Johnson, 05 July 2013; *Inquest into the death of* Darius Logan Claxton, CSU-2012-CCH-000330, Coroner S P Johnson, 10 July 2013; *Inquest into the death of* Poihaere Eru, CSU-2012-CCH-000626, Coroner S P Johnson, 10 July 2013.
[5] Child and Youth Mortality Review Committee, Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi "Special Report: *Unintentional Deaths from poisoning in young people* (Child and Youth Mortality Review Committee, August 2013).
[6] At 28.
[7] At 29.

IX. While there are warning labels on some spray deodorant cans, age of purchase restrictions do not appear to be in place for supermarket purchases of these types of products. This means that users, parents and care givers are not fully aware of its potential risk. It also means that these products are easily available to young people of any age.

X. In a recent findings, Coroner Cunninghame referred to a video released by the New Zealand Drug Foundation concerning volatile substances. It is intended for New Zealand parents, caregivers, whānau and those working with young people to understand basic facts about inhaling substances.[8] The New Zealand Drug Foundation notes on its website that while there is no safe way to use inhalants, the video can be used to explore the facts about huffing before discussing options.

XI. This video is a useful resource for initiating conversations with young people. It would be useful for future VSA campaigns to address the increased dangers of huffing alone, especially in inherently dangerous places such as in a closed space and around water.

XII. I therefore recommend, pursuant to s 57(3) of the Coroners Act 2006, that this finding be sent to the Ministry of Health - Manatū Hauora, Ministry of Youth Development –Te Manatū Whakahiato Taiohi and the Ministry of Education – Te Tāhuhu o te Mātauranga, in order to enhance education programmes by drawing the attention of the public to the dangers of inhaling ('huffing') toxic products.

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

Drugs and Alcohol

McKenzie [2022] NZCorC 128 (13 September 2022)

CIRCUMSTANCES

Shawn Kevin McKenzie also known as Shawn Kevin O'Connor, aged 45, died between 11 and 12 March 2019 in Christchurch of synthetic cannabinoid use in the context of pre-existing hypertensive heart disease and concurrent use of natural cannabis, methamphetamine and his antipsychotic medication zuclopenthixol.

In 2011, Mr McKenzie was diagnosed with a serious mental illness and had a number of admissions to Hillmorton Hospital for inpatient treatment. Around the same time, he started using cannabis. Approximately six months prior to his death, he started to use synthetic cannabis and was described as a heavy user.

On the afternoon of 11 March 2019, Mr McKenzie's friend drove him to a house to pay a bill, however his friend believed Mr McKenzie was "up to no good". Mr McKenzie's friend then dropped him home about 8:30pm. When his flatmate returned in the early hours of 12 March 2019, he found Mr McKenzie deceased.

[8] *Re Jordan Allan Smolenski, CSU-2017-CCH-000621*, Coroner A M Cunninghame, 10 September 2020, at [73]; NZ Drug Foundation "Did you know Volatile substances" <www.drugfoundation.org.nz>.

Toxicology analysis established the presence of zuclopenthixol, methamphetamine, caffeine, and a metabolite of nicotine in Mr McKenzie's blood. An immunoassay screen of his blood for recent use of cannabis was positive confirming presence of tetrahydrocannabinol and its acid metabolite. The synthetic cannabinoid 5F-MDMB-PICA and its acid metabolite were confirmed in blood samples. A carboxyindole, 5F-PB-22 3 and MDMB-FUBINACA were also confirmed as present. The level of zuclopenthixol was consist with normal therapeutic use but also associated with toxicity. The methamphetamine was detected at below quantitation limits.

COMMENTS OF CORONER DUGGAL

I. Mr McKenzie's death was caused by synthetic cannabis use in the context of his pre-existing heart disease and use of other drugs as well as his prescription medication.

II. The dangers of consuming synthetic drugs include:

a. It is passed off as a form of synthetic cannabis, but that there is no cannabis in the product.

b. The synthetic drug can be made to look like cannabis by using dried plant or other material, but it is saturated in a synthetic drug, not THC (tetrahydrocannabinol) the active ingredient in cannabis.

c. The pharmaceutical agents from which synthetic cannabis was developed 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 may be unknown to or poorly understood by the manufacturers/distributors in New Zealand.

d. The synthetic drugs, AMB-FUBINACA and 5F-ADB, have been the cause or contributing factor in a number of deaths in New Zealand and overseas.

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

f. Finally, 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.

III. Due to the circumstances and cause of this death I repeat 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:

IV. 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. He cautioned against an approach that penalises users. Penalising users can create a barrier to seeking medical attention, even in cases of emergency.

V. 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.

VI. 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. There should not be any delay in seeking assistance.

VII. Dr Quigley was a vocational specialist in Emergency Medicine and had completed additional studies in clinical toxicology and conducted research in forensic toxicology. He was a recognised expert in emergency management and treatment of drug and alcohol presentations.

VIII. While I agree with, and endorse, Dr Quigley's advice, I am unable to make any recommendations in this regard, as I have not heard any evidence. I am aware however, that Coroner Mills is conducting a joint inquiry into deaths from synthetic cannabis which occurred in Auckland. I will refer this suggestion to Coroner Mills to consider in the course of her joint inquiry. No recommendations will be made by me.

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

Leisure Activities

Beecroft [2022] NZCorC 113 (4 August 2022)

CIRCUMSTANCES

Vincent Curtis David Beecroft, aged 14, died between 23 January 2020 and 26 January 2020 at Second Beach, Cliffs Road, Dunedin of blunt force trauma consistent with a fall from rocks into water.

On the afternoon of 23 January 2020 Mr Beecroft and his friends Hamana Tahuri and Ceasar Wilson went to Second Beach. Mr Beecroft and Mr Tahuri decided to jump off the rocks. They had never jumped off these rocks before but had been fishing in the area. Mr Tahuri jumped off a rock into the sea and Mr Beecroft followed. Both landed in the water and climbed onto a rock before continuing to climb back up to where they had jumped from.

While climbing back up the rocks, Mr Beecroft slipped and fell. Mr Tahuri was able to gain hold of him in the water but was unfortunately unable to bring him back to shore due to the swell and seaweed. Mr Wilson phoned emergency services and an extensive search ensued. Mr Beecroft was found deceased on the morning of 26 January 2020 near where he had fallen.

COMMENTS OF CORONER MCKENZIE

I. A coroner may make recommendations or comments in relation to a death for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred. Recommendations or comments must:

a. Be clearly linked to the factors that contributed to the death to which the inquiry relates; and

b. Be based on evidence considered during the inquiry; and

c. Be accompanied by an explanation of how the recommendation or comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

II. In considering recommendations, I have focussed on specific safety measures that could reasonably be taken and popularised rather than, for example, a global recommendation to the population at large not to jump from rocks into the sea and/or to be cautious at such locations. I consider that specific recommendations directed at an identifiable agency/agencies are preferable to global or generic recommendations. Safety measures and education would be the practical vehicle by which to alert people to the dangers of such circumstances in "real time" and in an ongoing sense, rather than a generic/global recommendation that might remain static in time or might not reach those who actually visit a potentially dangerous location. That is, for example, signage alerting people to danger reaches every person in an immediate sense, at the location, and at the time they are there; or beforehand during the planning phase if seen on-line.

III. I consulted parties including the Dunedin City Council (DCC) and Otago Coastal Search and rescue on the below recommendations:

a. That the DCC install signage at the appropriate location(s) at Second Beach warning of the rock danger. The Dunedin City Council might helpfully consult Otago Coastal Search and Rescue to determine the best location(s) for the signage.

b. That the DCC add to its website "Beaches around Dunedin," and its other relevant websites, a warning about the slippery rocks at Second Beach and other similar locations. The Council might helpfully consult Otago Coastal Search and Rescue to determine the beach areas for such information.

c. That the DCC consider erecting warning signage at other locations on beaches within its jurisdiction where a risk of falling on rocks exists. Again consultation with Otago Coastal Search and Rescue might assist.

IV. I acknowledge that a person might not read a warning sign (or website information) or might read it and proceed anyway. However, I consider that warning information on-line and signage at relevant location(s) would help trigger a decision-making process regarding proceeding, both before travelling to a location and then in more "real time" at a location itself. I consider that such recommendations would be the practical vehicle by which to help alert people to relevant dangers. In turn, I consider that warnings would help reduce the chances of further deaths occurring in circumstances similar to those in which Mr Beecroft's death occurred, namely when he slipped and fell on the rocks while climbing back up.

V. The DCC relevantly replied:

....

2. We note Coroner McKenzie's anticipated recommendations as set out in your letter of 16 June 2022. The DCC supports the Coroner's objective of reducing further deaths at beach locations and comments as follows:

    a. DCC Parks and Recreation Staff and Otago Coastal Search and Rescue (SAR) are already working together on a range of matters, which include installation of warning signs at sites SAR identify are of concern or potential risk.

    b. On or about 22 January 2020 the DCC installed warning signs at Second Beach, Dunedin. One sign was installed at the start of the Second Beach track and another towards the end of the track. Both signs show icons of unstable rocks. Photographs of these two signs are attached.

    c. DCC staff continue to work with SAR in respect of Second Beach, and there is a plan to install a third sign at a point along the track.

    d. Currently, where there are known hazards on beach tracks, such as loose rocks above or possible risk of landslide, these locations are marked with a DCC sign showing a warning icon.

    e. The DCC will work to add these hazard warnings, particularly about the slippery rocks at Second Beach onto its websites.

VI. In the light of the DCC's response, I do not consider I need to formally make my proposed recommendations.

VII. I also turned my mind to a recommendation that the DCC erect fencing to help prevent access to dangerous areas in or around Second Beach. The Otago Coastal Search and Rescue had offered to facilitate a site visit. I consulted the DCC, noting though my preliminary view that it might not be reasonably practicable to do so. With respect to this matter, the DCC observed:

> We support the Coroner's view that it is not reasonably practicable to erect and maintain fencing to prevent access to all dangerous locations, including all places along the track at Second Beach. The DCC does fence some beach locations to prevent falls from cliff faces or from a significant height, such as at Lawyers Head, at the eastern end of St Kilda Beach.

VIII. Accordingly, while I would encourage this option to be explored and continued, I do not go so far as to recommend that fencing be erected. This is because in my view it may not be reasonably practicable to erect and maintain fencing to prevent access to all dangerous location(s).

IX. I thank the DCC for its engagement with this inquiry and for setting out the relevant actions it has or is taking with respect to safety at Second Beach and/or other locations.

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

Daly [2022] NZCorC 103 (19 July 2022)

CIRCUMSTANCES

Mark Francis Daly, aged 61, died on 8 November 2020 at 420 Glendhu Road, Greta Valley of a single shotgun wound to the torso.

On 8 November 2020, Mr Daly was shooting birds at his property. When he had not returned after several hours, his stepdaughter went looking for him and found him tangled up in a wire netting fence, which was loose. Mr Daly had a gunshot wound to the torso and his shotgun was lying on the grass nearby. Mr Daly was confirmed as deceased.

COMMENTS OF CORONER CUNNINGHAME

I. A similar death occurred in 2017 and I was the investigating coroner.[9] In that case the deceased was found dead with a gunshot wound to the chest in a paddock on his farm. He was lying on his front with his legs caught between the wires of a fence. His rifle was lying beside him.

II. In light of this, I consider that the advice in regard to crossing fences which is set out in the New Zealand Mountain Safety Council "Hunting: Know Before You Go" activity guide (Guide) bears repeating. The Guide complements the New Zealand Police Arms Code which sets out the seven basic rules of firearm safety.

III. Rule Two in the Arms Code is "Always point firearms in a safe direction". The Guide addresses crossing fences in the context of this rule and sets out the following procedure:

> If you are with another hunter, have one person climb over the fence without a firearm. Then, pass the unloaded firearms across, making sure that the actions are open and the muzzles are pointing in a safe direction.
>
> If you are on your own, unload your firearm, pass it through the fence muzzle first and lie it on the ground on the other side. Then climb over the fence.
>
> Take special care when crossing electric fences. Have your firearm unloaded and the action open before you get near an electric fence. An electric shock can make your muscles contract and your hand could clench shut around the trigger.

IV. The Guide states "NEVER climb a fence while carrying a firearm". I endorse this advice.

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

[9] *In the matter of an inquiry into the death of Duncan Bruce Cleugh,* CSU-2017-DUN-000070, Coroner Alexandra Cunninghame, 7 September 2020 (In Chambers).

Dening [2022] NZCorC 108 (28 July 2022)

CIRCUMSTANCES

Joanne Rachel Dening, aged 35, died on 20 February 2019 at Wenderholm Regional Park Boat Channel, Waiwera of accidental drowning whilst stand up paddleboarding.

On 20 February 2019, Ms Dening went paddleboarding with a flatmate at Wenderholm Regional Park. She was an inexperienced paddleboarder and was not wearing a personal floatation device. She secured herself to the paddleboard using a safety leash that was tied around her ankle.

Ms Dening started paddling from the boat ramp at Wenderholm Regional Park, which leads to a large estuary fed by the Puhoi River. From the estuary there is a channel to the Hauraki Gulf. As she moved from the estuary to the channel, the currents became stronger and she fell off the paddleboard. This caused the safety leash to become tangled around a marker buoy. As a result, and despite the efforts of her flatmate and a member of the public, Ms Dening drowned.

Maritime New Zealand investigated Ms Dening's death and considered marine safety guidance notes, the New Zealand Stand up Paddling Incorporated (NZSUP) Safe Code and guidance and consultation with NZSUP.

COMMENTS OF CORONER GREIG

I. At the core of preventing deaths in similar circumstances is the need for accessible and widely disseminated safety information relating to stand up paddleboarding. To quote Mr Dawes of NZSUP "Ultimately, stand up paddleboarding safety comes down to education. It's all about having the right knowledge." Evidence to this inquiry is that approximately 8000 new paddleboards "hit the [New Zealand] market each year". Ensuring that owners and users of stand up paddleboards (old and new) are reached with education is key to safe paddleboarding.

II. Pursuant to s 57(3) of the Coroners Act 2006 I make the following comments relevant to the circumstances of Ms Dening's death:

   a. Stand up paddleboarders should always use the correct leash for the conditions.

   b. On moving water (rivers, harbour mouths etc) stand up paddleboarders should use a leash with a quick-release system that can be operated from above the waist and never wear a leash attached to ankle or calf in moving water (as they cannot be released in a strong current).

   c. Novice stand up paddleboarders should limit themselves to paddling in sheltered waters with light winds and not paddle in areas beyond their expertise.

   d. Stand up paddleboarders should always familiarise themselves with the conditions and hazards in an area before setting out to paddle.

   e. A style of personal flotation device appropriate for the activity should be used.

   f. To ensure safe stand up paddleboarding it is important to be aware of, and follow, some basic stand up paddleboarding safety procedures. Paddleboarders should familiarise themselves with the New

Zealand Stand up Paddling Safe Code (https://www.sup.org.nz/safety/) and consider undertaking a Stand up Paddling Safe course.

RECOMMENDATIONS OF CORONER GREIG

I. Pursuant to s 57(3) of the Coroners Act 2006 I make the following **recommendations** for the purposes of reducing the chances of deaths in similar circumstances in the future:

II. I **recommend** that Auckland Council:

a. Place appropriate signage at the boat ramp at Wenderholm Regional Park warning stand up paddlers of the dangers of strong currents in the channel, the presence of marker buoys in the channel and the need for extra care in the environs of the marker buoys. (This recommendation has been accepted).

b. Continues its initiative to consult with the Auckland harbour master to identify whether there are other locations in Auckland where the same set of hazards exist and where new signage should be implemented. (This recommendation stems from advice from Auckland Council that it has commenced consultation with the harbour master as part of its response to the safety issues identified in these findings.)

c. Highlights the specific learnings identified in these findings with Drowning Prevention Auckland and Surf Life Saving Northern Region. (This action was suggested by Auckland Council).

III. I **recommend** that Maritime New Zealand:

a. Posts safety information on social media about the learnings on safety issues arising from the circumstances of Ms Dening's death. (This recommendation arises from Maritime New Zealand's advice to this inquiry that as part of its ongoing work to raise awareness of safety issues, it posts safety information on social media based on learnings from accidents.)

Response to comments and recommendations

IV. I provided Maritime New Zealand, New Zealand Stand Up Paddling Incorporated and Auckland Council with my provisional comments and recommendations and invited response.

Auckland Council response

V. Auckland Council has advised that it accepts my recommendation about the need to place additional water safety signage at Wenderholm Regional Park to address the specific hazards highlighted in my inquiry. In addition, it advised that it is considering other areas in its purview which may require signage. The Council's response, provided by Mace Ward, General Manager of Auckland Council's Parks, Sport and Recreations Department, the department that manages the water safety signs in Auckland's regional parks including Wenderholm Regional Park, is set out below.

