Office of the
CHIEF CORONER
New Zealand

Annual Report 2020/21

Kai Tirotiro Matewhawhati Rangatira o Aotearoa
Office of the Chief Coroner of New Zealand

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Ki te iwi Māori he tikanga nui tō te mate me te whakahemohemo. He taunga te whānau ki te tūpāpaku, ā, kei reira rātou mō te nuinga o ngā whakaritenga tae noa ki te nehunga. Ko te tiaki i te tūpāpaku, ko te tangi me te tuku kōrero ki a ia – puta ake ai ēnei hei whakaatu, ahakoa kua mate, ora tonu ai te wairua.

Death and dying are a central part of Māori life. The family have an intimate connection with the body of the deceased and are usually closely involved with the preparations leading up to the burial. Respect – in the form of caring for the tupāpaku, mourning the deceased and speaking to them – is shown because, although the physical remains of a person are lifeless, the spirits continues to live on.

New Zealand Law Commission, Coroners: A Review, Preliminary Paper No 36, Wellington, 1999, para 17.

INTRODUCTION

Welcome to the 2020-2021 Annual Report of the Chief Coroner

Tēnā koutou katoa,

The purpose of this Annual Report is to provide a summary of the mahi undertaken by coroners in the last financial year (2020/2021). This includes the ongoing receipt of reports of deaths and the subsequent investigations.

The financial year saw the arrival of COVID-19 in Aotearoa New Zealand. If a person dies from the effects of COVID-19, the death is treated as a death from natural causes (much like a death from influenza) and as such would not be reported to a coroner. However, if the cause of death is not known, or the death may have been caused by an adverse reaction to medication (such as a vaccine), a coroner will take jurisdiction and investigate the cause and circumstances of the death.

This report contains a summary of the provisional suicide statistics released by me every year. This year, the suicide rate decreased slightly from a rate of 11.8 deaths per 100,000 people, to 11.6 deaths per 100,000 people. Overall, the number decreased from 628 to 607.

The number of deaths reported to coroners has fallen slightly compared to last year, from 5,205 last year to 4,985 this financial year. Coroners took jurisdiction over 3,608 of these deaths.

I hope you find this Annual Report of interest. It contains a sample of the kinds of recommendations and comments coroners made during the year. This is an important aspect of a coroner's role, designed to prevent similar deaths occurring in the future. Further examples can be found in our recommendation recaps, which are published on the Ministry of Justice website.

coronialservices.justice.govt.nz/findings-and-recommendations/recommendations-recap

Nāku noa,

Judge D Marshall
Chief Coroner

CORONIAL SERVICES OF NEW ZEALAND

Purongo O te Ao Kakarauri

The New Zealand coronial bench comprises 25 coroners (17 full-time and 8 relief coroners) and one Chief Coroner. They are supported in their roles by the Ministry of Justice's Coronial Services Unit and operate throughout Aotearoa New Zealand.

The Chief Coroner's main function is to help ensure the integrity and effectiveness of the coronial system. This includes helping to achieve consistency in coronial decision-making and other coronial practices.

Coroners are independent judicial officers with a legal background who investigate sudden, unexplained or unnatural deaths. They are based throughout the country, with offices in Whangārei, Auckland, Hamilton, Rotorua, Hastings, Palmerston North, Wellington, Christchurch and Dunedin.

Coroner Erin Woolley

Auckland region

I have always been very interested in the role of a coroner, primarily because of the unique ability a coroner has to conduct investigations into a death and make recommendations to help prevent similar deaths.

In my view, the recommendatory function of a coroner provides a way to try and create something positive from what can be a very sad set of circumstances. This was my motivation to want to be a coroner — to try and contribute to public safety and wellbeing so that, where possible, preventable deaths do not occur.

The inquisitorial nature of coronial proceedings is an aspect of the job I am enthusiastic about. I see this as a real point of difference distinguishing the judicial office of a coroner from other judicial officers who adjudicate between the facts or legal arguments presented by the parties involved.

I believe this aspect of the role is well-suited to my curious mind. It also allows me to continue to be involved in court proceedings, which I enjoyed in my previous role as a Crown prosecutor, and I am looking forward to conducting my first inquest.

In my time so far in the role, I have enjoyed discovering the varied aspects my new position involves. From reviewing files during a receiving week and determining the direction of any further investigations to be made, to duty work, which is somewhat like being the prosecutor in the list court in that you move quickly from one matter to the next.

I enjoy the change of pace that duty work brings, and the ability to discuss matters in real time with medical specialists, family members and the Police.

I have also discovered there is great variety within the files themselves; one file is never like the next, and each has its own characteristics. I am excited to learn more about our health system through this role, and to broaden my knowledge of medical terms.

Another aspect of the coroner's role I am very much enjoying is the ability to work flexibly. I believe this is a fantastic benefit of the position and again, a point of difference from other judicial roles.

So far, I am greatly enjoying being a coroner and am looking forward to refining my skills in this role in the years ahead.

Coroner Alexander Ho

Auckland region

Unlike many of the other coroners, I was not born in this country, although I moved here at a young age and had the privilege of a New Zealand upbringing and education. After completing my BCom/LLB(Hons) degrees at the University of Auckland and working in private practice, I followed the well-worn path of other young Kiwis overseas – in my case, first to New York University as a Fulbright scholar and then on to London. I like to say that the Fulbright scholarship board showed great foresight in their selections that year. Not because of any self-congratulation or aggrandization on my part, but because the other lawyer they selected to study at NYU is now my wife!

After returning to New Zealand, I spent more time working in litigation in private practice before taking up my coronial appointment in 2021. Why the shift? In some ways the two jobs are not that different. Both present a varied mix of files, for example. In private practice I dealt with ships, planes and trucks; houses, malls and mines; buildings, plumbing and earthquakes. As a coroner, I deal with car crashes, drownings, and deaths in hospital; deaths of infants, teenagers and grandparents; from accidents, self-inflicted deaths and natural causes.

Coroners are tasked with determining the causes and circumstances of a death. The privilege of being able to examine someone's life is a weighty one, but there is a sense of professional accomplishment in knowing that you are playing a part in bringing closure and (hopefully) answering the questions of those left behind.

There is also an element of public good in the role of a coroner. Not only because of the inherent nature of the position, but because a coroner has the ability to make recommendations or comments that can help prevent similar deaths from occurring. That was one of the key factors that attracted me to the role.

In the brief time since taking up my appointment, I have already identified examples of processes that did not work as they should or opportunities for improvement by public agencies. I do not intend to shy away from making recommendations, because it is only by speaking for the dead that we can protect the living.

The varied nature of the role is also professionally satisfying. The role of coroner encompasses many different duties: Authorising post mortems and the release of bodies; considering the investigations that need to be made and information obtained about deaths; and writing findings. In this, I am fortunate to have the assistance and colleagueship of 25 other highly qualified and motivated coroners. In last year's Annual Report, a coroner described the role as one requiring "integrity, intelligence, empathy, dedication and professionalism". It is

difficult to find a better description of the various traits we need to bring to the role in order to ably discharge it.

Beneath the cover of each coronial file we pick up there is a human story of someone's parent, child, sibling or friend. I hope each is a story that is done justice under my care.

THE FIRST 48 HOURS

The National Initial Investigation Office (NIIO) is the initial point of contact when deaths are referred to the coroner. NIIO is a 24-hour service providing support to the duty coroner, who is drawn from the Coroners Court in a rotational weekly roster.

The NIIO team comprises 17 full-time staff who coordinate the 'first 48 hours' of the coronial process, delivering support services that encompass:

- initial reporting of a deceased person (tūpāpaku) by a doctor, hospital or the Police, for example
- arranging for the collection, holding, viewing and transporting of a body, as well as the coordination of a post mortem, if directed by a coroner
- release of the deceased's body to their family.