Steps Taken

Council regularly meets with its water safety partners and has discussed the recommendation [for appropriate signage] with Drowning Prevention Auckland ("DPA") and Surf Life Saving Northern Region

("SLSNR"). Both of these organisations are supportive of additional water safety signage at the boat ramp; a known entry point for recreational boats, stand up paddleboards, kayaks and other watercraft.

Council liaised with Waikato Regional Council to ensure consistency of any new signage [given the signage the Regional Council installed following a recommendation from Coroner Matenga in relation to paddleboard safety].

Council has also discussed the recommendation with the Harbourmaster who is responsible for the marker buoys.

As is its usual practice, when developing new water safety signage, Council has followed the best practice guidance in the Australian/New Zealand standard for water safety signs and beach safety flags AS/NZS 2416 Part 1 Specifications and Part 3 Guidance ("the standard").

Response

Council accepts the need to place additional water safety signage at Wenderholm Regional Park to address the specific hazards highlighted in the provisional issues and recommendations for this inquiry.

As mentioned above, for consistency Council refers to the standard when developing new water safety signage. The standard provides uniformity of water safety signs and beach safety flags which leads to increased familiarity and understanding of water safety messaging for the general public.

The existing water safety signage was informed by an assessment of the primary hazards for water users carried out by Nick Mulcahy of Coastal Research Ltd in or around 2012. This inquiry has identified additional site-specific hazards with the presence of the marker buoys coupled with strong currents in the channel.

Council has developed new signage using the best practice guidance and standardized symbols, where possible, for these hazards to warn all water users of their presence and to advises them to wear a lifejacket. The signage warns of the presence of marker buoys and moorings which present the same hazard for paddle boarders. As there is no applicable symbol for these objects in the standard an exclamation mark has been used. The colour scheme used is the same as other water safety signage as recommended in the standard.

This new signage is similar to Waikato Regional Council's signage in the Whangamata Harbour which warns water users of the fast currents and fixed markers; it also advises them to keep clear of mooring buoys and to wear a lifejacket.

Council acknowledges that the provisional recommendation is for water safety signage targeted at stand up paddlers. Both of the signs discussed in [the] paragraphs above are aimed at all water users and not targeted at a specific user group. Council takes the view that this water safety signage should not be directed at a particular user group as the hazard warnings are relevant for all water users. Additionally, the users of this body of water are many and varied. Targeted water safety signage could have the unintended consequence of other user groups disregarding the signage. This approach is consistent with the guidance in the standard.

Council agrees that the appropriate location for the new signage is at the boat ramp as this is where water users are inducted into the environment. While paddleboarders could enter the water at other locations; the boat ramp is a common entry point. Council will also draw on the knowledge and experience of its local park rangers and the harbour master to determine the best siting for any additional signs.

Mindful that there may be other locations in the Auckland region where the same set of hazards exist; Council has also sought advice from the harbour master on whether or not the new signage should be implemented at other locations.

Council has carefully considered the size and scale of the new signage and determined that consistent with best practice; the signage should be located at the entry point into the water. Users can then make informed decisions when entering the water rather than being warned of the hazards once they are already in the estuary. For signage to be easily read from the water it would need to be of a very large scale and located on either side of the estuary which Council does not support.

Council has strong relationships with DPA [Drowning Prevention Auckland] and SLSNR [Surf Life Saving Northern Region] and is happy to highlight specific learnings from this incident with these agencies. Council is aware that these organisations provide education on the use of stand up paddleboards targeted at new users and school children.

Finally, Council respectfully suggests that wide dissemination of the findings to those involved in water safety would be helpful to highlight the specific hazards for paddleboarders. Suggested agencies could include DPA, SLSNR, Water Safety NZ, NZ SUP Incorporated, harbour masters and Local Government NZ.

Maritime New Zealand response

VI. Peter Brunt Deputy Director, Regulatory Systems Design Maritime New Zealand provided a response on behalf of Maritime New Zealand. He advised that Maritime New Zealand would liaise with Auckland Council on the recommendation related to signage. He also stated:

> You invited Maritime NZ to provide ideas about how the safety issues identified in your provisional finding could be publicised to raise awareness for stand up paddleboards, as well as raise awareness about the NZSUP Safety Code. You also asked if Maritime NZ and its affiliated water safety organisations could play a role in raising awareness about stand up paddle board safety.
>
> Maritime NZ continually works to raise awareness of safety issues. We post safety information on social media based on learnings from accidents, and we have developed and released a stand up paddle board safety guide. We have also provided annual funding to Stand Up Paddle Board NZ to run safety workshops around the country. Currently, a review of the navigation safety rules in Part 91 is also underway, this includes considering whether people should be required to wear a personal flotation device while on a stand up paddle board in certain circumstances. It is expected any new rules will be in place by 2023. In the meantime, Maritime NZ will continue to work with other affiliated water safety organisations to identify further ways to improve safety.

New Zealand Stand Up Paddling Inc response

VII. Bill Dawes, NZSUP Safety Officer, stated:

> With regard to the recommendation for specific signage at the venue, this is an excellent idea and would be well worthwhile. Ideally, this should be standard at ALL the launch ramps inside of narrow harbour mouths all around New Zealand, where recreational paddlecraft operate. There are so many venues with calm sheltered water, but just around the comer from viciously strong currents at mid tide.
>
> As for how the safety issues identified in the provisional finding could be publicised to increase awareness of the issues for stand up paddleboarders, as well as raise awareness of the NZSUP Safe Code; this has been our main focus for the last few years and I would like to think that we are making useful progress with it, with the help of [some] funding from the Maritime NZ FED programme.
>
> - Printed SUP SAFE leaflets are distributed to SUP retailers and schools all over New Zealand and are also supplied to regional councils and harbourmasters. (30,000 have gone out over 3 years).
> - NZSUP runs SUP [Stand Up Paddling] SAFE courses and education programmes around the country, working with local paddle groups and clubs.
> - NZSUP offers free online SUP safety education courses (www.supinstructors.nz) which deliver an extremely comprehensive level of safety information and education. This can really make a difference at a local level, as everyone who completes the courses goes away well equipped with all the vital safety knowledge and information, which they share into their local paddling community.
> - We have worked closely with Torpedo7 - the biggest retailer of paddleboards in New Zealand - to assist them in creating their own safety collateral and really encouraging them to push this hard to all their customers. When your [findings] are made public we will go back to Torpedo7 to highlight the issues.
> - NZSUP has worked together with Maritime NZ to produce a new Paddlecraft Safety guide specifically for stand up paddleboarding. This has not yet been officially launched. The guide [which highlights the SUP Safe code] should go public any day now and will be a major platform within the whole Saferboating.org campaign (safer boating week, Kia Mataara, etc), with Maritime NZ marketing and promoting it.
>
> Ultimately, SUP safety comes down to education, as is clear from the findings in your report. It's all about having the right knowledge. Since really stepping up the education over the last 3 years, we're delighted to note that there have been no further fatalities and overall the number of stand up paddleboarding rescues has decreased dramatically too. The message is clearly getting out there. However, the problem will never go away - there are another 8000 or so new paddleboards hitting the market each year and needing to be reached with education.

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

Hala Latu [2022] NZCorC 132 (19 September 2022)

CIRCUMSTANCES

Kafoamotalau Hala Latu, aged 53, died on 10 October 2021 at Manukau Harbour of drowning.

Mr Hala Latu was at the top level of the sport of waka ama for 30 years and a strong ocean swimmer. On 10 October 2021, he decided to paddle from Cornwallis Wharf to Mangere Bridge. He collected a waka ama from the lock-up at Mangere Bridge, but selected one that needed repairs. He left his dry bag on the wharf containing his life jacket and cell phone.

Approximately one hour after Mr Hala Latu began paddling, the weather conditions changed, and the tide started to go out. Half an hour later, witnesses saw a black head bobbing in and out of the water. They saw a black paddle being waved and heard someone calling for help. They called emergency services and another witness went out on a wind foil to try to locate the person but was unsuccessful. Mr Hala Latu was later located by emergency services floating face down in the water in the Manukau Harbour.

Maritime New Zealand investigated the incident and examined the recovered waka ama. The kiato (cross beams connecting the ama or outrigger to the waka) were inserted into a cavity in both hulls and held in place with a clipping mechanism. They appeared to have broken at points where the high-density foam on the inside of the hulls had failed to run the full length of the hollow interior. The Coroner found that due to the conditions at the time of the accident, it is likely that water came into the cockpit of the waka ama making it heavier and placing additional strain on the kiato. Maritime New Zealand found there were design issues with the waka ama but noted that there are no design and construction standards for waka ama in New Zealand.

COMMENTS OF CORONER TETITAHA

I. I make the following comments pursuant to section 57A of the Coroners Act 2006.

II. According to Water Safety New Zealand,[10] 74 New Zealanders drowned in 2021 despite Covid-19 lockdown restrictions. Of those deaths 24% (18) were boating deaths (up 80% from the prior year's 10 deaths); 31% (23) Māori, 7% (5) Pasifika; and 84% male.

III. There is little doubt Mr Hala Latu's death was preventable if he had been wearing a personal flotation device or PFD and had a means of communication to seek assistance as soon as he was in trouble. This is the second decision I have written where an experienced waka ama paddler has drowned due to not wearing a PFD when the weather conditions have worsened.[11] All paddlers no matter their experience should wear PFD whilst paddling and have a means of communication.

IV. There is also a need to comment on the safety and design of the waka ama Mr Hala Latu had been paddling in. The kiato had separated from the waka causing the waka ama to fail and disintegrate in the water. If the waka ama had remained intact, Mr Hala Latu may have remained afloat and able to get to shore or been rescued.

[10] Water Safety New Zealand 2021 Provisional Drowning Report online publication https://watersafety.org.nz/2021-Report-Provisional
[11] An inquiry into the death of Debbie Maoate CSU 2019-AUK-000045.

V. There is no regulation in New Zealand regarding the design and construction standards for waka ama. Maritime New Zealand has made recommendations that the priority for waka construction should be strength and safety and that authorities work together to "promote improved design and construction practices" and to nominate "authorised persons" to conduct safety audits for waka ama.[12]

VI. There is merit in considering a recommendation to regulate the design and construction of waka ama. Poor design is a preventable factor likely to have contributed to this death. Building standards for waka ama may prevent similar deaths in future as well as being a safety initiative.

VII. These comments are directed to Maritime New Zealand and Ministry of Transport.

RECOMMENDATIONS OF CORONER TETITAHA

I. I make the following recommendations pursuant to section 57A of the Coroners Act 2006:

II. The Maritime New Zealand and/or Ministry of Transport consider drafting a waka ama building standard as a safety initiative to prevent similar deaths.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Mr Hala Latu during this inquiry, in the interests of decency.

Jennings [2022] NZCorC 101 (13 Juy 2022)

CIRCUMSTANCES

Caleb Peter Jennings, aged 31, died on 25 October 2018 at Christchurch Hospital of a traumatic brain injury after being caught in an avalanche and hitting rocks while descending Mount Harper on 22 October 2018.

Mr Jennings was a soldier in the New Zealand Army. He was very experienced alpine climber.

On 22 October 2018 Mr Jennings and his partner Shea Hickman were tramping/climbing in the Arthurs Pass area. The weather conditions for climbing that day were very good. It was forecast as clear and calm with a high freezing level of over 3000m.

As the couple were descending Mount Harper they climbed down a steep section of snow and traversed a moderate snow slope. Mr Jennings stopped in the shade beneath a big rock and removed his helmet while waiting for Ms Hickman to catch up. They then headed toward a bowl of snow when Mr Jennings inadvertently created a small snow slough (a layer of snow moving across another layer of snow), lost his footing, and fell. An avalanche formed, gained momentum, and Mr Jennings was carried over a steep bluff.

Mr Jennings came to rest further down the mountain, partially buried in avalanche snow. He was seriously injured. Ms Hickman set off her emergency locator beacon and some time later was assisted by other trampers in the area. Mr Jennings was flown to Christchurch Hospital where he passed away on 25 October 2018.

[12] Maritime New Zealand "Your Guide: Waka Ama Safety Rules" online publication https://www.maritimenz.govt.nz/recreational/documents/Waka-Ama-safety-rules.pdf

During the course of the inquiry Ms Hickman noted the importance of ensuring that avalanche forecasting is accurate; considering possible heuristic factors at play; and promoting a healthy culture about turning around and/or accepting that conditions may not be favourable on a given day. Ms Hickman reflected that Mr Jennings should not have stepped onto the slope and that too often the most experienced person in the group is relied on to make the decisions on route selection. However, these people may be more likely to be complacent, especially on easy/moderate terrain.

The New Zealand Mountain Safety Council (MSC) provided a report and concluded that the accident occurred due to a human judgement error. Despite his experience, Mr Jennings' choice to take a route above a terrain trap on a snow slope that had the potential for small loose wet avalanches resulted in the most severe outcome possible. It was unknown whether a helmet would have saved his life.

RECOMMENDATIONS OF CORONER MCKENZIE

I. A coroner may make recommendations or comments in relation to a death for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred. Recommendations or comments must:

   a. Be clearly linked to the factors that contributed to the death to which the inquiry relates; and

   b. Be based on evidence considered during the inquiry; and

   c. Be accompanied by an explanation of how the recommendation or comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

II. In considering whether any recommendations are appropriate in this matter, I have factored in the observations of Ms Hickman and the recommendations made by the MSC, a specialist body in this area. I consider I can do no better than the MSC's recommendations, which I endorse. Again I note that the MSC's expression of principles will necessarily be broad as seen in its point (d) which encourages climbers to be aware of the specific conditions. As Ms Hickman similarly points out, decisions can depend on a "myriad of variables."

III. The MSC encourages all climbers to consider the following points:

   a. Attend an official avalanche training course which also includes avalanche rescue techniques. Courses can be found here: www.avalanche.net.nz/education

   b. Always thoroughly read, discuss and make sure you understand the official NZ Avalanche Advisory for your area. If you are not sufficiently experienced or competent to understand the advisory, or have questions about the details, you should seek advice from a suitable source. The NZ Avalanche Advisory forecasts can be found here: www.avalanche.net.nz

   c. Low avalanche danger does not mean no avalanche danger. Read the forecast carefully to understand what dangers are still present so you can avoid them.

   d. Ensure that your climbing objective is in alignment with the current conditions. Always remain vigilant to changes in your environment and always be prepared to assess those conditions and turn around or change route.

e. When travelling in avalanche terrain, all members of the group should carry avalanche rescue equipment (transceiver, probe, shovel) and know how to use it.

IV. The MSC also recommended:

a. That climbers wear helmets as a way to minimise the risk of suffering a head injury due to slips, trips and falls on snow and ice, and also to protect against rocks and other items which can fall from above.

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

Maoate [2022] NZCorC 104 (20 July 2022)

CIRCUMSTANCES

Deborah Maoate, aged 57, died on 10 January 2019, at Onetangi Beach from saltwater drowning. Other conditions contributing to the death were a mitral valve repair complicated by right-sided middle cerebrum artery infarct and obesity.

Ms Maoate lived at Onetangi Beach. She was a competent swimmer and kayak user. On 10 January 2019, Ms Maoate and her niece planned to kayak off Onetangi Beach. When they arrived at the water's edge Ms Maoate noticed that she had left her lifejacket and mobile telephone at home but decided not to return to collect them.

Throughout the day the pair paddled around and the water conditions were observed to be calm. After stopping for lunch they began to paddle back to Onetangi Beach. On the way, Ms Maoate said she was feeling tired as the waves had picked up making it difficult to paddle. While navigating round a rocky outcrop, Ms Maoate fell out of her kayak. Her niece came to her aid but Ms Maoate was struggling to hold on to the kayak and her niece was unable to paddle to shore with her at the rear. Unfortunately, Ms Maoate lost grip of the kayak and slipped under the water. She started floating on her back with her face up while her niece continued paddling back to shore to get help.

Members of the public were able to bring Ms Maoate back to shore and attempted to resuscitate her but tragically she could not be revived.

COMMENTS OF CORONER TETITAHA

I. I make the following comments pursuant to section 57A of the Coroners Act 2006:

II. There is little doubt that if Ms Maoate had been wearing her lifejacket and had carried a waterproof way to quickly call for help, this death may not have occurred. The facts show she had a lifejacket and possibly a waterproof means of communication in the bag she left at her home. This indicates complacency which is dangerous for all paddlers including those who are as experienced as Ms Maoate.

III. This death is a reminder to all kayakers, including experienced paddlers of the need to wear a lifejacket (with a crotch strap if possible) and to have a waterproof means of communication whilst kayaking.

IV. This is the second death referred to this coroner involving an experienced paddler on a recreational vessel drowning due to the lack of a lifejacket in the Auckland/Northland regional area. This may indicate the need for ongoing education regarding the legal requirements for paddlers to wear a lifejacket whilst kayaking or

operating any other recreational vessel. Targeted education for kayakers during the summer peak season at popular recreational areas in Auckland/Northland as well as through national advertising campaigns may assist.

V. These comments are made to Maritime New Zealand.

RECOMMENDATIONS OF CORONER TETITAHA

I. I make the following recommendations pursuant to section 57A of the Coroners Act 2006:

II. That Maritime New Zealand consider an Auckland/Northland region and/or nationwide ongoing education campaign for users of kayaks reinforcing the need to wear a lifejacket and to carry waterproof means of communication.

III. Maritime New Zealand have provided a reply to the comments and recommendation regarding the need for ongoing education for paddlers to wear a lifejacket while kayaking.

IV. Maritime New Zealand states it "will continue to work with other affiliated water safety organisations to raise awareness of safety issues associated with recreational boating, including kayaking." Safety messages targeting all types of recreational craft are publicised throughout the country via multiple media channels.

V. Maritime New Zealand is thanked for its reply.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Ms Maoate during this inquiry, in the interests of decency.

Smith [2022] NZCorC 102 (18 July 2022)

CIRCUMSTANCES

Tracey Alison Smith, aged 55, died on 1 June 2019 at Speargrass Valley in the Nelson Lakes National Park of hypothermia.

On the weekend of 1 June 2019 Ms Smith and her teenaged son travelled to the Nelson Lakes National Park to hike to Angelus Hut. They spent the night of 31 May 2019 at the Travers Sabine Lodge where the manager advised Ms Smith that Angelus Hut was not a safe option in the deteriorating weather conditions forecast for the following day. The weather forecast was for 85km/h winds and -16 degrees Celsius temperatures. Ms Smith decided to hike Paddy's Track and stay at Bushline Hut instead.

On 1 June 2019 Ms Smith went to the Department of Conservation (DOC) Visitor Centre and discussed the weather with DOC staff. She informed them of her changed plan to hike to Bushline Hut. Despite having previously rented personal locator beacons, Ms Smith did not do so on this occasion.

Once Ms Smith was at the Mount Robert carpark she saw a large group of people hiking to Angelus Hut and made an on-the-spot decision to hike to Angelus Hut via the Speargrass Track. Ms Smith and her son left the carpark at about 9:45am. Shortly before reaching Speargrass Hut at 1:00pm, Ms Smith and her son joined another group of six people. Ms Smith's son reported that this part of the hike was comfortable and they continued together to Speargrass Hut where

they all stopped for a quick snack and a toilet break. They did not have time to eat a full lunch if they were to make it to Angelus Hut so they ate dehydrated apple crisps, scroggin, brie, pita chunks and a boiled egg instead. Ms Smith thought about staying the night at Speargrass Hut but left at 1:30pm with her son and the other group. The weather was overcast but not windy. The track was only lightly sprinkled with snow.

An hour into the hike to Angelus Hut, the snow was starting to get deeper, and the hill was getting steeper. It was cold and snowing lightly, but there was no wind and visibility was good. At one point the snow became thigh-deep for Ms Smith and knee-deep for her son when standing upright. Three quarters of the way on the ascent, he noticed that his mother had fallen behind. As he waited for her to catch up, the other group carried on. Ms Smith and her son became separated from the other group.

By then Ms Smith was taking small steps and told her son that she was experiencing a lot of leg cramping. She began falling over repeatedly. Her son tried to pull her along with a tramping pole and make the track easier by moving snow out of the way, but the depth of the snow made this very difficult. By 5.00pm the visibility was limited to about 200 metres, the temperature dropped further, and the wind increased. The other group saw ice blowing and water bottles hitched to backpacks froze. Given the reduced visibility the other group of hikers were unsure if Ms Smith and her son were still following or had turned back. They later told Police that even when they were able to see the valley behind them, they never saw Ms Smith and her son after becoming separated. The group arrived at Angelus Hut at about 6:15pm.

When it became dark Ms Smith and her son put on their head torches, but the wind was so strong that it blew them off. Her son felt that the wind was strong enough to “blow him over”. By this time, Ms Smith was tired, hungry and thirsty. Their water bottles had frozen. She kept eating snow to quench her thirst, despite her son telling her it would make her colder. Ms Smith was crawling, and her hands started to freeze from being in the snow.

When they were nearly at the top of the ridge, Ms Smith’s son realised that she had hypothermia. He saw icicles on her face and her skin had become so brittle it was starting to bleed. Ms Smith’s mouth was frozen and she had stopped talking and was groaning. Her vision had deteriorated significantly as she could not see the track poles. Realising that he was in danger of getting hypothermia too, Ms Smith’s son made the decision to carry on to the hut. By then, Ms Smith was lying face down in the snow. In the dark, cold and wind, Ms Smith’s son’s progress was painstakingly slow. He got lost but reached the hut at 11:15pm.

Once there Ms Smith’s son explained what had happened and said that his mother had died. The volunteer hut warden was woken and explained that she could not radio out as the DOC radio in St Arnaud was not staffed until 9:00am the next morning. The hut warden mistakenly understood that the only way to contact 111 was to activate a personal locator beacon. She advised the adults in the hut to activate their beacon. The group discussed whether to do so but decided not to as they thought Ms Smith had died. They thought that activating their beacons that night would initiate a search that would unduly place search and rescue staff at risk given the inclement weather. They decided to wait until the next day to raise the alarm.

Police were informed on the morning of 2 June 2019. Ms Smith’s body was found at Speargrass Valley later that morning.

COMMENTS OF CORONER DUGGAL

I. A Coroner may make specified recommendations and comments in relation to a death which may, if drawn to public attention, reduce the chances of further deaths in similar circumstances.

II. In its report, the MSC suggests a number of recommendations and comments, each of which I consider below, together with responses and information from the affected people or entities.

For trampers and hikers

III. The MSC made the following comments for trampers and hikers:

a. Act on advice given by trusted sources such as DOC visitor centre staff;

b. Always carry an emergency communications device, whenever heading into the backcountry or outside of reliable cell phone coverage.

c. Consider the experience and fitness levels of all members of your group and anticipate how the terrain may change in different weather conditions. Allow enough time to complete your trip in daylight hours and have alternative plans in case it takes longer, or conditions change.

d. Allow enough time to take regular rest breaks to eat and hydrate, particular in cold and wet conditions. If this is not possible, plan for refuelling or turning back.

e. Be prepared to make early and conservative decisions to stop and turn back, especially when encountering terrain and weather conditions beyond your experience and fitness.

f. Do not wear cotton layers as they draw heat away from the body when wet.

g. Always carry some form of emergency shelter, such as a tent fly, tarpaulin or bivvy bag on all tramping trips, even in summer.

h. Learn to identify the signs of hypothermia and act quickly to get warm again.

IV. I endorse these comments.

V. The MSC also considered the decision of the other hikers in Angelus Hut not to activate their personal locator beacon. They were told that Ms Smith had died, and they were concerned about unnecessarily risking the safety of other people in the severe weather conditions. These concerns were genuine and motivated by a laudable desire not to risk other lives. No personal criticism can be made of decisions that were made in tragic and highly stressful circumstances. Discussion of this issue is aimed at providing guidance to prevent future deaths.

VI. The MSC emphasised that the responsibility of deciding whether it is safe to respond in an emergency rests solely with the emergency response authority, either the New Zealand Rescue Coordination Centre or the Police. These authorities would have assessed the situation and considered the risks to the rescuers. Individual hikers should rely on their judgement and activate devices/beacons when a person's life is or may be at risk.

VII. DOC agrees with the MSC report on this issue and advises that the promotion of beacons is a key area of focus for it. Since 2019 DOC has provided information on beacons on its website and on social media. It lists beacons in the gear section of the information sent to people with bookings at Angelus Hut prior to their trip. DOC has beacons for rent at most of its visitor centres.

VIII. I endorse MSC's comments that trampers/hikers who have a beacon or emergency communication device should not hesitate to activate it when a person's life is or may be at risk. The relevant emergency response authority will make appropriate risk assessments and respond accordingly.

For the Department of Conservation

IX. The MSC observed that the volunteer hut warden did not know that the radio could be used to call 111, raising questions about the training given to volunteer hut wardens by the DOC. The MSC recommended a national review of hut training to address this issue and that emergency procedures were put in place to provide guidance to hut wardens.

X. DOC advises that changes have already been made in the Angelus Hut Warden Handbook and training programme. It is developing a national hut warden standard operating procedure. The standard operating procedure will set out the role of hut wardens including in emergency situations. This document is being drafted and will be completed in 2022.

For organisations involved in the emergency retrieval and care of hypothermic patients

XI. The MSC noted that Ms Smith's death was confirmed after a St John New Zealand ("St John") intensive care paramedic carried out an assessment of her to ascertain whether she had any signs of life. Based on St John's Clinical Procedures and Guidelines ("the Procedure"), MSC have raised whether consideration was given to delaying the pronouncement of death and transporting Ms Smith to a hospital with the facilities to provide cardiopulmonary bypass or ECMO, while she was warmed. The Procedure states as follows:

> "Because the metabolic rate drops significantly with severe hypothermia, it is possible for patients to survive prolonged cardiac arrest secondary to hypothermia. Survival…usually requires the patient to be transported to a hospital with the facilities to provide cardiopulmonary bypass or ECMO, while the patient is warmed."

XII. St John advise that Ms Smith was carefully clinically assessed. Her body was frozen solid, and she was not showing any signs of life. She was unresponsive, pulseless, not breathing and had fixed dilated pupils. The Intensive Care Paramedic deemed resuscitation efforts to be futile and pronounced her dead. The Clinical Director of St John, Dr Tony Smith, advised that, in his clinical opinion, the decision to declare Ms Smith dead was correct.

XIII. Dr Smith noted that the while it is possible for a very small proportion of patients who have cardiac arrest following hypothermia to survive, the challenge is the window of opportunity is very narrow and many people are not found until well after suffering cardiac arrest.

XIV. As there is no clinical evidence to suggest that St John's assessment of Ms Smith's death was incorrect, I make no recommendations or comments regarding this issue.

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

Tohu [2022] NZCorC 118 (23 August 2022)

CIRCUMSTANCES

Lee Victor Tohu, aged 52, died on 27 January 2020 in the waters off Kauri Island from drowning in the background of decompression sickness.

In the morning of 27 January 2020, Mr Tohu and two friends set off from the Tūtūkākā boat ramp to go scuba diving. At 10:30am Mr Tohu and his dive partner entered the waters off the coast of Kauri Island. At 10:45am they became separated. At 11:00am Mr Tohu's dive partner surfaced and, after establishing that Mr Tohu was missing, began to search for him. Shortly afterwards, and approximately 60 metres from where they started diving, Mr Tohu was found floating in the water. Emergency services were contacted and later confirmed that Mr Tohu had died.

The Police national dive squad (PNDS) investigated the incident and considered that Mr Tohu ran out of air supply while on his dive. When he got into trouble, he did not abandon his weight belt, and had insufficient air supply to ascend in a controlled manner. The most likely cause for why he prematurely ran out of air was because his regulators were in very poor condition and outside the cracking specifications, causing him to inhale harder.

Mr Tohu had a faulty submersible pressure gauge which was a significant contributing factor as it was providing Mr Tohu with incorrect and dangerous information resulting in him perceiving that he had more air supply than he did. Furthermore, Mr Tohu would not have an accurate idea of the maximum depth he had dived that day as his depth gauge was also faulty. This information is important in terms of regulating a safe return to surface. The Coroner found that those defects coupled with the fact that Mr Tohu did not have a dive watch or computer meant he was in essence, diving blind. Furthermore, the Coroner established that Mr Tohu was not qualified to scuba dive and toxicology tests showed he had consumed cannabis.

COMMENTS OF CORONER BELL

I. Pursuant to s 57A of the Coroners Act I have the ability to make recommendations or comments as part of the findings of this inquiry. Recommendations or comments may be made only for the purpose of reducing the chances of future deaths occurring in circumstances similar to those in which Mr Tohu's death occurred.

II. Recommendations or comments must be clearly linked to the factors that contributed to the death to which the inquiry relates, be based on evidence considered during the inquiry and be accompanied by an explanation of how the recommendation or comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

III. Scuba diving is an activity with a number of serious risks. One must not only be appropriately qualified to undertake the activity to be aware of those risks, and how to safely manage them, but also be meticulous in maintaining and servicing their diving equipment.

IV. PNDS provided several recommendations in its report. The most relevant of which I reproduce below:

a. A person should complete a scuba diving course and complete a refresher where they have not been diving consistently.

b. Ensure that they are medically fit to dive. Divers should seek medical advice when:

   i. There are changes in health.

   ii. Using or changing medication.

   iii. The diver turns 45 years of age, and at least every five years afterwards.

c. Divers should wear a watch or other timing device to assist in planning their dives and be familiar with how to use it.

d. Ensure dive equipment operates correctly and is regularly serviced, at least annually.

e. Divers should abandon their weights when in difficulty.

f. Dive with a buddy for the duration of the dive.

V. These recommendations are similar to those available on the Water Safety New Zealand website.[13] In particular, I draw attention to the importance of not consuming illicit drugs prior to scuba diving.

VI. I endorse the PNDS recommendations as well as those of Water Safety New Zealand as formal comments pursuant to s 57A of the Coroners Act. I also direct that these findings be provided to:

a. Water Safety New Zealand; and

b. the editors of the Dive New Zealand magazine for dissemination as appropriate.

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

Williams [2022] NZCorC 114 (4 August 2022)

CIRCUMSTANCES

Joe Tetou Williams (also known as Joe Tinirau Tata), aged 56, died on 21 September 2019 at Manukau Harbour. The cause of his death was saltwater drowning.

On 21 September 2019, Mr Williams went on a fishing trip with two of his relatives, College Jacob and Tauira Tapaitau. The group set off from Manukau Harbour towards Manukau Bar in Mr Williams' four-metre-long aluminium boat. The boat had a radio and was equipped with five life jackets. Mr Williams told Messrs Jacob and Tapaitau to put on their life jackets which they did, however, Mr Williams struggled to fit into his own life jacket and removed it.

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13 https://watersafety.org.nz/how%20to%20stay%20safe%20when%20diving#:~:text=It%20must%20be%20able%20to,seen%20by%20any%20approaching%20vessel.

During their journey, Mr Tapaitau observed that big waves were forming, and the water was rough. He thought it was dangerous but Mr Williams wanted to continue, noting that they would return if the conditions became any worse. Shortly after, a big wave hit the right side of the boat causing it to tip over and sink. All three men managed to get out of the boat and were floating on the surface of the water. However after some time Mr Williams drifted away and was found deceased several hours later.

Maritime New Zealand produced a report in relation to this incident, noting that, due to its size and location, the Manukau Bar is difficult to navigate and poses an increased risk for recreational boating. Since 2009, there have been three accidents on the Manukau Bar, resulting in four fatalities. In two of those, assistance was delayed due to no bar watch report being made with the Coastguard. Maritime New Zealand recommended that skippers seek local knowledge in order to ensure they are able to interpret the conditions and assess the ever-changing shape and location of channels over bars. Before crossing any bar, skippers should at a minimum consider:

(a). Preparing the vessel and briefing the crew for the crossing.

(b). Putting on life jackets / personal flotation devices. It is the skipper's responsibility to ensure personal flotation devices are worn in situations of heightened risk, such as bar crossings.

(c). Keeping an eye on the conditions and plan the intended route.

(d). Reporting to Coastguard or Maritime Radio both before and after crossing bars.

It was understood that Mr Williams had no experience crossing the Manukau Bar, and this may have contributed to the accident. The report concluded that the death may have been avoided had the safety information available on Maritime New Zealand's website been followed, in particular having two means of waterproof communication, which may have resulted in Mr Williams being rescued.

By law the skipper of a boat such as Mr Williams is required to have sufficient correctly sized lifejackets for each person on board and to ensure that lifejackets are worn in situations of heightened risk, such as crossing the bar (for example at the entrance to the Manukau Harbour).[14]

The Coroner found that had Mr Williams been wearing a properly fitted lifejacket, he may not have drowned.

RECOMMENDATIONS ENDORSED BY CORONER TETITAHA

I. I endorse Maritime New Zealand's recommendations for minimum considerations by skippers as set out in the report from Maritime New Zealand. I make no recommendations under s 57A of the Coroners Act 2006.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Mr Williams during this inquiry, in the interests of decency.

[14] Auckland City Council Navigation Bylaw 2021.

Miscellaneous

Ryan-Smith [2022] NZCorC 133 (21 September 2022)

CIRCUMSTANCES

Sasha Rosemary Ryan-Smith, aged 18 months, died on 15 December 2019 at Hillcrest, Hamilton of accidental positional asphyxiation.

Sasha usually slept in a cot with a foam mattress. However, the cot was missing a side bar, which had left space for Sasha to get out. To stop Sasha from getting out of the cot, a disused mattress protector (foldable rigid section of fabric covered in plastic) was placed against the side wall of her cot.