NIIO staff liaise with the families to explain the process and update them and all others involved in the process with information. The aim is to support families and minimise the stresses inherent in the process by providing an effective, efficient service, while also supporting and providing appropriate information to enable the coroner to make informed and timely decisions.
NIIO collects, collates and records the initial information and findings for the progression of a case to a coroner based at a regional office with a Coronial Service Unit supporting them.

PROFILE: JAMES HORSBURGH

- Senior Coordinator, National Initial Investigation Office (NIIO)

Initially I was completely unaware of the position's existence. Once I found the job role it was clear it was something where I would have the ability to help people having a tough, traumatic time. I've always wanted to work in a place where I can help people, and this seemed like a good fit.

Empathy is a key skill you need in this role, as you are dealing with people going through a traumatic period. Time management and multi-tasking skills are very important with the high workload that we work through on a daily basis. It is also important to have fast typing hands.

To start the day, we review all the files from the previous night. Once the duty coroner has made a decision, we call families to arrange actioning of their directions, i.e. a pathologist to conduct a post mortem, or calling GPs to see if we can get sign-offs on death certificates. As the day progresses, we handle results of the post mortems, arrange release of bodies, and advise families of the release and results from post mortems. Oftentimes, we are handling twenty or more cases in a small office, so it can be very busy.

It is often a somewhat traumatic experience talking to distraught family members, and a big part of our being able to get through that is just sharing these experiences with each other. Personally, I find humour is a great tool to help deal

with the challenges, and often there is a jovial mood throughout the office. This works to counteract the sad content of our work. We are also offered regular counselling, if needed.

NIIO is essential to the coronial system because we are the first point of contact. We play a large role in shaping how people view the coronial system, and we want to give them the best possible experience at such a traumatic time. From there, our coroners and regional office staff continue supporting families to give them the best experience possible. We are also dealing regularly with external stakeholders such as the Police, hospitals, and mortuary staff, and we place a lot of importance on maintaining good relationships to ensure we all continue working as a cohesive unit.

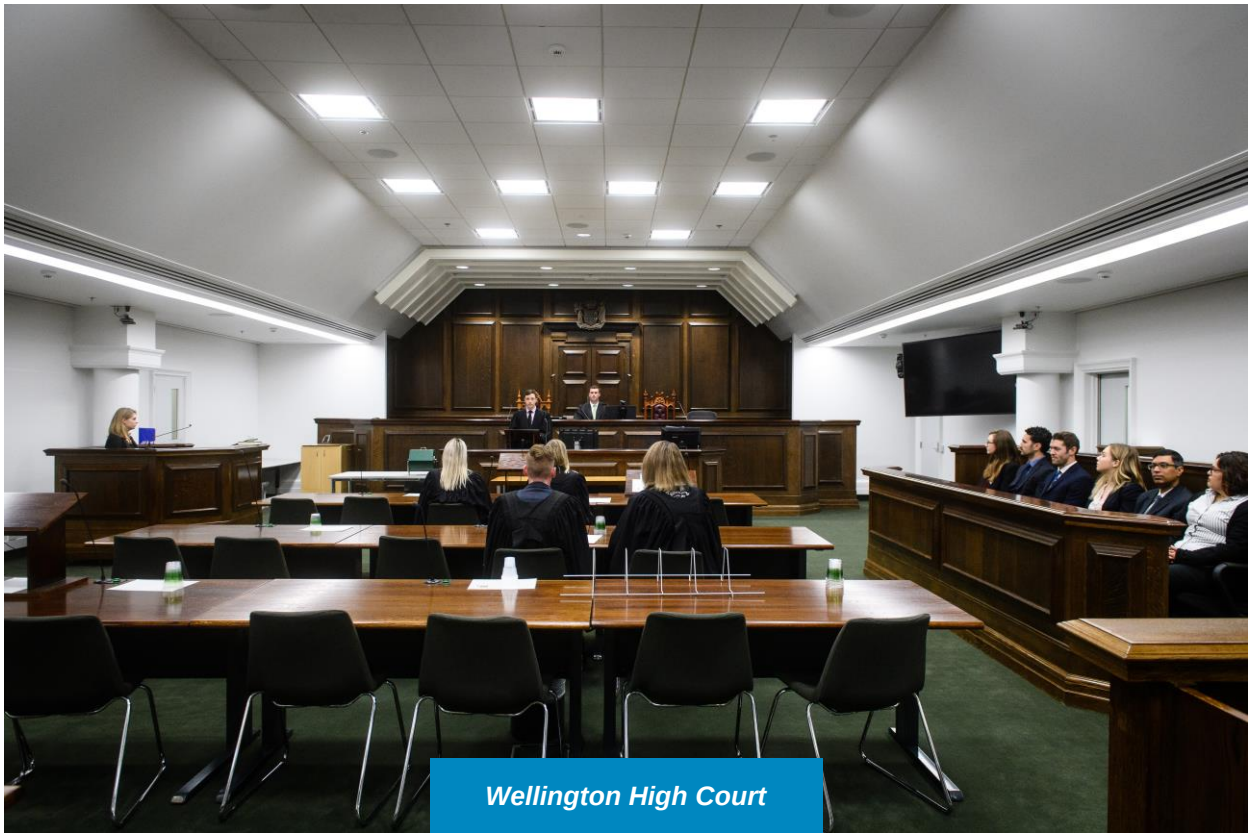
In 2020–2021 there was a decline in cases that were recorded and dealt with by NIIO, which can be attributed in part to events surrounding the Covid-19 pandemic. NIIO has remained fully operational throughout COVID-19 lockdowns and changes in designated Alert Levels.

Over the past year, a new manager was appointed, and two new senior coordinator positions were created and filled to better support daily operations.

In facing challenging events such as COVID-19, earthquakes, flooding and other such natural events that have an impact on how NIIO functions and operates, we continue to develop working practices that help ensure the ongoing operation of our 24-hour service. These practices include the ability to work remotely and in smaller groups, and the adoption of new systems, practices and technology.

JURISDICTION OF THE CORONER

The Coroners Court of New Zealand has jurisdiction under the Coroners Act 2006 (the Act) to investigate unexpected, unexplained or unnatural deaths, and to make recommendations or comments that may prevent further deaths in similar circumstances.



Wellington High Court

The coronial process is an inquisitorial, fact-finding jurisdiction that is informed by family/whānau concerns. Coroners have a statutory obligation to establish, where possible, the identity, causes and circumstances of reportable deaths, and to also make specific recommendations and comments to help reduce preventable deaths.

The Act also gives coroners the power to hold inquests, which is a hearing, normally held in court, for the coroner to investigate a death.

Reportable deaths

The coronial system in Aotearoa New Zealand is a 24-hour service, so there is always a coroner on duty to receive reports of deaths. About 5,700 deaths are reported to coroners every year, and coroners accept jurisdiction for around 3,600 of these deaths.

The Act states that a death must be reported if:

- the body is in Aotearoa New Zealand
- the death appears to have been without known cause, or self-inflicted, unnatural, or violent
- the death occurred during, or appears to have been the result of, a medical procedure and was medically unexpected
- the death occurred while the person concerned was affected by anaesthetic and was medically unexpected
- the death of a woman occurs while giving birth
- the death occurred in official custody or care
- the death is one to which no doctor has given a death certificate.

Coronial process

Once a death has been reported, the coroner decides whether to accept or decline jurisdiction. If a coroner accepts jurisdiction, they can open an inquiry or direct a pathologist to perform a preliminary inspection or post mortem.

A preliminary inspection can consist of an external visual examination of the body and/or the use of medical imaging. This helps to avoid unnecessary and costly post mortems. If a post mortem is needed, it can be either a full internal and external examination of the body, or a lesser examination. A pathologist often tries to perform the post mortem as soon as possible (usually the next working day), but in some cases it may take longer. Following the post mortem, the coroner decides whether to order further investigations, wait for the results of further investigations already under way, put the investigation on hold (due to other processes), or make their final findings about the death.

If an inquest is held, evidence is collected, and witnesses and experts are gathered to present their evidence to the coroner. During this process, the coroner and the immediate family/whānau can ask relevant questions. Written findings are issued after the inquest, and in some cases the coroner might make recommendations or comments to help prevent similar deaths in the future.