On 15 December 2019, Sasha's mother found Sasha in her cot, with the mattress protector on top of her with its edge against her throat. It was subsequently noted that Sasha had a large indentation on her throat and bruising around the area. Emergency services attended, but Sasha had sadly passed away.

The Coroner found that Sasha had suffocated as a result of the mattress protector falling on top of her while she was in her cot, causing her head to become wedged between the side of the cot and the mattress protector. The edge of the protector had pushed against her head resulting in asphyxiation.

COMMENTS OF CORONER BATES

I. In the past coroners have made multiple recommendations to agencies to ensure the safe-sleeping message from health professionals is consistent, and appropriately given to new parents. It is an important message because it is effective in preventing infant deaths.

II. Sasha's death is a reminder that every sleep for a baby should be a safe sleep. I note the Ministry of Health launched a sudden unexpected death in infancy (SUDI) prevention programme in August 2017, directed at significantly reducing the number of deaths of babies.

III. Considerable effort is being made in New Zealand to promote the message of safe sleeping practices. That is, for every sleep, babies 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.

IV. The challenge is to ensure the safe sleep message, and what research shows safe sleep means for a 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.

V. In the present case, upon discovering Sasha's cot had a missing side rail, an improvised measure was adopted. A rigid mattress protector was placed against the side of the cot, with the intention of preventing Sasha from exiting through the gap left by the missing rail. This measure was well-intentioned, and I presume meant to be temporary. However, it proved to be a serious error of judgement, as evidenced by Sasha's tragic death. It is unclear exactly how long the side rail had been missing from the cot. According to the evidence, it was at least long enough for Sasha to be able to exit her cot several days before her death.

It is unclear exactly when the improvised cot wall was put in place. Sasha's death serves as a reminder that baby's sleeping space should be kept clear of objects that may pose a suffocation or choking hazard. These hazards may not always be obvious, as in the present case.

RECOMMENDATIONS OF CORONER BATES

I. The message of safe sleeping practices should continue to be promoted. In addition to the message that babies 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, I wish to emphasise that a baby's designated safe sleeping space should be kept free of foreign or loose objects that may present a risk of choking, suffocation or asphyxia.

II. Additionally, the structural integrity of cots should be regularly checked and maintained by those with responsibility for the care of the baby. Improvised or short-term fixes should be avoided, unless they clearly comply with the original design of the cot and meet the safety standard intended for the properly constructed cot. If there remains any doubt about whether this safety standard has been achieved, an alternative safe sleeping space should be utilised for baby.

III. A copy of these findings will be sent to the Ministry of Health and Change for our Children for their records.

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

Tonga [2022] NZCorC 122 (30 August 2022)

CIRCUMSTANCES

Odeliah Cherub Tonga, aged 21 months, died on 11 January 2020 at an address in Papakura, Auckland from blunt injuries of head arising out of motor vehicle impact.

On the afternoon of 11 January 2020, Odeliah was with her father Taniela at a Papakura community hall. Taniela was packing things up in the kitchen while Odeliah watched videos on a cell phone in the main area of the hall. The kitchen was separated from the hall by a counter running the full length of the kitchen, but it was possible for an adult standing in the kitchen to look over into the main part of the hall.

At one end of the hall is an outwards opening access door, which opens onto an unenclosed asphalt area approximately six metres wide. A disabled parking space takes up about two thirds of the area, which is bound by the hall on one side and a toilet block on the other.

At just after 5:00pm, Odeliah's mother Sarah drove down the driveway past the community hall. She then turned left into the asphalt area between the hall and toilet block with the intention of stopping to pick up her family. After Sarah parked, Odeliah was found trapped underneath her car. She was pronounced dead at the scene.

The evidence indicated that Odeliah had left the hall through the door without her father seeing her, suggesting that the external door was open or capable of being pushed open at the time.

A visibility analysis by the Police Serious Crash Unit (SCU) identified that there was a significant blind spot area to the left for drivers turning into the parking space between the two buildings, in relation to people or objects 87 centimetres or lower. Since for the majority of the turning manoeuvre the lower section of the hall door was obstructed from view, the SCU concluded that the only time Odeliah would have been visible was if she was outside the doorway as the vehicle rounded the corner. If Odeliah had exited the building after the car began turning, there was almost no possibility of her mother being able to see her. The physical evidence suggested that Odeliah went under the front left tyre of the vehicle, making it "highly unlikely" that she was ever in front of her mother.

RECOMMENDATIONS OF CORONER HO

I. This was a tragic accident. However, there were steps which could have been taken to ensure that it did not occur.

If young children are unsupervised they should be in a secure area

II. It is critical that those in charge of supervising young children ensure that, as far as possible, the children are in a secure and safe environment. In addition to reducing the risk of danger within the room, the adult also needs to minimise the risk of the child being able to leave the room without the adult noticing. Toddlers of Odeliah's age are inquisitive, quick on their feet and do not appreciate the dangers around them. This can be a lethal combination.

III. In an ideal world, adults would have eyes on young children all the time. However, I recognise this is unrealistic. With the best will in the world, distractions such as sudden noises or other tasks may cause adults to look away. It is therefore important that adults ensure children's environments are as secure as they can be so that if distractions do occur and supervision is momentarily lost the consequences are not fatal.

IV. At the time that Odeliah ran outside she was under the supervision of her father. However, he was occupied cleaning up the kitchen in accordance with the church group's terms of use of the hall. He did not notice that she had left the hall. I do not criticise him for not keeping her closer to him; having her underfoot in the kitchen with ready access to kitchen implements might have brought about its own risks and dangers. However, the unfortunate fact remains that he was the adult responsible for ensuring Odeliah did not create a situation where she might have put herself in danger. Having chosen to leave Odeliah in the main hall under general, but not constant, sight, it was extremely important to check that the main part of the hall was secured – including closing and securing all external access doors – so that Odeliah remained within a defined area. A young child of Odeliah's age should not have been in a situation where she could freely access an external area with vehicles.

V. Odeliah's death is a tragic reminder to all adults that they need to know at all times the whereabouts of the young children they are supervising.

The blind spot danger in the asphalt area should be remedied

VI. The SCU report identified a material blind spot area for cars turning into the asphalt area between the hall and the toilet block. That blind spot covered a known egress from the hall and was particularly exacerbated

in respect of young children and those of lower height exiting through that door or standing near the hall's external wall.

VII. I make the following recommendations to Auckland Council, which operates the community hall:

a. Immediately remedy the hazard created by the blind spot area by installing a convex traffic mirror at the far end of the asphalt area so that drivers turning into the asphalt area are able to see the full height of the external door and any person entering or exiting through it.

b. Mount an ISO compliant sign warning of the presence of pedestrians and children in the asphalt area. Such a sign should be mounted in a location visible to drivers before they turn into the asphalt area.

c. Paint hatch marks along the side of the community hall where the access door is located so that there is a visual cue for drivers to take a wide, rather than sharp, left turn into that area.

d. Install a parking block at the head of the disabled parking space to discourage through-vehicle access.

e. Consider installing barriers and relocating the disabled parking space to prevent vehicles from entering the asphalt area.

VIII. I also recommend to Auckland Council that it undertake a review of its other facilities to identify any similar blind spots and to consider whether any of the above recommendations should also be implemented in such areas.

IX. Auckland Council was notified of my intention to make the above recommendations in accordance with s 57B of the Act. I did not receive any comments in response to my proposed recommendations.

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

Motor Vehicle

Alexander and Alexander [2022] NZCorC 116 (16 August 2022)

CIRCUMSTANCES

Graham Ross Alexander, aged 88, died on 31 January 2019 at Wellington Hospital of an aortic dissection in the context of a motor vehicle crash.

Enid Florence Alexander, aged 87, died on 28 January 2019 at her home in Porirua of high energy impact injuries resulting from a motor vehicle crash.

Graham and Enid's house was situated at the end of a cul-de-sac, below road level at the top of a hill. Their driveway had a straight downhill section from the road entrance and then suddenly curved sharply to the left behind the rear of their house, to a garage.

At around midday on 28 January 2019, Graham and Enid were returning home. Their neighbour observed that instead of turning left at the bottom of the drive, the vehicle went straight ahead and crashed into a tree at the bottom of the driveway. Emergency services were immediately contacted and attended. Enid was declared deceased at the scene by attending paramedics. Graham was taken to hospital for treatment however his injuries were un-survivable and he passed away two days later.

Graham had extensive atherosclerotic arterial disease with multiple erosions and fractures of the extensive plaque that was present throughout his aorta. It was not possible to determine with any certainty which occurred first, Graham's aortic dissection or the crash. Graham's cause of death was therefore recorded as an acute dissection of the arch of the aorta, in the context of a motor vehicle crash.

The Police Serious Crash Unit (SCU) conducted a full investigation and noted that Graham was not wearing a seatbelt at impact, while the vehicle was travelling at approximately 44km/h when it impacted the tree. An independent vehicle inspector examined the car and found that the brake fluid had a high water content, whereas a 2% maximum moisture level is recommended before full fluid replacement should be made. The SCU noted that this could cause an issue with the braking performance of a car, but that in this particular crash it was a related issue only, not a causative factor.

The SCU investigator spoke to several vehicle inspectors who voiced concerns about vehicles not having their brake fluid moisture fluid contents checked regularly and noted that due to New Zealand's aging vehicle fleet and the move towards 12 month warrants of fitness, there was greater potential for poorly performing brakes and for this issue to go largely undetected. While some vehicle manufacturers recommend that brake fluid be replaced at three-year intervals, if a mandatory moisture test was included in the warrant of fitness tests this would quickly identify any vehicles that have not been correctly serviced.

The SCU concluded that Graham did not apply the brakes to the car to regulate his speed as he came down the driveway. The deceased's son, Neville Alexander, provided details about Graham's usual practice when driving down the drive and noted concerns about Graham's mobility in the months before he died as he had been walking with difficulty. He also mentioned that Graham had recently been "scuffing up" both cars he owned while turning and had damaged the bumper of one of his cars in a minor collision.

Under New Zealand Driver Licensing legislation, a driver must renew their license at the ages of 75, 80 and then every two years thereafter. Under the Land Transport (Driver Licensing) Rule 1999, a driver needs to present a medical certificate each time they apply to renew their licence and may also need to sit an on-road safety test if a doctor decides that this is required.

Graham's most recent driving medical assessment was obtained from his doctor. It was noted that he was alert and oriented and he passed an eyesight test, with correcting lenses. His gait was slightly unsteady, but his central nervous system and upper limb neurological examinations were normal. His doctor advised that Graham was able to drive within his self-imposed limits but that he should be aware that he may no longer be safe by his next driving review.

COMMENTS OF CORONER ANDERSON

I. Because of the uncertainty regarding the cause of the crash, I do not consider any formal recommendations are necessary in the circumstances of this case. However, I note the issues raised by Neville Alexander about the desirability of a physical driving test when older drivers resit their license. While such a test can be

required under the current driver licensing regulation, it is not mandatory in all cases. Consideration may need to be given to whether routine practical tests could provide a more comprehensive assessment of the practical driving competencies of older drivers when they renew their licences.

II. While it has not been identified as a causative factor in this case, I also note the comments of the Crash Inspector regarding the general issue of moisture levels in brake fluid, and the potential impact this can have on the ability of brakes to function effectively.

III. As a result of both these matters, I have decided to send a copy of these finding to Waka Kotahi/Land Transport Agency so that the circumstances of this sad case can be taken into account when any consideration is given to the laws relating to vehicle licencing requirements for older adults and warrant of fitness check requirements.

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

Anderson [2022] NZCorC 100 (12 July 2022)

CIRCUMSTANCES

Shaun Donald Anderson, aged 42, died on 18 December 2019 at the intersection of and Rangitata Island Road of blunt force craniocerebral trauma secondary to motor vehicle accident.

On the evening of 18 December 2019 Mr Anderson was driving his Mazda RX8 with his adult step-son in the passenger seat from Timaru to Christchurch. At 10:20pm they stopped and smoked cannabis before continuing their journey.

At around 10:30pm Mr Anderson approached the intersection of State Highway 1 with Rangitata Island Road where a Toyota Hilux Ute (“Toyota”) was stationary and about to turn right. Mr Anderson’s vehicle crashed into the back of the Toyota. Mr Anderson did not appear to slow down or change course before the collision.

The force of the collision shunted the Toyota forward into the path of the oncoming Freightliner. The Freightliner hit the Toyota causing it to spin and impact Mr Anderson’s vehicle. As a result of the collision, Mr Anderson suffered fatal injuries and died at the scene.

The Police Serious Crash Unit (SCU) investigated the crash and noted that the area of the crash had been the subject of recent flooding and, as a result, under temporary 50km/h speed restrictions, road cones, and notification of new seal. Some of the signs had been knocked over and were laying by the roadside.

The Coroner was unable to determine whether the signs that were knocked over included any that Mr Anderson would have been expected to see as he travelled north. Thus there may have been no sign that would have warned him of the temporary 50km/h speed limit. However, there would still have been road cones in the area and the taillights and the right-turn indicator light of the Toyota would have been visible as Mr Anderson approached the intersection.

The Coroner accepted the SCU’s conclusions and found that the combination of speed, fatigue and drug use likely contributed to Mr Anderson failing to observe the stationary Toyota, which resulted in the crash. The severity of Mr Anderson’s injuries was affected by the speed he was travelling and the respective heights of the vehicles.

COMMENTS OF CORONER BATES

Speed

I. Waka Kotahi/New Zealand Transport Agency states:

> Excessive speed is one of the biggest killers on our roads. On average, 130 people die every year in New Zealand in speed-related crashes.
>
> Remember, the faster you go, the more likely you are to be killed or seriously injured if you crash.
>
> **Safe speed guidelines**
>
> You can drive at any speed under or equal to the limit, provided: …
>
> your speed is safe for the weather conditions (for example, slow down if it is raining, windy or foggy).

II. If Mr Anderson had been driving at a lower speed, he would have had more time to perceive the stationary vehicle ahead and potentially avoid the crash. The crash illustrates the importance of Waka Kotahi's advice, driving to posted and temporary speed limits and to the conditions at the time.

Temporary road signage

III. Having commented on driving at a speed which may have been excessive for the conditions, in fairness to Mr Anderson, I add that some of the temporary 50km/h speed restriction signs were knocked over, which may have limited his opportunity to appreciate the speed restriction. There is no evidence to suggest exactly which signs were knocked over, although there is reference in the SCU report and photographs in relation to a 50km/h temporary speed sign lying to the western side of the road in grass and another speed restriction and roadworks sign lying on the side of the road. There is no suggestion that Mr Anderson was travelling in excess of the usual posted speed limit of 100km/h immediately prior to the crash.

IV. Police were provided with a provisional copy of my Findings and invited to comment. In response I was advised that on the night of the accident, near the accident scene, there was a large illuminated sign that contained a message regarding damage to the roading. Some other temporary signs were still standing. A Met Service report advises that prior to the crash the wind was moderate, between 20-27km/h, which could account for some unanchored signs being blown over. Some signs had been anchored with sandbags or similar, others had not been anchored. Police are of the opinion that an observant and prudent driver would have noticed the 50km/h temporary speed signage that was still standing prior to entering the area where the crash occurred.

V. I consider that some signs may have been knocked over due to weather conditions (wind), or perhaps deliberately, accidentally, or in circumstances that I cannot know. Regardless, I recommend that best endeavours are made to ensure that all temporary signage is securely anchored to reduce the chance of it being knocked over, and that checks on temporary signage are regularly made to ensure it remains visible to motorists as intended. Presumably there is a reason for the particular number, placement and wording of all temporary signs, with the intention of reducing the possibility of harm to motorists. I expect that an appropriate sight management plan would address this.

VI. Waka Kotahi were provided with a provisional copy of my Findings and invited to comment. In response Waka Kotahi advises:

> It is important that temporary speed limit signs are positioned close to the roadway in order to be conspicuous to passing drivers. Whilst every effort is made by those responsible for the speed limit restriction to ensure signs for temporary speed limits are properly weighted down and remail upright, they can become dislodged over time, due to repeated exposure to adverse weather and the draft from passing vehicles. At times there may be delays in rectifying this situation, particularly in remote areas.
>
> Waka Kotahi is currently in the process of reviewing the guidelines for Temporary Traffic Management, which includes the installation and used of temporary speed limit signs. Accordingly, a specific review of the advice relating to the position and stability of all signs, including temporary speed limits, will be included in the process.

Cannabis use before driving

VII. If Mr Anderson had not used cannabis, he may have perceived the stationary vehicle ahead of him sooner and avoided the crash. The crash illustrates the danger of driving after using cannabis.

Fatigue

VIII. The dangers of driving while fatigued are evidenced by Mr Anderson's death. Waka Kotahi has identified the following warning signs of fatigue and I urge all motorists to be mindful of them:

a) Restlessness

b) Blinking frequently

c) Yawning

d) Excessive speed changes

e) Braking too late

f) Forgetting the last kilometres travelled

g) Drowsiness

h) Centreline drift

IX. Waka Kotahi note it is a common myth that coffee, fresh air or music help combat fatigue. These measures only help in the short-term. Waka Kotahi advise that stopping and getting a good night's sleep is the only cure for fatigue.

X. If Mr Anderson was driving while fatigued, this is likely to have limited his ability to perceive the stationary vehicle ahead of him, increasing the risk of crashing.

Comments

XI. I make the following comments pursuant to section 57A of the Coroners Act 2006:

XII. Mr Anderson died of injuries sustained in a crash on 18 December 2019. The crash was caused due to a combination of speed, fatigue and the effects of cannabis, which Mr Anderson had recently consumed.

XIII. Mr Anderson's death tragically illustrates the dangers of driving at a speed which may have been excessive for the conditions.

XIV. His death also illustrates the danger of driving after using cannabis. The New Zealand Drug Foundation states, 'Do not drive after using cannabis because this greatly increases the chance of an accident.'

XV. Given the prevalence of publicity and general information available regarding the harm that may result from recreational drug use generally, I do not consider it necessary to make further comments or recommendations pursuant to s 57(3) of the Coroners Act.

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

Dixon [2022] NZCorC 121 (29 August 2022)

CIRCUMSTANCES

Shae Noel Dixon, aged 43, died on 10 March 2021 at State Highway 29, between Soldiers Road and Ngamuwahine Road. The cause of death was fatal head trauma sustained in a motor vehicle collision.

At around 3:40pm on 10 March 2021, Mr Dixon was driving a Ford Courier utility vehicle on State Highway 29 towards Hamilton from Tauranga. He had two work colleagues as passengers. At the same time, Mr MacDonald was the sole occupant of a Toyota Dyna light truck travelling in the opposite direction. After negotiating a right-hand corner, Mr MacDonald failed to navigate a subsequent moderate left-hand bend and crossed the centreline of the road, colliding with Mr Dixon's vehicle. Mr Dixon suffered fatal injuries and died at the scene. His passengers suffered minor injuries. Mr MacDonald suffered serious injuries and was airlifted to Waikato Hospital to undergo surgery.

Police located a glass pipe used for methamphetamine consumption and a number of small point bags in Mr MacDonald's vehicle. Testing while he was in hospital confirmed the presence of methamphetamine in his blood. Mr MacDonald denied consuming methamphetamine on the day of the accident, claiming he had most recently used it on the day prior. He also described feeling tired on the day of the accident.

The Police Serious Crash Unit (SCU) identified that fatigue and methamphetamine use on Mr MacDonald's part were the likely factors contributing to the accident. The SCU also raised concern about the long hours Mr MacDonald had been working, including split shifts with limited rest times. On 10 March 2021, he had started work at 6:00am and been working for nine hours and 40 minutes when the crash occurred.

The SCU noted that one of the reasons people use methamphetamine is to keep them awake, as it is a stimulant. However, when the body withdraws from the drug the need to sleep can happen very quickly, especially if a person is already tired.

The SCU also identified that there were tall gorse bushes on the northern side of the road making it difficult to see oncoming traffic at the corner where the accident occurred.

Mr MacDonald pleaded guilty to various breaches of the Land Transport Act 1998. He was sentenced to 11 months' home detention and disqualified from holding or obtaining a driver's licence for two years. Mr MacDonald was also ordered to pay $5,000 reparation to Mr Dixon's next of kin.

COMMENTS OF CORONER WOOLLEY

I. I have found that the likely cause of the collision was that Mr MacDonald was driving while fatigued against a background of methamphetamine consumption.

Driver fatigue

II. The risks of driving while fatigued have been consistently conveyed to the public through various safety campaigns on many occasions and remains a key safety issue and theme for Waka Kotahi New Zealand Transport Agency's safety campaigns, particularly over the summer months when New Zealanders are known to be travelling around the country more. In 2020, addressing driving while fatigued was identified as priority issue for road safety at work in Waka Kotahi's road safety strategy: Road to Zero 2020-2030. The Road to Zero strategy also identifies fatigue, alongside alcohol and drugs, speed and distraction, as one of the leading contributing factors to death and serious injuries from motor vehicle accidents.

III. I note the following information from Waka Kotahi's website about driver fatigue that is relevant to the circumstances of this case:

a. People often think that driver fatigue means falling asleep at the wheel. Falling asleep, however, is an extreme form of fatigue.

b. Fatigue is tiredness, weariness or exhaustion. A person can be fatigued enough for it to impair their driving long before they 'nod off' at the wheel.

c. Driving home after spending extended hours at work is a risky time to drive because your body may be at its low point in alertness and you may be sleep deprived.

d. If a person is feeling drowsy, they may occasionally drift in and out of sleep without knowing it. Although these micro-sleeps may only last a few seconds, they can be fatal when driving as the person may not brake before colliding with another object.

e. Those involved in working extended hours or some form of shift work, are six times more likely to be involved in a car crash than other workers.

f. Fatigue often combines with other factors, such as substance use, to cause road crashes.

g. Signs of entering, or being in, the 'fatigue danger zone' when driving include not being able to remember driving the last few kilometres and drifting over the centre line or onto the other side of the road.

Methamphetamine

IV. In this case, there is evidence that Mr MacDonald was driving at a time when he had methamphetamine in his blood. Methamphetamine is a central nervous system stimulant and can make users feel energetic, alert,

talkative and confident.[15] It can also make users feel hyperactive, paranoid and aggressive.[16] When the effects of methamphetamine come to an end, the user can feel tired, or suffer a period of fatigue or exhaustion that occurs because the body is drained of energy.[17]

V. Research undertaken by Waka Kotahi about the dangers of driving while under the influence of illegal drugs, found that methamphetamine can have an indirect impact of assisting people to become exhausted. If such people then drive, they are more susceptible to fatigue-related crashes.[18] This research also indicates that many New Zealanders do not readily identify drug driving as a common cause of road trauma.

VI. Reducing drug impaired driving has also been identified as a high priority in the Road to Zero strategy and I understand that Waka Kotahi is developing a new drug-affected driving advertising campaign, which aims to reduce the harm caused by drugged drivers and raise awareness about the issue of drug affected driving.

VII. Given Waka Kotahi's previous and current work in the areas of driver fatigue and drug impaired driving, and acknowledging that Coroners, the Police, and NZTA have consistently highlighted the dangers of driving while fatigued, and driving while under the influence of drugs, I do not make any further formal recommendations or comments under the Coroners Act 2016. However, I note that the circumstances of this case highlight the fatal outcome that can occur if these messages continue to be ignored. Given that both driving while fatigued and methamphetamine use raise the risk of exhaustion and of impaired driving, or at the most extreme, falling asleep at the wheel, I urge members of the public to not drive if they are feeling fatigued or after consuming methamphetamine. I also note there is publicly available information on driving drug free on the New Zealand Drug Foundation's website. I strongly encourage anyone wanting to find out more information on this topic, or who wants to ensure they are driving safely, to read this information.[19]

VIII. This finding will also be distributed to Waka Kotahi to make them aware that the SCU Report identified that the tall gorse bushes on the northern side of the road made the corner where the accident occurred reasonably blind. There is no suggestion in the SCU Report that this was a causative factor in the accident so, again, I will not make any formal recommendations but will alert Waka Kotahi to this issue so that it can address maintenance of the gorse bushes at this location if it considers the bushes pose a wider road safety issue.

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

Fish [2022] NZCorC 130 (14 September 2022)

CIRCUMSTANCES

Daniel Peter Fish, aged 40, died on 19 September 2019 at Wellington Hospital, Riddiford St, Newtown of traumatic head injuries sustained in a single-vehicle crash (driver).

[15] https://www.drugfoundation.org.nz/info/drug-index/methamphetamine/
[16] As above.
[17] As above.
[18] https://www.nzta.govt.nz/resources/research/reports/664/
[19] https://www.drugfoundation.org.nz/info/being-safer/drug-driving

On the afternoon of 18 September 2019, Mr Fish was drinking with his flatmate at his home address in Nelson. Mr Fish drank two bottles of wine by midnight and wanted to visit a friend in Stoke. His flatmate drove them to Stoke in Mr Fish's Subaru Legacy. While at the address, Mr Fish got into the driver's seat of the car and drove away.

Shortly after entering a moderate right-hand bend along the Kohatu-Kawatiri Highway, Mr Fish began to steer the vehicle to the left, and lost control before crashing into a tree. A delivery driver located Mr Fish and went to assist him. He noted that Mr Fish smelled strongly of alcohol. Mr Fish was airlifted to hospital where he was declared brain dead later that day.

Toxicology analysis established the presence of alcohol, methamphetamine and cannabis. The level of alcohol in Mr Fish's blood was 144mg/100mL. For comparison purposes, the legal blood alcohol limit for a New Zealand driver aged 20 years or older is 50mg/100mL.

The Serious Crash Unit investigated the cause of the crash and concluded that Mr Fish's steering manoeuvre was delayed which is typical in a driver impaired by alcohol, drugs and/or fatigue.

COMMENTS OF CORONER BORROWDALE

I. Having given careful consideration to all of the circumstances of this death, I consider that there are comments that can usefully be made pursuant to section 57(3) of the Coroners Act 2006.

II. Mr Fish's death was avoidable. He made an effort to steer his way around a bend that should have been navigable without difficulty or danger. However, he was affected by alcohol and drugs that were capable of dulling his perception and slowing his reaction times. By the time Mr Fish attempted to respond to the bend, his steering input was too late and he failed to take the bend and crashed into a tree.

III. It is unsafe to drive a vehicle while intoxicated or under the influence of drugs.

IV. There is a wealth of publicly available information about the perils of driving while intoxicated by alcohol or affected by drugs. I encourage the driving public to follow the cannabis and alcohol awareness and driving safety advice that is promulgated by the Ministry of Transport, the NZTA, the NZ Drug Foundation and other entities, and abstain from driving while affected by alcohol and/or drugs.

V. In light of these comments, I make no recommendations under section 57(3) of the Coroners Act 2006.

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

Flavell [2022] NZCorC 120 (25 August 2022)

CIRCUMSTANCES

Trinity Rosemarie Violet Flavell, aged 18, died on 10 September 2020 at Auckland Hospital. The cause of death was traumatic brain injury due to a motor vehicle crash.

At around 1:25pm on 6 September 2020, Trinity was driving a car on Pipiwai Road, Matarau, with five passengers. They had planned to go to the beach that afternoon. While driving, Trinity accelerated up to between 120 to 150km/h and her passengers asked her to slow down. When she neared a right-hand bend with a 55km/h speed limit Trinity tried to slow

the car 60 metres before the bend but entered it too fast, causing the car to swing wide and slide sideways. Trinity overcorrected and the car slid out of control, crashing into a concrete power pole on the left-hand side of the road.

Trinity was critically injured and airlifted to Auckland Hospital. Her passengers also sustained serious injuries. Trinity's condition continued to deteriorate and she died on the morning of 10 September 2020.

A Police Serious Crash Unit (SCU) report noted the following contributing factors to the crash:

- Motor vehicle faults including no warrant of fitness and two worn rear tyres. One of the suspension bushes was also worn.
- Trinity was driving under the influence of MDMA (ecstasy), travelling at excessive speed and driving in breach of her restricted driver's licence.

The SCU also noted that there had been 36 recorded crashes on Pipiwai Road between 2015 and 2020, with the power pole that was hit the subject of a prior fatal crash. It recommended that an Armco barrier be installed on the northern side of the corner to deflect out-of-control vehicles away from the power pole.

COMMENTS OF CORONER TETITAHA

I. Given this is the second fatal crash in the same area involving the same power pole, I endorse the comments and recommendation of the serious crash unit for the erection of a shoulder barrier from the Matarau Road intersection to where the accident occurred (60 m in length). This is to prevent errant cars striking the power pole and causing a similar serious injury or fatality as occurred to Trinity.

II. I had initially sought comment from Waka Kotahi/New Zealand Transport Agency regarding this recommendation. They referred the coroner to the local District Council who was responsible for this area of roading.

III. The comments and the below recommendation were directed to the Whangārei District Council to comment. A reply has been received confirming the council will investigate the erection of a shoulder barrier in this location to prevent errant cars striking the power pole.

IV. I make the following comments pursuant to section 57A of the Coroners Act 2006:

RECOMMENDATIONS OF CORONER TETITAHA

I. That the Whangārei District Council consider erecting a shoulder barrier from the Matarau intersection eastwards to where the accident occurred of approximately 60 m in length.

Note: An order under section 74 of the Coroners Act 2006 prohibits the making public of any photographs taken of the deceased during this inquiry, in the interests of decency.

Gapes [2022] NZCorC 106 (26 July 2022)

CIRCUMSTANCES

Nicola-Jane Gapes, aged 43, died on 29 January 2018 at State Highway 16, Coast Highway of multiple injuries following a motorcycle and motor vehicle collision.

On 29 January 2018 Ms Gapes was a pillion passenger on a motorcycle. At 2:48 pm the motorcycle was travelling south on State Highway 16 behind a line of traffic.

The motorcycle pulled into the right-hand lane to overtake the line of traffic. At the same time, the car at the head of the line of traffic turned right into the entrance to the Mangakura boat club. As it did so, the motorcycle collided with the car and Ms Gapes suffered fatal injuries and died at the scene.

COMMENTS OF CORONER TETITAHA

I. I make the following comments pursuant to section 57A of the Coroners Act 2006:

II. Fulton Hogan have prepared a Fatal Crash report dated 29 January 2018 in respect of this death. The report contained several recommendations as follows:

   a. widen the carriageway to 8.5 m width at the time of the next pavement rehabilitation;

   b. investigate options for providing an NZTA PPM diagram D access way type for the entrance to the Mangakura boating club;

   c. remove the tree on the right-hand side, opposite the boating club entrance, from within the road reserve; and

   d. extend the existing southbound no overtaking lines north, to beyond the Mangakura boating club entrance.

III. I endorse these recommendations. All of these recommendations may have prevented this death. A wider carriageway may have provided room to manoeuvre and avoid this crash. An access way for vehicles turning into the boat club would ensure they were visible to traffic following. The removal of a tree to improve visibility would also assist turning traffic.

IV. However, the final recommendation to extend the no overtaking lines to beyond the Mangakura boating club would have the most impact because it would prevent these types of accidents occurring in future as drivers would be unable to legally overtake.

V. These comments are directed to the Ministry of Transport/Waka Kotahi who are responsible for this State Highway.

RECOMMENDATIONS OF CORONER TETITAHA

I. I make the following recommendations pursuant to section 57A of the Coroners Act 2006:

II. That the Ministry of Transport/Waka Kotahi consider implementing the recommendations set out in the Fulton Hogan report dated 29 January 2018.

III. The Ministry of Transport/Waka Kotahi provided a reply confirming that they will investigate the viability of recommendation [II(a)]; work with the boating club to assess the installation of a diagram D when turning right into the access way in recommendation [II(b)]; arrange for the removal of trees in recommendation [II(c)]; and program the extension of the no overtaking lines in recommendation [II(d)].

IV. The Ministry of Transport/Waka Kotahi is thanked for their reply.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Ms Gapes during this inquiry, in the interests of decency.

Haines [2022] NZCorC 126 (5 September 2022)

CIRCUMSTANCES

Jonathan Rex Haines, aged 57, died on 24 April 2020 at Tuakau Bridge-Port Waikato Road, Port Waikato from blunt force trauma to chest as a result of fall from motorcycle.

At approximately 4:10am on 24 April 2020, Mr Haines left for work on his motorcycle. His route took him east from Port Waikato township along the Tuakau Bridge-Port Waikato Road. Mr Haines was an experienced rider and familiar with the road.

Mr Haines' colleague raised concern to his wife when he did not arrive at work and as a result a search was commenced along the route he took to work. Mr Haines' body was discovered around 10kms east of Port Waikato township. He was lying in a drainage ditch on the side of the road with his motorcycle beside him. There was a dead wild pig lying on the road about 60 metres west of where Mr Haines was found. Traces of the pig were found on Mr Haines' motorcycle and clothing. Almost immediately opposite the pig carcass was a trail of worn grass and exposed dirt leading to a hole in the shrubbery adjoining the road which appeared to be a path trod by wild animals.

The Police Serious Crash Unit (SCU) investigated the crash and noted that wild animals were known to roam on the road on which Mr Haines crashed. There was evidence that some of the owners of land which adjoined the road bred wild pigs and allowed them to run wild for hunting purposes. The presence of wild animals was known to Waikato District Council (WDC) which had erected a sign, albeit one not ISO (International Organisation for Standardization) compliant, warning of wandering animals on the road. The SCU also noted that there might have been more animals on the road due to lower traffic volumes during the Covid-19 lockdowns, in line with similar observations in other countries.