CORONIAL RECOMMENDATIONS OR COMMENTS

Coroners' findings can also contain recommendations or comments made by the coroner to help reduce the chances of further deaths occurring in similar circumstances.

The Act ensures that recommendations or comments are:

- linked to the factors that contributed to death
- based on evidence considered during the inquiry
- accompanied by an explanation of how recommendations or comments, if drawn to public attention, may reduce the chances of similar deaths occurring.

Coroners must also notify any person or organisation to whom the recommendations or comments are directed and allow them time to respond.

The Office of the Chief Coroner maintains a public register of coroners' recommendations and comments. This register is publicly available on the Coronial Services of New Zealand website (**coronialservices.justice.govt.nz**) and the New Zealand Legal Information Institute (NZLII) website (nzlii.org). In some cases, such as deaths by suicide, publication restrictions prevent the publication of the recommendations.

The following are some of the recommendations or comments made and responses received by coroners during the financial year.

John William Kronast

Date of death: 19/07/2019

Date of findings: 19 April 2021

Coroner Michael Robb

CIRCUMSTANCES

John William Kronast (61), of Ōpōtiki, died on 19 July 2019 from head injuries due to high energy impact sustained in a motor vehicle collision with a loaded trailer at Bridge 2886 State Highway 2, Kutarere, Waiotahe Valley.

Around 8:40am on 19 July 2019, John was the sole occupant of his vehicle travelling west on State Highway 2. At the same time, a member of the public was travelling eastbound along the same stretch of road towing a loaded trailer. As the vehicles approached each other on Bridge 2886, the trailer detached from the towing vehicle, crossed into John's path and collided with his vehicle. John died at the scene from the injuries he sustained.

An examination of the towing vehicle and trailer by the Police showed that the towing vehicle was fitted with a detachable tow bar assembly specifically designed to be used with that model of vehicle. The body of the tow bar assembly (referred to as the "Receiver") was welded and bolted

to the rear of the vehicle chassis. The Receiver had two flanges on either side. Each flange had a drilled hole in the centre where a safety chain could attach. The steel frame on which the tow ball was attached referred to as the “ball-mount”), would slide into the Receiver. The ball-mount was secured to the Receiver by a locking pin that fitted into a cross drilled hole of the Receiver and ball-mount. The ball-mount had been modified to include a hole in which a D-clamp could attach from a safety chain instead of onto one of the flanges of the Receiver.

At the scene, the Police observed that the ball-mount and tow-ball were still attached to the drawbar of the trailer by the safety chain, which was attached to the modified hole in the ball-mount. The ball-mount had slid out of the Receiver because the locking pin was missing. The Police could not locate the locking pin to assess whether it had failed or had been removed and not replaced.

SUMMARY OF RECOMMENDATIONS AND COMMENTS

Coroner Robb found that the primary cause of the collision was the ball-mount sliding out of the Receiver because there was no locking pin. A significant contributory cause to John's death was the inability of the safety chain to prevent the trailer from breaking free of the towing vehicle.

Accordingly, the collision highlights a concerning gap in the regulations governing light vehicle towing in New Zealand. Specifically:

- There is no requirement for the safety chain of a trailer to be connected to the chassis of the towing vehicle.
- That a vehicle with a removable towing assembly will comply with the Land Transport Rule Vehicle Standards Compliance 2002 Rule 35001/2002 ("LTA Rule"), even if the securing point for a safety chain is the removable ball-mount.

Coroner Robb made the following recommendations:

- To Waka Kotahi — consider a requirement that removable tow bar assemblies must have the safety chain securing point affixed to the chassis of the vehicle.

- To the Ministry of Transport — consider a requirement that towing vehicles must have a safety chain connected from the trailer load to the chassis of the towing vehicle.

RESPONSES

In accordance with section 57B of the Coroners Act, Waka Kotahi and the Ministry of Transport were provided with the opportunity to consider and respond to the proposed recommendations.

The response from Waka Kotahi included the following:

- Waka Kotahi accepts that a safety chain connected to the chassis or tow bar crossmember could have made a significant difference to the outcome of this incident. However, it is likely that there are other mechanical solutions that could result in a failsafe system.
- Waka Kotahi accepts that there are gaps within current regulations and will be working with other relevant agencies such as the Ministry of Transport to make improvements in this area.
- The VIRM manual does not outline specific technical requirements for vehicles identified in the relevant legislation, but rather provides what Waka Kotahi believes is the most appropriate and lawful interpretation of the land transport rules applicable to the inspection of an individual vehicle.

- Waka Kotahi agrees that the connection of a safety chain to a removable tongue does rely on the safety of the locking pin, assembly or mechanism. If this locking mechanism is not functional or unsafe then the towing system becomes unsafe. This is similar to any other mechanical component in the towing system, such as the drawbar, low tiedowns or the tow bar to chassis connections of the tow bar itself.
- With respect to the specific recommendations made, Waka Kotahi advised that these options have been considered in the past and deemed to be impractical on many vehicles, or unable to be implemented in a reasonable manner that had notable increases in safe outcomes.
- Waka Kotahi accepts that there are risks and opportunities for improved safety outcomes within the light towing sector, and a project team that has been established is currently investigating.

Coroner Robb acknowledged the responses from Waka Kotahi, which provide an acceptance that improvements in safety measures in this area are warranted and are presently being investigated.

With respect to light towing, Coroner Robb acknowledged that a failure of one or more mechanical components in a towing system can lead to the towing system becoming unsafe. However, the safety chain serves the purpose of providing an extra layer of safety. If the safety chain is not connected to the vehicle, independent of the removable tow bar assembly, this secondary anchor ceases to be effective when the tow bar assembly fails.

For that reason, the recommendations outlined above remain unchanged. However, Coroner Robb acknowledged that through its project team, Waka Kotahi may well identify improved safety outcomes by way of a different solution.

No response was received from the Ministry of Transport.

SECTION 74 NON-PUBLICATION ORDERS

- Photographs of the deceased taken during the investigation into his death, on the grounds that it is in the interests of decency and personal privacy.

Alannah Lee Spankie

Date of death: 21/06/2017

Date of findings: 30 July 2020

Coroner David Robinson

CIRCUMSTANCES

Alannah Lee Spankie (20) died in the Intensive Care Unit at Dunedin Hospital on 21 June 2017 of a massive hepatic necrosis, presenting as acute liver failure secondary to a paracetamol overdose. The manner of death was accidental.

RECOMMENDATIONS OF CORONER ROBINSON

Coroner Robinson recommended to the Chair of the Medicines Classification Committee that the following restrictions be implemented as to the quantities of paracetamol available for purchase in New Zealand:

- Pharmacy sales restricted to 16g per transaction (i.e. 32×500 mg tablets).
- All other outlets restricted to 8g per transaction (i.e. 16×500 mg tablets).
- A maximum of 50g (i.e. 100 x 500 mg tablets) by prescription.

Pursuant to section 57A(3)(c) Coroners Act 2006, Coroner Robinson considered that the implementation of the recommendation will reduce the likelihood of deaths in similar circumstances by restricting the availability of lethal quantities of paracetamol. Based on overseas research, this has been established to be effective in reducing fatalities occurring in impulsive overdoses.

RESPONSES

In accordance with section 57B of the Coroners Act, the Medicines Classification Committee was provided with the draft recommendations for a response. The response of the Committee included the following passages:

> *In 2016, the committee concluded that they were satisfied that overall, the benefit of access outweighed the risks and that the classification of paracetamol was appropriate. I am not aware of any new evidence in this area that would require the committee to reconsider the classification of paracetamol pack sizes.*
>
> *I would support your recommendation to limit the number of packs per transaction and would suggest that you engage with the Food and Grocery Council to encourage them to restrict the number of packs per transaction.*

Without detracting from his primary recommendation as to restrictions on the availability of paracetamol, Coroner Robinson recommended that the Food and Grocery Council endorse a voluntary limit of one packet containing not more than 10 grams, or in powder form in sachets containing 1 gram or less, and not more than 10 grams per customer per transaction.