The SCU determined that Mr Haines hit the wild pig, lost control of the motorcycle, failed to navigate the upcoming curve and left the road. The SCU also considered that the long grass and vegetation growth was a contributory factor in the crash. Had the vegetation been trimmed, Mr Haines might have had additional time to sight and react to an animal entering the road. The SCU further noted that had roadside barriers been erected Mr Haines may not have left the road and therefore fallen into the drainage ditch.

The SCU conducted an analysis of recognition distance and perception response time available to Mr Haines. It found that even if the pig had been stationary in the middle of the road Mr Haines would not have been able to recognise and respond to the threat in time given his likely speed, the dark conditions and the size and colour of the pig.

RECOMMENDATIONS OF CORONER HO

Wild animals

I. I have found that the primary cause of the crash and Mr Haines' death was his impacting a wild pig on the road. While the risk of animals on roads in rural areas cannot ever be fully mitigated there was reported concern by locals that there appeared to be more animals on the roads than prior to the Covid-19 national lockdown. There was also some suggestion that nearby landowners were breeding wild pigs for hunting purposes. If correct this would appear to be contrary to the WDC's Keeping of Animals Bylaw 2015 which prohibits persons from providing sustenance to stray animals so as to cause the animal to become a nuisance to other persons.

II. Animals on roads cause danger to all road users. I recommend to WDC that it conduct a review of animal sightings on its roads and undertake an animal cull. It should also enforce, where appropriate, the provisions of its Keeping of Animals Bylaw in order to mitigate the numbers of wild animals causing nuisance.

Vegetation length

III. One of the factors that the SCU identified as possibly contributory to the crash was the long vegetation which might have obscured visibility of the pig. It is unlikely to have made a material difference in this case given the darkness and the road topography – but I acknowledge that it is possible that had the vegetation been shorter a rider in Mr Haines' position might have detected the pig's movement and taken prudent measures to reduce their speed. I recommend that WDC ensure that vegetation is cut back from the roadside to improve visibility, and appropriately maintained thereafter, especially in areas where wild animal sightings have been or are known to occur.

ISO compliant signs

IV. All road warning signs, including those warning of roaming wild animals, should be ISO compliant. Safety signs are important to prevent accidents and injuries and it is important to use symbols that are internationally agreed and globally accepted to ensure clarity and consistency regardless of language, culture or setting. The sign that was erected by WDC at the time and in the vicinity of Mr Haines' crash was not ISO compliant.

V. I recommend WDC review its road warning signage and replace any non-ISO compliant signs with ISO compliant ones.

Barriers along roadside

VI. The SCU opined that had roadside barriers been erected Mr Haines may not have left the road and therefore fallen into the drainage ditch. It is unclear whether this would have prevented his death as the presence of barriers may simply have substituted one fatal consequence (fall from motorcycle) for another

(motorcycle crashing into barrier at speed). However, I accept that roadside barriers might have been of utility in that they might have prevented the wild pig from entering the road and causing the accident in the first place.

VII. It would be impractical to barrier the length of every rural road in New Zealand. However, it would be worthwhile for local authorities such as WDC to review areas known to have a large number of wild animals interacting with traffic, such as those close to known wild animal habitats and crossings, and consider implementing barriers at those locations. I recommend accordingly.

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

Lines-Gerard [2022] NZCorC 97 (4 July 2022)

CIRCUMSTANCES

Matthew James Lines-Gerrard, aged 24, died on 1 May 2019 at Southland Hospital of intrathoracic and cranial trauma and haemorrhage in the context of a motorbike collision.

Matthew had been riding motorbikes since he was young and was described as a skilled rider who rode mostly for enjoyment.

On 1 May 2019 Matthew was at his uncle's house for dinner and drinks. He consumed seven Corona beers. Matthew joked with his cousins about who could ride motorbikes faster which led to a plan to ride the bikes. At 9:45pm, after pouring himself a cider, Matthew took the Honda motorbike from the shed. He was not wearing a helmet. The Honda was used for off-road racing and did not have a headlight. It was not warranted or registered to be used on the roads.

A neighbour heard a loud crash and walked out to the road at the same time Matthew's cousin arrived. They found Matthew lying on his back on the right side of a concrete power pole. He was bleeding and his breathing was very distorted. Family members carried out CPR until the ambulance arrived. Matthew was transported to Southland Hospital. He was in cardiac arrest when he arrived and died later that evening.

Toxicology analysis was carried out on samples of Matthew's blood and urine. Alcohol was detected in his blood and urine at 200 and 238 milligrams per 100 millilitres respectively. For comparison purposes, the legal blood alcohol limit for a driver 20 years old or over in New Zealand is 50 milligrams per 100 millilitres.

The Police Serious Crash Unit (SCU) investigated and concluded that Matthew rode the Honda out of the driveway, turned right and travelled about 35 metres before entering the gravel driveway of another property at an angle of approximately eight degrees. The Honda then travelled along a grass verge toward the concrete power pole. There was evidence of braking approximately eight metres before the power pole. Matthew and the Honda's left side collided with the side of the power pole facing the road.

The SCU identified three contributing factors: the Honda did not have lights, there was no street lighting on Watt Road and Matthew was four times over the alcohol legal limit. In addition, he was not wearing a helmet.

RECOMMENDATIONS OF CORONER DUGGAL

I. The dangers of driving after drinking alcohol are well known. In this case in addition to drinking, Matthew was riding a motorbike without headlights on an unlit road. His death at such a young age is a tragic loss which was sadly preventable. I reiterate and support the efforts of Waka Kotahi to prevent drunk driving.[20]

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

McClune [2022] NZCorC 105 (26 July 2022)

CIRCUMSTANCES

John Scott McClune died on 11 November 2016 at Whanganui from multiple injuries sustained in a fall from the back of a truck.

Over the course of the afternoon and into the evening of 11 November 2016 Mr McClune consumed alcohol with friends. At around 9:13pm Mr McClune was one of three passengers riding on the open deck of a truck belonging to him but being driven by his friend. The deck of the truck was loaded at the time with heavy items that had either been secured by chains or were tied down with strops. Mr McClune was seen to be holding onto a strop when he came off the vehicle and landed on the road. He received fatal injuries and died at the scene.

The Coroner, agreeing with the Police Serious Crash Unit (which investigated the incident), found that Mr McClune's actions whilst under the influence of alcohol were the most likely factor causing him to lose hold and fall off the truck.

RECOMMENDATIONS OF CORONER HESKETH

I. Despite Mr McClune's friends describing him as someone who could 'handle his booze' I record here again the toxicology results. A toxicology report analysed from a blood sample showed a blood alcohol level of 244 milligrams of alcohol per 100 millilitres of blood. That is a remarkably high reading, almost 5 times the legal blood alcohol limit for a person aged 20 years or older.

II. I do not accept he was someone who could 'handle his booze'. He fell from a moving truck travelling at low speed as those on board state Mr Emmett was still in the low gears. He fell because he had consumed too much alcohol. Heavy alcohol use results in cognitive impairment.[21]

III. Coroners have made recommendations about the dangers of excessive alcohol consumption many times. There are numerous agencies that can assist people that have an alcohol use disorder, whether that disorder be alcohol abuse or alcohol dependence. Those agencies include:

   a. Alcohol Drug Helpline -0800 787 797 (https://alcoholdrughelp.org.nz/)

   b. Alcohol.org.nz (http://www.alcohol.org.nz)

   c. Like a Drink (http://www.likeadrink.org.nz/)

[20] https://nzta.govt.nz/safety/what-waka-kotahi-is-doing/our-advertising/current-advertising-campaigns/
[21] Bernardin. Maheut-Bosser & Paille: Frontiers in Psychiatry 5, 78, 2014.

d. Living sober (http://www.livingsober.org.nz/)

e. Whaiora Online (https://www.whaioraonline.org.nz/login)

f. Community treatment services (/your-health/services-and-support/health-care-services/help-alcohol-and-drug-problems/community-services-alcohol-or-drug-treatment)

g. Live-in treatment services (/your-health/services-and-support/health-care-services/help-alcohol-and-drug-problems/live-services-alcohol-or-drug-treatment)

h. Help for families, whanau can be found at (/your-health/services-and-support/health-care-services/help-alcohol-and-drug-problems/help-families-whanau-friends)

i. There are a number of independent agencies that also help:

    i. Salvation Army (Addictions, Supportive Accommodation & Reintegration Service Enquiries – 0800 530 000

    ii. Higher Ground -09 834 0042

    iii. Community Alcohol Drug Services (CADS) – 0800 845 1818

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

Mullaly [2022] NZCorC 129 (13 September 2022)

CIRCUMSTANCES

Robert Henry Mullaly died on 12 January 2021 at Pound Road, Islington of high energy impact injuries to chest, abdominal organs, and spine as a result of a motor vehicle accident.

On 12 January 2021, Mr Mullaly was working as a gulley/sweeper driver. Drivers of sweeper vehicles are required to comply with all road rules, including wearing a seatbelt, at all times. Sweeper vehicles can be driven from both the left and right side of the vehicle. When being driven between locations, drivers are required to drive from the right-hand side of the vehicle. At 3:00am Mr Mullaly was driving the sweeper vehicle from the left-hand side of the vehicle northbound on Pound Road, Islington, Christchurch. He was the sole occupant of the vehicle and was not wearing a seatbelt. Mr Mullaly prepared to leave the area and pulled into the northbound lane of Pound Road to complete a U-turn at which point a truck which was travelling north crashed into him. Mr Mullaly was ejected from the sweeper vehicle.

The Canterbury District Serious Crash Unit (SCU) investigated the cause of the crash and concluded that Mr Mullaly could have survived the crash if he had worn his seatbelt. The SCU identified that it was highly likely distraction and inattention on behalf of Mr Mullaly were causative factors in this crash. Driver position was considered to be a likely contributing factor to the collision and cell phone use by Mr Mullaly was also a possible factor.

COMMENTS OF CORONER CUNNINGHAME

I. Advice on the Waka Kotahi NZ Transport Agency website states that wearing a seatbelt reduces your chances of being killed or seriously injured in a road crash by 40%.

II. I would like to reinforce the message that drivers and passengers should always wear a seatbelt. Seatbelts save lives and it is likely they would have done so in this case.

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

Poihipi [2022] NZCorC 115 (15 August 2022)

CIRCUMSTANCES

Aliceon Chappie Poihipi, aged 58, died on 7 October 2020 on Thames Coast Road, 650 metres north of Waikawau Valley Road from massive head injury with associated injuries.

At around 8:40am on 7 October 2020, Aliceon was riding his Yamaha motorbike south on Thames Coast Road. At the same time a truck and trailer unit was travelling in the opposite direction. Aliceon overtook the vehicle in front of him and, despite there being enough space for him to do so, failed to move back into his southbound lane before a blind corner. The truck and trailer unit was travelling north around the corner and collided with Aliceon and his motorbike. Aliceon died at the scene from injuries sustained in the collision.

Toxicology testing on samples of Aliceon's blood taken post-mortem confirmed the presence of cannabis and tetrahydrocannabinol. Aliceon did not hold a motorcycle licence and there was no evidence of his riding ability, or any motorbike training (formal or informal) that he may have received.

RECOMMENDATIONS OF CORONER ROBB

I. Significant effort is made in New Zealand to promote the need for motorcyclists to take care when they are riding. Specifically, there has been a recent advertising campaign reminding riders to "respect every ride", which encourages motorcycle riders to invest in the best gear they can afford, stay aware of the road they are riding on, and upskill and practice to improve their riding ability. Significant effort is also made to promote the idea that driving while under the influence of drugs is a dangerous activity that can easily result in death. The obvious dangers of failing to remain within one's lane are borne out by this collision.

II. Aliceon's death was tragically brought about by his own actions and was avoidable. This death would have been prevented if the well-documented warnings about the dangers of operating motorcycles on open roads had been followed. I reiterate those warnings and recommend appropriate rider training and certification be undertaken by any member of the public wishing to operate a motorcycle on a public road.

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

Rigg [2022] NZCorC 117 (18 August 2022)

CIRCUMSTANCES

Elizabeth Ann Rigg, aged 65, died on 5 April 2019 at the intersection of State Highway 6 and Glen Road in Wakapuaka, Nelson of severe traumatic injury to head, chest and abdomen.

At about 10:00am on 5 April 2019, Mrs Rigg was cycling on Glen Road heading towards Nelson. As she turned right onto State Highway 6, she was struck by a car approaching from her right. Mrs Rigg collided with the bonnet of the car and was flung about 30 metres along the road. Members of the public attempted resuscitation until the arrival of emergency services, but she was pronounced dead at the scene.

The Tasman District Serious Crash Unit (SCU) carried out an investigation into the crash. The SCU concluded that the crash occurred because Mrs Rigg failed to give way to the approaching car. Glen Road was clearly marked with give way signs and road markings. Mrs Rigg's cycle computer showed that she was still travelling at 20.9km/h approaching the give way limit line, indicating she had not intended to stop at it.

The SCU noted that the layout of the intersection can provide a false impression that there is no approaching traffic on State Highway 6 for drivers or cyclists approaching from Glen Road. This is due to the height difference between the two roads and the railing along State Highway 6, which partially obscures views of it from Glen Road.

To encourage road users to take the time to properly check for approaching vehicles before turning onto State Highway 6, the SCU recommended that the local road controlling authority consider a safety audit of the intersection and changing the give way to a mandatory stop.

RECOMMENDATIONS ENDORSED BY CORONER DUGGAL

I. I endorse the recommendation made in the SCU report.

II. The recommendation was shared with Waka Kotahi, the road controlling authority. Waka Kotahi advise as follows:

- Following a safety review of the intersection, the give way control has been replaced with a mandatory Stop control. This includes a "Stop 150m ahead" advance sign on Glen Road.
- Waka Kotahi has also completed a speed review of the area and reduced the speed to 80km per hour on the affected section of State Highway 6. The new speed limit was introduced on 30 July 2021.

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

Roys [2022] NZCorC 112 (2 August 2022)

CIRCUMSTANCES

Natasha Michelle Roys, aged 43, died on 1 January 2020 at Tokerau Beach due to a severe neck injury including fracture dislocation of C7/T1 with possible avulsion of midbrain/brainstem following being crushed by a motor vehicle.

Ms Roys was invited to go camping at a friend's bach at Tokerau Beach. She arrived after midday on 31 December 2019 and set up her tent on the property. The bach was located behind another house down a long driveway. The buildings were located on a part of the section that had a gentle slope until the far edge of the single garage. The section then sloped sharply down to a post and rail fence. Ms Roys had pitched her tent halfway along the post and the rail boundary fence at the southern end of the property.

Witnesses recall Ms Roys enjoying the day celebrating New Year's Eve with her friends. She went to bed in her tent at around 1:30am on New Year's Day on 1 January 2020. One of the attendees owned a blue Suzuki Escudo motor vehicle. He had been drinking and drove his vehicle between 1:30 and 2:00am to the beach with others. When he returned to the property, he parked the Suzuki vehicle "right at the top" and remembered putting the handbrake on. He went to bed at 2:30am.

The following day, the Suzuki vehicle was found down at the bottom of the slope against the fence. The car was immediately moved, and Ms Roys was located unresponsive and cold to touch. Emergency services were called and attended the scene. Ms Roys was confirmed deceased by attending paramedics.

The Police obtained opinions from several witnesses with mechanical expertise to provide evidence about the state of the vehicle. The Coroner noted the difficulties in ascertaining whether the handbrake had "excessive travel" due to the conflicting evidence provided by the mechanical experts. The vehicle inspector issuing the warrant of fitness (WOF) further advised that the handbrake did not exhibit "excessive travel" when the car was inspected at the most recent assessment.

The Suzuki vehicle was noted to have been modified after it passed its WOF. The vehicle inspector issuing the WOF considered whether the brakes being out of adjustment were due to the vehicle being modified. However, the company that modified the vehicle noted that they did a 2 inch lift kit and did not require certification as it was nonadjustable and only 2 inches. They also noted that none of the braking systems needed to be touched to fit the kit.

The Coroner considered the possibility of human error by the driver not setting the handbrake properly however she noted his belief that the car's handbrake was set and no other witnesses had come forward to disprove his version of events.

Following the family concerns and further investigations, the Police provided a report regarding several shortcomings with their investigation including:

- the failure to involve the serious crash unit (SCU);
- the failure to follow-up on statements made by the car owner about the state of the handbrake on the vehicle and his movements in and around the vehicle that evening;
- the failure to obtain witness statements from all attendees at the time of the incident;
- failure to take internal photographs of the blue Suzuki Escudo;
- no information on file regarding the deceased's property seized including the tent;
- the failure to seek assistance when this incident grew beyond the capacity of the attending officer in charge;

- communication at an early stage the matter was an accident prior to the facts being established. This caused anguish to all parties involved.