Coroner Robinson recognised the variability of compliance with a voluntary code evident in UK research, and the fact that even ingestion of 10g of paracetamol is sufficient to require medical intervention.[1]

SECTION 74 NON-PUBLICATION ORDERS

- Photographs of the deceased taken by Police as evidence, on the grounds that it is in the interests of decency and personal privacy.

[1] N Freeman, Paul Quigley "Care vs convenience: Examining paracetamol overdose in New Zealand and harm reduction strategies through sale and supply" Vol 128 No 1424 NZMJ.

Lauren Kimiyo Worrell (Kimi)

Date of death: 19/08/2018

Date of findings: 30 September 2020

Coroner Michael Robb

CIRCUMSTANCES

Lauren Kimiyo Worrell (Kimi, 28), a United States citizen living in New Zealand, died at Castle Rock, Waiau in the Coromandel, on 19 August 2018 from multiple rib and skeletal fractures, crush injuries to lungs, lacerations of liver and spleen, multiple soft tissue injuries, head injuries and blood loss following a fall.

At 9:50am on 19 August 2018, Kimi was rock climbing with her boyfriend Richard Graham at Castle Rock. Kimi had approximately three years of climbing experience in both the United States and New Zealand. She had climbed Castle Rock before.

Kimi and Richard planned to climb the Archibald Baxter route, by first descending the Quiet Earth route. At the top of the Quiet Earth route, two bolts were drilled into the rock face. Hooked onto the bolts was a nylon rope that ran from the top bolt and down the five-metre ledge to the first rappelling station. As Richard was preparing his equipment at the top of the pinnacle, he saw Kimi four to five metres below him on the ledge about to go over the steepest part towards the rappelling station. She then appeared to slip, falling over the edge of the ledge and out of his view.

Two other climbers in the area reported hearing a noise above them that sounded like a rock tumbling from the top of the cliff, then hearing a “snap” or “pop”. On looking up, they saw Kimi falling through the air with a full length of rope which appeared to be coiled around her body. They made their way to Kimi finding that she had suffered significant injuries. She was unconscious but breathing. Some 10 minutes later her breathing ceased, CPR was attempted. However, this was unsuccessful, and she died at the scene.

Police examined the scene where Kimi fell and recovered a purple-coloured nylon rope and two anchor points. It was noted that the rope appeared to be weathered and fatigued. The lower end of the rope was frayed, indicating the possibility that it had snapped, and a further piece was missing. Evidence suggested that Kimi did not anchor herself to a secondary point using her own ropes at the summit of Castle Rock, but instead relied solely on the nylon rope attached to the rock face, which was severely structurally compromised from elemental exposure. As she descended the ledge, she slipped, causing her to fall downwards. While the loop attached to her harness should have prevented her from falling, due to the deteriorated state of the nylon rope, it snapped causing her to fall some 120 metres to her death.

The investigation noted that using a fixed-point nylon rope alone was not good climbing practice. Best practice is for climbers to use their own ropes to avoid the potential for single points of failure.

SUMMARY OF RECOMMENDATIONS AND COMMENTS

Coroner Robb found that Kimi’s death would have likely been prevented had she not used the purple nylon rope to descend the rock ledge. He also acknowledged that the risks associated with rock climbing are well known.

The New Zealand Alpine Club's (NZAC) Rock Climbing Access Framework (2017) states that recreational rock climbing is not regulated, and that it is a fundamental climbing tenet that every climber is responsible for their own actions and safety at all times.

NZAC encourages all climbers to:

- comply with all access rules and the NZAC Crag Code of Conduct
- acquire the necessary skills and knowledge to climb safely
- encourage other climbers to do likewise.

Furthermore, the NZAC's Climbing Access Framework states that there are no regulations governing the development of rock climb routes. Route developers who attach fixed anchor bolts into rock faces are described as individuals acting privately or as part of a climbing club, "who seek to establish and/or maintain rock climbs". These fixed anchors are described as a "form of fall protection" that allows many types of rock to be climbed and should be installed in accordance with the NZAC's Bolting Philosophy & Standards.

With regard to the Anchor inspection/maintenance of bolting (fixed anchor) practices and hardware, the NZAC Bolting Philosophy and Standards (2017) states that climbers are responsible for checking the safety of bolts that they intend to use. If an issue is identified (such as corrosion, cracking, dangerous placement etc) climbers should speak to NZAC or a local climbing group.

The NZAC Code of Conduct for Rock Climbers (2017) advises that climbers are responsible for managing their own risk and that risk is inherent in climbing.

Coroner Robb endorsed the advice from NZAC and recommended all climbers use their own rope systems, and do not rely on ropes affixed to rock faces as a single point of safety.

RESPONSES

In accordance with section 57B of the Coroners Act, the NZAC was provided with the opportunity to consider and respond to the proposed recommendations.

The response from NZAC included their suggestion that having climbing organisations take responsibility for ropes and fixings on climb routes would be problematic.

- Identifying which entities fall within the descriptor 'climbing organisation' is difficult to definitively determine.
- As climbing is an unregulated individual pursuit, having clubs or other organisations taking responsibility for ropes and fixings would not be a pragmatic way of managing risk.
- There is no national entity in a position to identify every climbing route in New Zealand and monitor and maintain the ropes and fixings that any individual may have placed on any given route.

The NZAC proposed the following recommendations:

- Amend the NZAC's Rock Climbing Access Framework to discourage the installation and use of fixed ropes, slings and other soft equipment, to prevent climbers from being placed in a situation where reliance on weathered soft equipment is an option.
- Consider, if practicable, additional functionality to ClimbNZ (the online database of climbs hosted by the

NZAC) to allow climbers to self-report on safety issues associated with climbs.

Coroner Robb formally adopted the two recommendations put forward by the NZAC as measures that may reduce the risk of death occurring in similar circumstances in the future.

SECTION 74 NON-PUBLICATION ORDERS

- Photographs of the deceased taken during the investigation, on the grounds that it is in the interests of decency and personal privacy.

Baby A

Date of death: 17/07/2019

Date of findings: 17 June 2021

Coroner Alexandra Cunninghame

CIRCUMSTANCES

Baby A (nine months old), died on 17 July 2019 due to accidental asphyxia. On 17 July 2019, Baby A was put to sleep on a bed inside a 'sleep tent' which had been erected by his parents. Later that evening, Baby A's mother checked on him and found that he was hanging off the side of the bed, with his neck caught in the band that held the sleep tent to the mattress. Despite resuscitation efforts, Baby A could not be revived.

SUMMARY OF RECOMMENDATIONS AND COMMENTS

Coroner Cunninghame noted that while many coroners have commented on the importance of ensuring babies have a safe sleeping environment, these findings were the first to concern a death arising from use of a sleep tent.

The Coroner also acknowledged that Baby A tragically died as a result of a sleep accessory being used with the best of intentions by loving parents, who were unaware of the risks inherent in the use of such items for infants and young children.

Coroner Cunninghame stated she was not convinced a voluntary product safety standard developed for sleep tents would sufficiently limit risk to children, and instead concluded that consumer education was likely to have greater impact.

This involves ensuring parents are aware of up-to-date safe sleep advice to mitigate the risks inherent in using sleep tents. Organisations that work in the child and maternal health sector are best placed to disseminate this information, and this approach informed the following recommendations made by Coroner Cunninghame:

- The National SUDI Prevention Coordination Service (NSPCS) training model continues to promote the clear, unambiguous message that anything that is within or covers an infant bed is dangerous and poses risk.
- That organisations and individuals within the sector are encouraged to avoid listing items that may be dangerous for sleep, to avoid the risk of a caregiver assuming that an item not included in a list is safe to use.
- The Coroner directed that NSPCS disseminate a copy of the findings to the organisations with which it works, so that awareness of the use of sleep tents in New Zealand, and the risks they pose to infants, is shared among the sector.

RESPONSES

In accordance with section 57B of the Coroners Act, the National SUDI Prevention Coordination Service (NSPCS) was provided with the opportunity to consider and respond to the proposed recommendations.

Fay Selby-Law (NSPCS general manager), advised that her organisation was also unfamiliar with the use of sleep tents, but stated:

> *NSPCS agrees that safe sleep messaging information is vital in preventing SUDI in both antenatal and postnatal contexts. This death is a timely reminder to ensure safe sleep information is shared to whānau and families at every*

opportunity and every engagement by health professionals.

Anything that is within or covers an infant bed other than bedding is dangerous and poses risk. That is our message.

The NSPCS produces a suite of digital resources that support safe sleep and provide information about other risk and protective factors for SUDI, and works with the Maternal and Child health sector, including the Ministry of Health, District Health Boards (DHBs), Wellchild Tamariki providers, professional organisations, tertiary providers, and teen parenting units.

NSPCS regional coordinators hold the key connection between DHBs and the local safe sleep coordinators within the DHB system

Ms Selby-Law further advised that NSPCS will develop a specific training module for safe sleep, which will be rolled out over the next two years as the organisation updates its current training for the sector and interested parties. This training module will focus on keeping all babies safe, every time they sleep.

NSPCS will also look at how culturally relevant education for parents and caregivers of Asian and other ethnicities can be implemented.

The Coroner accepted the expert advice that sleep tents are not safe for use with infants, and that there are benefits in ensuring that the safe sleep message is delivered in a clear and unambiguous way.

She found there was no evidence that users of sleep tents have been given a false sense of security because they are not included as dangerous items in safe sleep information.

SECTION 74 NON-PUBLICATION ORDERS

Any details that will allow the identification of Baby A and their family, including the town where Baby A lived, as well as any photographs taken of Baby A, their bed and bedroom, in the interests of personal privacy and decency.

PERFORMANCE MEASURES

4,985

Deaths were reported to the National Initial Investigation Office

3,596

Number of cases in which coroners had jurisdiction

In 2020/2021, Coroners closed 3,321

Compared to 2019/20, this is an increase of

296 cases*

Closing a case took an average of

479 Days**

This is an increase of 97 days when compared with **2019/2020**

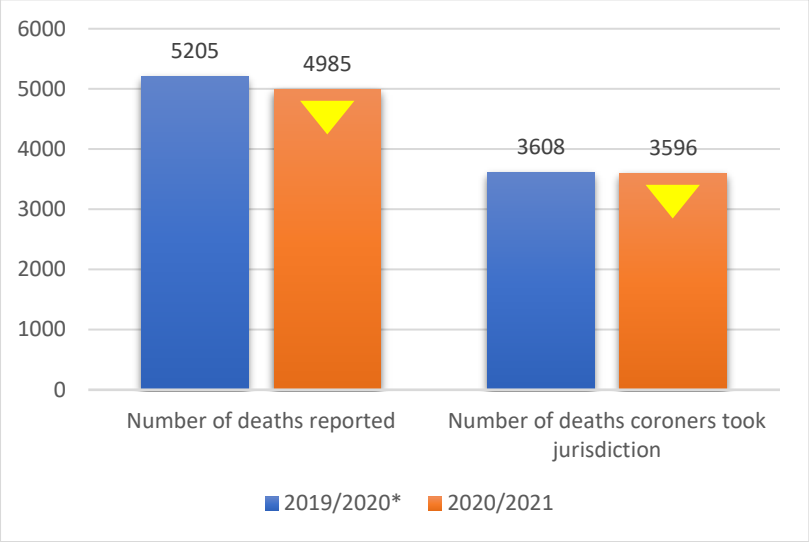
NOTE:

**Numbers are based on the Ministry of Justice's Case Management System as at end of 3 October 2021. Since this is an operational system, numbers for 2019/20 have been updated since published in previous annual reports.*

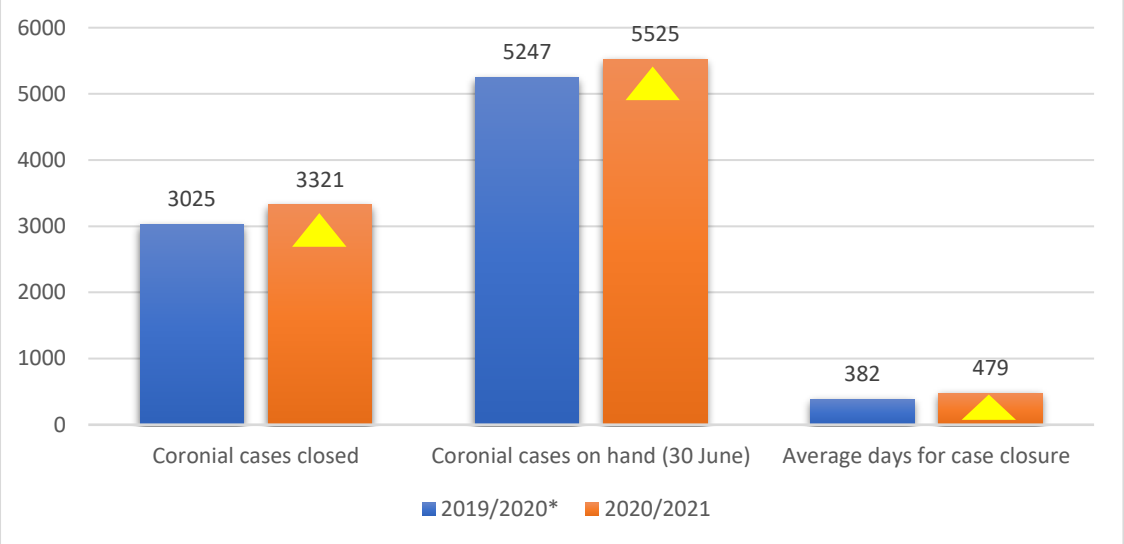
***This is the average age of coronial cases only, which are those cases where the coroner accepts jurisdiction for a death. The number published in previous annual reports also included advice cases, which are those cases where the coroner declines jurisdiction and a doctor certifies the death. This has had the effect of increasing the average time to close a case.*

Year in review: 2020-2021

During the 2020/2021 year, 4,985 deaths were reported to NIIO. Of these, coroners took jurisdiction over 3,596 deaths. As at 30 June 2021, coroners closed 3,321 cases. This is 296 more cases than in 2019/2020. On average, it took 479 days to close a case**. This is an increase of 97 days when compared with 2019/2020.*



The number of coroners' jurisdiction deaths has decreased compared to the previous year



Year in review	2019-2020	2020-2021	CHANGE	% CHANGE
Number of deaths reported	5,205	**4,985**	-220	-4%
Number of deaths coroners took jurisdiction	3,608	**3,596**	-12	~0%
Coronial cases closed	3,025	**3,321**	296	10%
Coronial cases on hand (30 June)	5,247	**5,525**	278	5%
Average days for case closure	382	**479**	97	25%

NOTE:

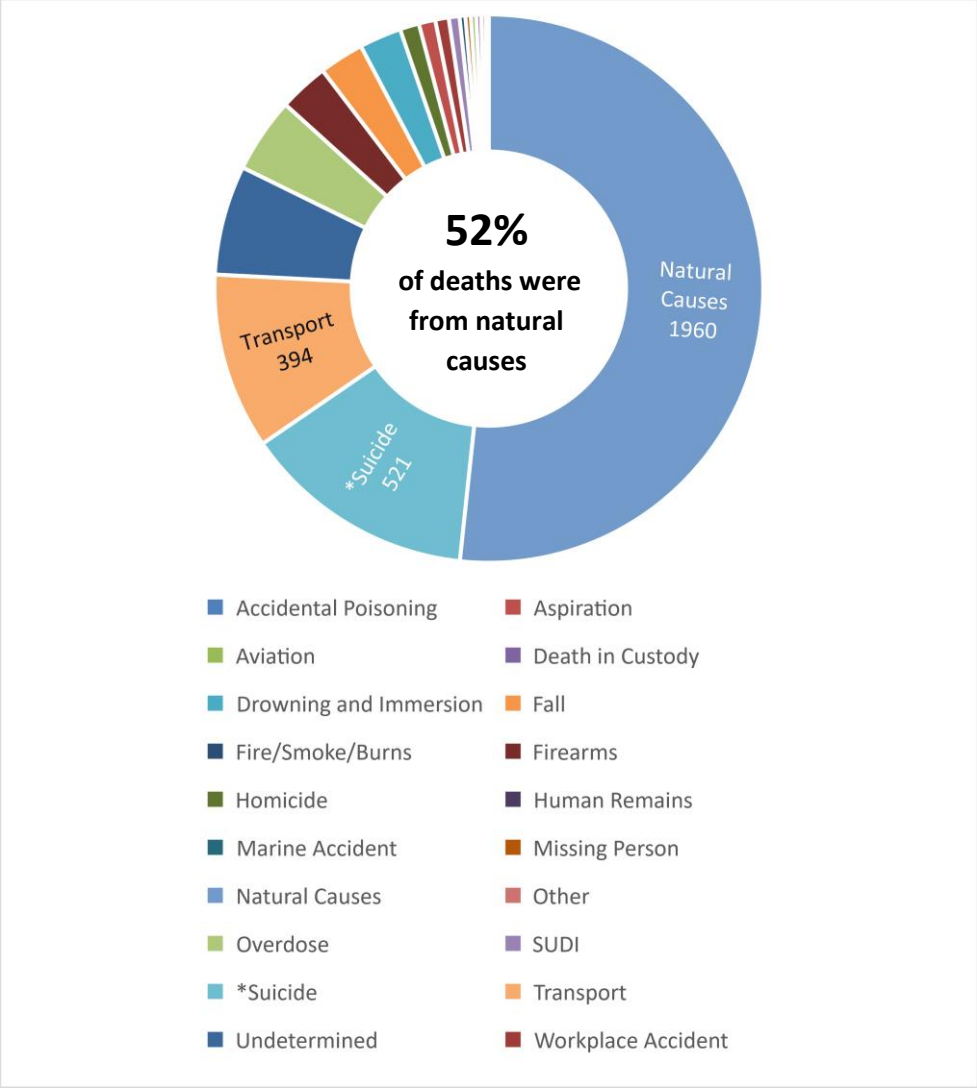
**Numbers are based on the Ministry of Justice's Case Management System as at end of 3 October 2021. Since this is an operational system, numbers for 2019/20 have been updated since published in previous annual reports.*

***This is the average age of coronial cases only, which are those cases where the coroner accepts jurisdiction for a death. The number published in previous annual reports also included advice cases, which are those cases where the coroner declines jurisdiction and a doctor certifies the death. This has had the effect of increasing the average time to close a case.*

NATIONAL STATISTICS

In 2020-2021, coroners took jurisdiction over 3,596 deaths. Of these, most deaths were due to natural causes, followed by suicide and then transport deaths.

Cause of death 2020-21	Deaths
Accidental Poisoning	1
Aspiration	60
Aviation	9
Death in Custody	16
Drowning and Immersion	94
Fall	70
Fire/Smoke/Burns	23
Firearms	46
Homicide	51
Human Remains	1
Marine Accident	5
Missing Person	6
Natural Causes	1887
Other	22
Overdose	162
SUDI	51
Suicide	510
Transport	393
Undetermined	164
Workplace Accident	25
Total	**3,596**



14% Suicide
11% Transport
5% Undetermined

Less than 5%: Firearms, Fall, Drowning and Immersion, Undetermined
Less than 1%: Accidental Poisoning, Aspiration, Aviation, Death in Custody, Drowning and Immersion, Fire/Smoke/Burns, Homicide, Human Remains, Marine Accident, Missing Person, Other, Workplace Accident

Notes:

** The cause of death categories is a broad description. Where there are multiple causes of death, one major cause category is used. For example, death in custody must be recorded as the primary category even if the death was a result of suicide or natural causes.*

Suicide reporting

Last year, approximately 607 New Zealanders took their lives. As part of the collective effort to reduce Aotearoa New Zealand's rate of suicide, the Chief Coroner releases the national provisional suicide statistics each year. A full report is available on the Coronial Services website at coronialservices.justice.govt.nz.

It is important to note that the Chief Coroner's data is provisional. It includes all active cases before coroners where intent has yet to be established. Therefore, some deaths provisionally coded as suicides may later be determined not to be suicides.

In Aotearoa New Zealand, the legal position is that a person dies by suicide if their death was self-inflicted with the intention of taking their own life and knowing the probable consequence of their actions. The coroner must be satisfied there is clear evidence inferring an intention to end one's life.

Provisional Suicide statistics: Men-Women

PROVISIONAL SUICIDE RATE 2008-2021

By sex

Rate per 100,000 people

Year	Men		Women		Rate	Total	
	Number	Rate*	Number	Rate*	(Men:Women)	Number	Rate*
2008/2009	385	17.7	125	5.6	3.16 :1	510	11.5
2009/2010	388	17.9	142	6.2	2.89 :1	530	11.9
2010/2011	388	17.6	121	5.4	3.26 :1	509	11.3
2011/2012	395	18.3	134	5.9	3.1 :1	529	11.9
2012/2013	380	17.1	150	6.5	2.63 :1	530	11.6
2013/2014	385	16.5	145	6.1	2.7 :1	530	11.2
2014/2015	420	17.8	132	5.6	3.18 :1	552	11.6
2015/2016	402	16.5	163	6.7	2.46 :1	565	11.5
2016/2017	437	17.5	144	5.8	3.02 :1	581	11.6
2017/2018	474	18.4	195	7.4	2.49 :1	669	12.9
2018-2019	459	17.9	178	7.3	2.45 :1	637	12.6
2019-2020	462	17.4	166	6.3	2.76 :1	628	11.8
2020-2021	**472**	**17.9**	**135**	**5.4**	**3.32 :1**	**607**	**11.6**

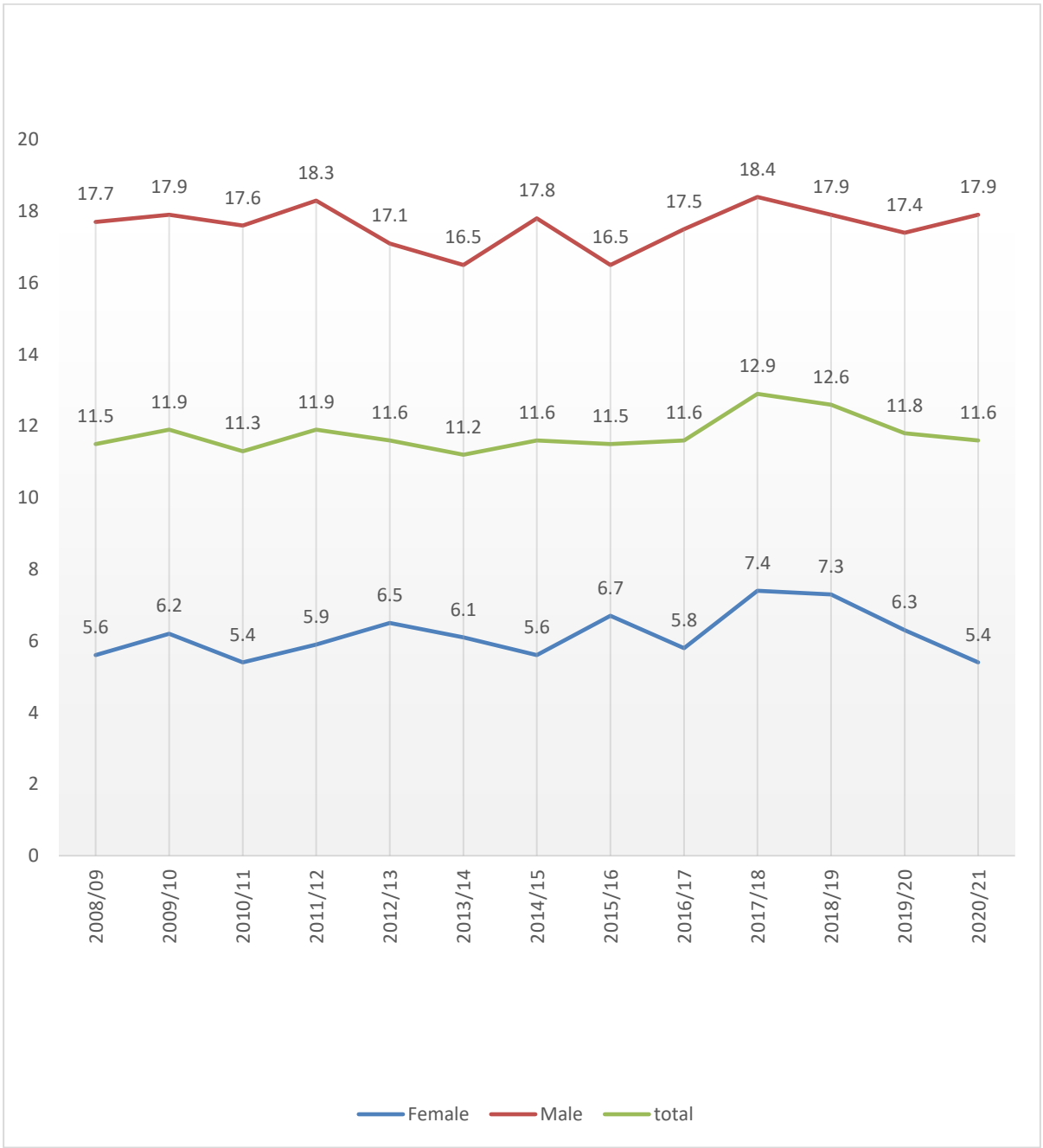
Notes:

1. Male and female populations come from Stats NZ's national population estimates as published at the end of each financial year.
2. The per 100,000 population rates for the male and female groups have been calculated using the male and female populations respectively.
3. Information about the estimated population of New Zealand can be found at https://www.stats.govt.nz/indicators/population-of-nz.

PROVISIONAL SUICIDE RATE 2008-2021

By sex

Rate per 100,000 people



Year (1 July to 30 June)

Notes:

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Provisional Suicide statistics: By sex and age

PROVISIONAL SUICIDE RATES 2020-2021

By sex and age

Rate per 100,000 people

Age Group (Years)	Male		Female		Total	
	Number	Rate*	Number	Rate*	Number	Rate*
0-14	10	2	3	*	13	1.3
15-24	74	22.2	36	11.4	110	17
25-44	196	27.8	46	6.6	242	17.2
45-64	142	22.7	40	6.1	182	14.2
65+	50	13	10	2.3	60	7.3
Total	472	17.9	135	5.4	607	11.6

Notes:

1. Male and female populations come from Stats NZ's national population estimates as published at the end of each financial year.
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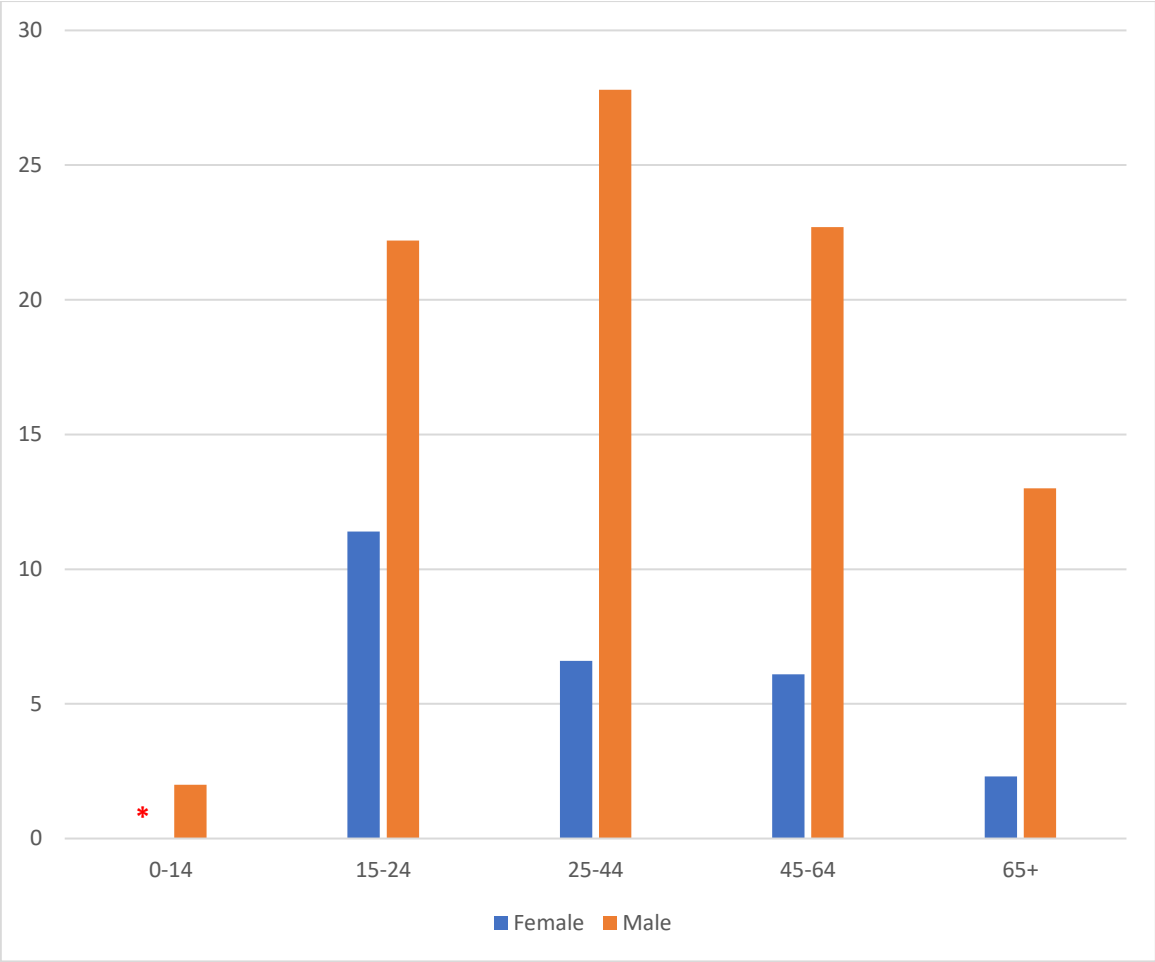
* *For groups where suicide numbers are very low, small changes in the numbers of suicide deaths across years can result in large changes in the corresponding rates. Rates that are based on such small numbers are not reliable and can show large changes over time that may not accurately represent underlying suicide trends. Because of issues with particularly small counts, rates are not calculated for groups with fewer than six suicide deaths in any given year.*

PROVISIONAL SUICIDE RATES 2020-2021

By sex and age

Rate per 100,000 people



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Provisional Suicide statistics: Ethnicity

PROVISIONAL SUICIDE RATE 2008-2021

By ethnic group

Rate per 100,000 people

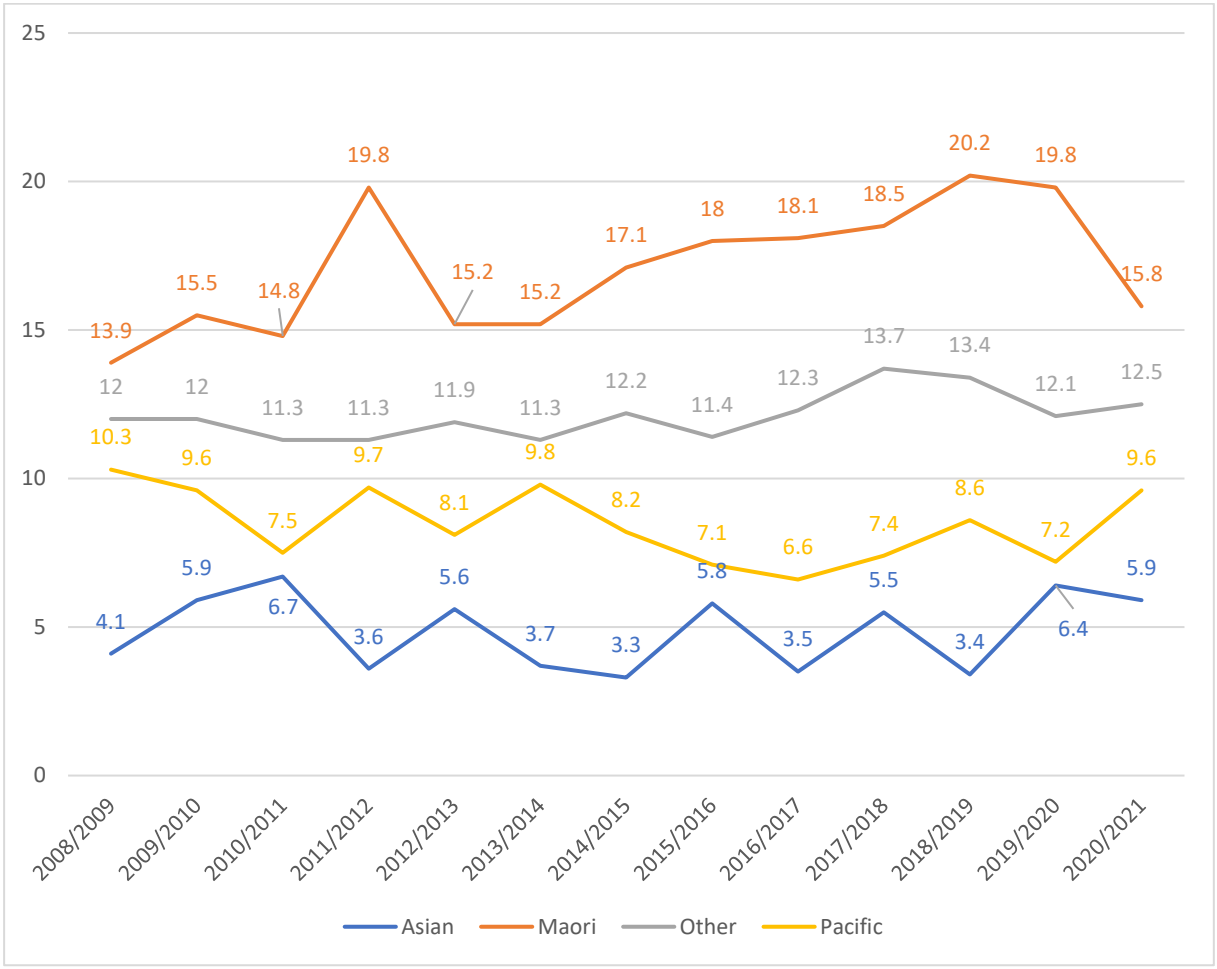
Year	Asian		Māori		Pacific		Other	
	Number	Rate*	Number	Rate*	Number	Rate*	Number	Rate*
2008-2009	17	4.1	89	13.9	28	10.3	376	12
2009-2010	29	5.9	98	15.5	26	9.6	377	12
2010-2011	30	6.7	98	14.8	21	7.5	360	11.3
2011-2012	20	3.6	132	19.8	28	9.7	349	11.3
2012-2013	30	5.6	101	15.2	24	8.1	375	11.9
2013-2014	23	3.7	102	15.2	30	9.8	375	11.3
2014-2015	20	3.3	118	17.1	25	8.2	389	12.2
2015-2016	40	5.8	130	18	22	7.1	373	11.4
2016-2017	26	3.5	135	18.1	21	6.6	399	12.3
2017-2018	41	5.5	143	18.5	24	7.4	461	13.7
2018-2019	27	3.4	163	20.2	29	8.6	418	13.4
2019-2020	53	6.4	160	19.8	25	7.2	390	12.1
2020-2021	51	5.9	129	15.8	34	9.6	393	12.5

Suspected intentionally self-inflicted death notes:
1.This data is that from the publicly available report 'Suicide web tool'. This web tool contains annual suspected suicides reported to the coroner between 1 July 2008 and 30 June 2021. This data is provided by the Chief Coroner to the Ministry of Health for inclusion in the 'Suicide web tool' which can be found on the Ministry of Health's website at https://minhealthnz.shinyapps.io/suicide-web-tool/
2.Information about suspected suicides is held by the Chief Coroner. Suspected suicides are those deaths that appear to be intentionally self-inflicted and are recorded in the Coronial Case Management System (CMS) as such.
3.Cases are included based on the date the death was notified to the coroner (this can differ from the date of death).
4.Suspected intentionally self-inflicted deaths included in this dataset are based on information reported at the notification of death unless closed in the same calendar or financial year, where closure information is used instead.
5.This data includes active cases that were recorded in the CMS as intentional self-harm at notification. These are considered suspected suicides and as such are provisional pending the coroner's official findings.
6.This data includes closed cases that were recorded in the CMS as intentional self-harm at closure. Closed cases have been heard by the coroner and final findings have been issued.
7.This data may differ from the 'provisional suicide statistics' reports previously published on the Coronial Services of New Zealand website. The methodology used to count suspected suicides has been revised. This revised methodology has been applied to all suspected suicide data in the 'Suicide web tool'.
8.This data was extracted from the Coronial Case Management System (CMS) on 14 July 2021.
9.Due to the manner in which information has been recorded by, or presented to the coroner, the statistics provided should not be taken as representing every instance of suspected suicide.
Additional notes:
1.Financial year is that of the death notification date.
2.Ethnicity is based on Ministry of Health records.
3.Age group is based on deceased's age at the time of their death.
4.Gender is based on Ministry of Health records.

PROVISIONAL SUICIDE RATE 2008-2021

By ethnic group

Rate per 100,000 people



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CORONERS AS AT 30 JUNE 2020

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Chief Coroner Judge Deborah Marshall

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Relief Coroner Alison Mills

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Auckland

Coroner Debra Bell
Coroner Sarn Herdson
Coroner Alexander Ho
Relief Coroner Erin Woolley
Relief Coroner Janet Anderson

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Coroner Matthew Bates
Coroner Michael Robb
Relief Coroner Louella Dunn

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219 Collingwood Street
Hamilton

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Coroner Bruce Hesketh
Coroner Donna Llewell
Relief Coroner Heidi Wrigley

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Coroner Tracey Fitzgibbon

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Palmerston North

Coroner Robin Kay

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Wellington

Coroner Peter Ryan
Coroner Brigitte Windley
Coroner Katharine Greig
Relief Coroner Mark Wilton
Relief Coroner Mary-Anne Borrowdale

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Level 5, Wellington District Court
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Christchurch

Deputy Chief Coroner Anna Tutton
Coroner Marcus Elliott
Coroner Sue Johnson

03 353 0444 | csu.christchurch@justice.govt.nz

Level 1, Justice and Emergency Services Precinct
20 Lichfield Street, Christchurch

Dunedin

Coroner Heather McKenzie
Relief Coroner Alexandra Cunninghame

03 470 1147 | csu.dunedin@justice.govt.nz
Dunedin District Court
Lower Stuart Street, Dunedin 9016

For more information

The Office of the Chief Coroner
Email: OfficeoftheChiefCoroner@justice.govt.nz

Report a death to the Coroner

National Initial Investigation Office (NIIO)
Phone: 0800 266 800
Email: NIIO@justice.govt.nz

Media liaison

Email: media@justice.govt.nz
Phone: 04 918 8836

Ministry of Justice
Te Tāhū o te Ture

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