COMMENTS OF CORONER TETITAHA

I. I make the following comments pursuant to section 57A of the Coroners Act 2006:

II. I am concerned about the sufficiency of the Police investigation into this death. There was no serious crash unit (SCU) report completed. This would have provided transparency regarding the circumstances that have led to this death and how similar deaths may be prevented in future.

III. I am aware that the SCU usually produces traffic accident reports relating to motor vehicle crashes upon public roads. However, their unique skills would have been of great assistance on this file.

IV. This was a matter that allowed Police to seize the motor vehicle for the purposes of further investigation. Section 123 Land Transport Act 1998 sets out the Police powers to seize a motor vehicle following a "serious traffic accident" which is defined therein as:

> ***serious traffic accident*** means an accident involving a vehicle that results in an injury to or the death of a person.

V. The legislation indicates any death involving a motor vehicle that results in injury or death should be investigated and the Police SCU is the appropriate vehicle for investigation and completion of a report. If the SCU had investigated at the time, the Coroner might have been able to make specific findings regarding the circumstances of this death.

VI. It is unknown if this is a nationwide or regional issue. Accordingly these comments are directed to the Northland Area Commander, Commissioner of Police and the Minister of Police.

RECOMMENDATIONS OF CORONER TETITAHA

I. I make the following recommendations pursuant to section 57A of the Coroners Act 2006:

II. New Zealand Police consider instructing the Serious Crash Unit to consider producing reports into all deaths involving a vehicle whether on public roads or private property.

III. New Zealand Police have provided a reply. The Police have made amendments to their traffic crashes policy to address the issues raised in these findings. The Police will now require an SCU analyst to attend any death on a private property (i.e. off-road) that has been caused by or involves a motor vehicle.

IV. The role of the SCU analyst will be to assist other policing staff to provide SME advice, such as determining evidence collection, reconstruction, and vehicle inspection considerations. The SCU analyst can also assist with determining whether other specialist such as the commercial vehicle safety team, should attend the crash in the event of possible health and safety at work act breaches.

V. These changes to the policy will come into effect on 1 May 2022.

VI. New Zealand Police are thanked for the reply.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photos taken of Ms Roys during this inquiry, in the interests of decency.

Young-Wardrop [2022] NZCorC 131 (15 September 2022)

CIRCUMSTANCES

Billie-Jean Della Young-Wardrop, aged 20, died on 16 June 2021 on State Highway 12 at Mamaranui from injuries caused by a motor vehicle accident.

On 16 June 2021, Ms Young-Wardrop was driving her car from Dargaville towards her home along State Highway 12. She lost control of her vehicle while rounding an easy right-hand bend. Her car rotated clockwise across the road, crossing the centre line, then hit a tree stump on the side of the road. The car continued on, before crashing into an electric fence separating a paddock from the side of the road where it caught fire. Ms Young-Wardrop died on impact. She held a learner's licence and was not permitted to drive alone.

Toxicology analysis established the presence of alcohol and cannabis. The level of alcohol in Ms Young-Wardrop's blood was 195mg/100ml. For comparison purposes, the legal blood alcohol limit for a New Zealand driver aged 20 years or older is 50mg/100mL.

The Serious Crash Unit investigated the crash and identified the right hand bend in the road was not marked by any chevron signage. However, Ms Young-Wardrop ought to have been familiar with this road as she would have to drive it frequently. It is possible that her level of intoxication may have resulted in her not being sufficiently aware of her surroundings and misjudging the degree of turn she had to make to successfully navigate the bend.

RECOMMENDATIONS OF CORONER HO

I. Drivers who drive under the influence of alcohol or other substances pose a fatal risk not only to themselves but also to other road users. This is why there are laws around drink and drug driving. I consider that these laws are sufficiently well known such that no further recommendation on these topics need be made under s 57A.

II. Although I have found that the primary cause of the crash was Billie's intoxication, it is possible that chevron signage might have alerted Billie to the upcoming curve and the need to slow down. Further, while it appears obvious during the day that the road bends to the right at that location, obviating the need for chevron signage, such signage would likely assist drivers at night or in other circumstances of impaired visibility. Greater forewarning can only improve safety for all road users by reducing the chances of accidents and fatalities.

III. Waka Kotahi New Zealand Transport Agency was notified pursuant to s 57B of my intention to recommend the installation of chevron signage at the curve where Billie crashed. It responded on 7 September 2022. It advised that the section of highway had recently been resealed and the centreline and edgeline rumble strips had been refreshed. However, it recognised that the road shoulders were narrow and provided little opportunity for drivers to correct their course if they were at the limits of their control. It acknowledged that a

more detailed assessment, including potential installation of chevron signage and associated advisory speed for the curve, was appropriate.

IV. I formalise my recommendation to Waka Kotahi that it install chevron signage at this location.

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

Self-Inflicted

Farrow [2022] NZCorC 123 (31 August 2022)

CIRCUMSTANCES

Michael Farrow, aged 54, died on 9 September 2018 at Auckland in circumstances amounting to suicide.

Michael had a history of depression and had been under the care of a private psychiatrist. Prior to his death he had been experiencing difficulties at work and was drinking heavily.

On 8 September 2018, at around 11:35pm, Michael was found by a member of the public attempting to end his life. He was intoxicated and disorientated, and was taken by ambulance to North Shore Hospital. The Emergency Department's (ED) initial triage assessment noted Michael to have "alcohol on board".

At approximately 12:33am on 9 September 2018 Michael was placed in a cubicle where he could be observed closely from the nursing station and was assisted to change into a hospital gown. His clothes were placed into a hospital property bag, which was left in the cubicle with him. Michael was assessed several times by nurses while waiting to be seen by a doctor. He admitted that he had tried to end his life, but repeatedly denied he still wanted to do so. The nurses did not therefore regard Michael as being suicidal at this time. When asked to provide an emergency contact, Michael refused to let nurses call his wife.

Unbeknown to the staff, Michael walked out of the hospital at 2:23am, having asked to visit the toilet. He was noted to be missing, as was his clothes bag, between 2:25 and 2:30am. The toilet and surrounding areas were checked but without success. Assistance was requested from the hospital security team, but they were unable to assist as they were attending another incident.

Michael's body was located by a member of the public just after 9:00am. Toxicology testing carried out post mortem revealed that Michael had a blood alcohol level almost four times the legal limit.

Waitematā District Health Board (now Te Whatu Ora / Health New Zealand Waitematā) conducted a serious incident review and implemented changes in response to Michael's death. Some of the implemented changes included developing a checklist and assessment form for self-harm patients presenting to the ED; ensuring patient property is removed from the cubicle on admission; ensuring that security guards based in ED are to remain in ED; and instruction to Mental Health Services and the ED to establish a process for monitoring and escalation in the ED.

The review also led to implementing a new model for providing acute mental health care within the North Shore Hospital ED, to ensure there are dedicated acute mental health clinicians working in the hospital, 24 hours a day, 7 days a week. Additionally, a “bundle of care” was developed to standardise the assessment for all patients with self-harm behaviour or ideation who present to the ED. The bundle covers identification of safety issues and situations where the need for a “watch” should be considered, and requirements around initial nursing assessments and checking of patient belongings.

RECOMMENDATIONS OF CORONER ANDERSON

I. I consider that alcohol was a factor in Michael’s death and that acute alcohol consumption contributed to the actions that he took on 9 September 2018. As such, I consider it appropriate to highlight the recent research establishing that acute alcohol use is a significant modifiable risk factor for a substantial group of suicide deaths in New Zealand and that acute alcohol use has a strong, persistent, and longstanding association with suicide.

II. In relation to Michael’s departure from the North Shore Hospital Emergency Department, I note the steps taken by the hospital since 2018 to improve access to mental health services for patients presenting to the Emergency Department; to improve practices around observation of patients and to respond more consistently to episodes of behavioural disturbances and self-harm.

III. However, I have formed the view that further steps are required. I have identified several areas that require attention in order to reduce the chance of future deaths occurring in similar circumstances. I have notified Te Whatu Ora Waitematā of my intention to make formal recommendations regarding these matters, as I am required to do under s 57A of the Act.

IV. I recommend that Te Whatu Ora Waitematā:

a. Continue to take steps to improve the timeliness and quality of urgent physical and mental health assessments of patients presenting to the North Shore Emergency Department following attempted self-harm;

b. Ensure that Emergency Department staff are aware of the association between acute alcohol consumption, impulsivity and suicide and that these risks are taken into account when decisions are made about whether to assign watches to individual patients;

c. Review its current policies and protocols for contacting family members or other support people when a patient who has self-harmed presents to the Emergency Department and considers whether any changes are required.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, 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 photographs of Michael entered into evidence, in the interests of personal privacy and decency.

Howearth [2022] NZCorC 110 (29 July 2022)

CIRCUMSTANCES

Carlos Were Howearth, aged 28, died on 6 November 2018 at Mangere, Auckland. His death was self-inflicted in circumstances amounting to suicide.

Mr Howearth was diagnosed with chronic polysubstance abuse and antisocial personality traits and had a history of depression for which he had been prescribed an antidepressant. The evidence shows he was not taking his medication. One of the reasons might have been his inability to collect the medications when required from his pharmacy due to finances, distance, lack of transport and opening hours.

When Mr Howearth was non-compliant with his medications, he suffered low mood and suicidal ideation. His inability to access this medication was a known contributor to his non-compliance. When he was medically compliant, this prevented low mood and reduced risks of suicidality.

COMMENTS OF CORONER TETITAHA

I. I make the following comments and recommendations pursuant to section 57A of the Coroners Act 2006, for the purposes set out in section 4.

II. When investigating the circumstances leading to a suspected suicide, identification of stressors preceding a death may indicate areas for improvement to prevent similar deaths occurring in future. This can form the basis for comments and/or recommendations to organisations to consider future preventative action.

III. The evidence in this case confirms the continuing links between medical non-compliance and suspected suicides. This gives rise to the need to consider making comments about this stressor and whether recommendations could be made for the purposes set out in s57A Coroners Act 2006 within my findings.

IV. The evidence gives rise to the circumstances leading to medication non-compliance due to lack of transportation.

V. A study of patients discharged from the Counties Manukau District Health Board (CMDHB) emergency department found patients aged between 10 and 24 years of age of Māori ethnicity, unemployed and cigarette smokers exhibited poorer primary medication adherence compared with other groups.

VI. The study noted access to a pharmacy remains a significant barrier to filling a prescription for many patients, and the costs of travel may compete with other demands, leading to non-adherence with possible worsening of the condition and/or readmission. Where an onsite pharmacy has been available at an ED, adherence rates were shown to be substantially higher, justifiably arguing the need for the provision of late-night pharmacies in areas where accessibility and cost are barriers for patients.

VII. The Ministry of Health has previously advised that it is undertaking work on the safer person-centred prescribing and dispensing work. This may indicate a need to review the accessibility of pharmacies including their locations in economically deprived areas and ability to provide an afterhours service.

VIII. I had directed these comments to the Ministry of Health and seeking its views regarding a recommendation for evaluating their current after-hours service provision and determining the best approach for delivering after-hours primary care to consumers in their region.

IX. The Ministry of Health had provided a written reply. However they have recently been replaced by Te Whatu Ora who have provided their own reply below.

X. Te Whatu Ora has recently replaced District Health Boards and has taken over the management of pharmacies from the Ministry of Health. It has provided a reply.

> It is noted that Auckland and Counties Manukau districts have already contracted with a sufficient number of pharmacies to provide after-hours pharmacy services to 95% of the population within a travel time of 60 minutes.
>
> It is unfortunate that Mr Howearth did not manage to contact pharmacy the next day when they were open on Monday, 5 November 2018 or on Tuesday, 6 November 2018 to arrange for olanzapine repeats to be dispensed. Te Whatu Ora notes that some pharmacies are already offering safe, contactless home medicines deliveries for the patients either free of charge or for a small fee.

XI. Te Whatu Ora has committed to reviewing the accessibility of pharmacies including the locations in economically deprived areas and their ability to provide an after-hours service “as part of future locality planning and commissioning.” This shall take “some time to get up and running”.

XII. In respect of the recommendation to consider funding online pharmacies to provide the home delivery of medications, Te Whatu Ora notes the current telehealth pharmacies are “for those who have elected to utilise those pharmacies” and it is inappropriate for Te Whatu Ora to recommend specific providers as it is the patient’s choice to choose the preferred service provider as outlined in the code of Health and Disability Services consumers rights.

XIII. The Ministry of Health and Te Whatu Ora are thanked for their replies. I infer from both the Ministry and Te Whatu Ora’s replies that they allow pharmacies to determine when and where to offer after hours service or contactless home delivery without reference to the needs of persons such as Mr Howearth. It is expected persons such as Mr Howearth have the ability to search and find an afterhours pharmacy within a reasonable distance of their homes.

XIV. There is no evidence the pharmacy Mr Howearth attended or any of the pharmacies within a reasonable distance from his home provide contactless home medicine delivery “free of charge” or for a small fee that persons such as Mr Howearth could afford. Even if one pharmacy did offer these services, there is no obvious way Mr Howearth could have discovered this.

XV. One of the stresses in Mr Howearth’s life was medical non-compliance and its effects upon his mental health and wellbeing. Te Whatu Ora could ensure similar persons to Mr Howearth living in economically deprived areas have access to free home delivery of medication. If this stress could be addressed, similar deaths may be prevented.

XVI. Te Whatu Ora could take steps with its funding process to ensure pharmacies provide afterhours and free contactless home delivery for medically non-compliant patients.

RECOMMENDATIONS OF CORONER TETITAHA

I. Having considered the above replies, I have determined that there is a need to make a recommendation pursuant to section 57A of the Crimes Act 2006 as follows:

II. Te Whatu Ora review the funding and improving access to medications by patients who have exhibited historic medical non-compliance. Options such as funding pharmacies that provide free home delivery of medications could be explored.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Mr Howearth during this inquiry, in the interests of decency.

Hussey [2022] NZCorC 125 (2 September 2022)

CIRCUMSTANCES

Kori Wharehuihuinga Hussey, aged 32, died between 10 and 11 January 2019 in circumstances amounting to suicide.

Toxicology testing identified the presence of alcohol in Mr Hussey's blood, as well as methamphetamine and paliperidone (an antipsychotic).

Ms Hussey lived in Whangārei. She had a stressful and challenging life, and was known to abuse alcohol and illicit drugs, which led to interactions with mental health and addiction services. She had also been admitted to acute mental health units in Whangārei and Counties Manukau District Health Board in 2017 as a result of using methamphetamine.

Although Ms Hussey successfully completed a detoxification program in May 2017, she disengaged from mental health services and presented again a few months later as acutely psychotic after using amphetamine. Ms Hussey continued to refuse to engage with mental health services and was discharged in March 2018. It was noted that she moved from Rawene to Whangārei during this period.

COMMENTS OF CORONER TETITAHA

I. I have reviewed this file and wish to make comments pursuant to section 57A of the Coroners Act 2006.

II. There have been concerns raised about the mental health care Ms Hussey received prior to her death. Ms Hussey was itinerant, moving between several mental health service providers within the Tāmaki Makaurau and Te Tai Tokerau areas. As a consequence, her health care had to be transferred between multiple community-based providers. Her access to consistent health care was dependent upon these providers efficiently and effectively ensuring her care transferred whenever she relocated.

III. A report from the Northland District Health Board notes concerns about the management of the transfer of between the mid-north and Whangārei districts within Te Tai Tokerau and the effect upon the standard of health care she received. These concerns are detailed below:

> Despite clients key worker in Whangārei being a community mental health nurse (last entry 29/10/2017) no indication is found that a community mental health nurse (CMHN) was allocated/involved when transferred mid-North.
>
> The reason for this is unclear as the "client allocation to key worker representation" document dated 1/11/17 clearly captured the words "working diagnosis of schizophrenia on a background of illicit use of methamphetamine and alcohol".
>
> Furthermore the psychiatrist (from Whangārei) letter dated August 2017 clearly outlines the rationale of ongoing use of antipsychotic medication, albeit in a small doses.

IV. The above comments indicate a lack of communication between Whangānui and Mid-North mental health services with regards to Ms Hussey's ongoing care under a community mental health nurse. Her last noted contact with an alcohol and drug clinician was on 13 December 2017.

V. The Northland District Health Board has now provided a serious event analysis report (SEA report). The SEA report notes:

> The absence of clear accountabilities and responsibilities orientation, educational workforce and case supervision and new service set up lead to ineffective support and guidance for staff regarding case management and transfer of care processes increasing the likelihood of the client not receiving care on relocation.

VI. The report recommends:

> When a new regional service commence[s] there are clear accountabilities between coordination roles and local team leaders regarding the orientation of newly appointed staff members.

VII. Ms Hussey's long-term addictions and resulting psychosis required a care plan monitored by one lead provider. It was imperative for her well-being to have had a high level of communication between mental health providers. This may have ensured a better follow-up and engagement by Ms Hussey with an alcohol and drug clinician post 13 December 2017. Given her toxicology results, medical assistance with her drug and alcohol abuse may have prevented this death.

VIII. If Ms Hussey had been properly monitored by mental health services, her ongoing addictions may have been better managed. This could have prevented her death.

IX. This case highlights defects in the communication between Whangārei and Mid-North community mental health services. There appear to be a lack of protocols regarding the transfer of patients between Whangārei and Mid-North community mental health services. There does not appear to be any oversight including monitoring and auditing of patient files upon transfer.

X. These comments are directed to the new Health Authority, Te Whatu Ora.

RECOMMENDATIONS OF CORONER TETITAHA

I. I make the following recommendations pursuant to section 57A of the Coroners Act 2006:

II. Te Whatu Ora consider reviewing the communication and process for the transfer of patients between Whangārei and mid-North community mental health services including completion of a transfer plan, monitoring and auditing of patient files.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may, unless the person is granted an exemption under section 71A or has permission under section 72, to make public the matters referred to in section 71(2). An order under section 74 of the Coroners Act 2006 prohibits publication of any photographs taken of Ms Hussey during this inquiry, in the interests of decency.

Hutchins [2022] NZCorC 98 (5 July 2022)

CIRCUMSTANCES

Jade Reuben Caipilli Hutchins, aged 42, died on 6 December 2020 at Whakatāne in circumstances amounting to suicide.

Jade suffered from low mood, depression, and alcohol abuse for many years, much of which was due to his childhood circumstances. Jade had expressed thoughts of suicide to his family on various occasions. Although he never sought professional mental health support for his conditions, he was well loved and supported by his family.

On 6 December 2020, Jade contacted various family members expressing thoughts of suicide. During the conversations he accepted that he needed professional help and was reassured by his family that he would be supported through the process of receiving mental health support. Following his final phone call with his sister, Jade disabled his social media account and ceased any further contact with his family. That evening, Jade's family reported him as missing to the Police and an extensive search and rescue operation was conducted for several days. Jade body was eventually found at a local park in Whakatāne on 13 December 2020.

COMMENTS OF CORONER ROBB

I. I do not make, nor intend to imply any criticism of anyone who Jade had direct contact with and to whom Jade made threats about suicide. As noted above, these were comments that were made often and over a long period, but not acted upon. Again, as noted above, Jade was well loved and well supported by his whānau who did everything in their power to help him with the impact that his childhood had on his mental health, and his resultant significant personal troubles. For the benefit of others who may struggle with thoughts of self-harm I provide a reminder about the Ministry of Health advice for anyone who becomes aware of suicide threats being made.

II. The Ministry of Health website provides the following information:[22]

> **If you're worried someone may be suicidal**
>
> If you are worried that someone is suicidal, ask them. It could save their life.
>
> **If they need urgent help**
>
> If someone has attempted suicide or you're worried about their immediate safety, do the following.

[22] https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal#urgenthelp

- **Call your local mental health crisis assessment team or go with them to the emergency department (ED) at your nearest hospital.**
- If they are an immediate physical danger to themselves or others, call 111.
- Remain with them and help them to stay safe until support arrives.
- Try to stay calm and let them know you care.
- Keep them talking: listen and ask questions without judging.

If you think someone is at risk

Ask them – it could save their life

Asking about suicide will not put the thought in their head.

Ask them directly about their thoughts of suicide and what they are planning. If they have a specific plan, they need help right away.

Ask them if they would like to talk about what's going on for them with you or someone else. They might not want to open up straight away, but letting them know you are there for them is a big help.

Listen and don't judge. Take them seriously and let them know you care.

Help them find support

Help them to find and access the support they need from people they trust: friends, family, spiritual, community or cultural leaders, or professionals.

Don't leave them alone – make sure someone stays with them until they get help.

Support them to access professional help, like a doctor or counsellor, as soon as possible. Offer to help them make an appointment, and go with them if you can.

If they don't get the help they need the first time, keep trying. Ask them if they would like your help explaining what they need to a professional.

How to be supportive

Be gentle and compassionate with them. Don't judge them – even if you can't understand why they are feeling this way, accept that they are.

Try to stay calm, positive and hopeful that things can get better.

You don't need to have all the answers, or to offer advice. The best thing you can do is be there to really listen to them.

Let them talk about their thoughts of suicide – avoiding the topic does not help. Ask them if they've felt this way before, and what they did to cope or get through it. They might already know what could help them.

Do not agree to keep secrets about their suicidal thoughts or plans. It's okay to tell someone else so that you can keep them safe.

Don't pressure them to talk to you. They might not want to talk, or they might feel more comfortable talking to someone who is not as close to them.

Don't try to handle the situation by yourself. Seek support from professionals, and from other people they trust including family, whānau or friends.

Services that offer more information and support

Listed on the Ministry of Health website. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated.

III. I do not make any further comments or recommendations pursuant to section 57(3) of the Coroners Act 2006.

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

Reweti [2022] NZCorC 127 (12 September 2022)

CIRCUMSTANCES

Rangiora Tieka Reweti, aged 18, died at Temuka on 17 August 2021 in circumstances amounting to suicide.

Rangiora was of Tūwharetoa descent and was living with her girlfriend in Temuka at the time of her death. She grew up in Timaru and had seven siblings. Rangiora's parents' marriage ended in 2020 and her father died in circumstances amounting to suicide in July of that same year. Rangiora's mother entered into a volatile and violent relationship with another man.

Oranga Tamariki provided a report about its interactions with Rangiora, which showed she first met with their staff on 17 November 2020. A plan was made which included counselling for grief, loss and trauma for "all the children", and then family harm education for the "adult children". Oranga Tamariki followed up with Rangiora several times, including a review ten days later where it was agreed Rangiora would get social work support to help her find a job. Rangiora met with a social worker on 21 December 2020. On 5 January 2021 the social worker contacted Rangiora who was away at the time, and encouraged her to make contact upon her return. There is no evidence that any further contact occurred.

Oranga Tamariki completed its Tuituia assessment on 3 March 2021, noting that the whānau could meet Rangiora's needs and Oranga Tamariki could close the case. A review hui-ā-whānau was held on 22 April 2021 and it was recorded that Rangiora was still looking for work and living with her partner.

Prior to her death Rangiora would make comments to her girlfriend about killing herself. She would also self-harm. Following Rangiora's death, Oranga Tamariki reported to the Coroner that it had no records of any assessments regarding Rangiora's wellbeing or suicide risk. It also had no records that counselling had been facilitated for Rangiora, despite the plan to do so.

RECOMMENDATIONS OF CORONER CUNNINGHAME

I. The outcome for Rangiora may well have been different if she had received targeted support. Oranga Tamariki recognised this need, and yet Rangiora slipped through the cracks.

II. I determined that it is appropriate for recommendations to be made to the Oranga Tamariki's staff which worked with Rangiora, with the hope that a review of its practices will result in more robust support being offered to bereaved teenagers who Oranga Tamariki is working with. Further mental health and counselling support to these vulnerable young people will help reduce the chance of further deaths occurring in similar circumstances.

III. In accordance with s 57B of the Act, I advised Oranga Tamariki's Aoraki office that I proposed making the following recommendations:

   a. That staff review their practices for referring young people to counselling.

   b. That where a plan for referring young people to counselling after a hui-a-whānau or similar is made, staff document the steps they take to engage a counsellor, or alternatively clearly document the reasons why a counsellor is not engaged.

c. That when a young person fails to make contact with staff as previously arranged, staff take active steps to contact the young person and record these steps, and that if they decide to cease follow-up, that they record their decision and the reasons for it.

IV. Oranga Tamariki responded, advising that it accepts the recommendations, and that its Te Kakahu o Aoraki site has developed the following plan:

a. Practice Leaders of Te Kakahu o Aoraki team will present a training session for kaimahi about counselling services in the area. Local providers will be invited to meet with the team, discuss their service, referral process and methodology for therapeutic interventions. This is to be completed by 2 November 2022.

b. All counselling referrals will be discussed in supervision between the social workers and their supervisors. A plan, including the timeframe for referral, will be uploaded onto CYRAS (online case management system), the social worker will follow up and complete all referral tasks. Supervisors will ensure the young person is discussed at next supervision session (within one month) and ensure all identified tasks have been completed.

c. Social workers will refer the young person to Towards Wellbeing[23] for monitoring and follow up on any recommendations that are suggested by Towards Wellbeing clinicians.

d. Practice Leaders will invite a Towards Wellbeing clinician on site to talk about their service, the supports available and their referral processes. This is to be completed by 2 November 2022

e. The Practice Leader is to review the referral mechanism for Hui-ā-Whānau and allocation of responsibilities for recording and updating CYRAS records.

f. The practice leader and Kairaranga-ā-Whānau are developing a training session about Hui-ā-Whānau processes and expectations; this training will be completed by 14 October 2022.

g. All social work staff will be expected to attend the training sessions noted. These sessions will serve as a reminder for staff about the importance of follow up and follow through with young people and to record actions taken.

h. By 5 October 2022, the practice leader will facilitate a session, with all supervisors to highlight the expectation they monitor social worker practice plans when working with young people. These plans will be reviewed monthly to ensure this work is planned, had completion dates, are reviewed, and followed up in supervision. All Staff will be expected to case note progress, on CYRAS, of plans from Hui ā-Whānau and any contact they have with young people.

[23] The Towards Wellbeing suicide prevention programme is delivered by Clinical Advisory Services Aotearoa to support social workers working with mokopuna who are experiencing suicidal ideation or have attempted suicide. Support is provided by Towards Wellbeing clinical advisors (clinical psychologists and mental health social workers) with expertise in the field of prevention of youth suicide.

i. All staff will be reminded of the Practice Standard "Keep Accurate Records"[24] and the importance of ensuring CYRAS case notes are up to date, and record analysis of decision making, actions taken and follow up required. This training session will be completed by the practice leader by 30 September 2022.

j. In situations where a change of social worker occurs there is an expectation that a case handover occurs. This should occur between the original social worker, the new social worker, and the supervisor. Any tasks that require action are to be clearly identified and recorded on CYRAS. Actions requiring follow up have clear time frames, and social workers will record dates and note in work calendar to ensure follow up occurs. The social worker will support and remind young people of their agreements, if situations change, they must ensure the changes and reasons why are recorded clearly in CYRAS case notes.

V. I thank Oranga Tamariki for its careful consideration of this matter, and for its proactive approach to implementing changes in Te Kakahu o Aoraki.

Note: Section 71 of the Coroners Act 2006 applies. Accordingly, no person may make public the method of death, or any detail that suggests the method of death. Pursuant to s 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 photographs that show Rangiora, in the interests of decency.

Sudden Unexpected Death in Infancy (SUDI)

Franklyn [2022] NZCorC 99 (11 July 2022)

CIRCUMSTANCES

Lincoln Caeser Hoani Franklyn, aged just over six months, died on 14 January 2021 at Opotiki of sudden unexplained death in infancy.

Lincoln was born at Waikato Hospital on 4 July 2020. He was the first born to his parents. Lincoln's mother smoked during her pregnancy and after his birth. She smoked heavily once she ceased breast feeding. Lincoln's father would also smoke inside the house.

Until he was three months old, Lincoln slept in a bassinet or Moses basket during the day. After that, he slept on a single mattress on the floor of the lounge. Although his parents were aware of the dangers of co-sleeping, Lincoln regularly slept with his father.

On 11 January 2020 Lincoln's father took Lincoln to stay with his parents in Opotiki. They stayed in a front room of the house which had a single bed. Lincoln shared this bed with his father.

[24] Keep accurate records – is an Oranga Tamariki Practice Standard. Social workers are required to document their key actions and decisions for each tamariki they work with, in order to ensure significant decisions are clearly evidences and transparent.

On the evening of 13 January 2021 Lincoln was put down to bed at about 9:00pm. His father went to sleep at around 11:00pm and Lincoln lay in his arms. The bedroom door was open, however, the window was closed. They were covered by a sheet and blanket.

At about 2:00am on 14 January 2020 Lincoln's father prepared a bottle for Lincoln then fed him. Lincoln drank 80 mL from the bottle, whereas he normally drank about 200 mL at that time of the morning. His father then attempted to 'wind' Lincoln without success. The two went back to sleep; Lincoln was lying on his back with his head cradled by his father.

Lincoln's father woke at 6am and discovered Lincoln was not breathing. He immediately started CPR and also sucked out what he described as vomit from Lincoln's nose. Lincoln was cold to the touch and despite his efforts, his father could not revive him.

RECOMMENDATIONS OF CORONER HESKETH

I. Coroners have made recommendations to various agencies in the past to ensure that the safe-sleep message is consistent between health professionals and community organisations to ensure it is appropriately given to new parents. As set out in a prior Coroner's decision[25] it is an important message as it is effective in preventing infant death.

II. The Ministry of Health guidelines were launched to reduce the sudden unexpected deaths of infants.[26] The guidelines key focus is to target the two key modifiable risks for SUDI: exposure to tobacco smoke during pregnancy (which includes the period following birth in the whānau/family, in the home and in the waka/car) and unsafe bed sharing (i.e. co-sleeping in the bed with baby).

III. The Ministry of Health; Needs Assessment Planning Guide offers conversations, questions, advice and care options before, during and after birth. The guide is designed to provide the easy to remember four steps framed around the acronym PEPE; the top four ways of preventing SUDI:[27]

   a. **Place** baby in their own baby bed in the same room as their parent or caregiver.

   b. **Eliminate** smoking in pregnancy and protect baby with a smoke-free family or whānau, whare (home) and waka (car).

   c. **Position** baby flat on their back to sleep – face clear of bedding.

   d. **Encourage** and support exclusive breast-feeding and gentle handling of baby.

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

[25] *Re Laraya-Amelia Ngatuakana* [2017] Coroners Court Auckland CSU-2017-AUK-1054, 27 February 2020.
[26] Ministry of Health – National SUDI Prevention Programme: National Safe Sleep Device Quality Specification Guidelines. Wellington: Ministry of Health -published 08 May 2019.
[27] Above note 26.

Workplace

Wohlers [2022] NZCorC 119 (23 August 2022)

CIRCUMSTANCES

Eric Graham Wohlers, aged 79, died on 11 September 2020 at 84 Carter Street, Te Kuiti from a severe head injury with associated crush injuries and blood loss.

Eric lived alone on a farm property. The farm's terrain consists of rolling hills and is steep in parts.

At about 8:30am on 12 September 2020 Eric's neighbour was doing stock work on his property when he saw Eric's tractor and bale buggy (a trailer used to feed hay and silage to farm stock) against the boundary fence. The neighbour approached the fence and saw Eric lying in the paddock nearby. It was apparent Eric was deceased.

Police attended and reported it had recently rained and the ground was sodden.

Waikato Serious Crash Unit (SCU) investigated and concluded that the crash occurred after Eric entered a steering input to the left in an attempt to drive out of the situation and regain control of the tractor and bale buggy by following the natural curve of the track downhill. This was noted to be a common technique used by rural machinery operators but increased the risk of a jack-knife or rollover when traversing a slope. The tractor and bale buggy jack-knifed and entered a roll. As Eric was not wearing a seatbelt he was ejected from the tractor. The SCU recommended that continuing education for rural employers and employees is provided on negotiating slopes while towing and to wear seatbelts on all rural machinery where it is available.

WorkSafe also investigated the incident and noted that the task Eric was performing was a common task of feeding out silage to stock. On any other day he may have completed it without incident, however as the ground was sodden and soft, it appears that as he applied the brakes, the tyres lost traction and slid. The only reasonably practicable action that Eric could have taken was to operate the tractor on flat terrain until the ground dried out. This was impractical if Eric had to move stock into another paddock when they required feeding.

WorkSafe investigators concluded that the weight of the bale buggy with the silage bale inside was sufficient to cause the tractor's tyres to slide in the soft ground when the brakes were applied, and pushed the rear of the tractor sideways, causing the tractor and bale buggy to jack-knife. The tractor then rolled, throwing Eric from the seat and onto the ground, where the tractor rolled on top of him.

WorkSafe reminded that towing heavy loads on a hilly countryside can lead to loss of control. In addition, it was noted that seatbelts are not compulsory on tractors, but it is recommended they are worn if fitted.

WorkSafe noted that this scenario was very similar to one that appeared in ACC's *Advanced Tractor Safety* book published in 1988. It stated that the best course of action in this scenario is to avoid using the brakes and to power out of the skid providing you have a straight run. Braking causes the operator to lose control particularly if the tractor is being pushed by a heavy load.

RECOMMENDATIONS ENDORSED BY CORONER DUNN

I. I endorse the recommendations and comments made by the SCU and WorkSafe and encourage continuing education for rural employers and employees be provided on negotiating slopes while towing. They should be reminded that towing heavy loads on hilly countryside can lead to loss of control. In addition, I remind operators to wear seatbelts on all rural machinery where it is available.

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

OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND