OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments made between **1 July** and **30 September 2021**

Office of the Chief Coroner | 2021 (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 64 recommendations and/or comments issued by Coroners between 1 July and 30 September 2021.

Contents

Recommendations and comments

1 July to 30 September 2021

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/

Drowning

De Luen [2021] NZCorC 160 (23 September 2021)

CIRCUMSTANCES

Portia Lilly De Luen, aged 14, died on 19 May 2020 at Auckland City Hospital. The cause of death was drowning.

On the morning of 19 May 2020, Portia, her twin sister Ocean, and their friends A and B were dropped off at Karekare Beach, on the west coast of Auckland. There were no lifeguards on duty and few other people at the beach that day. Portia and Ocean's mother had expressed her concerns the night before that the beach was not safe for swimming, and warned them of the risk of being caught in a rip.

Despite "really big" waves, the four girls decided to go swimming at about 12:00pm. They were all caught in a powerful rip after being hit by a large wave, and struggled to swim back to shore. B was able to do so unassisted and ran to seek help. Members of the public helped A and Ocean out of the water. A had seen Portia floating face down and managed to turn her over, before being swept away from her by large waves.

Shortly after 12:15pm, a member of Karekare Beach surf lifesaving club's emergency callout squad located Portia's body floating in the water and pulled her to shore. He performed CPR with assistance from members of the public until the Westpac helicopter arrived. Despite prolonged resuscitation efforts at the scene and on arrival in hospital, sadly Portia could not be revived.

COMMENTS OF CORONER MILLS

I. Coastal drownings have continued to increase in New Zealand and surf beaches pose the greatest risk.[1] Over the last 10 years 38% of beach and coastal fatal drownings occurred at a surf beach in New

[1] Surf lifesaving New Zealand, "National Beach and coastal safety report Ten year overview 2010-20 and 1 year overview 2019-20.

Zealand. 22% of beach and coastal fatal drownings in the year 2019 to 2020 occurred while swimming or wading.[2]

II. Auckland's west coast beaches are well known for the high risk they present. Portia's mother had warned Portia about swimming and the dangers at the beach. There were also signs at the beach that were clearly visible. However, no criticism can be directed at a decision to allow 14-year-old girls to spend the day at the beach as such activities should be encouraged.

III. While the girls were alerted to the risks associated with swimming at the beach, the evidence suggests they were not aware of what to do should they get into difficulty. The four girls all tried to swim back to shore rather than follow the 3R rule - "**Relax, Rise, Ride**" when caught in the rip.

IV. Surf Lifesaving New Zealand provided some recommended safety messaging to help prevent other drowning in similar circumstances. I therefore reiterate and reinforce the following messages:

a. Don't swim at unpatrolled locations;

b. Don't overestimate your ability to cope in the conditions;

c. Watch out for rip currents as they can carry you away from the shore. If caught in a rip current, **RELAX** and float, **RAISE** your hand to single for help, **RIDE** the rip until it stops, and you can swim both safely back to shore. Remember-nobody is stronger than a rip;

d. If in doubt, stay out;

e. If you see someone in trouble 111 and ask for the Police.

V. The above comments are made pursuant to section 57A of the Coroners Act 2006 in the hope that, if drawn to public attention, may increase the awareness of what to do if caught in rip and reduce the chances of further deaths occurring in similar to circumstances.

Note: Orders under section 74 of the Coroners Act 2006 prohibit the publication of any photographs taken of Portia during this inquiry (being photographs of a deceased person), in the interests of decency, as well as the names, and any particulars likely to lead to their identity, of Portia's two friends (referred to as "A" and "B" in the finding), in the interests of personal privacy.

Finney [2021] NZCorC 120 (4 August 2021)

CIRCUMSTANCES

Kevin Shand Finney, aged 60, died between 20 August 2020 and 22 August 2020 in the vicinity of Lagoon Bay Mahurangi Harbour of drowning.

[2] Ibid.

Kevin was an experienced yachtsman who lived on his boat. He was last heard from on the night of 20 August 2020 when he exchanged text messages with a friend. When his partner did not hear from him the next morning she went to his boat and found it empty, however his lights were on and his dinghy was missing. Kevin was reported missing. His body was found the next day, on a nearby beach. The Coroner concluded that Kevin must have fallen into the water while trying to get into, or while using, his dinghy in the vicinity of his boat, sometime around 11:52pm on 20 August 2020. This would be consistent with the last use of his phone, the data obtained from his smart watch, and the drift pattern calculations combined with the location where his body was found.

Kevin's body was found with one work boot on, indicating he may have been trying to remove his clothes when he fell into the water. Kevin would have struggled to stay afloat fully clothed and wearing heavy boots. His dinghy was not in good repair and was flat bottomed making it less stable. He was not wearing a life jacket (a personal floating device or PFD) and did not have his phone or other communication device with him at the time. Consumption of alcohol may also have affected his balance and judgements that evening. The wind and the cold sea conditions are also likely to have contributed to his accident and subsequent death.

COMMENTS OF CORONER MILLS

I. I make the following comments pursuant to section 57A of the Coroners Act 2006: I endorse and repeat the key safety messages promoted by Maritime New Zealand that when on boat, especially a vessel less than six metres long:

   a. wear a correct sized PFD;

   b. check the marine weather;

   c. carry emergency devices; (at least two forms of waterproof communication)

   d. avoid alcohol; and

   e. be a responsible skipper.

II. I also have considered the NZ Safer Boating Forum position on PFDs, which is that all people on a recreational vessel of 6 metre or less must wear a personal flotation device while the vessel is underway. In its statement it referred to research which support the proposition that the wearing of PFD's saves lives. I also note the Maritime NZ investigator's comment that had Kevin been wearing a PFD, he may have survived.

III. There are currently over 17 different regulations around New Zealand regarding the wearing of PFDs. I agree with the Safer Boating Forum's view that this is confusing and unsatisfactory. I accept that if consistency could be achieved this would remove the confusion, uncertainty and mixed messages given to boaties. It would also simplify public education campaigns.

IV. I note that Coroners have previously made recommendations about the wearing of PFDs. They have also previously recommended that government consider amending the Maritime rules Part 91 to require mandatory wearing a personal floating devices in vessels of 6 metres or less.

V. I have been advised that the Ministry of Transport and Maritime NZ are jointly undertaking targeted stakeholder engagement on when lifejackets and other PFDs should be worn on small recreational vessels. It is anticipated that this engagement will be completed by late August/early September 2021. Advice will then be provided to the Minister of Transport for consideration. In these circumstances I do not consider further recommendations are required but do endorse the views previously expressed by other Coroners and support the review that is currently underway.

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

Landig [2021] NZCorC 104 (2 July 2021)

CIRCUMSTANCES

Michael Lajara Landig, aged 38, died on 29 November 2020 in the waters off Papanui Point, Ruapuke from drowning.

At around 8:30am on 29 November 2020, Mr Landig was swept into the waters off Papanui Point, Ruapuke while fishing from rocks with his friends. Despite efforts by Mr Landig's friends to retrieve him from the water, a large wave rolled over the top of him. Mr Landig then disappeared under the water and his friends lost sight of him.

There was no buoyancy aid available to Mr Landig's friends as the one that had been installed at the top of the chains descending onto the rocks below was missing. Furthermore, the warning signs that had been installed by the Department of Conservation were weathered, difficult to read, and detracted from the important message which they conveyed. Specifically, the signs warned of the danger of fishing in the area; advising to stay well away from the water line, not to fish alone, and to wear a buoyancy aid. The warning signs also referred to the possibility of large rogue waves being frequent in the area.

COMMENTS OF CORONER ROBB

I. A copy of this Finding was provided to the Waikato District Council and the Department of Conservation with an opportunity to respond to the following recommendations:

a. The Waikato District Council replace the buoyancy aid located at the end of the path at Papanui Point.

b. The Waikato District Council install another buoyancy aid at the base of the chains.

c. The Waikato District Council implement a fortnightly check of the buoyancy aids to ensure they are in place and in a useable condition.

d. Individuals fishing from rocks in an area known to be significantly impacted by sea swells wear, or have ready access to a buoyancy device, such as a lifejacket.

e. The Department of Conservation signage at Papanui Point already includes advice to members of the public to use a lifejacket went fishing from those rocks. Photographs of the signage reveal it to be weathered, which in my view negatively affects the attention it attracts

and negatively impacts on its effectiveness. I recommend the signage be replaced and in doing so steps taken to draw further attention to the signage- such as “STOP-Read this before entering this area”.

II. The Waikato District Council provided a response that included:

a. Council has sought to ensure that a buoyancy aid is available at the end of the path for use in emergency situations. Regrettably, emergency buoyancy aids are regularly stolen from their locations around the Waikato Council District, including the aid at Papanui Point. When Council becomes aware that these buoyancy aids have been removed, it takes steps to replace these aids with urgency. It appreciates the significance of these devices and the difference they make to a person survival in an emergency situation.

b. Council has contractors attending Ruapuke on a fortnightly basis to clean the toilet facilities and can instruct their contractors to travel to Papanui Point to check the buoyancy aid at the end of the path is in place and is in a usable condition, and to advise Council if the aid is missing so it may organise replacement.

c. Council is concerned at the potential safety implications to its staff and contractors if a buoyancy aid was installed at the base of the chains, and staff or contractors were required to descend to check the status of that aid. In its view this may create a hazard to Council staff and Contractors.

d. Council has considered other measures that can take to highlight for users of the area both the importance of the buoyancy aid remaining in place for use in an emergency, and the need to warn users of the significant dangers associated with the area. Council is taking steps to erect signage beside the buoyancy aid with the following wording:

Flotation sign words

This may save a life

Do not remove except in an emergency

If this flotation device is missing, please phone 0800 492 452

Warning sign words

Warning: Dangerous waves at any time

Life jackets required beyond this point

e. The signage will be erected at the end of the path beside the location of the buoyancy aid as soon as is possible.

f. Council also wishes to express its sincere condolences to the family and friends of Mr Landig.

III. I acknowledge the above response to the recommendations as a pragmatic and appropriate response that I am grateful to have received. The response highlights the dangers of members of the public

removing emergency flotation devices for their own purposes rather than in response to an emergency. I only hope that that practice stops, and if detected criminal prosecutions are undertaken.

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

Lee [2021] NZCorC 143 (31 August 2021)

CIRCUMSTANCES

Te Ariki William Robin Tawha Lee, aged 14 months, died on 5 October 2018 at his home in Parklands, Christchurch with the cause of death being consistent with drowning.

On 5 October 2018, Te Ariki was playing at home and his mother could hear him from inside. At one point, she went into the bathroom and then returned into the lounge of the house but could no longer hear Te Ariki. She went outside to check on him and found Te Ariki in a pool in the yard of the family home. Te Ariki died later in the day at Christchurch Hospital.

Police noted that the pool was a relatively inexpensive, commonly available and widely used type of pool, constructed with white PVC tube framing and a blue liner/pool surface. These pools need to be assembled by consumers. There was no means, such as barriers or fencing, to restrict access to the pool. Although Te Ariki's entry into the pool was unwitnessed, Police considered that he likely accessed the pool by climbing on a wooden sawhorse located directly next to the pool.

Christchurch City Council (CCC) investigated Te Ariki's death and assessed whether any offences under the Building Act 2004 had occurred. They noted that the pool did not have any means to restrict access to it, such as adequate fencing, as required by that Act. CCC decided not to take enforcement action in this case.

COMMENTS OF CORONER BATES

I. This case is a very sad reminder of the dangers of young people being left unsupervised around bodies of water.

II. KidsHealth is a joint initiative between the Paediatric Society of New Zealand and the Starship Foundation and is supported by the Ministry of Health. Their webpage on water safety states that "drowning is the leading cause of death from injury in young people."[3] Pre-schoolers are most likely to drown in home swimming pools and unfenced water hazards.

III. It appears that in the present case there was confusion regarding fencing requirements for non-permanent pools, such as the one at Te Ariki's home. I take this opportunity to remind the public of the requirements set by the Building Act 2004. Pools with a depth of water of 400mm or more must have physical barriers that restrict access to unsupervised children aged 5 years or younger.[4] The owners of

[3] https://www.kidshealth.org.nz/water-safety
[4] Pools are defined in the Building Act 2004 as generally being an excavation, structure or product that is used for swimming, paddling or bathing. See section 7 for the full definition.

pools and the owners of the property where pools are situated (i.e. landlords) must ensure this rule is followed.

IV. The Building Code (contained within Schedule 1 of the Building Regulations 1992) provides obligations and requirements for certain build structures.[5] The Code specifies that any barriers built to surround a pool must:

a. surround the pool;

b. have no permanent objects or projections on the outside that could assist children in negotiating the barrier; and

c. have gates that are self-closing and open away from the barrier.

RECOMMENDATIONS ENDORSED BY CORONER BATES

I. I endorse the following advice from KidsHealth in relation to young people around water:

a. always keep within arm's reach of your child when they are in and around water.

b. never leave children, especially those under 5 years of age, unsupervised near water, including baths, buckets, ponds, streams and water troughs.

c. be aware of unfenced landscape water features, storm water catchment ponds and urban streams near homes.

d. use pool fencing that completely surrounds your pool and separates it from the house.

II. Additionally, remove any objects (chairs, toys, etc.) that young people may use to climb over a pool fence, into an unfenced pool, or to gain access to any other body of water.

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

Phillips [2021] NZCorC 125 (10 August 2021)

CIRCUMSTANCES

Howard Robert Phillips, aged 68, died on 4 November 2017 at Lake Te Anau of cold water immersion.

On 4 November 2017, Mr Phillips, who had many years of sailing experience, participated in a yacht race on Lake Te Anau with his two friends.

The race was organised by the Southland Trailer Yacht Squadron in conjunction with the Marakura Yacht Club. It was intended to be from the Yacht Club to Dome Island and back. On completing entry forms, race participants were given

[5] Building Regulations 1992, sch 1, cl F9.

sailing instructions, which included specific safety requirements including the use of lifejackets and a working radio, set to specific channels.

The yacht Mr Phillips was on was suitable for the intended race and well equipped, having five life jackets, a personal locator beacon, a hand-held radio, an outboard motor, a horseshoe life ring, oars, and flares. However, Mr Phillips was not wearing a lifejacket and the radio was not set to the correct channel.

As the yacht cleared Dome Island, it ran into stronger wind, which caused it to broach, meaning the water was entering the cockpit. As a result, Mr Phillips was forced into the open water. His friends used the radio to call for help from the race organisers. When Mr Phillips was retrieved from the water, he was unresponsive.

RECOMMENDATIONS OF CORONER MCKENZIE

I. Various issues arose during this inquiry as set out regarding the management of trailer yacht events and allied matters such as crew communication and clothing. Dr Denholm raised the issues of there not being a safety or rescue boat behind Mr Phillips' boat which was the last boat in the race when it broached. Dr Denholm also suggested that wearing a GPS might help locate a person who had fallen in the water as discussed above.

II. Provisional findings were circulated for comment to relevant interested parties, namely Dr Denholm, Messrs McCulloch and Fraser, the Marakura Yacht Club, the Southland Trailer Yacht Squadron, and Yachting New Zealand. The provisional findings included the draft recommendations relating to Yachting New Zealand amending the Safety Regulations of Sailing relating to trailer sailer vessels. As part of the consultation process, I received a detailed response from Yachting New Zealand. It became apparent that global changes to the Safety Regulations might not cater to the variety of events or could encounter practical difficulties leading to potential unintended consequences.

III. I set out the draft recommendations below as consulted on followed by Yachting New Zealand's responses.

IV. The draft recommendations were that Yachting New Zealand amend the Safety Regulations of Sailing relating to trailer sailer vessels to provide for:

a. The mandatory fitting of a fixed multichannel VHF radio of sufficient wattage to communicate (without interference) with land based and/or waterborne parties from any point within the area the craft will be operated.

b. The mandatory wearing by crews of:

i. sufficient thermal protection in the event of immersion; and

ii. a high visibility outer layer.

c. The mandatory use of a "chase boat" or "support boat" in any race undertaken by any club affiliated to Yachting New Zealand.

V. There was a further draft recommendation that the Southland Trailer Yacht Squadron and Marakura Yacht Club review policies as to the radio channels to be used for communications during races to ensure that the chosen frequencies allow for effective communication with land based and/or waterborne parties from any point within the area where craft will be operated. I received no direct comment on this recommendation.

VI. With respect to the recommendations to amend the Safety Regulations, Yachting New Zealand replied:

a. *The mandatory fitting of a fixed multichannel VHF radio of sufficient wattage to communicate (without interference) with land based and/or waterborne parties from any point within the area the craft will be operated*: a fixed VHF requires a power source with a maintained battery which are not easily installed or are impractical on the majority of trailer yachts. In most cases, the height of the aerial is more important that the power of transmission in order for VHF radio to communicate effectively. For example: transmitting at 5 watts with a handheld while standing on a cabin top is more effective than transmitting at 25 watts through an aerial low on the deck. The quality of connections in an aerial system are an important consideration and not an issue with a handheld unit itself.

   Placing one person below (to operate a fixed VHF) does not contribute to the effective retrieval of a person from the water. Trailer yachts are often crewed by three to four members and standard procedure in a person overboard situation is to have a dedicated person watching the person in the water and pointing at them while communicating the individual's position in relation to the boat with the rest of the crew, a person steering the vessel, and the rest of the crew maintaining the sailing or steaming of the boat.

   In the case of down flooding, especially in a small trailer boat, a fixed VHF radio and battery could be rendered useless compared to a waterproof handheld VHF radio.

b. *The mandatory wearing by crews of sufficient thermal protection in the event of immersion and a high visibility outer layer*: prescribing the type of clothing to be worn is not considered a practical recommendation given the variety of designs of trailer yachts and types of sailing events for which trailer yachts are sailed in New Zealand. It is not the intention of a trailer yacht crew to have water coming onto crew regularly or to be in the water as compared to when sailing a sport multi-hull, sports boat, or dinghy. Thermal protection remains an option and sailor's choice given weather and sea conditions.

   The requirement to wear a life jacket on the outer layer already supports the recommendation for a high visibility outer layer. When a lifejacket is inflated the colour of the bladder with its reflective strips ensures visibility is maintained as does a foam life jacket.

c. *The mandatory use of a "chase boat" or "support boat" in any race undertaken by any club affiliated to Yachting New Zealand*: there is a diverse variety of locations and types of sailing events for which trailer yachts are sailed in New Zealand. Yachting New Zealand believes the decision to have a safety boat on the water should be made by the organising authority based on the venue and conditions. The majority of trailer yacht events are short course regattas where boats generally remain close together and are held in sheltered waters. These events regularly have at least one rescue boat on the water to start races and/or

lay marks. Fellow competitors are usually close by to assist should someone go overboard or if a vessel/crew need help.

Weather and sea conditions as well as the type of venue provides important context as to whether a vessel is suitable to be a chase or support boat as these usually vary in type, size, and engine power (and therefore suitability) to provide support to a spread out and diverse fleet of trailer yachts. A requirement to have a mandatory chase boat or support boat on the water would require more context.

VII. Yachting New Zealand advised that it had consulted at length internally before responding to the draft recommendations. I accept its advice in relation to the practical issues that might arise in making global amendments to the Sailing Regulations given the diversity of trailer yachting events across New Zealand, including location, water type, and weather. It appears that a "one size fits all" approach to the Safety Regulations of Sailing relating to trailer yacht vessels would not factor in an individual event's specific context and might have unintended consequences. In this setting, I step back from making the draft recommendations relating to a global change to the Regulations.

VIII. However, the issues of helping ensure effective radio communication during an event; crews wearing sufficient thermal protection in the event of immersion and being clearly visible in the water; and the use of a chase, rescue, or support boat should, in my view, be clearly in the minds of event organisers and crew before and during events.

IX. It is important to note that by not making formal recommendations to change the Sailing Regulations I am not implying that these issues were not material to the event on 4 November 2017 and/or are not fundamental matters for organisers and crew in sailing events. Instead, I have stepped back from making formal global recommendations that would appear to encounter practical difficulties in their application given the very context-specific environment in which sailing events take place, including the conditions changing during an event.

X. I do make however the more targeted recommendation that the Southland Trailer Yacht Squadron and Marakura Yacht Club review policies as to the radio channels to be used for communications during races. This is to help ensure that the chosen frequencies allow for effective communication with land-based and/or waterborne parties from any point within the area where craft will be operated. I consider this recommendation is specifically targeted to the context of a particular event at hand.

XI. I also strongly encourage all trailer yacht event organisers and crew to actively consider the issues raised by this inquiry in their planning, running of, and participation in events. These include reliable radio communications, being visible in the water, wearing appropriate thermal protection and a life jacket, and the availability of a support or chase boat.

XII. As Yachting New Zealand has pointed out, events are context specific. In my view, there might be occasions or contexts where stronger safety measures are required beyond the draft recommendations. Or, the status quo might be sufficient to enable the safe running of events. Again, considering the specific context of an event will be paramount to event organisers and crew as they help ensure the safe running of events, including helping mitigate the situation when a person is overboard in cold and rough waters.

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

Ruarangi [2021] NZCorC 111 (20 July 2021)

CIRCUMSTANCES

William Ruarangi, aged 52, died on 19 April 2017 at Manukau Harbour due to immersion, presumed drowning.

On 19 April 2017, William and his daughter were fishing on the Manukau Harbour. As they were returning to the shore they were pushed out of their boat by a wave. They could not re-enter the boat and were stranded in the water. William and his daughter were wearing life jackets, but he lost his while in the water.

As it started to turn dark, William was struggling to stay afloat and sunk under the water. Police were successful in rescuing his daughter. William's body was located on 26 April 2017 near Wattle Bay Reserve at Manukau Peninsula.

Maritime New Zealand investigated William's death and reported that he was most likely not wearing his lifejacket properly, which lead to him losing it while in the water.

RECOMMENDATIONS ENDORSED BY CORONER DUNN

I. The evidence indicates that William was not wearing his life jacket correctly, which resulted in him losing it once in the water. I take this opportunity to urge the public to ensure that a life jacket is worn and used correctly while out on the water. Maritime New Zealand report that most accidents on water occur suddenly with no warning and that it is extremely difficult, if not impossible, to put on a life jacket once you are in the water.[6] Given this, the importance of wearing a life jacket properly (being completely zipped up) at all times when on a boat out on the water is paramount.

II. The New Zealand Coastguard offers the following advice around wearing and using life jackets:[7]

   a. Coastguard recommends the use of life jackets with correctly fitted crotch straps in situations other than very calm water.

   b. Even when tightly secured, life jackets have a tendency to ride up on the wearer if there is any wave action. Crotch straps are mandatory for all child-sized lifejackets and in some yacht racing situations.

   c. When choosing a life jacket, consider:

      i. The type of recreational activities you do on water

      ii. The distance you plan to travel away from shore

      iii. The weather and sea conditions you will encounter

[6] https://www.maritimenz.govt.nz/recreational/safety/lifejackets/default.asp
[7] https://www.coastguard.nz/boating-safely/lifejackets/

iv. The local bylaws that may apply to your region

v. The sizes available for children

III. I endorse the above advice.

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

Smith [2021] NZCorC 109 (14 July 2021)

CIRCUMSTANCES

Matthew Ryan Smith (Matt), aged 18, died on 22 August 2016 at sea in the vicinity of the Sugar Loaf Islands. The most likely cause of death was drowning.

At approximately 6:00am that day, Matt and his close friend Brett Collett launched a five-metre aluminium boat, from the boat ramp at Port Taranaki. They headed to the Sugar Loaf Islands, looking for crayfish pots that Brett had put out the previous week.

At approximately 6:30am, the boat was struck by a large wave and it overturned, throwing Matt and Brett into the sea. After considering the options, they decided to swim to the nearest island. Matt got into difficulty and disappeared from Brett's view. Whilst Brett made it to shore, Matt did not.

Despite extensive searches conducted over several days, Matt's body could not be located (and has not been to this day).

In 2010, Maritime New Zealand proposed an amendment to rule 91.4 of the Maritime Rules which would have made it compulsory to wear a lifejacket on boats of six metres or less in length. The rule would have permitted the removal of lifejackets when the skipper of the boat considered the risk to those on board as low. Whilst the Government at that time decided not to amend the Rules, some regional authorities subsequently enacted bylaws that reflected Maritime New Zealand's proposal.

When Matt and Brett decided to go boating, rule 91.4 stated that:

> No person in charge of a recreational craft may use it unless there are on-board at the time of use, and in a readily accessible location, sufficient personal flotation devices of an appropriate size for each person on board.

Brett, who was the person in charge of the boat, had ensured that there were readily-accessible lifejackets on board for both him and Matt. As such, rule 91.4 was complied with. However, the effect of rule 91.4 is that whilst it was compulsory to carry lifejackets, it was not compulsory to wear them, except in times of heightened danger.

As part of the Taranaki Regional Council's (the Council) review process, Maritime New Zealand made written submissions on 22 July 2020 to the Council. Maritime New Zealand said:

> Maritime New Zealand supports the mandatory wearing of personal flotation devices (PFDs) by all persons on recreational vessels of 6 m in length or less at all times while the vessel is underway. This is consistent with the agreed position of the

> New Zealand Safer Boating Forum on the use of PFDs on recreational vessels. The Forum encourages local authorities to introduce this as a mandatory requirement in local bylaws, as failure to wear PFDs in small craft is one of the key causal factors in fatal and non-fatal recreational boating accidents. The Forums policy rationale for this position can be found on the Maritime New Zealand website at https//www.maritimenz.govt.nz/about/people-we-work-with/safer-boating-forum/documents/NZ-Safer-Boating-Forum-lifejacket-position-statement.pdf.
>
> Maritime NZ supports this position and encourages Regional Councils to raise the standards for PFD use through bylaw provisions. I strongly recommend the draft Bylaws are amended to reflect the Forum's position.

However, the Council declined Maritime New Zealand's request stating that *Navigation Safety Bylaws for Port Taranaki and its Approaches* would only cover a small area of the Taranaki Coastal Marine area. The Bylaws therefore will not achieve the regionwide wearing of PFDs. The Council also felt that it would be confusing to the public and difficult to implement/enforce to have different jurisdictional requirements over a small geographical area.

The Council considered that the most effective method of implementing recommendations of the New Zealand Safer Boating Forum, would be through Maritime New Zealand amending the Maritime Rules Part 91 to require the mandatory wearing of PFDs in vessels of six metres of length or less while the vessel is underway. The Coroner considered that the Council's observations had some weight and noted that it was envisaged that such a step would reduce the number of boating-related drownings in New Zealand.

RECOMMENDATIONS OF CORONER KAY

I. The Court makes the following recommendation:

To: The Minister of Transport

Parliament Buildings

Wellington

That the Minister contemplate inviting Parliament to consider whether the present provisions of the Maritime Rules Part 91 – Navigation Safety Rules, relating to the carriage and wearing of personal flotation devices on recreational craft, should be reviewed AND whether the occupants of vessels of six metres or less in length should be required to wear such devices at all times such vessels are underway.

II. It is directed that a copy of these findings be sent to the Chief Executive Officer, Maritime New Zealand, PO Box 27006, Wellington; the Chief Executive, Ministry of Transport, PO Box 3175, Wellington; and the Chief Executive, Taranaki Regional Council.

Walsh [2021] NZCorC 142 (30 August 2021)

CIRCUMSTANCES

Richard James Walsh, aged 58, died on 30 January 2021 of drowning in the sea approximately 1.5 kilometres north of Beach Road, Seadown, Timaru. His death was accidental.

Mr Walsh lived with his wife Rachel and their three young children at Levels Valley, near Pleasant Point. On Saturday, 30 January 2021, Mr Walsh and his family were with friends, Graeme and Tess Braithwaite, at the beach at the end of Beach Road, Seadown. Children from both families were paddling and playing in the waves up to their shins, while the adults chatted and watched nearby.

Mr Walsh's seven-year-old son slipped and was hit by a large wave, which knocked him over and dragged him into the sea. Mr Walsh, clothed in a t-shirt, jeans and his work boots, immediately ran into the water and managed to throw his son towards the shore. Mrs Walsh and Mrs Braithwaite entered the water and assisted the boy to safety. Mr Walsh was close to the shore and appeared calm, but was repeatedly being hit by large waves. Mr Braithwaite notified emergency services, while Mrs Walsh kept track of Mr Walsh's position in the water.

When Police arrived at about 4:45pm, Mr Walsh could be seen briefly every few minutes between 60 to 80 metres from the shore. He appeared to be drifting north at a rate of about 50 - 100 metres every five minutes. Emergency services considered the conditions too dangerous to attempt a water rescue. At about 5:18pm, the Westpac helicopter arrived at the scene. Mr Walsh was located in the sea about 1.5 kilometres north of Beach Road. He was winched up and transported to Timaru Hospital, where it was confirmed that he had died.

Police and locals advised that the Beach Road area is not safe due to the underlying current and rogue waves, as well as a steep drop off. At the time Mr Walsh died, there were no signs at the beach advising about the dangers of swimming or paddling there. Timaru District Council has since replaced the no swimming sign which was vandalised and pulled down several years prior.

RECOMMENDATIONS OF CORONER JOHNSON

I. A Coroner may make recommendations or comments for the purpose of reducing the chances of further deaths occurring in similar circumstances.[8] Any person or organisation to whom the comment or recommendation is directed must be given the opportunity to comment on the proposed recommendation or comment.[9] I therefore provided a copy of my draft Findings with the following recommendation to Timaru District Council.

> It is heartening to know that Timaru District Council has replaced the no swimming sign. However, I recommend to Timaru District Council that it also erects signs at the beach at Beach Road, Seadown, advising people to keep out of the water as there are strong currents. This is because Mr Walsh was rescuing his son who had been carried out to sea by a wave while playing at the edge of the sea.

II. Timaru District Council responded to my draft Findings saying that it agrees to erect further signage warning of the specific hazards for this locality. A photograph of signs, similar to the ones proposed, was attached to the response and these show the hazards of strong currents and large waves very clearly set out both in writing, and in drawings in large yellow triangles. The signs include very visible red, yellow, white and blue colours and also the advice in writing and a drawing to "Supervise children at all times".

[8] Coroners Act 2006 section 57A.
[9] Coroners Act 2006 section 57B (1).

III. I consider that the proposed new signs to be erected by Timaru District Council may reduce the chances of future deaths occurring in circumstances similar to those in which Richard Walsh died.

Note: A permanent order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of the deceased taken by Police and entered into evidence, in the interests of decency and personal privacy.

Drugs and Alcohol

Moore [2021] NZCorC 136 (24 August 2021)

CIRCUMSTANCES

Anthony Mark Moore, aged 47, died on 13 April 2018 at 1 Maurice Street, Papakura, Auckland of synthetic cannabinoid toxicity (AMB-FUBINACA).

At the time of his death Mr Moore was a client of Counties Manukau Mental Health Intensive Care Team and was subject to a compulsory treatment order (indefinite) pursuant to section 29 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. He had been receiving support from Mahitahi Trust (a Kaupapa Māori mental health and addictions provider) since August 2015 and resided at a Mahitahi Trust residence in Manurewa with three other clients.

At around 11:00am on 13 April 2018, Mr Moore went to the property of acquaintances, Peter and John Manukau, in Papakura. Mr Moore appeared drunk and had a beer in his hand.

The witness evidence was contradictory. Peter said that he had heard Mr Moore ask John for a synthetic smoke, which Mr Moore was known to like. According to Peter, money was exchanged before Mr Moore entered the house with John. However, John reported that he was asleep when Mr Moore arrived at the property and entered his room. He briefly spoke to Mr Moore before going back to sleep. When he woke up a short time later, he saw Mr Moore sitting on the floor of his bedroom leaning up against a small fridge appearing to be asleep. He soon realised that Mr Moore was not breathing and started CPR. Emergency services were contacted, but despite resuscitation efforts Mr Moore died at the scene.

Toxicology testing found that Mr Moore had alcohol, cannabis and THC, and AMB-FUBINACA (synthetic cannabinoid) in his system. The forensic pathologist reported that the direct cause of Mr Moore's death was synthetic cannabinoid toxicity (AMB-FUBINACA). He advised that this type of synthetic cannabinoid has profound effects on the central nervous system and respiratory system, which can result in death.

COMMENTS OF CORONER GREIG

I. The use of synthetic drugs has been recognised as a major public health problem in New Zealand. Since June 2017, there have been 83 deaths in New Zealand provisionally attributed to synthetic drugs.

II. A review of these deaths (both open and closed) shows that the most at-risk group are male (91% of deaths), Māori (63%), ages 40 or older (54 %) and being treated for mental illnesses (54%). All of these factors apply in Mr Moore's case.

III. The dangers of consuming synthetic drugs include:

a. They are promoted or sold as a form of synthetic "cannabis", but there is no cannabis in the product. While the synthetic drug can be made to look like cannabis by using dried plant or other material, it is saturated in a synthetic drug not THC (tetrahydrocannabinol) the active ingredient in cannabis.

b. The nature of the synthetic drug is unknown to the purchaser and unknown or poorly understood by the manufactures/distributors in New Zealand.

c. The synthetic drug, AMB-FUBINACA (which was the cause of Mr Moore's death) has been the cause or contributing factor in a number of deaths in the Auckland, and elsewhere in New Zealand, and overseas. The quantity and strength of this drug is an unknown gamble which can have fatal consequences.

d. Individuals who become unconscious after consumption of synthetic drugs can die if they do not receive timely and appropriate medical assistance. The deaths can occur in several ways: from a cardiac event induced by consumption of the drug, as a result of being comatose and asphyxiating on their own vomit, or from a hypoxic brain injury.

IV. In his finding in relation to the death of Andrew McAllister, Coroner Matenga considered the expert opinion of Dr Paul Quigley, Emergency Medicine Specialist, Wellington Regional Hospital.[10]

V. In his evidence, Dr Quigley advised that efforts should be made to publicise (particularly to users of synthetic cannabinoids and their families and associates) the dangers of synthetic cannabinoids and the need to get help immediately if someone collapses.[11]

VI. Dr Quigley's advised that if a person who has used synthetic cannabinoids collapses, that person should be immediately shaken to attempt to rouse them. If the person rouses, they should then be placed in the recovery position and a call for help should be made. If the person does not rouse, then call for help and commence chest compressions. The call taker who answers the emergency call for help will provide assistance. Do not delay.

VII. This is an important safety message which I endorse. Follow the steps outlined by Dr Quigley and call 111.

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

[10] *In the matter of an inquiry into the death of Andrew Brian McAllister* CSU-2017-HAM-000336, Coroner G Matenga, 4 July 2018 (In Chambers).
[11] *In the matter of an inquiry into the death of Andrew Brian McAllister* CSU-2017-HAM-000336, Coroner G Matenga, 4 July 2018 (In Chambers).

Parker [2021] NZCorC 165 (29 September 2021)

CIRCUMSTANCES

Piripi Raha Turaki Parker, aged 23, died on 15 December 2019 at 18a Norman Street, Hamilton from acute cardiac failure against a background of recreational methylenedioxymethamphetamine (MDMA) and alcohol use.

Mr Parker spent the evening of 14 December 2019, and early morning of 15 December 2019, drinking alcohol with friends. At some point during the night, he left his friend's house to get 'weed'. He returned later saying that he had just had six lines of cocaine.

Mr Parker's friend noticed that Mr Parker was becoming sleepy and encouraged him to lie down. The friend talked with Mr Parker for 15 to 20 minutes, during which time Mr Parker seemed very intoxicated. Mr Parker then began fitting and struggled to breathe. His friends placed him in the recovery position and called emergency services, but Mr Parker could not be revived.

Subsequent toxicological analysis confirmed MDMA in Mr Parker's blood at a level of 0.3 mg/L. It was noted that this level of MDMA has been associated with both recreational use and MDMA related deaths. Alcohol was also confirmed in Mr Parker's blood at a level of 127 milligrams per 100 millilitres. For comparison purposes, the legal blood alcohol limit for a New Zealand driver 20 years or older is 50 milligrams per 100 millilitres.

COMMENTS AND RECOMMENDATIONS OF CORONER BATES

I. The clear dangers of consuming certain recreational drugs, such as methamphetamine, are well-known, well-publicised and generally accepted. That is not necessarily the case with other recreational drugs, such as MDMA, also widely known as ecstasy. Although MDMA is a derivative of amphetamine and can be very harmful, it seems to enjoy a reputation as a 'good time' or party drug that attracts relatively little negative attention. It is a psychoactive drug primarily used for recreational purposes. Desired effects include increased energy and feelings of pleasure. However, MDMA can cause respiratory depression, somnolence, cardiac arrhythmia, coma, and increases the risk of sudden death.

II. The New Zealand drug foundation reports that after cannabis, MDMA is the second most used illegal drug in New Zealand.[12]

III. Combining drugs such as MDMA with alcohol increases the risk of serious harmful effects or, as with the present case, may lead to a fatality. In my view, given the prevalence of MDMA and alcohol use amongst some sectors of the community, it is appropriate to raise public awareness of these risks and, in particular, educate regarding the matters referred to by Dr Arendse at paragraph [24] of these findings. I repeat them here –

> MDMA initially floods the brain with serotonin (which is thought to mediate some of the feelings of wellness, connection, and empathy). This abnormal release of serotonin leads to a relative depletion of

[12] https://www.drugfoundation.org.nz/matters-of-substance/august-2012/about-a-drug-mdma/

the neurotransmitter in the days after use.[13] The comedown from MDMA grimly referred to as "suicide Tuesday" includes symptoms such as depressed mood, lethargy, low motivation, somnolence, fatigue, and anorexia.[14]

Alcohol is the most common drug abused in combination with MDMA.[15] Mixing the two can be very risky. In such settings, people may drink too much water and subsequently develop hyponatraemia – a potentially dangerous deficiency in serum sodium levels. MDMA is thought to disrupt normal water balance and serum electrolyte concentration[16] leading to hyponatraemia (low sodium levels) dehydration leading to muscle spasms, muscle weakness, mental status changes, confusion and potentially seizures.

Alcohol when combined with MDMA extends or enhances the feeling of wellness from MDMA, however the combination of alcohol and MDMA causes increased cardiac cellular stress and toxicity leading to heart-related toxicity. MDMA raises the body temperature and can cause hypothermia, in addition to causing cardiac arrhythmias and potentially stroke.

IV. The NZ Drug Foundation provides the following advice on its website:[17]

When to get help

Large doses or a strong batch of MDMA may result in overdose resulting in symptoms such as: irregular or racing heartbeat, high body temperature, high blood pressure, convulsions, difficulty breathing, passing out, symptoms of heart attack and stroke.

If things have gone wrong for you or for someone you know because of MDMA use (or any other drug) call for an ambulance immediately (dial 111).

V. In an emergency, which includes difficulty breathing or talking and unconsciousness, call 111, as Mr Parker's friends did in this case.

VI. In addition, free health advice is always available, 24 hours a day, on Healthline, on 0800 611 116. Healthline is staffed by registered nurses, paramedics and health advisors who can provide health information and advice on care, including in relation to a friend or family member if you are with him or her.

VII. I recommend that these findings are brought to the attention of media agencies in the hope of raising further awareness of the dangers of MDMA use, particularly when combined with alcohol, as tragically highlighted by Mr Parker's death. It is my hope that this will go some way towards preventing further harm to the public.

[13] National Institute on Drug Abuse (2017). What are MDMA's effects on the brain?
[14] Kim J, Fan B, Liu X, Kerner N & Wu P (2011). Ecstasy use and suicidal behaviour among adolescents: findings from a national survey. Suicide & life-threatening behaviour, 41(4), 435-44.
[15] Althobaiti Y, Sari Y (2016). Alcohol Interactions with Psychostimulants: An Overview of Animal and Human Studies. J Addict Res Ther 7:281.
[16] Campbell G and Rosner M (2008). The Agony of Ecstasy: MDMA (3,4-Methylenedioxymethamphetamine) and the Kidney. Clinical Journal of American Society of Nephrology, 3(6), 1852-6.
[17] https://www.drugfoundation.org.nz/info/drug-index/mdma/

VIII. Given the prevalence of publicity and general information available regarding the harm that may result from alcohol and 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 Parker taken during the investigation into his death in the interests of decency and personal privacy.

Parsons [2021] NZCorC 162 (27 September 2021)

CIRCUMSTANCES

Joshua Bernard Parsons, aged 44, of Wellington, died on or around 11 April 2017. Joshua died from intentional drug ingestion of U-47700, resulting in U-47700 toxicity.

While living in the United Kingdom between 2012 and 2015, Joshua was diagnosed with depression and anxiety and began taking antidepressant medication. In 2015, he began smoking heroin, a habit which escalated until he eventually disclosed his addiction to his wife. After they returned to live in New Zealand in early 2016, Joshua appeared to be drug-free.

During 2016, Joshua had three admissions to the emergency department of Wellington Hospital after episodes of confusion, agitation and losing consciousness. He disclosed thoughts of suicide, while his wife reported a recent significant deterioration in his mental state. In February 2017, Joshua admitted to his wife, family and medical professionals that he had been abusing fentanyl for the past year and apologised for misleading them about his drug use. He disclosed that he had been purchasing fentanyl and mephedrone (a central nervous stimulant) via the internet. He also acknowledged an awareness that fentanyl and its associated group of substances have a high risk of death by accidental overdose.

Joshua was referred to Care New Zealand (a drug and alcohol addiction service) on 27 February 2017. At his assessment on 8 March 2017, he reported that his situation was stabilising. His mood had also appeared stable during his last appointment with his psychiatrist on 6 March 2017. He denied any suicidal ideation and said he was relieved the truth about his drug use was no longer hidden.

On the evening of 11 April 2017, Joshua's father was unable to contact him and went to Joshua's apartment to check on him. He obtained entry with a spare key and found Joshua lying unresponsive in his bed. Despite emergency services attending, Joshua could not be revived and was pronounced deceased at the scene. Items found by Police were consistent with drug use. Forensic toxicology testing revealed that Joshua's blood had a fatal level of U-47700, also known as pink heroin (a synthetic opioid 7.5 times more potent than morphine).

The Coroner considered that Joshua's death was accidental.

COMMENTS OF CORONER DUNN

I. Pursuant to section 57A of the Coroners Act 2006 I can make a recommendation or comment if that recommendation or comment may reduce the chance of further deaths occurring in circumstances

similar to Joshua's. Any such recommendation or comment must be specifically relevant or linked to the facts of the inquiry.

II. Joshua's family have shared with me their concerns regarding the prevalence and dangers of opioid medications. They are concerned that as a family who had been endeavouring to support Joshua as best as they could they were unaware of his opioid addiction. They believe the Mental Health and Addiction Service could be improved and suggest the following:

- To undertake more thorough assessments that include questions about and testing for opioid use and interviews with the family of each patient.
- Adopt a crisis response to a person's exposure to synthetic opioid addiction.
- Provide more specialised and intensive help to people with opioid addictions.
- Provide more information, support and assistance for families.

III. Joshua's family make the valid comment that in New Zealand synthetic opioid addiction is a relatively rare problem but nonetheless carries a high consequence. New Zealand has seen an influx of new drugs like U-47700 coming into the country. I accept that such drugs are dangerous and carry the risk of death particularly when purchased via the internet from an unknown and potentially untrustworthy or disreputable supplier.

IV. I endorse the comments made by Joshua's family [at para II above]. I intend to provide a copy of this finding to the Capital and Coast District Health Board in the hope that the family concerns are made known to the C&CDHB. I am unable however to make a recommendation. Any recommendation made by a coroner must be specific and linked to the factual determinations made in the inquiry. This inquiry reveals resourcing issues and sadly such an issue is all too common in the New Zealand mental health care system.

V. This inquiry revealed that Joshua was aware of the dangers of using opioids and successfully concealed his use from many health professionals and his family. The reality is that people who are addicted to illicit drugs will avoid detection at all costs. Health professionals are aware of the various strategies employed to avoid detection. The health professionals dealing with Joshua were regularly reviewing and assessing him to detect any drug use. Given that Joshua had been candid regarding his previous drug use in the United Kingdom it was reasonable of health professionals to take his denials at face value. I note that from time to time Joshua did undertake blood tests and spent periods in hospital.

VI. Once health professionals and family were aware of Joshua's drug use, they referred him to CareNZ. I appreciate family take the view that the referral was not made quickly enough, however as stated that is a resource issue. Ultimately Joshua attended CareNZ on 8 March 2017, being 14 days after his admission of drug use. It does appear that Joshua had become resistant to help and support.

VII. What has concerned me in this inquiry is the ease with which a dangerous opioid such as U-47700 can be purchased and brought into the country. It is well known that the use of drugs such as opiates (like

U-47700) are dangerous and carry the risk of death. This is particularly so when purchased via the Internet from an unknown and potentially disreputable supplier.

VIII. The earliest identified seizure of U-47700 by the Customs-ESR Screening Laboratory crossed the New Zealand border in October 2016. Joshua was purchasing the illicit drug around the same period. It is widely accepted that U-47700 is responsible for many deaths worldwide. The drug is listed in the United States of America (USA) on Schedule 1 Drugs, since November 2016. The importation of that drug into the USA is primarily from clandestine chemical laboratories in China.

IX. U-47700 is known to be liable for similar health risks as other opioid drugs such as fentanyl, heroin and morphine. Effects include respiratory depression and depressed consciousness. As stated earlier in this finding, U-47700 is approximately a tenth as potent as fentanyl and 7.5 times as potent as morphine. There is a high potential for dependence and due to the short duration of the effects a further urge to re-dose.

X. On 27 June 2017 the Institute of Environmental Science and Research (ESR) Drugs group determined that U-47700 would not be considered a controlled drug analogue as it does not have a structure sustainably like that of any listed controlled drug in the Misuse of Drugs Act 1975. Given its potentially dangerous and addictive effect this is disappointing.

XI. Currently U-47700 is not listed in the Misuse of Drugs Act 1975. Fentanyl is a Class B controlled drug under the Misuse of Drugs Act 1975. However, I am encouraged that some progress has been made to criminalise this harmful drug.

XII. On 16 October 2018 the Ministry of Health expert advisory committee agreed that “U-47700 posed a very high risk of harm and subsequently recommended that the drug be scheduled as a Class A Controlled drug under the Misuse of Drugs Act 1975”. I have been advised by the New Zealand Medicines and Medical Devices Safety Authority (MEDSAFE) that it is likely the scheduling of U-47700 will be completed in early 2022. This is a positive step forward in the need to control the importation, supply and use of U-47700.

XIII. I have been advised that since Joshua’s death there have been two further deaths reported associated with the use of U-47700. Both deaths occurred in 2017. I support and encourage the appropriate authorities to progress without further delay the inclusion in the Misuse of Drugs Act 1975 of U-47700 as a Class A Controlled Drug. Hopefully such categorisation will educate both the public and health professionals of the dangers of this drug.

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

Witehira [2021] NZCorC 122 (4 August 2021)

CIRCUMSTANCES

Tamati Eruera Witehira, aged 24, died on 26 July 2017 at Middlemore Hospital. The cause of death was hypoxic ischaemic encephalopathy caused by cardiorespiratory arrest due to the use of synthetic cannabis, namely AMB-FUBINACA.

Tamati was admitted to hospital on 24 July 2017 after he collapsed at his home address in Papakura, Auckland. Tamati's mother reported that he appeared to be 'high' before he collapsed, and his brother said he saw a synthetic joint lit on the ground near to where Tamati collapsed. Tamati was transported urgently to Middlemore Hospital where it was confirmed that he had suffered a hypoxic injury to his brain.

COMMENTS OF CORONER WOOLLEY

I. Unfortunately, Tamati's consumption of synthetic cannabis has resulted in his death.

II. The dangers of consuming synthetic drugs include:

a. It is promoted or sold as a form of synthetic cannabis, but that there is no cannabis in the product.

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

c. The pharmaceutical agents from which synthetic cannabis was developed were attempts to create new medications to treat spasms and epilepsy but were found to be unsuitable and were discarded. The nature of the synthetic drug is unknown to the purchaser and unknown or poorly understood by the manufactures/distributors in New Zealand.

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

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

f. Finally, and of most relevance to Tamati's death, 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:

a. In order to prevent future deaths from synthetic cannabinoids, Dr Quigley suggested that an all-encompassing harm reduction approach which reduces demand, supply and easy access to treatment for those seeking assistance should be developed. He cautioned that any recommendations on increasing enforcement, targets manufacture, trafficking and supply, while not overly penalising users as this can create a barrier to those seeking medical attention, even in cases of emergency.

b. 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.

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

IV. Dr Quigley is a vocational specialist in Emergency Medicine, he has completed additional studies in clinical toxicology and conducted research in forensic toxicology. He is a recognised expert in emergency management and treatment of drug and alcohol presentations.

V. 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 any photographs that show the deceased, in the interests of decency and personal privacy.

Fall

Crafar [2021] NZCorC 133 (23 August 2021)

CIRCUMSTANCES

Kevin James Crafar, aged 34, died on 14 September 2020 at Middlemore Hospital. The cause of death was due to neck injuries following a fall.

Mr Crafar arrived at his cousin's home at 307A Bairds Road, Otara around 10:00am on 12 September 2020. He appeared to be drunk and under the influence of drugs. He came into the house to use the toilet then went outside, where he sat on top of the hand railing at the front door. His feet were dangling down.

Mr Crafar's cousin was outside when she saw Mr Crafar flip backwards off the railing and hit his head on the grass lawn. His neck appeared to be bent. Mr Crafar was initially unresponsive but breathing. He appeared to be drunk and passed out. He began speaking and moving but after being moved on to a mat he stopped talking and passed out. About 30 minutes later his cousin noticed bubbles coming out of his mouth and his lips turning purple. Emergency services were called and Mr Crafar was transferred to Middlemore Hospital.

The hospital undertook a scan which showed spinal injury and brain swelling. Mr Crafar remained unresponsive on a ventilator. After discussions with his family life support medication was withdrawn. Mr Crafar died on 14 September 2020.

COMMENTS AND RECOMMENDATIONS OF CORONER TETITAHA

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

II. The evidence raises the possibility that the hand railing that Mr Crafar was seated on may have been inadequate and/all non-compliant with the required building standards. The building standards provide minimum standards for compliance to presumably prevent accidents or falls similar to Mr Crafar.

III. I had intended making the following comments and/or a recommendation for Kainga Ora to complete a physical inspection of the railing at 307A Baird Road, Otara, Auckland to ensure it complies with all applicable New Zealand building standards and its own internal building standards. A copy of my draft comments and recommendation were provided to Kainga Ora and the Auckland City Council. Both provided replies.

IV. Following the receipt of the draft comments/recommendations, Kainga Ora engaged Babbage Consultants Ltd to complete an inspection of 307A Baird Road, Otara on 8 July 2021 and a report has been provided. Although the report appears to recommend no further action, there are two matters that require attention:

> Some deterioration was observed to the barrier in the form of mild corrosion and a detached mid-rail. Maintenance works are now required to reattach of the absent rail and clean corrosion.
>
> …
>
> The height of the guard did not comply in 1965 when it was constructed and does not comply with the current acceptable solution of the NZBC for barriers or handrails. The level of non-compliance is considered negligible (discrepancy of 30 mm barrier height) and does not necessarily increase the risk of falling.

V. Having considered the information received and in light of the circumstances leading to the death of Mr Crafar, I would make the following recommendations pursuant to section 57A Coroners Act 2006:

> That Kainga Ora consider the replacement of the handrail at 307A Baird Road, Otara with one that is compliant with the New Zealand Building Code.

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

Fire

Kaan [2021] NZCorC 113 (26 July 2021)

CIRCUMSTANCES

Joy Helen Kaan, aged 64, died on 10 August 2017 at Awaroa Road, Helensville from smoke and soot inhalation and thermal injuries.

Joy lived at Awaroa Road, Helensville with her husband Pieter.

On 10 August 2017 Joy and Pieter were awoken by a loud bang. They went into the living room and saw a white smoke haze. When they looked through the kitchen door, they could see a glow coming from the internal stairs.

Joy and Pieter returned to their bedroom and noticed the smoke had become black and rancid. Pieter told Joy to get down on the floor and follow him. However, after crawling out of the house, he realised that she had not followed him. After the fire was extinguished, firefighter found Joy in the bedroom, deceased.

COMMENTS OF CORONER DUNN

I. Pursuant to section 57(3) of the Coroners Act 2006 I make the following comments:

a. While Pieter and Joy were alerted to the fire, which they were able to investigate, they made the fateful decision to return to their bedroom before escaping.

b. I endorse the message provided by Fire and Emergency New Zealand on their website:

> If there's a fire in your house, you'll have around 3 minutes to get out before the fire becomes unsurvivable.
>
> Here are the things you should do immediately:
>
> - If there are others in the house, shout 'FIRE, FIRE, FIRE!'
> - If there's smoke, get on your hands and knees and crawl low and fast to escape smoke. The smoke will be hot and poisonous, and if you breathe it in, it can kill you. Remember: Get Down, Get Low, Get out.
> - If you can, close doors behind you to stop the fire spreading.
> - If you can't get out of the house, close the door of the room you're in and put a towel under it to stop the smoke coming in. Go to the window and yell 'FIRE, FIRE, FIRE!'. Wait for help.
> - If you can't open a window (if it has security stays, for example), consider using a chair or other furniture to break the glass. Use bedding to cover any remaining sharp pieces of glass to escape unharmed.

- As soon as it's safe, call 111 immediately either from a mobile phone or a neighbour's house.
- Meet at your agreed safe meeting place — somewhere safely away from the house.

II. I do not make any comments about the lack of functioning smoke alarms as it is not clear on the evidence before me whether this contributed to Joy's death.

III. I do not make any recommendations pursuant to 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 Joy in the interests of decency and personal privacy.

Leisure Activities

Corridon [2021] NZCorC 131 (21 July 2021)

CIRCUMSTANCES

Paul Francis Corridon, aged 71, died on 10 November 2019 at Christchurch Hospital from internal chest injuries (traumatic aortic rupture) which he sustained in an earlier fall from Rapaki Rock.

In the morning of 10 November 2019, Mr Corridon and his climbing partner began to climb Rapaki Rock. Mr Corridon intended to practice his lead climbing; this required that he climb ahead and place anchors before belaying from top.

The New Zealand Mountain Safety Council (MSC) provided a report to the Coroner addressing possible causes of the fall. The MSC considered the lack of anchored safety gear by Mr Corridon to be the primary contributing factor. The MSC emphasized the importance of establishing a solid stance and placing safety gear at regular intervals when conducting a lead climb. Furthermore, the MSC explained that the route up Rapaki Rock selected by Mr Corridon afforded few places to establish an anchor in the lower and mid sections. Consequently, the MSC advised that that route was better suited to top rope rather than to climb on lead.

RECOMMENDATIONS OF CORONER ELLIOTT

I. MSC said:

> **Face Variation should not be climbed as a lead climb**
>
> As the route that Corridon was climbing, Face Variation, lacked suitable protection, MSC recommends that climbers do not attempt to climb this route as a lead climb. The route description should be updated on ClimbNZ (a community site coordinated by the New Zealand Alpine Club) and in any future climbing guidebooks, both new and revised, which feature Rapaki Crag.
>
> It is worth mentioning that there are likely to be many other climbs in NZ with limited opportunities for protection, especially on the lower sections of the climb. MSC recognises that the development of these

route guides is through the hard work and dedication of volunteers and often over the period of many years. There is no organisation or individual solely responsible for the publishing and maintenance of route guides, nor for the safety and upkeep of climbing crags. Nonetheless, this should not be a reason not to make such a recommendation.

Route guides should contain information on the quality and availability of protection

MSC believes that it is in the best interests of public safety if clearer information is available on the quality and availability of protection on each climb, and therefore encourages the climbing community to make further use of the available communication channels to share these key messages. One such example is the comments function found under each climb listed on the ClimbNZ website.

Recommendations for climbers

Traditional lead climbing is an inherently risky recreational pursuit, and it is often this balance between risk and reward that attracts and motivates climbers. It is impossible to remove all the risks from traditional lead rock climbing, so occasionally things do go wrong and despite best intentions and actions, serious accidents occur.

Through reviewing all the evidence available and considering at length how this accident can be used as a learning point for others, MSC encourages all rock climbers to consider the points below:

- Placing multiple protection pieces at the start of a climb is extremely important in preventing a ground fall. These should be placed to allow for both outwards and downwards loading.
- Placing protection requires an elevated level of skill and judgement. It takes time to perfect the skill and a sequential approach to learning is important. This includes getting instruction from qualified instructors, starting with practicing placing gear on the ground, then on top rope before lead climbing. Attempting climbs well below the climber's own ability and testing pieces while on top rope are also important considerations.
- Each climb is different in the type and number of quality pieces available. Having a wide range of available equipment, and knowledge of how to use each piece, is essential.
- Not every route needs to be lead-climbed. Before climbing, identify where the best places for placing protection are. Many climbing guidebooks suggest where places for good protection exist, so make sure you familiarise yourself with this detail. If you cannot see any suitable places in the first 2 or 3 metres, then find another route to climb, or set up a top rope.
- Following this assessment, both the climber and belayer need to consider the consequences of a fall at every stage of the climb. Look for large ledges in the

climber's fall line and assess if there still a chance the climber could hit the ground due to a long run-out section.

II. I endorse these comments. I recommend pursuant to section 57A of the Coroners Act 2006 that the New Zealand Alpine Club takes the steps identified by MSC. As noted, New Zealand Alpine Club was given an opportunity to comment on this proposed recommendation and made no comment.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs that show the deceased upon the grounds of personal privacy, decency and that there is little public interest in photographs such as these being published.

Gibbons [2021] NZCorC 147 (8 September 2021)

CIRCUMSTANCES

Shane Gibbons, aged 50, died on 18 March 2019 at Hollyford River, Fiordland of blood loss from lower limb trauma sustained when he was trapped under a jet boat that had collided with a submerged river rock and rolled onto a gravel island in the river.

Mr Gibbons was one group of approximately 12 friends and business associates who set out on a four-day jet boating trip, in the Hollyford area of the Fiordland National Park organised by Paul Turner.

On 18 March 2019, at around 6:50pm four of the group, including Mr Gibbons and Mr Turner travelled in Mr Turner's jet boat from Lake Alabaster Hut to a fishing spot approximately 12 kilometres away, on the Hollyford River near Lake McKerrow. Mr Gibbons sat in the rear seat, behind Mr Turner (the driver). All on board had consumed alcohol that day, including Mr Turner.

Approximately one hour later the group decided to head back to Lake Alabaster. By this time, it was well into dusk and the light was fading. About seven kilometres into their return journey they reached a section of the river with a gravel bar/island in the middle of it. Mr Turner saw the gravel island at the last minute and turned the boat to the port side. During this manoeuvre, the rear starboard side of the jet boat came into contact with a submerged rock, causing it to roll. All occupants were thrown clear of the jet boat, except Mr Gibbons who was trapped by his legs under it. He was pulled out, but had sustained significant injuries. Despite resuscitation attempts, Mr Gibbons could not be revived and died at the scene.

The Police charged Mr Turner with operating a ship in a manner which caused unnecessary danger to other persons, pursuant to section 65(1)(a) of the Maritime Transport Act 1994 (the MTA). Mr Turner pleaded guilty and was convicted and sentenced.

COMMENTS OF CORONER JOHNSON

I. Mr Turner was not charged with causing Mr Gibbons' death and also did not feel intoxicated at the time of the collision with the rock. But, did his drinking beforehand contribute to Mr Gibbons' death? I find that it did. The test for whether something contributed to a death is found in the case of *Carroll v*

Auckland Coroner's Court: to contribute something is to be partly instrumental in, or partly responsible for it. And there needs to be a proper evidential foundation for such a finding.[18]

II. The evidence before me includes the Judge's Sentencing notes and those show that the Judge told Mr Turner

> . . .you should not have been driving at all: you should not have been operating in those conditions, and you should not have been drinking beforehand. While you say that you did not feel intoxicated, the level of alcohol in your system at the time would have undoubtedly affected your judgment and your reactions and you should have known that. The combination of those factors had a fatal outcome.

III. I am satisfied that this evidence before me shows that the level of alcohol consumed by Mr Turner was one of the two factors that resulted in Mr Gibbons' death. Mr Turner's drinking was therefore partly responsible for Mr Gibbons' death and thus contributed towards it.

IV. I have therefore considered whether there are any recommendations or comments I could make to prevent future deaths occurring in similar circumstances.

V. Following Mr Gibbons' death, the Transport Accident Investigation Commission (TAIC) investigated this jet boat accident and in February 2020 released its final report.

VI. The report shows that Maritime New Zealand has developed a fatal accident database and records show that since January 2015, 79 people have died in recreational boating accidents. And between January 2019 and October 2019, 19 people died in recreational boating accidents. TAIC said,

> It is unclear how many of these fatal accidents were a consequence of the skippers being impaired, because there are no specific powers to test recreational boat drivers and skippers for the presence of alcohol or drugs if they are involved in accidents.

VII. In 2007, the New Zealand Safer Boating Forum's (the Forum)[19] Boating Safety Strategy review, estimated that alcohol consumption was involved in at least 18% of recreational boating and watercraft fatalities between 2000 and 2006 based on post-mortem investigations. However, the Forum noted that the actual percentage of alcohol-related recreational boating and watercraft fatalities is likely to be higher because alcohol and drug testing was not always carried out post-mortem.

VIII. TAIC's report shows that it has previously made a recommendation for appropriate legislation or rules to prohibit people in safety-critical roles being impaired by alcohol or drugs. Its recommendation includes people operating recreational vessels.

IX. In response to TAIC's recommendation, the Ministry of Transport undertook policy work, including commissioning a report by the New Zealand Institute of Economic Research. The report estimated that there were about 43 recreational boating fatalities in the period from 2002 to 2011 "where substance abuse might have been a factor".

[18] *Carroll v Auckland Coroner's Court* [2013] NZHC 906.
[19] Formerly known as the National Pleasure Boat Safety Forum.

X. The TAIC report states that NZ Police and Maritime New Zealand have supported enforceable drug and alcohol limits. And that NZ Safer Boating Forum's 2014 strategy recommended mandatory alcohol limits for recreational skippers.

XI. TAIC states that the Ministry of Transport considers that the current data on alcohol and drug related incidents does not justify the intervention proposed by TAIC but would reconsider that decision if new data gathered by the regulators indicated a widespread problem.

XII. TAIC found that there is limited data available to determine the extent of alcohol use in the recreational maritime sector and its influence on accident statistics. TAIC acknowledged the work that Maritime New Zealand has done in developing its fatal accident database, but has recommended to its director that Maritime New Zealand continues to develop its fatal accident database to improve the quality of its data so that the maritime sector is better able to understand the risks of alcohol and drug use in recreational boating fatalities.

XIII. On 5 March 2020, the Director of Maritime New Zealand replied to TAIC:

> Maritime NZ accepts the recommendation and can confirm that it is in the process of implementing it. Updating and improving the quality, fidelity and timeliness of data held in Maritime NZ's internal Maritime Fatal Events Database is an ongoing and continuous task for Maritime NZ data analysis staff.
>
> Noting the importance of building the reliability of the dataset, there is a focus on detail such as skipper impairment and causal factors. This will allow for more detailed analytical review over time.
>
> In light of the ongoing nature of this work, Maritime NZ does not consider it prudent to specify a completion date for this recommendation. An update on progress on the increasing reliability of the data set could, however, be provided as that becomes evident.

XIV. In June 2020, Maritime NZ released the statistics from its annual survey of recreational boat operators in its Recreational Boating Survey (the Survey).[20] These show that only 63% of boat operators who responded to the survey in 2020, and 52% in 2019 viewed boating safety as being very important.[21]

XV. The Survey also identified that 65% of respondents avoided alcohol before or during boating.[22] Of the respondents who were drinkers, 57% said that they thought it was OK to drink alcohol for their kind of type of boating. And 54% said that it is up to individuals whether they decide to drink alcohol when boating, and only 25% disagreed with that.

XVI. The Survey noted that the main challenge in reducing on-board alcohol consumption in New Zealand "is the social pressures that inhibit people's likelihood of trying to reduce others' drinking." To address this behaviour the Survey report stated:[23]

[20] Maritime NZ. Maritime NZ 2020 Recreational Boating Survey-Top-Line Results (June 2020).
[21] Maritime NZ. Maritime NZ 2020 Recreational Boating Survey-Top-Line Results (June 2020) page 27.
[22] Maritime NZ. Maritime NZ 2020 Recreational Boating Survey-Top-Line Results (June 2020) page 19.
[23] Maritime NZ. Maritime NZ 2020 Recreational Boating Survey-Top-Line Results (June 2020) page 35.

> drinkers would potentially benefit from guidance on how to set the default position of not drinking on board and how this could be reframed as the 'collective responsibility' of all passengers.

XVII. The Survey also identified that only 60% of boat operators recalled seeing any Maritime New Zealand safety advertising.

XVIII. Most Australian States (except two) have laws stating an upper legal blood alcohol concentration of no more than 50 milligrams of alcohol per 100 millilitres of blood when operating a boat. This includes recreational boating. In many Australian States random breath testing on the water is permissible, and boat operators can be fined if found to be under the influence of alcohol.[24] Other regulations in place to improve boating safety include mandatory licensing of boat operators and compulsory vessel registration of powered boats.

XIX. TAIC considers that the need for appropriate legislation or rules to prohibit people in safety-critical roles, including people operating recreational vessels, being impaired by alcohol or drugs is a long-standing safety issue and its recommendation to the Ministry of Transport remains open and is still on TAIC's watchlist.[25]

XX. TAIC also stated that Mr Gibbons' death highlights the ongoing risk of not implementing safety actions to address its recommendation.

XXI. In order to reduce the risk of future boating deaths associated with alcohol use, a copy of these draft finding was sent to Te Manatū Waka Ministry of Transport (the Ministry) with the following proposed recommendation.

- I recommend that Te Manatū Waka Ministry of Transport reconsiders its current position regarding TAIC's recommendation for appropriate legislation or rules to prohibit people in safety-critical roles, including people operating recreational vessels, being impaired by alcohol or drugs.

XXII. The Ministry responded to my proposed recommendation advising that although in 2017 the MTA was amended to enable drug and alcohol testing in people in safety sensitive roles in the commercial sector, the Ministry has decided not to proceed with such a scheme in the recreational sector. This is because it considers that section 65 of the MTA (which Mr Turner was convicted under) prohibits operating any vessel in a dangerous manner "which necessarily includes operating a recreational boat while affected by alcohol or drugs", and because

> Enforcement would be particularly complex for recreational boating, due to the high number of recreational boat users operating over a large area, and the low number of police vessels. There is also limited evidence from other countries that an enforcement-based response has improved recreational boating safety outcomes.

[24] Stacey Wilcox-Pidgeon et al "Boating-related drowning in Australia: Epidemiology, risk factors and the regulatory environment." (2019) 70 Journal of Safety Research 70 117 at 118.
[25] https://www.taic.org.nz/watchlist/regulations-preventing-substance-impairment

XXIII. However, there is nothing in s 65 of the MTA that assists people who are not aware that they may be affected by alcohol. Mr Turner did not feel intoxicated. There is nothing in s 65 that provides for an alcohol limit that can guide people to know when they are illegally operating a recreational vessel in a dangerous manner. Road users are clearly advised of the alcohol limit for operating a vehicle on the road. They are also told how many standard drinks that upper limit is. The fact that "enforcement would be particularly complex" should not be a reason for not having a rule in the first place.

XXIV. I agree with TAIC that having no legislation or rules specifically to prohibit people operating recreational vessels being impaired by alcohol or drugs is a safety issue. And I agree with TAIC that Mr Gibbons' death highlights the ongoing risk of not implementing safety actions to address its recommendation.

RECOMMENDATIONS OF CORONER JOHNSON

I. That Te Manatū Waka Ministry of Transport reconsiders its current position regarding TAIC's recommendation for appropriate legislation or rules to prohibit people being impaired by alcohol while operating recreational boats.

II. A copy of this finding will also be sent to Maritime New Zealand.

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

Wells [2021] NZCorC 145 (2 September 2021)

CIRCUMSTANCES

Ian Gregory Wells, aged 54, died on 24 March 2018 at Doubtful Sound, Fiordland, of an unascertained cause.

Mr Wells was an experienced diver who had held a PADI open water diving qualification since 1991. On 24 March 2018, he was observed to be in difficulty during a dive near Bauza Island. At a depth of approximately 20 metres, while a diving companion was attempting to assist him, Mr Wells suddenly sank downwards. He was relieved of his weights at a depth of approximately 30 metres and immediately assisted to the surface. Despite CPR efforts for over one hour, Mr Wells was unable to be revived. Pathologist Dr Balachandra concluded that his death was most likely due to a sudden cardiac event.

After Mr Wells' death, the Police National Dive Squad examined his diving equipment and provided a report. The report concluded that the following factors, while not necessarily fatal on their own, had a domino effect which, when combined, led to fatal consequences:

- It appeared that the filling operation of the dive cylinders by members of the dive party did not comply with The Hazardous Substance (Compressed Gases) Amendment Regulations 2012.
- The air supplied by the fillers was not within the required safe levels as directed by The Hazardous Substance (Compressed Gases) Amendment Regulations 2012.

- The regulators used by Mr Wells were not serviced correctly, making it harder for him to breathe whilst at pressure.
- Mr Wells' buoyancy compensator device (BCD) was not appropriate for his weight. A damaged inflater hose connection on the BCD prevented him from inflating it when in difficulty to assist him to the surface.
- Mr Wells did not abandon his weight belt when in difficulty.
- During the dive, Mr Wells separated from his dive buddies for a reasonable period of time and this is when he got into difficulty.

The Coroner could not determine whether Mr Wells' death could have been prevented due to the uncertainty around his precise cause of death.

RECOMMENDATIONS ENDORSED BY CORONER MCKENZIE

I. I am required by section 57A of the Coroners Act 2006 to confine any recommendations made to those which can be clearly linked to the factors that contributed to the death.

II. Given that legislative restriction, I cannot make any formal recommendations given the lack of confidence around a particular cause of death.

III. I consider however that the recommendations made by the Police National Dive Squad for recreational divers in its report are helpful to repeat:

   a. All persons using a compressor to fill dive cylinders be made aware of their requirements under the Hazardous Substance (Compressed Gases) Amendment Regulations 2012.

   b. Ensure dive equipment operates correctly and is regularly serviced.

   c. Divers should abandon their weights and catch bag when in difficulty.

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

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

Medical Care

Clark [2021] NZCorC 166 (30 September 2021)

CIRCUMSTANCES

Professor John Clark, aged 73, died on 15 July 2017 at Dunedin Public Hospital of acute respiratory distress syndrome and multi organ failure, secondary to atelectasis resulting from his cholecystitis.

On the evening of 7 June 2017, Professor Clark presented to the Emergency Department at Dunedin Hospital complaining of abdominal pain. He was assessed by a junior registrar, Dr Miller, who examined his abdomen and recorded a differential diagnosis. She performed a bedside ultrasound to exclude potential abdominal aortic aneurism but was not trained to undertake an ultrasound examination to identify other abdominal pathologies, such as cholecystitis. Dr Miller's impression was recorded as "?gastritis" and Prof Clark stayed in hospital overnight for observation. He was discharged the following morning. There was no record that a physical examination was undertaken before discharge, but the doctor who ordered discharge stated that he believed one would have been completed.

Prof Clark suffered a fall on 10 June 2017, and was taken to Dunedin Hospital by ambulance, again complaining of abdominal pain. He was diagnosed with cholecystitis and admitted to a surgical ward early on 11 June 2017.

A surgical booking was made at 8:30am on 11 June 2017, listing Prof Clark as a "P4" priority, which indicated that the surgery should occur within 24 hours of the booking. Prof Clark's surgeon directed that the Acute Theatre team be informed that the surgery was expected to occur within the next "24 to 48 hours". The care was then handed to a different junior registrar, Dr Becker, who made a call to the anaesthetic registrar, Dr Thompson, to advise that an anaesthetic review was needed to determine whether Prof Clark was a suitable surgery candidate. This appeared to be at variance with policy, which required the submission of a booking form for anaesthetic reviews. Once forms are submitted, the details are transferred to the "Theatre White Board", which displays all patients waiting for surgery to most effectively utilise emergency theatre time. There was evidence of some communication between Dr Becker and Dr Thompson that day, and a booking form was ultimately submitted at 8:30pm on 11 June 2017.

Prof Clark deteriorated from 8:30pm on 11 June 2017, at which point he was reviewed by a house officer. There was no evidence that a medical review was subsequently performed by a registrar or more senior doctor. Nursing notes state that quetiapine was administered, but there is no record of this medication having been prescribed to Prof Clark by a doctor. There was also no record of a medical review occurring the following morning.

Prof Clark was operated on during the afternoon of 12 June 2017. The surgery revealed a perforated gallbladder with a four-quadrant bile contamination. The gallbladder was removed and the abdomen washed out, but Prof Clark did not improve over the succeeding days, deteriorating and ultimately passing away.

On 6 September 2017, Dr Thompson sent an email to a consultant anaesthetist outlining her interactions with Dr Becker from 11 June 2017.

RECOMMENDATIONS OF JUDGE ROBINSON

I. The making of recommendations is governed by section 57A Coroners Act 2006. Subsection (3) provides:

> (3) 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. Recommendations are therefore restricted to matters where there is a causal link between the subject matter of the recommendation and the death concerned. That restriction, a consequence of the 2016 amendments to the Act is unfortunate, as it precludes the making of formal recommendations on matters disclosed during an inquest that are not causative of death.

III. In my view, consistent with the submission of the Chief Coroner, Judge Marshall to the Select Committee considering the then proposed amendment, is that the provision severely limits the utility of the coronial process by precluding comment on matters which could legitimately be identified as opportunities for improvement but which are not connected to the cause of death.

IV. Bearing in mind that restriction, I make the following recommendations:

> The Southern District Health Board should develop, and implement an algorithm to guide junior doctors on the assessment of abdominal pain, similar to that annexed to the advice of Dr Finnell.[26]

V. The DHB has made changes since Prof Clark's death for which it is to be commended:

a. Adopting the more sensitive NZEWS early warning system;[27]

b. Running a second acute theatre on Sundays;

c. Instigating a morning meeting of theatre management staff to review utilisation.

VI. Ultimately, in large part, the timing of surgery for Prof Clark on 12 July 2017 came down to a matter of resources. I do not think I am well placed to make recommendations as to the allocation of public health resources. Regrettably we must all accept that health resources are limited, and that it is for management and clinicians to guide the most effective use of those. Any recommendation I might be tempted to make about increasing resources for acute surgery at weekends could well have unintended flow on consequences to other services. I accordingly refrain from doing so.

VII. Beyond that, if I did have jurisdiction to make recommendations on other matters identified that were not causative of death, I would have suggested a review of the surgical priorities and use of the booking system.

VIII. As to priorities, it was evident that surgeons' views of the timeframes for surgery under P4 priority differed from policy (24 – 48 hours vs 24 hours). In my view, the terms of the policy, and surgeons' understanding or expectation of the timeframes should align.

[26] Bundle 1/45.
[27] https://www.hqsc.govt.nz/assets/Deteriorating-Patient/PR/Vital_sign_chart_user_guide_July_2017_.pdf

IX. My impression was that the manner in which the booking system was used in reality varied from the applicable process, resulting in a degree of informality or looseness that could, depending on the particular circumstances of the case be detrimental to the best interests of the patient.

X. The evidence disclosed that there was no formal record of telephone requests for anaesthetic review. Dr Watts acknowledged that such requests could be "consigned to memory",[28] while Dr Thompson advised her practice was to record such requests in her notebook.

XI. The process envisages that the Theatre booking system be the place for recording requests for anaesthetic review, and the concerns or condition giving rise to the request. The use of an ad hoc telephone system, recognising the very considerable work pressures on the weekend anaesthetics registrar in my view leads to much scope for requests for reviews to be lost or overlooked.[29]

XII. The theatre booking whiteboard is capable of recording and displaying requests for anaesthetic reviews. While I accept there is a place for telephone contact with an anaesthetics registrar, (such as where advice is being sought), my view is that the preferable course is for there to be a documented record of a request for anaesthetic review (i.e. on the acute theatre whiteboard as a consequence of submitting a theatre booking form).[30] As Dr Thompson noted, verbal requests for an anaesthetic review could "get lost".[31]

XIII. Further, the processes around timing of submission of theatre booking form could benefit from review. The evidence was of the clock running from the time of the booking form was submitted. Accordingly, assuming two cases of equal priority, the case that was bought earlier in time would likely receive surgery sooner. While I accept that cases would be operated on based on their clinical priority, (with reprioritisation occurring in the event of deterioration), inconsistencies around the timing of submission of form could prove to be detrimental in certain cases.

XIV. The record-keeping in this instance left a lot to be desired. There was, for example, no record of Prof Clark having been reviewed by a registrar subsequent to the house officer review at about 8:30pm on the 11th. There is no evidence of review through the early hours of the morning, or of the antipsychotic quetiapine having been prescribed.

XV. Finally, notwithstanding the timely complaints to the District Health Board by the Clark family and referral to the Health and Disability Commissioner, certain of the clinicians involved did not appear to have been notified of the family's concerns with the consequence that they did not make any time to note of their involvement to facilitate further enquiries into the matter. Dr Becker had no notes from which to base his evidence apart from the clinical record. Dr Thompson was in a slightly better position in that her September email was available, but any inquiry into the circumstances of Prof Clark's death

[28] NOE 207/4. Telephone calls played an important part, allowing for provision of more nuanced discussion, but best practice would be for an electronic system recording information from the earliest times surgery was considered, supplemented by verbal advice: NOE 220/17.
[29] NOE 218/14.
[30] That accords with the approach of Dr Watts: NOE 217/29.
[31] NOE 254/20.

would have been assisted by those clinicians being aware of the complaint at an early stage, so they could have documented their recollection of the events, closer to the time.

XVI. The District Health Board may wish to reflect on this with a view to a policy of notifying affected staff of potential enquiries early in the piece.

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

Dornan [2021] NZCorC 152 (15 September 2021)

CIRCUMSTANCES

Ann Dornan, aged 78, died on 28 September 2019 at Whanganui Hospital of acute left subdural haematoma.

On 9 July 2019, Mrs Dornan collapsed and was taken to Tauranga Hospital (she was transferred to Waikato and then to Whanganui Hospital for further treatment over the coming days). A CT scan revealed a large subarachnoid haemorrhage from an aneurysm (stroke). Mrs Dornan underwent endovascular stent-assisted coiling of the left posterior communicating artery aneurysm. She went to rehabilitation and following improvement was discharged on 26 August 2019.

On 16 September 2019, Mrs Dornan was re-admitted to Whanganui Hospital after presenting to the emergency department with stroke related symptoms. An MRI scan revealed a right cerebral infarction. Mrs Dornan remained in hospital for treatment. She was in a “High Watch” room (which requires staff to check on patients every 15 minutes) and was given a “stroke bed” which is alarmed and has sides that lock into place to prevent falling out.

Mrs Dornan continued to show signs of physical recovery. However, she had poor insight about her new impairments, including belief that she was able to independently do things that she actually could not e.g. stand and walk. On 28 September 2019, Mrs Dornan had an unwitnessed fall from her bed. The bed rail was found in the down position. Her condition deteriorated and she died the same day.

The Whanganui District Health Board commissioned a report into Mrs Dornan’s fall following her death. It found that there was no documentation of Mrs Dornan being checked on every 15 minutes. It also found general issues with Mrs Dornan’s hospital notes and that there were issues experienced by staff and patients relating to the stroke bed alarms.

COMMENTS OF CORONER HESKETH

I. Medical staff are often very busy on Wards in the Hospitals around the country. Staff work different shifts as health is not a 9-5 profession. Medical staff are often confronted with challenging situations and people. The DHBs create policy and procedure to ensure patients are cared for to the highest standards possible. In most cases these standards are met, and medical professionals work tirelessly to ensure they deliver their best abilities, often in challenging and busy periods.

II. The recording of clinical notes is an important procedural requirement to ensure both present and oncoming staff are kept up to date with relevant information about patients. Given Mrs Dornan’s

medical condition it is concerning that no record was made of her being seen to lower the bed rail as later alleged.

III. That is not only from the perspective of there being no record of an event that has subsequently become subject to an internal investigation but also from the need that other staff should have been aware of her actions as further monitoring would have been required.

IV. I also comment on the Falls Report section on bed alarms. The report authors discovered that staff had expressed their concern in the past about the bed alarms not always working. Staff had reported these faults however it appears from the report the staff concerns had not been addressed. Furthermore, some bed alarms appeared to be faulty as they continually "beeped" leading to staff developing a syndrome they referred to as "bed fatigue". They became so used to the noise that they ignored it until the patients complained.

RECOMMENDATIONS OF CORONER HESKETH

I. I recommend the Whanganui DHB produce guidelines for High Watch patients to ensure they are observed at 15 minute intervals and a record of those observations is kept.

II. I recommend Ward staff be reminded of or if necessary, receive further training around the importance of the need for attention to detail when recording patient's clinical notes. Matters that are relevant to the care plan of a patient should be recorded.

III. I recommend Whanganui DHB attend to fixing any defective bed alarms so that staff will have confidence in knowing when a bed alarm activates it is a genuine incident.

IV. These recommendations are made in accordance with section 57A of the Coroners Act 2006. I notified Whanganui DHB of my comments and recommendations. They have responded to my notice in writing in which the Clinical Quality and Risk Advisor records:

a. The DHB discussed my provisional finding and recommendations and are fully supportive of these.

b. Since Mrs Dornan's death the DHB have the stroke beds serviced and the alarms checked regularly. Staff have been formally reminded to document all matters regarding a patient irrespective of their source, that is from visitors and other patients as well as from direct observation and contact.

c. The DHB are currently reviewing their observation procedure to ensure high watch is well defined and there is a recording sheet to support the required 15 minute observations.

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

Richards [2021] NZCorC 135 (23 August 2021)

CIRCUMSTANCES

John Richards, aged 72, died on 5 February 2021 at North Shore Hospital, Auckland, from aspiration pneumonitis due to a nasogastric tube in the lower oesophagus.

On 6 January 2021, Mr Richards was discovered at his home seriously injured, having appeared to have fallen down some stairs. Emergency services were called and he was taken to Auckland City Hospital. There, the extent of his injuries was determined and included (among others) subdural haematoma.

On 12 January 2021, a nasogastric tube was placed in order to commence nasogastric feeding. It was recommended that Mr Richards undergo a chest x-ray in order to "site tip of tube before use". Following the x-ray, the radiology report noted that the tip of the tube was excluded from the study but was well below the level of the diaphragm. On 14 January 2021 Mr Richards was transferred to North Shore Hospital for ongoing care, and had mittens placed on to his hands to stop him pulling out the nasogastric tube.

On 19 January 2021 Mr Richards was coughing and vomiting, including nasogastric feed. The nasogastric feed was stopped. He was then sent for a further chest x-ray which noted the nasogastric tube was in the lower oesophagus. He subsequently developed aspiration pneumonia because of the vomiting and subsequently died on 5 February 2021.

A report from Waitematā District Health Board highlighted some concerns to the Coroner, noting that "there is an opportunity for review of the nursing management of patients with a nasogastric tube in situ, to ensure that the position of the tube is correct prior to the commencement of any nasogastric feeding at least daily, and usually prior to the connection of any feeding bag."

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 procedures followed by the Hospitals when placing Mr Richards nasogastric tube. Correct nasogastric tube placement prior to feeding commencing is important to prevent vomiting and aspiration pneumonitis. The method for checking nasogastric tube placement before feeding commences is by way of chest x-ray.

III. Following the placement of the nasogastric tube, there was a recommendation for a chest x-ray to view the tip of the nasogastric tube. The chest x-ray completed on 12 January 2021 excluded the position of the tip of the nasogastric tube. The chest x-ray undertaken on 19 January 2021 showed the tip of the nasogastric tube was within the lower oesophagus and not within the stomach. This leaves open the possibility that Mr Richards' nasogastric tube was incorrectly placed on 12 January 2021.

IV. A report from the Waitematā District Health Board indicates there is no standardised method of recording the checks undertaken by nursing staff prior to nasogastric feeding. This is concerning as it may lead to mistakes.

V. Patients such as Mr Richards are especially vulnerable because they would be unable to communicate any distress caused by a nasogastric tube feeding.

VI. There may be a need to review the Hospitals' existing policies and training and competency frameworks regarding nasogastric tube placement and feeding. Mandatory documentation of the method by which the nasogastric tube's position is confirmed and ongoing documentation confirming correct placement should safeguard against accidental and/or catastrophic use of nasogastric tubes. This may avert similar deaths to Mr Richards'.

VII. These comments were directed to Waitematā District Health Board and Auckland District Health Board.

RECOMMENDATIONS OF CORONER TETITAHA

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

II. I sought comment from the Waitematā District Health Board and Auckland District Health Board regarding my draft findings, comments and recommendation.

III. The Auckland District Health Board have provided a reply. They do not agree the nasogastric tube was incorrectly placed on 12 January 2021 because the phrase "well below the level of the diaphragm" indicates the tip is correctly placed in the stomach. Further the nasogastric tube was placed under direct visualisation by gastroscopy. They referred to the report that Mr Richards tried to pull out his NGT as the reason for it subsequently being incorrectly placed. They attached the Auckland DHB's policy on nasogastric and nasojejunal care for an adult.

IV. They confirmed that they have looked into their current practices regarding documentation of nasogastric tube placement and can confirm there is not currently a mandatory documentation method for nasogastric tube placement "but this is something that should be implemented."

V. The Waitematā District Health Board have also provided a reply as follows:

> Having read the provisional findings we are satisfied with the Coroner's comments and recommendations in respect of the Waitematā DHB. We can advise that it is standard practice across the organisation for feeding tubes to be checked following placement to ensure they are correctly positioned, and this is done and documented before feeding occurs. However, we accept we need to ensure the monitoring of correct positioning over a period of time. As checking the position at the nose does not ensure the tip of the feeding tube is in the correct position, therefore a review in line with the Coroner's recommendation regarding nasogastric tube placement and feeding has commenced.

VI. Both District Health Boards are thanked for the replies. After considering both, I make the following recommendations pursuant to section 57 a Coroners Act 2006:

a. Continue to review the existing policies and training and competency frameworks regarding nasogastric tube placement and feeding.

b. Consider implementing mandatory documentation of the method by which the nasogastric tubes position is confirmed and ongoing documentation confirming correct placement.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Mr Richards during this inquiry (being photographs of a deceased person) upon the grounds of decency and that there is no legitimate public interest or benefit in such photographs being published; publication in fact is likely to be injurious to the public and breach acceptable standards of decency.

Robinson [2021] NZCorC 107 (9 July 2021)

CIRCUMSTANCES

Clive William Robinson, aged 70, died on 21 June 2015 at Southland Hospice, 75 Elles Road, Invercargill of a poorly differentiated neuroendocrine tumour.

On 8 January 2014 Dr Williams, Mr Robinson's GP, referred Mr Robinson for direct access colonoscopy at Southern District Health Board (SDHB), due to a change in bowel habit and mild anaemia. However, on 7 February 2014 the colonoscopy referral was declined by SDHB. The triage form queried the nature of the change in bowel habit, the nature of the polyps removed 20 years prior and the lack of iron deficiency associated with the mild anaemia. The SDHB sent Dr Williams a declinature letter on 13 February 2014 noting these issues, and stating that a new request should be submitted should the clinical situation alter. The availability of a colonoscopy through the private sector was also noted.

On 13 June 2014, a CT colonography was performed on Mr Robinson at the request of Mr Konrad Richter, a colorectal and general surgeon at SDHB. It appears Mrs Robinson, who knew Dr Richter as a work colleague, had directly approached Mr Richter to arrange this assessment as she was concerned about the declined colonoscopy.

There were technical difficulties with the CT colonography, due to a lack of distention of the bowel. Although no abnormality was seen, the radiologist recorded that it was a "suboptimal study". The radiologist also noted that investigation by means of a colonoscopy might also be technically difficult because of the markedly redundant sigmoid colon.

On 17 February 2015, Mr Robinson reported to Dr Williams that he had had diarrhoea for two weeks. Dr Williams was alarmed that Mr Robinson was continuing to show significant symptoms and, on 27 February 2015, made a referral for a gastroenterology appointment. Dr Williams reported that he labelled Mr Robinson's diagnosis as inflammatory bowel disease because Mr Robinson had had such a diagnosis previously and "because inflammatory bowel disease should, according to the 'Referral Criteria for Direct Access Outpatient Colonoscopy', receive a high urgent priority for getting a colonoscopy done".

On 5 March 2015, Mr Robinson was advised by the SDHB that the referral for a gastroenterology appointment had been received and assessed as "semi-urgent", with a waiting time of "approximately more than 3 months".

Dr Williams reviewed Mr Robinson on 8 April 2015, recording that he was experiencing worsening diarrhoea and had lost approximately 3kgs in weight. Mr Robinson's blood count was slightly below normal, but his inflammatory markers were within normal range. On 10 April 2015, Dr Williams wrote to the SDHB to request expedition of Mr Robinson's appointment and expressed his disappointment with the gastro/colonoscopy access for Invercargill GPs. Dr Williams noted that Mr Robinson had a wait of three months before he would be seen, before a specialist might determine a colonoscopy was required "and the whole process begins again".

Before the appointment could be expedited, on 21 April 2015, Mr Robinson presented to Southland Hospital with a one-week decline in cognitive function. A CT scan revealed a sigmoid lesion indicating bowel cancer. On 29 April 2015 Mr Robinson had a flexible sigmoidoscopy which confirmed the presence of a partially obstructing tumour in the distal sigmoid colon. On 30 April 2015 Mr Robinson underwent a Hartman's colostomy procedure in theatre. A large colonic mass was found and part of the bladder removed.

Mr Robinson developed sepsis post surgery and was put on antibiotics. He was tachycardic and agitated, then developed a fever, and faeces appeared to be coming out of the abdominal wound. The stoma was noted to be dark.

On 15 May 2015, Mr Robinson underwent a second operation. Just prior to surgery, it was reported to the surgical team that a segment of the left ureter was found attached to the resected sigmoid colon. A laparotomy was performed with evacuation of an abdominopelvic clot, ligation of the previously transected ureter, refashioning of the colostomy stoma, debridement of the abdominal wall and placement of a VAC (negative pressure) dressing.

On 9 June 2015, a CT scan showed Mr Robinson had multiple liver metastases. A biopsy showed a metastatic neuroendocrine tumour. Mr Robinson was deemed unsuitable for oncological treatment and was transferred to hospice care for palliation, where he died on 21 June 2015.

After Mr Robinson's death, his wife Carolyn Robinson, raised a complaint with the Health and Disability Commissioner (HDC) predominantly about the screening system for colonoscopies, and the fact that Mr Robinson had not had a colonoscopy following the colonography on 13 June 2014. The HDC conducted an investigation that was considered as part of this Inquiry along with other expert opinion that was sought.

COMMENTS OF DEPUTY CHIEF CORONER TUTTON

I. The HDC has thoroughly investigated the circumstances of Mr Robinson's death and determined that the care Mr Robinson received from SDHB was appropriate in the circumstances. No recommendations were made by the HDC.

II. I note the opinion of Dr Maplesden, the HDC in-house clinical advisor, that there was no particular clinical indication for Mr Robinson to undergo screening colonoscopy during the first quarter of 2014, and Dr Peng's conclusion that, on the evidence available, it does not seem there were particularly strong indications for a colonoscopy until February 2015, when another referral was made and accepted.

III. Mr Robinson had a rare and aggressive neuroendocrine tumour of the sigmoid colon. Whilst noting it was unlikely that any single action could have prevented Mr Robinson's death, Dr Peng made the following comments and recommendations:

   a. It should be highlighted that the national colonoscopy referral criteria specify that atypical presentations need to be considered.

   b. Electronic referral processes including check boxes of symptoms, blood tests and family history details, with an email link back to GPs, would allow for better referral tracking.

c. GPs should be allowed to request faecal immunohistochemical tests (FIT) and faecal calprotectin tests. FIT are used in some centres to triage symptomatic patients for colonoscopy (although not for PR bleeding.)

d. CT scan reports should be sent to the requesting doctor and copied to the patient's GP.

e. An 'alert' system where abnormal/suboptimal results are automatically emailed to the referring doctor could reduce clinical risk.

f. Doctors should be reminded that suboptimal studies in symptomatic patients are not diagnostic and that clinical assessment is important.

g. Surgical audit and peer review are strongly encouraged by the Royal Australasian College of Surgeons to maintain standards in surgical care. Complications in surgery unfortunately do occur and clinicians are encouraged to review their own data (e.g. in a group surgical audit) to identify if any improvements can be made.

IV. On the evidence available to me, I do not consider it necessary to make any recommendations. However, I direct that this finding is sent to DHBs and the Ministry of Health to enable the recommendations of Dr Peng to be considered.

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

Miscellaneous

Hamilton [2021] NZCorC 130 (17 August 2021)

CIRCUMSTANCES

Jason Matthew Hamilton, aged 53, died on 19 May 2019 at Christchurch Hospital from the combined effects of carbon monoxide poisoning and severe ischaemic heart disease, after using a gas stove to create an improvised heater in an enclosed space. The manner of his death is an accident.

Mr Hamilton lived in a caravan on a property in Christchurch. He had a two-burner gas cooker in the caravan that was attached to a gas cylinder outside. To heat the caravan Mr Hamilton would place a large metal chain on top of the burners and turn on the cooker. When the metal chain was hot it was sufficient to heat the relatively small space.

In the afternoon of 14 May 2019, Mr Hamilton's goddaughter found him unconscious in his bed in the caravan. She could smell gas. When emergency services arrived, they found the chain sitting on top of the cooker. It was glowing red and burning hot. The gas cooker was on.

Mr Hamilton was admitted to the Intensive Care Unit at Christchurch Hospital with a primary diagnosis of carbon monoxide poisoning. He did not regain consciousness and died after life support was withdrawn on 19 May 2019.

COMMENTS OF CORONER CUNNINGHAME

I. Sadly, Mr Hamilton's death was preventable. While his heart disease may have rendered him more susceptible to carbon monoxide fumes, it was use of the improvised heater which led to his death. Accordingly, some comments are justified if bringing the circumstances of this death to public attention will deter others from constructing improvised heaters.

II. When hydrocarbon fuels are burned they combine with oxygen to produce heat and light. If there is inadequate oxygen to sustain complete combustion carbon monoxide may be emitted as well as carbon dioxide and water vapour. Carbon monoxide can quickly build up to fatal levels in a poorly ventilated space.

III. In addition to poor ventilation, carbon monoxide can also be produced by practices such as placing a pot directly on a cooker's burner head rather than offsetting it by a trivet, which results in the flame being cooled and the combustion process restricted.

IV. It is an unfortunate reality of life in Aotearoa that not all of us have access to safe and affordable heating in our homes. I understand why people who live in dwellings which are not connected to a power supply, or who need to keep heating costs to a minimum, might try to devise cost effective and fast heating methods, particularly in the colder months. However, this practice is very dangerous, as Mr Hamilton's death sadly shows.

V. Mr Hamilton is not the first person in New Zealand to die as a result of carbon monoxide poisoning after making an improvised heating device using metal. In July 2014 Daniel Gilbert was found dead in his van near Temuka. Mr Gilbert was in the habit of heating the van by lighting a fire outside, heating steel rods in the fire, and then placing the hot rods and hot embers from the fire inside a metal pot which he took inside the van.

VI. Gas stoves, ovens, cooktops and BBQs are not designed for use as heaters. They should only be used for cooking purposes in adequately ventilated areas. Users should ensure to follow all manufacturer's instructions to ensure their safe use.

VII. Furthermore, hot metal should never be used to heat an enclosed space. Placing the chain directly on the burner head may have exacerbated the production of carbon monoxide by restricting the combustion process.

Henderson [2021] NZCorC 117 (30 July 2021)

CIRCUMSTANCES

Tahi Rapana Henderson, aged 20 months, died on 21 December 2019 at Mataura, Gore District from lethal cranial trauma sustained in a motor vehicle accident.

On 21 December 2019, Tahi was playing in his grandparents' yard, which was separated from the driveway by a tall fence. The fence had a gate that was always kept closed and latched. At the same time, Tahi's uncle was packing a Ford Ranger vehicle, as he was preparing to leave with his family. After going through the gate, he closed it but did not latch it.

When the Ford Ranger was packed, Tahi's uncle got inside without checking the front of the vehicle. He could not see any obstructions as he looked out the windscreen, but he was not able to see anything immediately in front of the vehicle due to its height. As he drove out the driveway, he ran over Tahi. Nobody saw Tahi leave the backyard or witnessed him in the driveway.

COMMENTS OF CORONER BATES

I. The following comments are in no way intended as criticism of Tahi's whānau, who clearly loved him and took very good care of him. I make the following comments pursuant to s57(3) of the Coroners Act 2006:

   a. Tahi's death is a tragic reminder of the need for young children to have constant adult supervision.

   b. If direct supervision is not possible, however briefly and for whatever reason, children are permitted to play in a secure area for their own safety, all care must be taken to ensure that area remains secure and the child cannot exit it. As will be appreciated, children move quickly, quietly, and as in this case, often without detection. Many are naturally curious and will explore given the opportunity. They may take their lead or opportunity by following others through unsecured doors or gates.

   c. Tahi's death is also a reminder of the importance for drivers to check and ensure a vehicle's path is clear on any driveway, particularly when small children are in the vicinity and visibility from inside the vehicle is restricted.

II. Given the particular combination of circumstances contributing to Tahi's death, I do not consider it necessary to make any further comment or formal recommendations pursuant to s 57(3) of the Coroners Act 2006.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Tahi taken during the investigation into his death on the grounds of decency and personal privacy.

Motor Vehicle

Campbell [2021] NZCorC 106 (6 July 2021)

CIRCUMSTANCES

Thomas McRae Campbell, aged 27, died on 7 June 2017 at Mai Mai Creek Bridge, State Highway 6 of traumatic fracture dislocation high cervical spine.

On 7 June 2017, Mr Campbell was travelling south on State Highway 6. He had left Ohakune the day prior to drive to Wanaka. At the time of his death he would have been travelling for 18 hours and 50 minutes with very little rest. Toxicology testing confirmed cannabis in Mr Campbell's blood.

At the time of the crash, Mai Mai Creek Bridge had a temporary posted speed limit of 30 km/h. Witnesses reported that Mr Campbell appeared to be travelling at between 80 – 90 km/h as he approached the bridge.

As drivers approach Mai Mai Creek Bridge from Mr Campbell's direction, the road's white painted edge line veers slightly right in order to align drivers onto the bridge. At the time of Mr Campbell's death, there was tree and scrub growing at the end of the bridge, giving the illusion of a straight line onto the bridge. Furthermore, driver visibility travelling towards the bridge was greatly reduced due to sun-strike. The Police's Serious Crash Unit (SCU) report concluded that Mr Campbell failed to recognise the painted edge line veering slightly right onto the bridge and instead continued driving straight. After colliding with the bridge abutment, his car tipped over the edge of the bridge and landed on its roof in the creek below.

The right side of the bridge (travelling in Mr Campbell's direction) had rotting wooden guard rails. The left side had no guard rails, as these had been demolished during an accident that occurred four and a half months earlier. Plastic orange netting was placed along the edge of the bridge. The SCU report found that if the bridge had had metal Armco barriers, the impact would have been reduced and the crash may have been survivable.

COMMENTS OF CORONER HESKETH

I. Considerable effort is made in New Zealand to promote the messages that driving a vehicle at excessive speed and driving under the influence of drugs are dangerous activities and can easily lead to a fatal outcome. In the context of such readily available information about these dangers, I make no comments.

II. In Mr Campbell's case I am not satisfied this was the principal cause of the crash, albeit his fatigue and cannabis consumption would not have helped him. The primary reason for this crash is a combination of the sun strike, the poor layout of the approach to the Mai Mai Creek Bridge, the condition of the bridge, his speed and potential fatigue.

III. The Police recommended their SCU report be sent to New Zealand Transport Agency as it recommends that Armco barriers be installed along both sides of Mai Mai Creek Bridge and that additional road markers be erected to improve drivers' visual awareness that the road alignment changes as it nears the bridge.

IV. I am aware from photographs the Police have sent to assist my inquiry in January 2018 that Waka Kotahi NZTA have installed metal Armco barriers along both sides of Mai Mai Creek Bridge. However, the additional road markers recommended be erected to improve drivers' visual awareness that the road alignment changes as it nears the bridge have not been installed.

RECOMMENDATIONS OF CORONER HESKETH

I. I recommend that the additional road markers proposed in the SCU report be erected.

II. I also recommend that signage be erected on State Highway 6 close to the scene of this crash, preferably on the rise just past the suspension bridge before vehicles reach the straight leading to the Mai Mai Creek Bridge warning of sun-strike.

III. A copy of my findings are to be forwarded to Waka Kotahi NZTA.

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

Covich [2021] NZCorC 148 (9 September 2021)

CIRCUMSTANCES

Peter Stanley Covich, aged 63, died on 16 March 2019 at Tangowahine Valley Road, Tangowahine, Dargaville of massive severe injuries including depressed compound skull fracture and brain lacerations.

On 16 March 2019, Mr Covich was participating in a group motorcycle ride. He was riding his Harley Davidson motorcycle in tow with four others. There were approximately 90 motorcycles in convoy.

At around 4:00pm Mr Covich was traveling on Tangowahine Valley Road at approximately 70 km/h. As the group approached a one-lane bridge Mr Covich rode too far to the right of the bridge and hit the railing on the right side. He then continued to travel along the railing, and at the northern side of the bridge, was thrown from his motorcycle.

Mr Covich sustained significant injuries in the crash and was confirmed deceased at the scene. Another motorcyclist located Mr Covich's helmet beside Mr Covich's motorcycle on the ground. The chin strap was still tied.

Toxicological testing identified the possible past use of methamphetamine, while cannabis and tetrahydrocannabinol were confirmed in the blood.

COMMENTS OF CORONER BELL

I. Whilst there is not a specific link in the evidence between Mr Covich's helmet coming off and his fatal injuries, I do note that Mr Covich's helmet was described as an old type of open face.

II. I am aware of another Coroner's comments regarding consideration of motorcycle helmet safety.

III. Deputy Chief Coroner Tutton in her finding[32] sought a report from Waka Kotahi New Zealand Transport Agency (the Agency) seeking statistical data held by the Agency regarding motorcycle helmet failures, number of deaths where helmets have come off/and or failed in the crash and whether the agency has conducted any publicity campaign or produced information or guidelines regarding the safe wearing of motorcycle helmets.

IV. The Agency reported that it operates New Zealand's Crash Analysis System (CAS), which was established to capture information on where, when and how road crashes occur. The Agency also

[32] CSU-2018-CCH-000053, Blackburn.

advised that helmet failures are not captured in the CAS as they would not be a causative factor in a crash.

V. The Agency also noted that helmet failures are not consistently recorded in the Traffic Crash Reports it receives from the New Zealand Police. The Police confirmed to the Agency that they do not hold any other information regarding motorcycle helmet failure statistics.

VI. The Agency reported that it is responsible for producing the Official New Zealand Road Codes. Within this series of publications is the Motorcycle Road Code and information on wearing the right gear when motorcycling, along with the safety standards for motorcycle helmets.[33] Specifically this information states:

> If you fall off your motorcycle, it's likely that your head will hit the road hard. This is why the law requires every rider and pillion passenger to wear an approved safety helmet securely fastened on the head. A good helmet can prevent serious injury.
>
> An approved safety helmet will have a sticker on it showing that it meets an approved safety standard. Don't buy or wear any helmet that isn't approved.
>
> Your helmet should also:
>
> - fit snugly – it shouldn't be too tight or too loose (a loose helmet is almost as bad as no helmet at all)
> - be securely fastened when riding
> - be a bright colour, such as white, orange, yellow or red
> - have red reflective material on the back and sides.
>
> You will need to replace your helmet if it is cracked, has loose padding, frayed straps or exposed metal, or is damaged in any way, as it may not be safe. Dropping it onto a hard surface can cause damage that can't always be seen. For this reason, never buy a second-hand helmet.
>
> Soap and water are the best way to clean a helmet. Never use petrol, methylated spirits or any other solvent to clean a helmet, as they can weaken the shell or the shock-absorbent lining. For the same reason, you should never use paints or stickers with unsuitable glues on a helmet.

VII. The Agency advised that it launched a motorcycling campaign "Respect every ride" in early 2020 as part of the national road safety advertising programme. The campaign aims to highlight the vulnerability of motorcyclists on the road and reminds individuals not to be complacent when riding.[34] General safety information relating to motorcycling can also be found on the Agency's website.[35]

VIII. I endorse the safety information the Agency has published on its website.

[33] https://www.nzta.govt.nz/roadcode/motorcycle-code/you-and-your-motorcycle/wearing-the-right-gear/
[34] https://www.nzta.govt.nz/safety/driving-safely/motorcycling/motorcycling-advertising/respect-every-ride/
[35] https://www.nzta.govt.nz/roadcode/motorcycle-code/you-and-your-motorcycle/

IX. As Deputy Chief Coroner Tutton noted, it is unfortunate that statistics regarding the incidence, prevalence and aetiology of helmet failures in road crashes and their association with fatalities on New Zealand roads cannot be obtained. While a helmet failure may not be the cause of an accident, it can certainly be the cause of death in a crash sequence when a rider's unprotected head makes contact with a hard surface.

X. Without appropriate data I am unable to make specific comments or recommendations for the purpose of reducing the chances of future deaths occurring in similar circumstances.

XI. I recommend, however, that this finding is sent to the Ministry of Transport (Te Manatū Waka), Waka Kotahi New Zealand Transport Agency, and the Motorcycle Association of New Zealand, for their consideration of further research and data gathering with regard to the incidence, prevalence and aetiology of motorcycle helmet failures in the aftermath of crashes.

XII. I note that methamphetamine and cannabis were identified in Mr Covich's blood. The dangers of driving under the influence of drugs are well known in the community. I consider it likely that Mr Covich misjudged the curve of the bridge and a lack of signage did not alert him to this. Consequently, the speed that he was travelling at on his motorcycle was excessive and he was unable to successfully negotiate the corner.

XIII. Mr Covich's death is also a tragic reminder of the obvious dangers of riding whilst under the effects of methamphetamine and cannabis and excessive speed. Given the existing publicity in relation to the dangers, I do not consider there are any recommendations I can usefully make in relation to those issues.

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

Cox [2021] NZCorC 139 (26 August 2021)

CIRCUMSTANCES

Tracey Jean Cox, aged 22, died on 22 February 2020 outside 1493 Morrinsville-Tahuna Road, Tahuna, from severe traumatic head injuries sustained in a motor vehicle collision.

On 22 February 2020, Tracey, who had a learner drivers' licence, was traveling home from work alone in her vehicle. The vehicle was fitted with a mismatched set of tyres on the front axle, and a matching pair of snow tyres on the rear axle. As she navigated a slight corner, she lost control of her vehicle and crossed into the path of an oncoming vehicle.

The Waikato region had experienced approximately 80 days of dry weather prior to the collision. However, intermittent rain on 22 February 2020 had caused the roads to become more slippery than usual, requiring a lower than usual driving speed. The Police Serious Crash Unit, who investigated the collision, advised the Coroner that the slippery phenomenon is known as "summer ice" and that the effects of summer ice would have been compounded by the mismatched and inappropriate tyres fitted to Tracey's vehicle.

COMMENTS OF CORONER ROBB

I. I am reminded that I may only make comments or recommendations, if such are likely to reduce the chances of further deaths occurring in circumstances similar to those in which Tracey's death occurred.[36] I am satisfied that the circumstances of this death are such that comments are warranted.

II. Tracey's death is a tragic example of understanding the characteristics of New Zealand roadways where there has been a sustained period of no rain, followed by an episode of wet weather. It also highlights the importance of having appropriate tyres fitted to a vehicle in order to ensure the vehicle's stability and cornering is not compromised.

III. Tracey was conscientiously undertaking work and no doubt practical necessities led her to drive where not appropriately licensed, there is nothing to indicate that she was in any way reckless in the manner in which she drove. However, her tragic death also highlights the importance of being appropriately experienced in order to best identify, and adjust driving speed, to accommodate driving in an older vehicle on a wet and potentially slippery road.

Snow / winter tyres

IV. The Land Transport Rule: Tyres and Wheels Amendment (No 2) 2009, amended the Land Transport Rule: Tyres and Wheels 2001 by making it a requirement that if a vehicle is fitted with winter tyres, that those tyres must be fitted to all road wheels of the vehicle. That requirement came into effect on 1 April 2010.

V. Waka Kotahi (the New Zealand Transport Agency) describes the effect of mixing winter tyres with non-winter tyres:[37]

> ...Mixing winter tyres with other tyres on the same vehicle can result in different levels of grip on the front and rear axles, which can make the vehicle unbalanced and difficult to control in an emergency or during hard braking. This has been shown to have been a contributing factor in crashes.

VI. The circumstances of Tracey's death highlight and demonstrate why that rule is necessary.

Summer ice

VII. Waka Kotahi has very clearly explained what summer ice is and the steps road users can take to manage summer ice. I reproduce that explanation and advice below:[38]

> **What is summer ice?**
>
> During long dry spells, dust, dirt, oil and other materials build up on the road surface. When it rains, the road surface becomes greasy, making it very slippery – the greatest risk to drivers

[36] Coroners Act 2006, ss 57(3) and 57A(2).
[37] https://www.nzta.govt.nz/media-releases/new-rules-for-winter-tyres-from-1-april/
[38] https://www.nzta.govt.nz/safety/driving-safely/driving-to-the-conditions/summer-ice

being shortly after the rain starts. The term ‘summer ice’ is used to describe these conditions that are similar to the black ice that you get in winter.

Even a little rain after several days of dry weather can trigger these conditions, creating a potential danger for unsuspecting drivers.

…

Be summer ice smart by:

- keeping your speeds down on wet roads after a long dry period
- taking extra care on curves
- increasing your following distance from vehicles in front of you
- braking and steering gently
- allowing extra travel time in case you encounter summer ice conditions.

VIII. I endorse Waka Kotahi’s guidance on how to manage the risks of summer ice. I accept that, as with other weather-related changes to road conditions, it is incumbent on the road user to adjust their driving to accommodate the risks. However, I am reproducing Waka Kotahi’s advice in the hopes of drawing it to the public’s attention and to highlight the specific phenomenon of summer ice.

IX. Accordingly, I recommend further efforts be made to bring the risks of summer ice and how to manage those risks to the public’s attention.

Distribution

X. A copy of these findings will be provided to each of the following organisations to assist with their road safety messaging and campaigns:

a. Waka Kotahi;

b. AA New Zealand; and

c. Tyre Safety Awareness New Zealand.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Tracey taken during the investigation into her death upon the grounds of personal privacy and decency.

Crone [2021] NZCorC 105 (5 July 2021)

CIRCUMSTANCES

Ethan Phillip Crone died on 30 May 2017 at Easterbrook Road, Fernside from injuries to his head, chest and limbs which he sustained in a motor vehicle crash.

At approximately 8:30am on 30 May 2017 a witness who was walking on Hicklands Road saw a damaged road sign and a car against a tree near the T intersection between Hicklands Road and Easterbrook Road. She went to the car and found Mr Crone lying on the ground on the driver's side of the vehicle. Mr Crone's family reported that he was familiar with this intersection.

The Serious Crash Unit (SCU) report stated that Mr Crone should have turned left at the intersection, but tyre marks indicate that he travelled straight ahead without braking or attempting to steer to the left. There was no signage warning of the approaching intersection for vehicles travelling in Mr Crone's direction. There was a black and yellow warning chevron on the other side of the intersection, which Mr Crone's vehicle knocked out of the ground.

At the time of the crash there was heavy fog in the area, and it was dark with no streetlights. The SCU report provided that Mr Crone was travelling at between 76 and 85 km/h. The area had a posted speed limit of 100 km/h, but due to the fog and darkness a safe speed would have been between 45 and 50 km/h.

Toxicology testing confirmed the presence of cannabis and tetrahydrocannabinol in Mr Crone's blood.

COMMENTS OF CORONER ELLIOTT

Signage

I. Police advised that new signage on Easterbrook Road alerting traffic to the intersection has been installed. This is a larger double chevron sign.

II. I therefore make no comments or recommendations in this respect pursuant to s 57A of the Coroners Act 2006.

Speed

III. Waka Kotahi/New Zealand Transport Agency states:[39]

> 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)

IV. If Mr Crone had been driving at a lower speed, he would have had more time to perceive the corner and sign. The crash illustrates the importance of Waka Kotahi's advice. The chances of death in similar circumstances may be reduced by a comment to this effect.

Cannabis use before driving

[39] https://www.nzta.govt.nz/roadcode/general-road-code/road-code/about-limits/speed-limits/

V. If Mr Crone had not used cannabis, he may have perceived the corner and sign and avoided the crash. The crash illustrates the danger of driving after using cannabis. The chances of death in similar circumstances may be reduced by a comment to this effect.

Comments

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

> Ethan Crone died of injuries sustained in a crash on 30 May 2017. The crash was caused due to the conditions, the speed and the effects of cannabis, which Mr Crone had recently used.
>
> Mr Crone's death illustrates the dangers of driving at a speed which is excessive for the conditions.
>
> 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.'

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.

Eades and Haques [2021] NZCorC 153 (15 September 2021)

CIRCUMSTANCES

Minna Kattri Pettridotter Haques and Benjamin David Eades, aged 15 and 25 respectively, died on 7 December 2017 at Dairy Flat Highway from multiple blunt force injuries due to motor vehicle crash.

At around 9:30pm on 7 December 2017, Minna and Benjamin were travelling on Dairy Flat Highway near Potter Road. They and another friend had been at Orewa Beach. Benjamin and the other friend had been drinking, so Minna (who was sober) decided to drive.

While on Dairy Flat Highway, Minna was overtaken by a boy racer's vehicle travelling at speed. She sped up but lost control of the vehicle on a sweeping left-hand bend. While trying to regain control she collided with a car travelling in the opposite direction. Both Minna and Benjamin died as a result of the crash.

The Police Serious Crash Unit investigated the death and found that speed and inexperience were both contributing factors to the crash. It was noted that Minna was ineligible for a driver's licence until she turned 16 and that she likely had limited or no experience driving on a high speed rural road at night, using a vehicle she was unfamiliar with.

COMMENTS OF CORONER HO

I. This is a sad case involving three friends who responsibly nominated one of their number to be the designated sober driver. Their decision shows that consistent messaging around drink driving are having an effect. It is particularly clear given Benjamin's blood alcohol levels that he was in no fit state to drive and it is commendable that he did not try to drive his own car after consuming significant amounts of alcohol.

II. Regrettably, their decision to have Minna drive meant that the friends simply swapped one risk for another. Age limits and license restrictions are in place for a reason, one of which is to ensure that new drivers develop their skills in a safe environment with an appropriate supervisor and without the

distraction of passengers. This case is an unfortunate demonstration that the consequences of driving while inexperienced can be just as fatal as driving while under the influence of alcohol or illegal drugs. Waka Kotahi New Zealand Transport Agency statistics show that drivers on a restricted license are seven times more likely to be involved in a fatal or serious injury crash than other drivers, and young restricted drivers are more at risk of having a serious crash in the first six to twelve months of driving solo on their restricted license than at any other time in their lives. The risk of crashing diminishes with experience and the development of decision-making skills to recognise risky situations and make safe choices.

III. The dangers of driving at excessive speed or under the influence of alcohol and illicit drugs are well publicised through television advertisements and other media channels. It was less clear to me the attention given to the dangers of inexperienced driving. I invited comment from Waka Kotahi. The agency advised that in 2016 it jointly launched a programme called “Drive”, which is promoted directly to young people through targeted digital advertising and which is designed to help young people learn the road rules, get their license and ultimately become safer and more competent drivers. The Drive programme is available through a website and mobile phone app. Waka Kotahi also advised that more recently, Drive has begun targeting parents of young drivers with an annual advertising campaign and has partnered with MyMahi, an educational platform with strong links to over 200 secondary schools, to further extend the reach of the messaging. Waka Kotahi confirmed that education and advertising will continue to deliver programmes and campaigns on young drivers and speed.

IV. In light of Waka Kotahi’s response I do not consider it necessary to make any formal recommendations.

Auckland Transport road safety recommendations

V. Following the crash Auckland Transport undertook a review of the bend in question. Notwithstanding that the road was not a primary contributing factor to the crash AT nevertheless identified six general road recommendations:

a. investigate necessity of improved delineation along the reverse curve and confirm the value of the posted advisory speed;

b. reinstall lane reduction sign posted with a supplementary 200 m sign;

c. investigate skid resistance improvements;

d. undertake a street lighting assessment;

e. continue to promote road safety campaigns regarding young driver licensing and speeding; and

f. investigate whether a lower speed limit is appropriate along the entire length of Dairy Flat Highway.

VI. I issued AT with a statutory notice under s 120 of the Coroners Act 2006 requiring it to provide, by 14 August 2021, information about the current status of each of these recommendations. I considered that this information would be helpful to me in understanding any road safety improvements that had been implemented at the crash location and which might inform any recommendations I might in turn wish to make.

VII. Auckland Transport did not respond to the statutory notice by the due date or otherwise. I considered whether to delay issue of these findings until AT responded. I chose not to, for the following reasons:

i. The recommendations made by AT, with the possible exception of recommendation (e), would likely not have made a difference to Minna and Benjamin had they been implemented.

ii. As to recommendation (e), I address this below in the context of a proposed recommendation that I intended to make and for which I invited comment from both Waka Kotahi and AT.

iii. I did not consider it fair to Minna and Benjamin's families for these findings to be delayed as a result of AT's non-compliance. Minna and Benjamin died nearly four years ago. Their families deserve some sort of closure.

iv. It is not the responsibility of this Court to follow up with entities to whom statutory notices are issued to ensure that they comply with their obligations to respond.

VIII. It is disappointing that AT did not provide the information that was sought. While my view is that recommendations (a), (b), (c), (d) and (f) were unlikely to have made a difference to Minna and Benjamin, this does not mean that their implementation might not have value to other road users in the future. It would have been beneficial to have included in my findings an update on those recommendations. It is unfortunate that I was not able to do so.

Comment – unnecessary overlap on road safety messages between agencies

IX. I note that one of AT's six recommendations was to continue to promote road safety campaigns regarding young driver licensing and speeding. It is unclear to me the role that AT has to play in such road safety campaigns. It seems to me that is properly the domain of Waka Kotahi. I am concerned that having multiple agencies try to convey the same message may create confusion. It would be best for one agency, preferably Waka Kotahi being a national agency, to take the lead unless there are considerations which require a targeted regional approach.

X. Waka Kotahi advised me that since 1995 it had maintained a strong focus on the issue of driving at excessive speed through the national road safety advertising programme. It also advised me that several road safety initiatives also take place regionally and that where possible, it encourages the regions to align their road safety campaigns to those of the national agency by referring to its publicly available road safety advertising campaign information and calendar. This seems a sensible approach. I endorse it. I do not make any formal recommendation.

XI. I invited AT to comment on my view that road safety messages should be primarily formulated and implemented at a national level. It did not respond. I infer that it has no comment to make. I repeat my

comment above that in promoting road safety messages regarding young driver licensing and speeding AT should consult with, and take the lead of, Waka Kotahi.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Minna and Benjamin taken during the investigation into their deaths, in the interests of decency and personal privacy.

Edwards [2021] NZCorC 140 (30 August 2021)

CIRCUMSTANCES

Elizabeth Jayne Edwards, aged 59, died on 9 May 2020 at Te Teko Road, Te Teko from significant craniofacial injuries sustained in a motor vehicle collision with a horse roaming on the roadway.

At approximately 11:15pm on 9 May 2020, Ms Edwards was driving home from work along Te Teko Road. Being a rural road with no streetlights, it was very dark. At around the same time, residents reported hearing horses running on the road. Ms Edwards collided with a horse, which travelled through her windscreen and into the vehicle. Ms Edwards sustained fatal injuries and died at the scene.

COMMENTS OF CORONER ROBB

I. I understand that the area where the collision occurred has an issue with roaming horses, and that Police and local council have worked together to put preventative measures in place to stop similar types of crashes. Following these efforts, a number of actions will be taken, namely: Police will treat wandering stock reports as a priority, the Whakatane District Council will run a media campaign for residents in relation to wandering horses, and further discussion will be undertaken, giving consideration to how quality levels of roadside fencing could be assessed.

II. Based on the above, I am satisfied that actions are being taken to prevent similar deaths occurring in the future.

III. I have considered suggesting the introduction of street lighting in rural New Zealand. I have decided against making such a suggestion in this case. While the darkness may have impacted Elizabeth's ability to react in time to avoid a collision, the cause of this collision was the presence of an untethered horse on the road, and not the darkness itself.

IV. I do not consider it appropriate to make any recommendations pursuant to s 57(3) of the Coroners Act in the circumstances.

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

Hepi [2021] NZCorC 110 (15 July 2021)

CIRCUMSTANCES

Tremane Justin Puke Hepi, aged 24, died on 24 September 2019 at State Highway 1, Topuni of multiple injuries antecedent to a motor vehicle accident.

At 1:56am on 24 September 2019, Mr Hepi was driving north on State Highway 1. At the same time, a Fonterra Volvo tractor unit was travelling in the opposite direction. As Mr Hepi approached a left-hand bend, he crossed the centreline into the path of the oncoming milk tanker. The vehicles collided and Mr Hepi died at the scene.

Toxicology testing confirmed methamphetamine and tetrahydrocannabinol in Mr Hepi's blood.

COMMENTS OF CORONER TETITAHA

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

II. According to statistics kept by the Ministry of Transport,[40] in 2019 where driver alcohol/drugs were a contributing factor there were 137 fatal crashes, 286 serious injury crashes and 1409 minor injury crashes. In 2019 where driver alcohol/drugs were a contributing factor 160 people died, 391 people were seriously injured and 1936 people suffered minor injuries in crashes. 60% of drug drivers who died in alcohol/drug crashes between 2017 to 2019 were aged between 20 to 24 years. 38 fatal crashes involved head-on crashes. Late at night or in the early morning, from Friday night through to Sunday morning, is when the highest number of fatal crashes involving alcohol/drugs occurred between 2017 to 2019.

III. The risks of drug driving were considered in a report by Waka Kotahi: NZ Transport Agency dated May 2020.[41] The report undertook a literature review examining the available information about driver impairment due to recreational drug use, and the resultant risks to road users.

IV. The review found that all three drugs have a negative impact on the driving of people using them. This may be an acute impact due to recent ingestion of the drug, or more long-term impact from being a regular user. All three drugs also form more dangerous combinations when used with alcohol and other drugs, than on their own.

V. The types of impacts of the use of these drugs upon driver behaviour is set out in the table below:

[40] Minister of Transport "Safety-Annual Statistics Alcohol And Drugs" https://www.transport.govt.nz/statistics-and-insights/safety-annual-statistics/sheet/alcohol-and-drugs
[41] Waka Kotahi NZ Transport Agency "Impacts of Recreational Drug Use on Driving" May 2020 https://www.nzta.govt.nz/assets/resources/research/reports/664/664-Risks-of-driving-when-affected-by-various-drugs-literature-review-summary.pdf

Cannabis/synthetic cannabis	Methamphetamine	Ecstasy
Increased reckless driving	Release the brakes and appropriately when stopping	Higher urban speed
Slower driving, larger it weighs	Drive too fast for the traffic conditions	More simulated crashes
Impaired control of speed, headway and lateral position	Travel slower on the freeway in an emergency	More skidding
Decreased car control as task demand increases	Impaired control of lateral position	More signalling errors
Decreased performance on road tracking tasks	Execute right turn against movements with a smaller gap	More inappropriate breaking
Decreased psycho motor skills, reaction time, visual functions, attention and encoding	More aggressive driving	Less safe following distances
		More aggressive driving

VI. The report concluded that deterrence is a useful tool. The review showed that measures to deter people from driving after drug ingestion is a crucial tool for combating the harmful impacts that drug driving can have on road safety.

VII. Deterrence measures should include both general operations, to deter the practice at a societal level, and target operations aimed at groups known to be at high risk of offending. To be effective at a societal level, the deterrence operations need to be backed up by appropriately supportive public education about the risks of driving while under the influence of drugs. Due to the extra risks associated with combinations of drugs with alcohol, the report recommended the government consider introducing drug testing for those drivers who have tested positive for alcohol.

VIII. There is currently legislation seeking to impose a new drug driver testing and enforcement scheme to improve road user safety. In July 2020 the Government introduced Land Transport (Drug Driving) Amendment Bill that would introduce a compulsory random roadside drug testing scheme in New Zealand. Cabinet has agreed to set criminal limits and blood infringement thresholds in legislation based on the advice of an independent expert panel on drug driving. This legislation is still progressing through Parliament.

IX. However, there did not appear to be any complimentary public education campaign about the risks of driving under the influence of drugs. Given the recommendations in the Waka Kotahi: New Zealand Transport Agency Report about effective deterrence, this should also be prioritised as part of the government's response to drug driving.

X. I sought comment from the Waka Kotahi New Zealand Transport Agency. They advised they have "maintained a strong focus on drug-affected driving from a marketing perspective since 2012." The last campaign was "the Unsaid" launched in July 2019 with the aim of raising awareness around drug-impaired driving and shared true stories that show the impact of this.

XI. I have viewed the YouTube videos relating to the last campaign. The videos are impactful but unfortunately unable to deter this death or the 159 other people who died in 2019 of drugs or alcohol related driving.

XII. This may indicate a need to review the effectiveness of these education campaigns upon young drivers aged between 20 to 24 years and comprising 60% of the increasing numbers of deaths by drug driving.

XIII. A more targeted education campaign coupled with legislative change may have prevented this death.

RECOMMENDATIONS OF CORONER TETITAHA

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

II. That Waka Kotahi New Zealand Transport Agency review its current education campaign to target young drivers aged between 20 to 24 years such as the deceased.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Mr Hepi during this inquiry (being photographs of a deceased person) on the ground of decency.

Jones [2021] NZCorC 163 (27 September 2021)

CIRCUMSTANCES

Erica Lynne Delany Jones, aged 26, died on 10 November 2018 on State Highway 35, bottom of Tatapouri – Makorori Hill, near Gisborne, from multiple injuries sustained in a heavy truck and motor vehicle collision.

At around 8:00am on Saturday, 10 November 2018, Erica was the sole occupant of her vehicle travelling north on State Highway 35 from Gisborne. Near the bend at the bottom of Tatapouri – Makorori Hill, a logging truck and Erica's vehicle collided in the northbound lane. Erica sustained non-survivable injuries and passed away at the scene.

Police provided a Crash Analysis Report as well as an independent expert analysis of the crash scene, vehicles and the crash sequence. Based on all the evidence, the Coroner concluded that the main causative factor of the collision was the logging truck being driven in the wrong lane. Several of the formal predictors that infer fatigue were present in the collision. It was a head-on crash, the roading leading up to the area of impact was straight, the truck driver worked shift-work patterns and had not had the requisite 10-hour break between shifts. Contrary to his statement, the scene evidence did not support the truck driver's assertion of a "swerve-to-avoid" manoeuvre or any other emergency action. It seemed most likely that the truck had drifted into the northbound lane due to the truck driver's inattention or fatigue. The Coroner concluded that Erica had had no time or opportunity to take evasive action.

Erica's whānau made several recommendations to the Coroner's inquiry in the hopes of avoiding a similar tragedy, including:

i. making it mandatory for all heavy trucks to have dashcam cameras at all times;

ii. installation of a mid-road barrier over Tatapouri – Makorori Hill;

iii. installation of an interactive solar flashing sign to alert drivers to slow down;

iv. reducing the speed limit in the vicinity;

v. kick-starting Government's safety assessment, planning and implementing safety measures for all highways; and

vi. improving the consultation process in relation to State Highway 35 to include heavy truck drivers who use the highway on a daily basis.

RECOMMENDATIONS OF CORONER LLEWELL

I. Under section 57 of the Act, I must consider whether it is appropriate to make any comments or recommendations to reduce the chances of further deaths occurring in similar circumstances to Erica.

II. Senior Constable Dougal Watts identified patches of resealing and tar-bleed in both lanes at the time of the crash investigation. On my further inquiry, he confirmed that the road surface was re-sealed a couple of weeks after the collision, speed limit changes have come into effect for State Highway 35 between Gisborne and Te Puia Springs (from Makorori to Pouawa the limit was reduced from 100km/h to 80km/h effective 8 September 2020), and signage has been erected in proximity to Tatapouri – Makorori Hill and closer to Gisborne advising motorists of a "High Crash Area". At the time of the collision, the corner bend had an advisory speed of 65km/h which is still effective.

III. With reference to the Jones whānau suggestions at paragraph [55]:

a. Points i), v) and vi) are commendable ideas but are not directly linked to the factors that contributed to Erica's death or matters which may reduce the chances of death occurring in similar circumstances;

b. Point iv) has been implemented by reduction of the speed limit; and

c. Point ii) has been considered, but I am advised that the road layout and width on Tatapouri – Makorori Hill makes it impracticable to install a mid-road barrier.

IV. The main causative factor in this collision was that the logging truck was being driven in the northbound lane, possibly due to inattention, distraction or fatigue. It cannot be stressed enough that drivers of heavy vehicles must observe the regulatory requirements for breaks between shifts (and rest breaks during their shift) to maintain optimal driving capability.

V. Static signage has improved near the collision site, however, in these circumstances a more obvious or illuminating sign may have alerted the truck driver's attention and may reduce the chances of other fatalities in similar circumstances.

VI. Accordingly, I endorse point iii) and make the following recommendations directed to Waka Kotahi / NZ Transport Agency:

a. The installation of an interactive solar flashing sign positioned before the bend and rise up Tatapouri – Makorori Hill which alerts drivers to their speed and to slow down; and

b. Consider reconfiguration of Tatapouri – Makorori Hill roading camber and layout to allow a left-hand slow vehicle passing lane as a means to incentivise safer driving of heavy vehicles and to avoid manoeuvring onto the incorrect side of the road to climb the hill.

VII. In accordance with section 57B(1) of the Act, Waka Kotahi / NZ Transport Agency was provided the opportunity to comment on my proposed recommendations.

Feedback from Waka Kotahi / NZ Transport Agency

VIII. I received feedback by way of letter dated 23 September 2021 which was appreciated. Waka Kotahi confirmed that installation of a medium road-barrier over Tatapouri – Makorori Hill has been considered; however, the road layout and width of that section of state highway makes it impracticable for the barrier to be installed. They also confirmed the speed limit on this corridor has been assessed to determine the safe and appropriate speed, with reduction of the speed limit to 80km/h.

IX. In relation to my recommendation a) above, they stated that whilst speed of both vehicles reduced the amount of time available to the drivers to recognise and react to their vehicles being in the same lane, Waka Kotahi committed to investigating the installation of a speed warning sign for the southbound traffic in advance of the curve and commencement of the slow vehicle lane.

X. In relation to my recommendation b) above, they stated that the current curve warning advisory speed is 65km/h. This has been based on the standard assessment of the combination of curve radius and superelevation at the locality. Using the High-Speed Data collected in December 2020, Waka Kotahi confirmed that the curve has a combination of cross-fall and radius that aligns with the curve advisory speed of 65km/h.

XI. The maximum recommended value for cross-fall on the state highway network is 10 percent. This represents a practical limit for road surface maintenance and also limits the risk of instability for heavy vehicles with a high centre of gravity. Increasing the cross-fall to this value for this curve would have the effect of increasing the advisory speed by 10km/h. This would require significant additional surfacing to be added on the outside of the curve.

XII. Unfortunately, because of the steep topography beyond the road safety barrier system, it would be impractical to increase the superelevation by this amount. In addition, the change in height of the road would also require replacement of the barrier system. Waka Kotahi indicated there is an existing southbound slow vehicle passing facility that starts approximately 150m south of the collision location.

XIII. In conclusion, I also noted from Waka Kotahi's National Land Transport Programme 2021 - 2024[42] (August 2021) funding commitments to continue to deliver State Highway 35 resilience improvements to strengthen and stabilise "hot spots" along the coast and additional passing opportunities to alleviate driver frustration and risky overtaking as a result of heavy freight vehicles using this state highway.

[42] Available at http://www.nzta.govt.nz/nltp

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

Kareko, Walters and Walters [2021] NZCorC 112 (21 July 2021)

CIRCUMSTANCES

Maurice James Spark Kareko, and his children Rhiannon Kuini Walters, aged 11, and Alec Tamati Te Maru Walters, aged 5, died on 23 February 2020 at Whananaki. Mr Kareko and Rhiannon died of severe head injuries sustained in a motor vehicle crash, and Alec died of multiple injuries sustained in a motor vehicle crash.

On 22 February 2020, Mr Kareko, his wife, and their four children spent the evening with family. Mr Kareko and his wife consumed alcohol, sharing a pack of 15 stubbies between five adults. Mr Kareko left sometime around midnight with his four children, while his wife stayed with her family. Witnesses reported that Mr Kareko had seemed intoxicated, but it is unclear whether anyone knew he was taking the children with him or tried to stop him from driving.

At approximately 2:00am on 23 February 2020, witnesses found Mr Kareko's ute, which had crashed into a tree. Mr Kareko and his children were inside the vehicle.

The Serious Crash Unit (SCU) investigated the crash and concluded that there were a number of factors present that were consistent with fatigue related crashes, including that Mr Kareko appeared to have driven straight into a tight corner when he should have made a conscious steering movement. The SCU also concluded that Mr Kareko, Rhiannon and Alec were not wearing seatbelts, and that Alec was not appropriately restrained in a child car seat. The other two children were wearing seatbelts.

Toxicological testing confirmed alcohol in Mr Kareko's blood at a level of 158 milligrams per 100 millilitres. For comparison purposes, the legal blood-alcohol level for a New Zealand driver aged 20 years or over is 50 milligrams per 100 millilitres.

COMMENTS OF CORONER MILLS

I. There are three key factors that contributed to this accident and the subsequent deaths – the failure to wear seatbelts, alcohol and fatigue.

Seatbelts

II. It is not simply a coincidence that the two survivors of this tragedy were the only two wearing seatbelts. Waka Kotahi (NZ Transport Agency) states that wearing a seatbelt reduces the risk of being killed or seriously injured in a road crash by about 40%.[43] If everyone wore their seatbelts an estimated 25 lives could be saved from road crashes each year.

III. Waka Kotahi also state[44] "Without a seatbelt, front seat occupants can be thrown through the windscreen and onto the road. Back seat passengers can be thrown onto the front seats or the front

[43] https://nzta.govt.nz/safety/driving-safely/seatbelts/
[44] https://nzta.govt.nz/safety/driving-safely/seatbelts/

seat passengers or can hit the roof." Sadly, this appears to be exactly what happened to Rhiannon, Maurice and Alec.

IV. The driver of the vehicle is legally responsible for ensuring all passengers under 15 years are wearing seatbelts or in age appropriate child restraints that are correctly fitted into their vehicles. Children under the age of seven must be properly restrained in an approved child restraint. Alec was five and was not in an approved child restraint or wearing a seat belt.

V. Tragically, this accident is a prime example of why seatbelts and age appropriate car seats should always be used. It was not high-speed crash and, had everyone been appropriately restrained, others may have survived.

VI. The law is clear that it is the duty of the driver to ensure that anyone under 15 years in the car is appropriately restrained. Coroners have previously made numerous comments and recommendations regarding the importance of wearing seatbelts and using age appropriate car restraints. In these circumstances there is little more I can do but to reiterate and reinforce the message that wearing seatbelts saves lives.

Alcohol

VII. For decades, Coroners have made findings in which they warned against drink driving. There have also been numerous public campaigns aimed at ensuring the public are aware of the risks of drink driving. In addition, there have been numerous campaigns aimed at encouraging friends and whānau to intervene when another person intends to drive whilst under the influence of alcohol - the "ghost chips" and "bloody legend" campaigns are examples that many will be familiar with.

VIII. Maurice had been drinking with his whānau and witnesses confirm he was clearly intoxicated. It is not clear from the evidence whether those present tried to prevent him from driving, but presumably if they did, they were unsuccessful.

IX. It is always unsafe to consume alcohol when driving. Even low quantities of alcohol greatly magnify the risk of causing a fatal vehicle accident. When combined with tiredness or personal distress the risk is higher.

X. Contrary to common belief, drinkers do not have the ability to accurately assess whether they are "okay to drive" after having consumed alcohol. Even at alcohol levels far in excess of the legal blood alcohol level, the drinker may not appear to observers to be intoxicated. But the appearance of sobriety does not translate into the safe operation of a motor vehicle.

Fatigue

XI. Rather than make any further recommendations, I simply repeat the advice of Coroners over the years: do not drink and drive and further, do not let those you love drink and drive. If someone had prevented Maurice from driving that night, these tragic events would not have occurred.

XII. Fatigue was also a possible contributing factor to this accident. Fatigue and/or tiredness increases reaction times and affects a driver's ability to pay attention. Alcohol also increases the effect of fatigue increasing the risk to all concerned.

XIII. Coroners have already made numerous recommendations and comments about the risk of driving whilst tired, and there has also been a number of public campaigns aimed at raising public awareness about the risks of driving whilst fatigued. Again, I simply reinforce those messages.

XIV. Given the matters set out above I make no recommendations however, the above comments are made pursuant to section 57A of the Coroners Act 2006 which, if drawn to public attention, may reduce the chances of deaths in similar circumstances.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Mr Kareko, Rhiannon and Alec taken during this inquiry (being photographs of three deceased persons) on the grounds of decency.

Larkins [2021] NZCorC 124 (6 August 2021)

CIRCUMSTANCES

Ryan Michael Anthony Larkins, aged 19, died at State Highway 23, Raglan on 1 December 2019 from a head injury due to a motor vehicle collision.

On 1 December 2018, at around 1:00am, Ryan was driving a friend’s BMW vehicle west towards Raglan with two passengers, who were asleep. He drove across the centreline, off the side of the road and into a ditch. Tragically Ryan died from injuries he sustained in that collision.

The time of day, lack of stimulus from passengers, and lack of any steering or braking indicate that Ryan was most likely fatigued.

COMMENTS OF CORONER ROBB

I. The dangers of driving in the early hours of the morning and driving while fatigued have been the subject of media campaign warnings promoted on behalf of the New Zealand Police and others. I reiterate those dangers and warnings, particularly in respect of young drivers driving at night on unlit open roads. I anticipate Ryan's passengers were likely asleep, and in the absence of stimuli from conversation, the risks of being overcome by fatigue are increased. The consequence of driving while fatigued is obvious in this tragedy, were a young man has lost his life. I make no additional comment or recommendation in the context of previous recommendations and media campaigns.

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

Luke M and T, Poutawa A, C, D, J and K, Rodgers [2021] NZCorC 144 (2 September 2021)

CIRCUMSTANCES

Jennifer Rodgers, aged 51, David Poutawa, aged 42, Margaret Luke, aged 35, Trinity Luke, aged 13, Chanley Poutawa, aged 11, Jahnero Poutawa, aged 10, Akacia Poutawa, aged 8, and Khyus Poutawa, aged 7, died on 28 April 2019 on State Highway 1 in Kinleith Forest between Ohakuri and Atiamuri, 35km north of Taupō and 300m north of the intersection with Ohakuri Road, from severe traumatic injuries antecedent to a motor vehicle collision.

At about 10:30am Ms Luke was driving a seven-seater Honda Steam north on State Highway 1, with her partner Mr Poutawa and six of their children as passengers. As she drove around a gentle left-hand corner, Ms Luke lost control of the Honda and crossed over double yellow centrelines into the southbound lane, directly into the path of Ms Rodgers' Kia vehicle. An unavoidable collision occurred. Ms Rodgers, Ms Luke, Mr Poutawa and the five abovenamed children died at the scene from their injuries. The only survivor was David Poutawa Jr, who suffered significant head injuries. He and Khyus Poutawa were both thrown from the Honda.

The evidence supported a conclusion that Ms Luke was likely fatigued at the time of the crash. She had received at most only 4-5 hours of sleep the night before, then drove for approximately 2 hours and 20 minutes before the crash occurred. Toxicological analysis of her blood showed she had recently consumed cannabis, which can result in a loss of attention and coordination. In addition, Ms Luke was driving on a learner's licence without the presence of a full licence holder. She was also wearing gumboots, which is not recommended while driving as they can negatively impact on the operation of the foot pedals.

The Honda first lost control at the start of a smooth patch of reseal with lower friction than the surrounding road surface, although it met required standards even when wet, as at the time of the crash. Video footage of the incident showed the Honda travelling at approximately 115km/h prior to the loss of control, above the posted speed limit of 100km/h. Excess speed likely led to the initial loss of control. In addition, the rear wheels of the Honda had been inappropriately fitted with winter/snow tyres and had less than 4mm of tread, below warrant of fitness standard. The Honda was not equipped with traction control, which may have assisted in bringing it back under control prior to the collision. There is no advisory speed posted nor advance curve warning signage for the corner, and no barrier between the two opposing lanes to prevent a collision.

It was further noted that occupants of the Honda exceeded the available number of seats and were not restrained by seat belts. The Coroner considered these were additional factors increasing the number of fatalities.

COMMENTS OF CORONER ROBB

Fatigue

I. The dangers of speeding and driving while fatigued have been the subject of multiple media campaign warnings promoted on behalf of the New Zealand Police and others. I reiterate those dangers and warnings.

II. Driving while fatigued, particularly when driving in excess of the posted maximum speed limit can obviously have fatal consequences.

III. Driving at the same open road speed, without significant change in terrain, and without having to stop for intersections, with little external stimuli, is recognised as aggravating the impact of fatigue. This can occur on longer journeys particularly where the driver is already fatigued, and where the driver is the only person awake in the vehicle.

IV. These tragic and entirely avoidable deaths highlight those dangers.

V. Those dangers are present not only for the driver, but for those that they transport, here the precious cargo of six children from the same family. For the Luke and Poutawa whānau the consequences have been horrific.

VI. Those dangers extend to other, entirely responsible and innocent members of the public using the roadway at the same time. Here Jennifer Rodgers needlessly lost her life in circumstances over which she had absolutely no control. That is no less horrific for her family to have to endure.

Tyre tread/appropriate tyres

VII. There may be multiple reasons, including financial reasons, leading to a vehicle being driven with insufficient tyre tread and with mismatched tyres. I recognise those practical impediments, but insufficient tread and mismatched tyres negatively impact on control of a vehicle. While not the principal cause for the collision, anything that negatively impacted on Margaret's ability to control the vehicle is an important consideration. These tragic deaths highlight the importance of meeting those obligations to maintain tyre tread and ensure that mismatched tyres are not placed on a vehicle.

Seat belts

VIII. I acknowledge the practical difficulties in transporting a large family of eight. This makes travelling in a single vehicle difficult and may lead to the temptation to have children sharing seats, and to have more occupants in the vehicle than available seats.

IX. Seatbelts serve an important safety purpose. Restraining occupants of a vehicle prevents them being thrown from the vehicle in the course of a collision. As a Coroner I have investigated multiple deaths where individuals have been thrown out of a vehicle with fatal consequences as a result of seat belts not being worn. Seat belts also reduce the extent of injury sustained in any collision, depending on the nature of the collision they can be the difference between suffering a survivable injury and dying.

X. Finance and practical difficulties can lead to seatbelt rules being broken, corners being cut, but the dangers are again highlighted in this inquiry.

Roading

XI. While not a direct cause of the collision, a centre barrier separating the two lanes may have prevented the collision between the Honda and the Kia, if nothing else, preventing the death of Jennifer Rodgers. Drivers can make mistakes, but barriers between lanes can reduce the risk, and potentially the extent of harm to road users.

XII. The corner had been subject to an area of resealing, which met standard requirements on friction testing. However, the Honda's loss of control began on that area of resealing. In combination with excess speed and a wet road surface, the lower friction qualities of the area of resealing was an additional factor in the collision.

XIII. As noted above, speed was likely the most significant factor in the collision. An advisory speed and/or curve warning sign would serve to warn drivers to reduce their open road speed in navigating the corner.

Opportunity to respond to comments and recommendations

XIV. Pursuant to section 57A of the Coroners Act 2006 I extended the opportunity to Waka Kotahi to respond to the comments and recommendations set out above, and I also invited them to provide me with any update on any planned roading improvements in the area.

XV. I also provided a copy of this draft finding to the families. I extended the opportunity to review the finding and draft comments, and to consider whether they evaluated any comments as adverse to their loved one. I extended the same opportunity for them to provide me with additional information and submissions in response to any adverse comment that they felt it necessary to address. Mr Whaitiri Poutawa provided a response on behalf of the Luke and Poutawa whānau.

XVI. I have reviewed the responses and amended this finding to acknowledge those responses where I have evaluated this as appropriate.

Waka Kotahi

XVII. Waka Kotahi took the opportunity to respond. Waka Kotahi began by expressing its condolences to the family of Jennifer Rodgers and the Luke and Poutawa whānau before providing this further information:

> In December 2019, the Government announced Road to Zero: New Zealand's Road Safety Strategy 2020-2030 (the Strategy). The strategy sets our vision and commitment to a New Zealand where no one is killed or seriously injured in road crashes. Road to Zero is guided by the Safe System approach, a holistic view to road safety which provides a framework to assess, guide and improve travel by ensuring safer roads and roadsides, vehicles, speeds and driver behaviour.
>
> Further information and advice for road users regarding the Strategy, including messaging and safety advertising campaigns on the matters of fatigue, the use of seatbelts and driving to the conditions, is available at www.nzta.govt.nz/safety/.
>
> In addition, Waka Kotahi publishes safe winter driving brochures, including a Winter Tyre brochure that can be downloaded or printed by businesses, associations, and members of the public. The brochure contains specific advice against the mixing of winter tyres with other tyres. Tests have shown that, if winter tyres are mixed with summer tyres on the same vehicle, the different degrees of grip can make the vehicle unbalanced and difficult to control in an emergency or during hard braking. The brochure is available at: www.nzta.govt.nz/assets/resources/winter-tyres/docs/winter-tyres-pamphlet.pdf

I will respond to the remainder of the comments and recommendations in turn.

Installation of a median barrier in this location

The installation of median barriers on New Zealand roads has resulted in a marked decrease in the number of fatal and serious injury crashes. There is little doubt that a median barrier at this location would have at least mitigated the severity of the crash impact, if not eliminated the crash altogether.

Waka Kotahi has a programme to investigate the viability of installing median barriers on all sections of the state highway network where the posted speed limit is 80km/h or greater. However, because of a limited funding environment, we are prioritising locations where the traffic volume is greater than 10,000 vehicles per day for 80km/h or 6,000 vehicles per day for 90km/h or 100km/h. It should be noted that the current volume of daily traffic on this corridor is in the order of 7,000 and will be prioritised accordingly in the national Speed and Infrastructure programme.

Difference in road surface

Although the road surface in this location had been visibly patched with some surface smoothing, the surface friction provided was checked and found to be satisfactory. It is conceivable that the change in surface friction exacerbated the difference in the performance of the contrasting tyres that were fitted to the vehicle.

Advisory Speed and curve warning signs

It is noted that, at the time of the crash, the curve had a combination of multiple and single chevrons installed that provide additional delineation, though it does not have an associated advisory speed.

Curve advisory speeds are only displayed when the measured value is 15km/h or more below the speed limit. A lack of speed warning implies a comfortable negotiation speed for this curve would be between 85km/h and the speed limit of 100km/h. However, Waka Kotahi will review the requirement for a speed advisory sign in this location and install one as appropriate.

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

Perenara [2021] NZCorC 132 (20 August 2021)

CIRCUMSTANCES

Alex Jade Apakura Perenara, aged 18, died on 7 September 2017 at Auckland Hospital of a closed head injury.

At 9:30pm on 6 September 2017 Mr Perenara left home to get cigarettes and chocolate from the local gas station. A witness saw Mr Perenara pull out onto State Highway 12. She was traveling at about 100km/h and saw his vehicle speed off out of sight. She noted the vehicle was not being driven erratically. At that time the weather was consistently raining, dark and overcast. Shortly afterwards Mr Perenara lost control of his motor vehicle. Another witness saw Mr Perenara's vehicle coming towards him from the direction of Kaihu. The vehicle was going sideways and was in the wrong lane. He

saw it go into the drain, travelled along the drain then hit a power pole. Mr Perenara was removed from his car and airlifted by the Northland Rescue Helicopter to Auckland Hospital.

Unfortunately, Mr Perenara did not recover from his injuries and on 7 September 2017 the decision to switch off the machinery assisting his breathing was made. Mr Perenara was subsequently verified as deceased by a medical practitioner.

COMMENTS OF CORONER TETITAHA

I. I am making the following comments directed to Waka Kotahi: NZ Transport Agency (NZTA) pursuant to s57A Coroners Act 2006.

II. Between 2017 and 2019 the NZTA crash analysis system recorded 122 fatal crashes in Northland. There have also been 25 motor vehicle crashes in Northland that involved a post or poles. This includes light, power, phone, utility poles and objects practically forming part of a pole (i.e. 'Transformer Guy' wires).

III. Since 2003 there have been 5 crashes (including Mr Perenara's) in this area of State Highway 12. The other four accidents were minor or non-injury crashes. Similar to Mr Perenara, three of the crashes occurred during the daytime, including one when there was light rain and two when it was overcast.

IV. While this crash may have been the result of weather conditions, vehicle and driver failures, there are road and environment factors that could be changed to avoid similar road crashes (and deaths) in this area such as those suggested in the Opus report above.

V. In particular the curve prior to where this accident occurred, has a stated curve speed of 85 km/h. At the time of the accident, there were no warning signs regarding this curve speed and no signs warning of the need for speed reduction prior to the curve or on the curve itself. This is concerning given the road has a 100 km/h speed limit.

VI. Combined with the reduced seal width of the road at the point of impact, it is unsurprising Mr Perenara's vehicle ended up in the roadside drain if he was travelling at the stated speed limit of 100 km per hour in wet weather conditions.

VII. There also appears to be some concerns raised in the Opus report about the hazards of the roadside drain and power pole that Mr Perenara struck. It is described as follows:

> 2.4.7 Hazards
>
> On the left side of the road, there is a road side drain, immediately adjacent to the road reserve boundary, which is approximately 4 m from the edge line, with several large trees on private property around the outside of the curve.
>
> On the right-hand side of the road, there is a roadside drain, approximately 1 m deep, which the crashed vehicle traversed. There are also power pole is on the other side of the drain to the carriageway, and it was one of these polls which was struck. The power poles appear to be positioned as close as possible to the road reserve boundary.

VIII. I have sought comment from Waka Kotahi NZ Transport Agency (NZTA) regarding the above comments and draft recommendations based upon the comments. Waka Kotahi have advised as follows:

- a Waka Kotahi contractor has carried out maintenance including cleaning of the edge marker posts in both directions of the crash location;
- large horizontal curve chevron boards have been installed 1.5 m north of the crash location;
- at the curve in question, curve ahead warning signs including a 65 km/h speed advisory signs were installed;
- there is no pavement rehabilitation or reseal in the current forward work program to increase the length of the carriageway or remark shoulders or lanes in accordance with the State Highway control manual. However, this section of State Highway 12 will be put forward for future consideration as part of network improvements;
- Waka Kotahi have started a speed management review program for Northland and Auckland North which includes the section of State Highway 12.Considerable D

RECOMMENDATION OF CORONER TETITAHA

I. Both Opus and Waka Kotahi are thanked for their responses. After considering the above, I make the following recommendations pursuant to section 57A of the Coroners Act 2006:

a. That Waka Kotahi New Zealand Transport Agency put forward for future consideration as part of network improvements pavement rehabilitation or reseal in the current forward work program to increase the length of the carriageway or remark shoulders or lanes in accordance with the State Highway control manual.

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

Petrie [2021] NZCorC 150 (14 September 2021)

CIRCUMSTANCES

Ben Russell Petrie, aged 34, died on 11 February 2018 at State Highway 1 near Te Paki from severe head and neck injuries sustained as a result of a motor vehicle accident.

At around 3:30pm on 11 February 2018, Mr Petrie was driving his motorcycle on State Highway 1, near Te Paki. He was riding with two friends as part of the group's road trip in Northland.

Mr Petrie approached a slight rise in the road after which there was a left-hand bend. Because of the topography of the road, the bend was not visible to Mr Petrie until the top of the rise. There was no warning signage indicating a bend was ahead.

Mr Petrie did not see the bend until he was at the top of the rise. He leaned his motorcycle over to the left in an attempt to navigate the corner, but lost control and slid across the road into the opposite lane. At that moment, an oncoming car collided with the motorcycle. Mr Petrie was struck by the vehicle and died at the scene.

A serious crash review conducted by Police identified two main facts that contributed to the crash. The first factor was the poor visibility of the corner presented by the topography of the road and the lack of warning signage. The second was corrugations and ruts in the wheel tracks of the northbound lane just prior to the corner. This was likely to have adversely affected the handling of the motorcycle, especially when leaning over at an extreme angle.

COMMENTS OF CORONER HO

I. Following the crash Opus Fulton Hogan reviewed the section of the road where the crash occurred and made the following recommendations:

   a. a chevron board be provided for each direction on the curve;

   b. the pavement defects on the curve be investigated and repaired;

   c. a small tree in the road reserve be removed, presumably to improve visibility.

II. It also recommended that Waka Kotahi New Zealand Transport Agency review the provision of curve warning signage for the adjacent curves through the Te Paki area and also review the curve warning signage for the proximate section of SH1 to ensure consistency with a similar road nature.

III. I endorse these recommendations. Prior to issuing these findings I asked Waka Kotahi to provide an update on whether these recommendations had been implemented. I received a response from Ms Elston, National Manager System Design, on 13 September 2021. Ms Elston stated:

> Waka Kotahi acknowledges that due to the geometry of the state highway at the crash location, there was no indication of the curve for northbound traffic until motorists neared the top of the vertical crest curve. Since the fatal crash on 11 February 2018, I can confirm that a full survey and analyses of the curves at the site was carried out and the following actions have been completed:
>
> i. Chevron boards have been installed for each direction of the curve.
>
> ii. A review of curve warning signage at the crash location has changed the advisory from 55km/h to 45km/h.
>
> iii. A review of the curve warning signage for the length of State Highway 1N, RS0 took place in 2020.
>
> In addition, Waka Kotahi has completed the required pavement and pothole maintenance on this section of the state highway network and is waiting on confirmation of funding for a full geometric design

investigation of the curve in question. This work will also include the removal of a small tree that appears in the road reserve at RP 0/15.58.

IV. In light of Waka Kotahi's response, I do not consider that it is necessary to make any formal recommendation under s 57A of the Act.

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

Phelps [2021] NZCorC 156 (17 September 2021)

CIRCUMSTANCES

Blair Allison Phelps, aged 42, died on 5 April 2019 at Cambridge Road, Te Awamutu from multiple injuries sustained in a road traffic incident.

At around 7:00am on 5 April 2019, two motorists were driving southwest on Cambridge Road. Both motorists reported that there was thick fog and that visibility was limited. Mr Phelps was driving in the opposite direction.

One of the motorists attempted to pass the other. He checked the lane and saw that it was clear, except for some headlights in the distance. When he was about halfway along the vehicle in front, he saw the single headlight from Mr Phelps's motorcycle approximately 75 metres ahead of him. The motorist collided with Mr Phelps, who died as a result of the crash.

The Police Serious Crash Unit (SCU) reported that the cause of the crash was the motorist's attempt to overtake the vehicle in dark and foggy conditions. The SCU noted that the motorist who crashed into Mr Phelps had smoked cannabis the night before, and this could not be ruled out as a causative factor.

COMMENTS OF CORONER BATES

I. The SCU report completed by Crash Analyst Constable Chris Johnston contains the following recommendations, which I endorse:

- Continued education and enforcement in respect of overtaking manoeuvres.
- Continued education and enforcement in respect to driver behaviour on rural roads.
- Continued education and enforcement in respect to driving to the conditions.
- Continued education and enforcement in respect to drugged driving.

II. I do not consider it necessary to make any 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 Phelps taken during the investigation into his death, in the interests of decency and personal privacy.

Rangikataua P and R, Morgan-Rangikataua A, M, and K [2021] NZCorC 157 (20 September 2021)

CIRCUMSTANCES

Rangi Rangikataua, aged 26, died on 1 April 2019 at Tirohanga Road, Atiamuri from severe head injuries sustained in a motor vehicle crash. Peter Ricky Rangikataua, aged 44, died on 1 April 2019 at Tirohanga Road, Atiamuri from multiple traumatic injuries sustained in a motor vehicle crash. Kahukura Elaine Morgan-Rangikataua, aged 12, died on 1 April 2019 at Tirohanga Road, Atiamuri from multiple traumatic injuries sustained in a motor vehicle crash. Michelle Rangimarie Morgan-Rangikataua, aged 15, died on 1 April 2019 at Tirohanga Road, Atiamuri from severe traumatic crash injuries to her head sustained in a motor vehicle crash. Aroha Morgan-Rangikataua, aged 14, died on 1 April 2019 at Tirohanga Road, Atiamuri from severe traumatic injuries to her head sustained in a motor vehicle crash.

On 1 April 2019, at some time after 4:00am, Rangi was driving with his uncle, Peter, and Peter's children Isaac, Kahukura, Michelle and Aroha. On a straight stretch of road, Rangi's vehicle crossed the centreline, left the road and collided with a group of roadside trees. As a result of the collision, everyone in the vehicle, except Isaac, suffered fatal injuries and died at the scene. Toxicology testing revealed the presence of cannabis and methamphetamine in Rangi's blood.

The crash was investigated by the Serious Crash Unit (SCU). The combination of the effects of methamphetamine and cannabis, the early time of day, and the shallow angle of departure from the road indicate that the loss of control of the vehicle was due to fatigue. The speed of the vehicle when it collided with the trees, in combination with the failure of the occupants to wear seatbelts, likely contributed to the severity of the injuries sustained.

COMMENTS OF CORONER BATES

I. The SCU report recommended that the speed limit of Tirohanga Road be reviewed.

II. A copy of the SCU report was sent to the Taupō District Council. They have advised me that Tirohanga Road's speed limit was reviewed in 2017 as part of their speed limit bylaw review and found to be appropriate. Waikato District Council is currently developing a regional speed management plan. Once this is complete, Taupō District Council will develop their local speed management plan before making further speed limit changes.

III. I endorse this approach and direct that a copy of this finding be supplied to Taupō District Council and to Waikato District Council.

IV. The importance of wearing seatbelts has been the subject of many public safety campaigns. None of the occupants of the Ford were wearing seatbelts. Had seatbelts been worn, their likelihood of survival would have been higher. However, as there were four occupants in the rear seat, one person would not have had a seatbelt available to them. Clearly, vehicles should not contain more occupants than the number of seatbelts available.

V. The dangers of driving while affected by intoxicants, such as methamphetamine and cannabis have also been the subject of many public safety campaigns.

VI. The dangers of driving whilst fatigued have been well publicised. Waka Kotahi regularly feature fatigued and drowsy driving public messaging in social media campaigns. Their education includes a general information web-page on driver fatigue. Online education resources are available to the public through the Waka Kotahi website.

VII. Tragically, these deaths were preventable.

VIII. As a result of the circumstances outlined above, I do not make any recommendations or further comments pursuant to s 57(3) of the Coroners Act 2006.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of the deceased taken during the investigation into their deaths in the interests of decency and personal privacy.

Robinson [2021] NZCorC 137 (24 August 2021)

CIRCUMSTANCES

Richard Robinson, aged 57, died on 19 July 2017 at Preston Road, Otara, from chest injuries as a result of a motor vehicle collision.

In the morning of 19 July 2017, Mr Robinson was driving at about 5 km/h when he crossed through an intersection into oncoming traffic and collided with a bus shelter on the wrong side of the road. This was witnessed by Police officers who came to his aid. His condition led the Police officers to consider whether he was having a medical event due to possible consumption of synthetic cannabis and sought medical attention.

During medical assessment he began to communicate and informed officers that he had consumed synthetic cannabis. Consequently, Mr Robinson was arrested and taken to a Police station where he was charged with careless driving and driving under the influence of a drug (third and subsequent charge). He was summonsed to appear in Court and was also forbidden from driving for a 12-hour period, commencing at 12:00pm on 19 July 2017. Police informed him that he could not drive his car. He acknowledged this, said it was the first time he had smoked synthetic cannabis and understood that it was dangerous. Police then brought him home leaving him with his car keys.

At 2:15pm on 19 July 2017, Mr Robinson was driving his motor vehicle on Ormiston Road in Otara. He was observed driving erratically and Police attempted to stop him by activating their red and blue lights and initiating a pursuit. However, he failed to stop. He then drove through a red light at the intersection of Ormiston Road and Preston Road, and, without braking, went through a metal pole fence and crashed into a concrete brick building resulting in his death.

Post mortem toxicology analysis of blood taken from Mr Robinson's body confirmed the presence of AMB-FUBINACA acid metabolite in Mr Robinson's blood consistent with the use of synthetic cannabinoid AMB-FUBINACA.

COMMENTS OF CORONER WOOLLEY

Driving under the influence of synthetic cannabis

I. I have found that the cause of the collision was that Mr Robinson was driving while under the influence of synthetic cannabis (AMB-FUBINACA) and was travelling at an excessive speed immediately before the collision.

II. The risks of speeding when driving have been consistently conveyed to the public through various safety campaigns on many occasions. In 2020, reducing drug impaired driving was identified as a high priority in NZTA's road safety strategy: Road to Zero 2020-2030. The NZTA is currently 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. NZTA's research on this issue indicates that many New Zealander's do not readily identify drug driving as a common cause of road trauma.

III. Given NZTA's work in this area, and acknowledging that Coroners, the Police, and NZTA have consistently highlighted the dangers of driving at excessive speed, 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 in several other findings I have issued on the issue of synthetic cannabis, I have identified that one of the dangers of consuming synthetic cannabis is that individuals can fall unconscious after consumption of synthetic drugs. Given this is a risk of consuming synthetic cannabis, I urge members of the public to not drive after consuming synthetic cannabis.

Enforcement of driving prohibition

IV. I have been provided with the current Police Policy on Alcohol and Drug Impaired Driving on forbidding a person to drive and how to enforce a prohibition on forbidding a person to drive (Policy). I am advised the Policy has been modified since the date of Mr Robinson's death and the Police are not sure of the exact policy that was in place at the time of Mr Robinson's death. This is understandable given the time that has passed between Mr Robinson's death and the date of these findings. No criticism is intended from that observation.

V. I note that the Policy advises Police officers that where a person is forbidden to drive, they can enforce that prohibition by:

    a. Requiring the driver, or person in charge of the vehicle to surrender all vehicle keys, and/or

    b. Rendering the vehicle immobile.

VI. I do not make any formal recommendations or comments under the Coroners Act 2006 in respect of the Policy but record that I support Police officers using either, or both, of the actions above to enforce a prohibition on driving.

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

Samatua [2021] NZCorC 149 (13 September 2021)

CIRCUMSTANCES

Teinatonae Samatua, aged 48, died on 29 June 2017 at Karaka, Auckland of multiple injuries secondary to a motor vehicle collision.

Ms Samatua was a taxi driver contracted to United Taxis in Auckland and held a class “P” taxi driver licence.

Ms Samatua had several long term health conditions. Due to her depression, her class “P” (taxi driver) licence was cancelled by Waka Kotahi New Zealand Transport Agency (NZTA) on or about March 2015 but was reinstated shortly thereafter. On 26 May 2015 Ms Samatua informed her GP that she had fallen asleep at the wheel due to a late shift. Her GP warned her that she could potentially lose her driving licence or licence to drive a taxi. The warning was recorded in her medical notes. In July 2016 Ms Samatua was involved in a motor vehicle accident where her car was hit by another vehicle. As a result she sustained a shoulder injury to her right arm and was receiving ACC support until March 2017. During this time she continued to work part time as a taxi driver and received a top up to her wages in a form of sickness benefit from Work and Income New Zealand (WINZ). No restrictions were placed upon her driving.

On 21 June 2017 Ms Samatua presented to her GP with dizzy spells and was diagnosed with otogenic vertigo, a disorder of the inner ear resulting in dizziness. She was offered a “time off work” certificate which she refused. Her GP prescribed prochlorperazine for her dizziness and efexor xr for her depression. Both medications have side effects such as sleepiness and drowsiness, and have warnings against driving. The GP believed he verbally advised Ms Samatua at the time not to drive but made no notation in the medical notes about this. He also believed that he gave her a handout about her condition, warning her about driving. Ms Samatua continued to work as a taxi driver.

On 26 June 2017 at approximately 8:00pm Ms Samatua drove from her home to the hospital in her taxi van to visit her daughter who had just given birth. Ms Samatua then decided to sleep in her van at the hospital rather than return home. Later that evening, around 11:45pm, her employer rang and asked that she take a booking for the next day (27 June 2017) at 4:45am. Ms Samatua agreed to take the job and told her employer she would sleep until then.

On 27 June 2017 at 3:56am Ms Samatua left to collect her passengers but got lost and had to be directed to the correct address. She picked up the passenger at 5:00am and they later reported that Ms Samatua was driving erratically during their trip. While driving north along Linwood Road, Ms Samatua failed to turn at a right bend. As a result, her van travelled straight ahead onto soft gravel on the left side of the road. She overcorrected, causing the van to cross the centre line before rolling until it had rotated around.

Ms Samatua was not wearing a seatbelt and was ejected from the van. She suffered fatal injuries and died at the scene. Her passengers were seriously injured.

COMMENTS OF CORONER TETITAHA

I. I have concerns and wish to make comments about the circumstances leading to this death. There are concerns about the contradictory advice regarding not driving following the medical assessment that Ms Samatua was unfit to do so. There are also concerns about her employer’s allocation of a taxi job at 11:45pm starting within four hours at 3:56am the next morning.

II. If NZTA had been required to be notified about Ms Samatua's inability to drive, it is likely this scenario would not have occurred. Her "P" license could have been suspended and/or cancelled and she would have been unable to drive a taxi.

III. Further if Ms Samatua had been allocated the taxi job 8 to 10 hours prior, she may have been less fatigued because she would have had more opportunity to ensure she had adequate sleep. This death and the consequential injuries to her passengers may not have occurred.

The legal requirements to notify NZTA - s 18 Land Transport Act 1988

IV. The lawful requirements for medical practitioners to notify NZTA about persons unfit to drive are set out in Section 18 of the Land Transport Act 1998 (LTA) below:

> **18 Doctors and optometrists to give Agency medical reports of persons unfit to drive**
>
> (1) This section applies if a medical practitioner or optometrist, who has attended or been consulted in respect of a driver licence holder, considers that—
>
> (a) the mental or physical condition of the licence holder is such that, in the interests of public safety, the licence holder—
>
> (i) should not be permitted to drive motor vehicles of a specified class or classes; or
>
> (ii) should only be permitted to drive motor vehicles subject to such limitations as may be warranted by the mental or physical condition of the licence holder; and
>
> (b) the licence holder is likely to drive a motor vehicle.
>
> (2) If this section applies, the medical practitioner or optometrist must as soon as practicable give the Agency written notice of the opinion under subsection (1)(a) and the grounds on which it is based.
>
> (3) A medical practitioner or optometrist who gives a notice under subsection (2) in good faith is not liable to civil or professional liability because of any disclosure of personal medical information in that notice.

V. Upon notification the NZTA could revoke or have conditions imposed upon the driver's license under clauses 42, 56 or 82 Land Transport Driver Licensing Rule 1999.

VI. The Act also protects medical practitioners from civil or professional liability as a result of notifications given in good faith that disclose personal medical information (s18(3).

VII. However, Westlaw legal commentary opines that third parties whom suffer damage because of a practitioner's failure to notify the Agency where the statutory grounds were clearly present, may potentially raise a civil action against the practitioner.

VIII. The only mandatory reporting is where an individual becomes subject to a compulsory treatment order or becomes a 'special patient' under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Section 19 LTA).

How to apply section 18 LTA - Guidance for Medical Practitioners

IX. The Agency has produced a booklet titled *Medical aspects of fitness to drive: A guide for health practitioners* (the Booklet). The Booklet is self-described as being part of New Zealand's legislative framework, albeit as a guide to good practice and not legally enforceable criteria.[45]

X. The Booklet identifies two main legal obligations health practitioners have relating to fitness to drive. They are as follows:[46]

a. to advise the Agency (via the Chief Medical Advisor) of any individual who poses a danger to the public safety by continuing to drive when advised not to (s18 of the Land Transport Act 1998 (LTA)); and

b. to consider the Booklet when conducting a medical examination to determine if an individual is fit to drive.[47]

XI. The Booklet also notes that:

> Driving is not a right and the health practitioner has a legal and ethical obligation to ensure that the safety of other road uses, as well as the individual, is the primary concern in making any decision on fitness to drive.

XII. The Booklet outlines the procedure the practitioners should follow when notifying the Agency under s18:[48]

- Inform the individual that they are unfit to drive and the reasons for this.
- **If the individual accepts they are unfit to drive and advises they will not drive, take no further action.**
- **If the individual does not accept the advice and is likely to continue to drive**, advise the Transport Agency (section 18 of the Land Transport Act 1998).

XIII. It also provides:[49]

[45] NZ Transport Agency "Medical Aspects of Fitness to Drive. A Guide for Health Practitioners" (NZ Transport Agency, June 2014) at 1.1 [the Booklet]; This document can be located online at https://www.Waka Kotahi.govt.nz/resources/medical-aspects/.
[46] At 1.1.
[47] See Part 7 clause 41(4) of the Land Transport (Driver Licensing) Rule 1999.
[48] The Booklet, above, at 1.4.
[49] At 1.4.

> Health practitioners can usually successfully negotiate short-term cessation of driving with patients. However, if longer periods are necessary, it is recommended that health practitioners advise their patients both verbally and in writing. It is also recommended that the patient be told how soon they might expect to have this situation reviewed.
>
> If a practitioner suspects that a patient is continuing to drive against medical advice, they are legally obliged to inform the Transport Agency under section 18 of the Land Transport Act 1998 (see above).

Vertigo and driving

XIV. The Booklet outlines the recommended minimum stand-down periods from driving for GPs. These only apply where an individual's medical condition has been adequately treated and stability has been achieved so that road safety is not compromised.[50]

XV. With regard to severe disabling giddiness, vertigo or Meniére's disease the medical standard for all licence classes and/or endorsement types is:[51]

> Where the attacks of giddiness are sufficiently disabling that they may impair an individual's ability to drive safely, the individual should be advised not to drive until their condition is sufficiently treated.

XVI. With regard to vertigo, the Booklet advises GPs that:

> Vertigo occurs for many reasons, most of which are due to inner ear disturbances. The most common form of paroxysmal relatively disabling vertigo is benign paroxysmal positional vertigo, which can occur in relation to head movement. Some individuals may feel sufficiently disabled by their vertigo that they should not drive, while others who have attacks are able to pull over to the side of the road.
>
> There is no general prohibition on driving with vertigo except where the attacks of vertigo are sudden, or unpredictable, and are sufficiently disabling that they may impair an individual's ability to drive safely, e.g. where an individual is unable to concentrate on driving because of disabling giddiness.

XVII. The Booklet's general advice to health practitioners in relation to vertigo is:

> Where an individual is subject to attacks of disabling giddiness, health practitioners should discuss with their patients the potential seriousness of their attacks on their driving. For example, individuals who suffer attacks where there are some warning signs should be advised to pull over to the side of the road it this is safe to do, rather than try to continue driving during the attack.

What is meant by "likely to drive" s 18(1)(b) LTA

XVIII. It is settled law that the meaning of "likely" and in particular the degree of probability it contemplates is best expressed as a "real and substantial risk that the stated consequence will happen".[52]

[50] The Booklet, above n1, at 20.
[51] At 20.
[52] *Port Nelson Ltd v Commerce Commission* [1996] 3 NZLR 554 (CA) at 562-563 at 226 [*Port Nelson*].

XIX. The Court of Appeal in *Port Nelson v Commerce Commission* considered that the meaning of "substantial"[53] was defined as being "real or of substance" and paraphrased it as "not insubstantial or nominal".[54] Gault J was of the opinion that merely ephemeral or minimal would not suffice.

XX. In *NZME Limited v Commerce Commission* the Court of appeal considered that an effect is "likely" if there is a "real and substantial risk" or "real chance" that it will occur. It must be more than a mere possibility but need not be more likely than not. The likely existence of such a risk is a practical or economic question. In general terms, a real and substantial risk might be one that had at least 30 per cent prospect, although that is not to suggest precision but to demonstrate that the threshold is not that a given effect is more likely than any alternative; rather it must follow that more than one alternative may qualify for consideration.[55]

XXI. The test in s18(1)(a) and (b) is subjective because it requires notifying NZTA if the medical practitioner "considers" the patient is both "unfit" and is "likely to drive". It is notable that no statutory penalty applies if the medical practitioner fails to notify the NZTA.

Was Ms Samatua "unfit" and "likely to drive" under s 18(1)(a) and (b) LTA?

XXII. A report dated 6 July 2017 was provided by Ms Samatua's GP. The report noted amongst other things a diagnosis of vertigo of otogenic origin for which she was prescribed prochlorperazine.

XXIII. A further report was sought from the GP about the steps taken about Ms Samatua being unfit to drive and whether any notification to NZTA was made. A report dated 12 October 2020 stated:

> I saw Teina for the last time on 21 June 2017. She consulted me regarding vertigo symptoms as well as some other matters.
>
> As part of management of vertigo, it is my usual practice to give advice to all such patients to cease driving till they fully recover. I do this by telling them verbally and also I provide a printout of a Patient Info sheet (Murtagh's patient Handout) for Vertigo. This handout (enclosed) includes general advice about vertigo including care not to drive. Next I routinely give all patients a time off work certificate usually 4-5 days and I mention the advice not to drive in this time off work certificate - so this advice gets recorded in the patient's medical notes.
>
> In accordance with this practice, I recall giving Teina verbal general advice including advice not to drive and to rest during the period she remains unwell. I also gave her the written advice printout sheet and asked her to return for follow-up if she continued to experience the symptoms beyond 3-4 days. Since Teina did not want a time off work certificate instead she was seeking a WINZ medical certificate for her next 3/12 incapacity, I did not issue her the usual time off work certificate.
>
> Most patients with Otogenic vertigo recover within few days of treatment and it is a short-term disability. Also most patients comply with the advice given. My understanding has been that I have an obligation

[53] Now specifically defined within s2(1A) of the Commerce Act 1986 as "…substantial means real or of substance".
[54] *Port Nelson,* above, n [52], at 226.
[55] *NZME Limited v Commerce Commission* [2018] NZCA 389 at [86].

under section 18 of the Land Transport Act 1990 to inform the NZTA if I consider a patient is going to continue to drive after I have advised them not to. I had no reason to believe that Teina was not going to follow my advice, therefore I had no grounds to inform the NZTA.

XXIV. Although Ms Samatua was assessed as unfit to drive and may have been verbally advised not to drive, she was given a handout and the GP completed a WINZ medical certificate that contradicted that advice.

XXV. The handout provides information about benign positional vertigo (BPV) and its effects. The GP highlighted the advice in the handout about driving which states "the affected person has to be careful with driving". This appears to permit Ms Samatua to continue driving against the verbal advice.

XXVI. I have obtained and viewed the WINZ capacity medical certificate dated 21 June 2017. This makes no reference to Ms Samatua's vertigo or any restriction on driving. Further the medical certificate confirms she can continue to work during the period of her alleged disability albeit "fewer than 15 hours a week".

XXVII. Ms Samatua's toxicology results confirmed the presence of prochlorperazine in her blood. Prochlorperazine was the medication prescribed for her vertigo. This indicates she was continuing to take medication for vertigo at the time of her death. This medication may have also contributed towards her fatigue as the side-effects include sleepiness and drowsiness.

XXVIII. There was sufficient evidence to show Ms Samatua was unfit to drive. However, the advice not to drive was contradicted by other material. This raises concerns about the need for health practitioners to record both the advice not to drive and their patients' receipt of the same.

Waka Kotahi New Zealand Transport Agency

XXIX. I sought comment from Waka Kotahi New Zealand Transport Agency (NZTA) regarding a requirement for notification to NZTA of vertigo for "P" class licence holders. Their reply is set out in summary below:

- Any changes to s18 LTA would require decision by the Ministry of Transport.
- NZTA considers the current regulatory framework for health practitioners assessing medical fitness to drive is adequate.
- There are practical implications mandating a health practitioner to notify Waka Kotahi of any medical fitness concerns they have about a passenger endorsement holder.
- There are 53,000 passenger endorsement holders and mandatory notification would create a significant administrative impact upon Waka Kotahi.
- This would limit NZTA's ability to respond effectively to other concerns raised by a health practitioner.
- Many driving stand-down periods recommended by health practitioners may be for very short periods, for example 1 or 2 weeks. This means that the stand-down period

will often be over before the drivers licence suspension/revocation documents were received by Waka Kotahi and served upon the licence holder.

- The only recommendation was that when providing advice to a patient not to drive, all health practitioners ensure that this advice is clearly noted on the patient's file.

XXX. I have considered the above comments. My comments and recommendations regarding changes to section 18 LTA shall be forwarded to the Ministry of Transport.

XXXI. The practical implications for medical practitioners and the administrative impact upon NZTA of notifying "P" class drivers with temporarily disabling illnesses such as vertigo must be measured against the safety of passengers and other road users. I note UK drivers are required to advise their UK equivalent, the Driver and Vehicle Licensing Agency (DVLA) if they experience dizziness or vertigo.[56]

XXXII. There is no defined stand down period of 1 to 2 weeks for drivers affected by vertigo in the Booklet nor in statute or otherwise. This may indicate a need to set recommended stand down periods from driving where temporarily disabling illnesses such as vertigo are detected.

XXXIII. It may be timely to consider reviewing the guidelines for health practitioners regarding fitness to drive. Given the circumstances that have occurred in this case, there is a need to ensure medical advice not to drive is recorded, communicated and received by the patient. There is no requirement for health practitioners to keep a written record of the assessment undertaken or to record the advice to a patient not to drive or provide the patient with the same.

XXXIV. NZTA could consider drafting a standard form for health practitioners to keep and provide to patients that they are unfit to drive and have been advised not to drive. If the patient is a commercial driver, the form could also include reference to the patient informing their employer of any disabling condition that may impact upon their ability to work in the transport industry. This form could also be translated into several languages.

RECOMMENDATIONS OF CORONER TETITAHA

I. I make the following recommendations to the Ministry of Transport and Waka Kotahi New Zealand Transport Agency pursuant to section 57A of the Coroners Act 2006:

II. That the Ministry of Transport consider making changes to s 18(1)(a) Land Transport Act 1998 requiring health practitioners to mandatorily report to NZTA any patient deemed to be unfit to drive whom hold passenger vehicle licenses (P class licences).

III. That Waka Kotahi New Zealand Transport Agency review the guidelines for health practitioners to include:

[56] https://www.gov.uk/dizziness-and-driving

a. Require health practitioners to record a patient's assessment of unfitness and the giving of advice not to drive including a notation about timeframe;

b. Alternatively NZTA could draft standard forms for health practitioners to record their advice about unfitness to drive, the advice not to drive (including the period of time this applies) and the consequences of continuing to drive namely notification to NZTA. If the patient is a commercial driver, the form could also include reference to the patient informing their employer of any disabling condition that may impact upon their ability to work in the transport industry. This form could also be translated into several languages.

IV. Waka Kotahi New Zealand Transport Agency have provided a reply to the above recommendations. The Agency confirmed it commenced a formal review of the medical aspects of fitness to drive publication in April 2021 expected to take 2 years to complete. They have agreed to include both recommendations as part of this review.

V. Ms Samatua's GP has also provided a response. He agrees there is scope for improvements in the current guidelines for commercial drivers with vertigo or dizziness. He noted the purpose of the handout was to assist her in understanding the nature of her symptoms and to be careful around driving and operating machinery. The WINZ medical certificate was for her case manager to review her benefit and the completed certificate is an electronic template whose wording cannot be altered.

VI. I thank Waka Kotahi New Zealand Transport Agency and Ms Samatua's GP for their helpful responses.

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

Stansfield [2021] NZCorC 121 (4 August 2021)

CIRCUMSTANCES

Tannor Stansfield, aged 24, died at Cameron Road, Mangateparu from severe head injuries sustained in a motor vehicle crash

In the weeks prior to his death, Mr Stansfield worked up to 72 hours a week and would travel approximately 57 kilometres each way. He had type 1 diabetes, which was poorly managed.

On 25 June 2019, Mr Stansfield was driving west on Cameron Road, Mangateparu. He failed to negotiate a left-hand bend in the road. His vehicle crossed the centreline and the westbound lane, and collided with a roadside tree. As a result of the collision, Mr Stansfield suffered fatal injuries and died at the scene. Toxicology testing revealed the presence of cannabis in his blood.

The Coroner concluded the combination of cannabis use, distance travelled, long work hours, lack of driver vehicle correction, and the early time of the crash indicate Mr Stansfield was fatigued. Due to fatigue, Mr Stansfield failed to

navigate a left-hand bend and his vehicle crossed the road before colliding with a tree, which contributed to the severity of his injuries.

RECOMMENDATIONS OF CORONER BATES

I. As a result of the circumstances outlined above, I make the following recommendations pursuant to s 57(3) of the Coroners Act 2006:

   a. Continued education and enforcement action in respect of driving while fatigued and while affected by drugs, in this case cannabis;

   b. That Waka Kotahi, New Zealand Transport Agency continue to remove/reduce roadside dangers (in this case it was a row of mature trees bordering the road at a high-speed corner) or, alternatively;

   c. Install roadside barriers where it is impracticable to remove roadside dangers (in this case along the section of Cameron Road where the crash occurred).

II. Response to recommendations

   a. My provisional findings in this matter were forwarded to Waka Kotahi for comment. Waka Kotahi advised the Road Controlling Authority responsible for the section of road where Mr Stansfield crashed is the Matamata Piako District Council. The Council were provided with my findings and have responded they

      … are addressing this route as part of [their] Road to Zero programme. [They] are looking at installing barriers at high risk locations and/or removing the roadside obstructions as this bend has already been identified as a crash risk with people coming off the road and hitting the tree that is located within private property.

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

Steele [2021] NZCorC 164 (28 September 2021)

CIRCUMSTANCES

Ruby-Jean Helen Steele, aged 17, died on 9 November 2018 at Waiuku Road, Waiuku of multiple blunt force injuries sustained in a motor-vehicle crash.

At about 2:20pm on 9 November 2018, Ms Steele was driving west on Waiuku Road when she failed to negotiate a moderate left bend. She crossed the centreline and collided with a utility vehicle that was travelling in the opposite direction. Ms Steele's cell phone records showed there were calls and text activity on it at about the time of the collision, indicating that she may have been using her phone while driving.

Following Ms Steele's death, Auckland Transport investigated the road where the crash occurred. The resulting report recommended the continuation of awareness campaigns regarding the dangers of distracted driving.

COMMENTS OF CORONER GREIG

I. I endorse Auckland Transport's recommendation for the continuation of awareness campaigns regarding the dangers of distracted driving. I am aware that Waka Kotahi, some telecommunications providers, New Zealand Police and Auckland Transport have undertaken work on a collaborative response to tackling the problem of distracted driving as the result of phone use and texting and on developing targeted initiatives aimed at raising awareness of the risks and spreading the word on the importance of driving undistracted.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of Ms Steele at the scene of the crash entered into evidence upon the grounds of personal privacy and decency.

White [2021] NZCorC 138 (24 August 2021)

CIRCUMSTANCES

Daniel Peter White, aged 25, died on 25 November 2018, at the intersection of State Highway 3 and Huxley Road, Maxwell, from multiple injuries sustained when he lost control of the motor vehicle he was driving and collided with a concrete power pole.

In the morning of 25 November, Daniel and his brother were traveling in his brother's Toyota Altezza motor vehicle to Whanganui. Daniel's brother was originally the driver however at some point during their journey Daniel took over driving. The road surface was wet from rain.

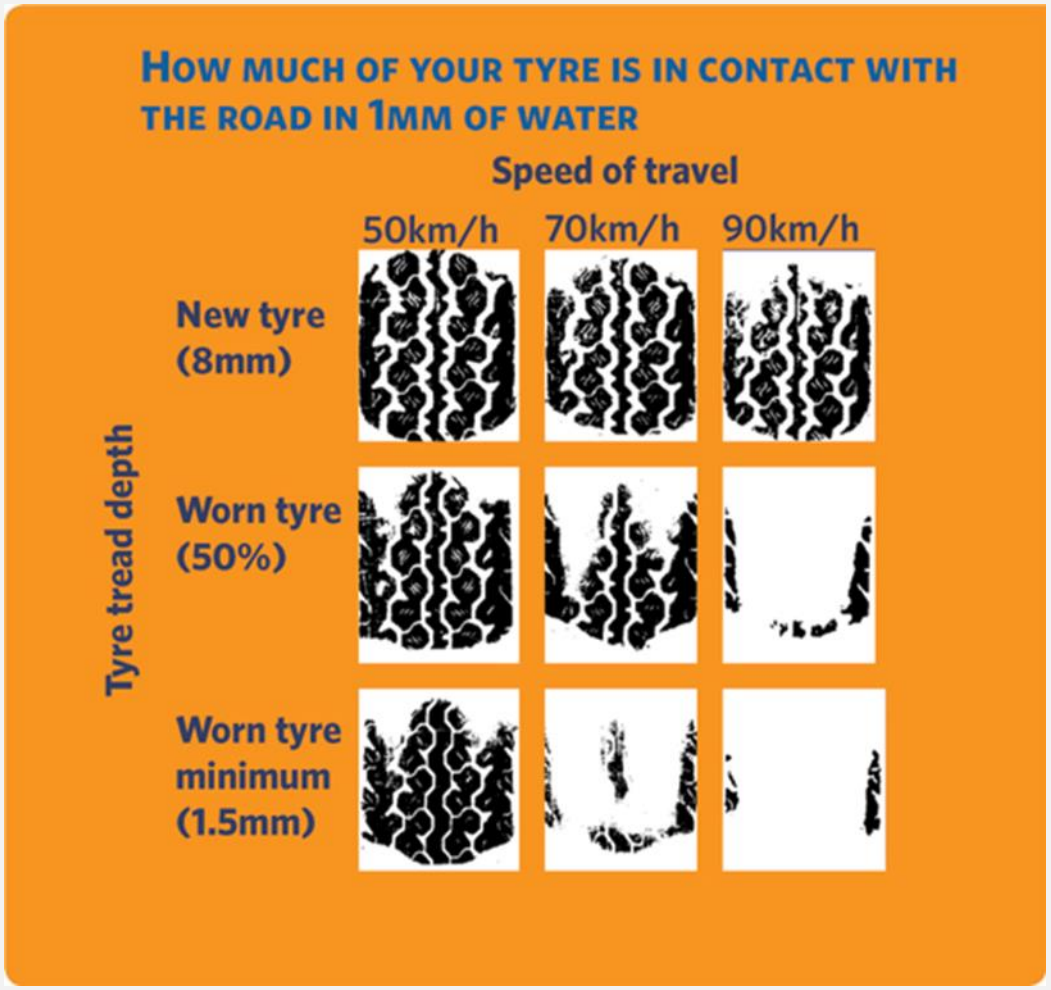
The scene of the collision, the Altezza, and witness accounts were analysed by Constable James Bennett, a Crash Analyst from the Central District Serious Crash Unit of the New Zealand Police. Constable Bennett considered that the Altezza was traveling at speed in excess of 100km/h when it collided with the concrete power pole. In forming this opinion, he considered the trajectory of the tyre marks made by the Altezza, the damage to the vehicle, and the witnesses' accounts.

When the Altezza was examined, it was found that the right rear tyre no longer complied with the legal tread depth requirement of 1.5mm. Furthermore, the right front tyre pressure was 18PSI and the rear left tyre pressure was 10PSI, well below the recommended pressure of 33PSI.

COMMENTS OF CORONER WRIGLEY

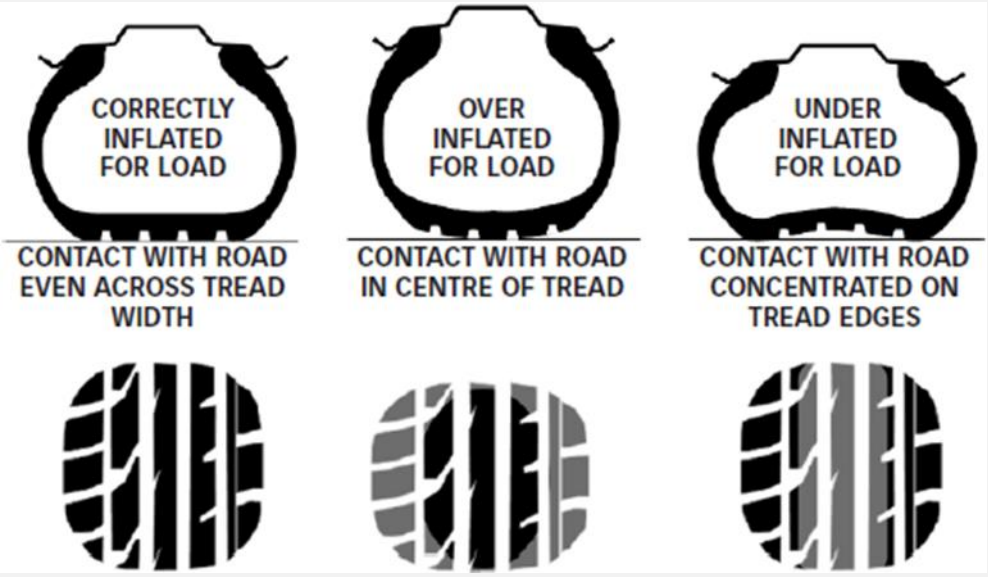
I. The message about the dangers of travelling at speeds more than the posted speed limits and too fast for wet conditions is well known.

II. Waka Kotahi, NZ Transport Agency, addresses safety issues related to the condition of tyres on motor vehicles on its website.[57] The website explains that the depth of tread on tyres is very important for the safety of vehicles. The minimum legal depth is 1.5 mm but the more tread on a tyre, the better the grip, particularly in wet conditions and at high speeds. This is illustrated with the following:



III. The website also addresses proper tyre inflation, described as being "essential for safety". It explains that tyre pressure needs to be kept at that recommended by the vehicle manufacturer and ought to be checked regularly as tyres naturally lose a little air pressure over time. The following is used to illustrate the importance of correct tyre pressure:[58]

[57] https://www.nzta.govt.nz/vehicles/choosing-the-right-vehicle/check-your-car-safety-basics/tyres/ (24 August 2021)
[58] Sourced from www.yorktyresales.co.uk.



IV. The Waka Kotahi website also provides guidance on how and when to check tyre pressure and tread depth.

V. The preceding comments are made because, if drawn to public attention, they may increase the likelihood of motorists taking steps to ensure the safe condition of the tyres of their motor vehicles and thereby reduce the chances of further deaths like Daniel's.

VI. Constable Bennett observes that the presence of an Armco barrier around the edge of the intersection may have "mitigated the outcome in the circumstances". I agree that an Armco barrier in front of the concrete power pole may have reduced the severity of the collision by absorbing some of the impact energy. Nonetheless, I accept the position of Waka Kotahi, NZ Transport Agency in relation to installation of an Armco barrier at the scene of the collision: the section of road where the collision occurred does not satisfy the risk-based criteria requirements used to prioritise such a safety intervention. It is tragically unfortunate that the Altezza hit the concrete power pole when control of it was lost, but such a random event is not a proper basis on which to allocate limited resources for road safety intervention. That is particularly so when the loss of control resulted from travelling at an unsafe speed in wet weather with tyres in poor condition.

VII. Given the clear public messaging around speed and information available on the Waka Kotahi website, I do not propose to make any further comments or recommendations in this matter.

Note: An order under section 74 applies prohibiting making public any of the photographs Police took of Daniel, in the interests of decency.

Wikaira [2021] NZCorC 127 (11 August 2021)

CIRCUMSTANCES

Geoffrey Wayne Wikaira died on 23 December 2018 in Auckland Hospital from a closed head injury due to multiple blunt trauma sustained in a motorcycle collision with another vehicle.

At about 1:20pm on 20 December 2018 Mr Wikaira stopped at a red light on his Aprilia motorcycle along Central Avenue in Whangārei. After the light turned green he accelerated away from the lights. At the same time a car was travelling along First Avenue, which bisects Central Avenue. The car had pulled out from the intersection to cross Central Avenue and Mr Wikaira was unable to stop in time. Mr Wikaira's head smashed into the "A" pillar and windscreen of the other car, causing major head injuries. He then fell from the motorcycle to the ground underneath the car.

The cause of the crash was Mr Wikaira travelling over the posted speed limit and colliding with another vehicle.

COMMENTS OF CORONER HO

I. I do not make any formal recommendations. This matter is an important reminder of complying with posted speed limits. As this case demonstrates, local authorities may determine placement of parking spaces or other obstructions near intersections based on a field-of-vision analysis which assumes that vehicles travel at or close to posted speed limits. Drivers who exceed posted speed limits can increase the risk of collisions at such intersections because other drivers do not have the visibility and time to react.

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

Self-Inflicted

Barnes [2021] NZCorC 151 (15 September 2021)

CIRCUMSTANCES

Cuba Eathen Peter Barnes, aged 19, died on 26 August 2018 at Tauranga Hospital in circumstances amounting to suicide.

Mr Barnes had recently returned to New Zealand after living in Australia for several years. He was living with his cousin who managed a motel on Turret Road, Tauranga. Mr Barnes had a girlfriend back in Australia. On the evening of 25 August 2018, Mr Barnes attended a party and consumed alcohol. During the party he had an argument with his girlfriend on the phone and allegedly spoke of killing himself.

At approximately 1:50am Mr Barnes was found in a reserve on Turret Road by motel guests. He was taken by ambulance to Tauranga Hospital where he later died.

COMMENTS OF CORONER BATES

I. I do not make, nor intend to imply, any criticism of anyone who Mr Barnes had direct contact with and to whom Mr Barnes may have made comments about suicide on the evening of 25 August 2018. However, Mr Barnes's tragic death does provide an opportunity to reiterate and 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:[59]

> **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.
>
> - 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.

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

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 history of health website. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated.

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 Mr Barnes taken during the investigation into his death, in the interests of decency, personal privacy and public interest.

Bennett [2021] NZCorC 146 (8 September 2021)

CIRCUMSTANCES

Terence Mountfield Bennett, aged 74, died on 9 October 2018 at Brick Bay Drive in circumstances amounting to suicide.

Terence lived with his wife in Auckland. He was described as being fit and healthy up until several months before his death. In early September 2018, Mr Bennett lost the sight in his right eye permanently. He indicated to his wife that he felt depressed by this, and he subsequently lost interest in his hobbies and in life in general. At around the same time, Mr Bennett was exposed to stressors concerning his family

On 8 October 2018, Terence went missing from his home. He was found the next morning deceased.

COMMENTS OF CORONER ANDERSON

I. I do not consider that any recommendations, of the type contemplated by the Coroners Act 2006, are required in this case. However, for the purposes of raising public awareness I draw attention to some of the options available for those who are experiencing suicidal thoughts and who may be reluctant to seek help or assistance for these matters. This includes information available from the Mental Health Foundation at https://mentalhealth.org.nz/help and on the Ministry of Health website at https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide. Urgent advice can be obtained by contacting the local Mental Health Crisis Team through the nearest District Health Board.

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 Terence entered into evidence, in the interests of personal privacy and decency.

Cleaver [2021] NZCorC 129 (17 August 2021)

CIRCUMSTANCES

Larnce Timothy Cleaver, aged 26, died between 27 August 2021 and 31 August 2018 at Dome Forest, Conical Peak Road, Dome Valley. The circumstances of his death amount to suicide.

At the time of his death, Mr Cleaver was undergoing relationship difficulties with his wife. When she went to stay with her sister, Mr Cleaver threatened to take his own life. He had made similar threats in the past, and Mrs Cleaver spent time trying to reassure him over text messages.

The last known contact with Mr Cleaver was on 27 August 2018. He was found on 31 August 2018 by family members who were looking for him.

COMMENTS OF CORONER GREIG

I. At the time he died Mr Cleaver was under considerable pressure for a number of reasons, but it is not possible for me to say why he chose to make the decision to take his life. People who take their own lives usually do so as a result of a complex range of factors. The Ministry of Health has reported that “it is usually the end result of interactions between many different factors and experiences across a person’s life”.

II. It appears that Mr Cleaver was a solitary and private man. Over the course of his relationship with his wife, he had at times spoken of suicide – including telling her that if she left him, he would take his life. He did so again when Mrs Clever told him she needed a break and went to stay with her sister – his talk of suicide contained in a vortex of text and snapchat messages to Mrs Cleaver during which his mood appears to have been very labile. He made clear that he wanted Mrs Cleaver to come home and if she did not, she would not see him again. One text talked about how he had thought of how to take his life. Mrs Cleaver spent time trying to comfort and reassure him.

III. Hindsight can give 20/20 vision not obvious at the time, and I am not critical of Mrs Cleaver's actions over the period she was away. Tragically however, the circumstances of Mr Cleaver's death highlight an important message that all New Zealanders should be aware of : experts advise that it is important to assume that all threats by a person to end their life are serious and should be taken seriously and that help/support for the person should be sought. The Ministry of Health website sets out steps to take if you consider someone may be suicidal -

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

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 Larnce Cleaver entered into evidence upon the grounds of personal privacy and decency.

Edwards [2021] NZCorC 118 (2 August 2021)

CIRCUMSTANCES

Jacqueline Freda Shakylah Edwards, aged 14, died on 14 March 2019 in circumstances amounting to suicide.

COMMENTS OF CORONER BELL

I. Sadly, there is clear evidence of Jacqueline's mental distress, both in her writings and in comments she made to friends and whānau. It can be inferred that this knowledge provided opportunities to intervene and support Jacqueline, but it cannot be known whether this would have ultimately prevented her from taking the steps she did.

II. Numerous Coroners have drawn public attention to the need to take thoughts of suicide seriously, particularly in the context of young people. Coroners have acknowledged that it is difficult for peers and whānau to deal with such issues,[60] but there is publicly available advice from the Ministry of Health which I consider bears repeating in the circumstances of Jacqueline's death:[61]

[60] See for example, CSU-2009-PNO-000260 (Coroner na Nagara), CSU-2014-HAM-000487 (Coroner Matenga), CSU-2016-DUN-000401 (Coroner Tutton), CSU-2016-DUN-000180 (Coroner Tutton) and CSU-2018-WGN-000250 (Coroner Borrowdale). There are various orders under ss 71 and 74 of the Coroners Act 2006 pertaining to these Findings.
[61] https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal#urgenthelp

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.

- **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 history of health website. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated.

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 Jacqueline entered into evidence upon the grounds of personal privacy and decency.

Hanchet [2021] NZCorC 159 (22 September 2021)

CIRCUMSTANCES

Roy Stanley Hanchet, aged 65, died on 28 September 2017 at Auckland City Hospital. His death occurred in circumstances amounting to suicide.

Mr Hanchet had a difficult upbringing and suffered from longstanding problems with anxiety. He experienced considerable stress due to the collapse of his business in 2010 and ongoing associated litigation. The development of persistent tinnitus also had a significant impact on his quality of life in later years. At the time of his death, Mr Hanchet was estranged from his siblings and had recently separated from his wife of 39 years.

Auckland District Health Board (ADHB) reported that between April 2015 and late November 2016, Mr Hanchet presented to community mental health services on three occasions with symptoms of acute depression and was admitted for brief periods of inpatient unit care under the Mental Health Act. These periods were followed by intermittent adherence to his prescribed medication and disengagement with mental health services.

In late 2016, electroconvulsive therapy (ECT) was recommended and agreed to by Mr Hanchet's family, and he was readmitted as an inpatient. However, the ECT service at the time was at full capacity. After four weeks there was still no

viable update for ECT treatment and Mr Hanchet was discharged home to continue treatment with antidepressant medication.

Mr Hanchet was last seen by an ADHB clinical psychiatrist in May 2017. He appeared moderately depressed, but was taking his medication and had no suicidal plans or intent. Between 24 August and 21 September 2017, no concerns were raised in phone calls with his community mental health keyworker.

On 26 September 2017 Mr Hanchet's meeting with his keyworker was cancelled. Mr Hanchet requested a support phone call and was called back by the duty keyworker. He reported that things were "really bad at the moment" and believed he had an "adverse reaction" to being "poisoned". The phone call was then disconnected. The duty keyworker phoned him back, but the phone went straight to voicemail. She tried calling another three times, both to his mobile phone and landline, with no success. She left voicemails and sent a text message offering support and encouraging Mr Hanchet to reconnect with the service.

The duty keyworker consulted with the mental health crisis team, who opined that Mr Hanchet's mental health had declined but that he did not present an imminent safety concern. On the team's advice, the keyworker tried to contact Mr Hanchet again, once to his mobile phone and once to his landline, with no success. A plan was made to hand over to the usual keyworker to make contact with Mr Hanchet the next day. There was no recorded follow-up, and Mr Hanchet did not initiate further contact.

At 6:30pm on 28 September 2017, Mr Hanchet was observed by members of the public taking deliberate actions to end his own life. He was taken to Auckland City Hospital, where he was declared dead.

RECOMMENDATIONS OF CORONER HO

I. Mr Hanchet's decision to commit suicide appears to have been the result of several unhappy factors in his life. I have considered whether any of those factors give rise to recommendations or comments that should be made to reduce the chances of further deaths occurring in similar circumstances, as follows.

II. I have carefully considered the clinical evidence provided by the ADHB clinical psychiatrist. I have not identified any fault with the general care that was provided to Mr Hanchet by community health services. It was unfortunate that there was no capacity to implement the preferred ECT course of treatment in late 2016 but that was not the fault of ADHB or community health services. Rather, it appears to be a resource constraint for which it is the responsibility of the appropriate government department or local health board to address at a governance level.

III. I record one concern. Mr Hanchet's final encounter with community mental health services was a phone call two days prior to his death in which Mr Hanchet told the duty keyworker that things were "really bad at the moment" just before the phone was disconnected. The keyworker properly attempted to reconnect with Mr Hanchet and left messages. However, I was concerned that there did not appear to be any follow-up. The abrupt disconnection, Mr Hanchet's self-admission that things were bad, and that this admission represented a marked deterioration from Mr Hanchet's most recent interaction with mental health services, should in my view have encouraged a more proactive response. For example, it would have been appropriate to try to call again at regular intervals through the day, or at least at the

end of the day, with follow-up calls the next day. It is possible that had contact been made and Mr Hanchet counselled he would not have made the decision that he did.

IV. Prior to issuing these findings, and in accordance with the requirements of the Coroners Act 2006, I notified ADHB of my concerns. ADHB responded that it had conducted a serious incident review and identified that there was confusion with the phone duty system, which was newly introduced at the time, in relation to who was allocated to follow up with Mr Hanchet. It determined that the duty person system required review in relation to crisis team responsibilities, duty responsibilities and clarification of the role of reception. ADHB advised it had made specific changes following this incident, comprising education to duty roles and a handover book whereby the duty keyworker makes a note of the interactions during their shift for the following duty person to review and follow up as appropriate.

V. I also advised ADHB of my intention to recommend that it implement guidelines for dealing with disconnected calls where the caller has expressed distress. These guidelines should include an onus on the community health provider to attempt to reconnect with the distressed patient, the regularity of which should be commensurate with the level of distress exhibited by the patient at the time of the disconnection. ADHB advised me that it considered its current system, by which I took to mean its education of duty roles and the handover book, adequately responds to situations such as disconnected calls on a case-by-case basis which is commensurate with the level of distress exhibited by the patient.

VI. To the extent that there are no formal guidelines to assist duty workers, my view remains that it would be good practice for such guidelines to be formalised rather than left to ad hoc education. Having written guidelines ensures that the duty worker has an appropriate reference point, and minimises the risk of relying on an informal expectation that a duty worker is able to have the time and capacity to make a clinically appropriate decision during a busy shift. I accordingly formalise my recommendation above.

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 unless they are granted an exemption under s 71A or have permission under s 72. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Hanchet taken during the investigation into his death, in the interests of decency and personal privacy.

Ioane [2021] NZCorC 126 (11 August 2021)

CIRCUMSTANCES

Pologa Junior Ioane, aged 28 and of Samoan descent, died on 7 July 2017 at Waikōwhai Bay, Auckland in circumstances amounting to suicide.

In the months before Pologa's death his desire to gamble began to control his decisions and negatively affect his personal, professional and family relationships. This caused Pologa a lot of stress, in particular the pressure of his gambling debts, the guilt he felt for having succumbed to his addiction, and the impending consequences of his actions, collectively overwhelmed him.

Pologa's friends and family tried to help with his gambling habits however, he struggled to properly engage with this help.

COMMENTS OF CORONER DUNN

Problem gambling

I. Pologa's tragic death is a real example of the devastation problem gambling can have not only for the individual gambler but also on loved ones and their community. The Gambling Act 2003 recognised that problem gambling is a public health concern by tasking the Ministry of Health ("MoH") with developing a problem gambling strategy.[62]

II. The Strategy to Prevent and Minimise Gambling Harm 2019/20-2021/22 (MoH Strategy) acknowledges that "harmful gambling behaviours often co-exist with other forms of addiction and mental health issues and need to be treated as a risk factor…".[63]

III. The MoH Strategy cites research that found that gambling harm is experienced disproportionately by Māori and Pasifika adults who were more likely to develop problems from gambling than other New Zealanders. Notably:[64]

> Māori, Pacific peoples and Asian peoples are each more than twice as likely to experience moderate to severe gambling harm than the European/other population.

IV. The MoH Strategy consists of eleven objectives, each of which is designed to achieve the common goals of preventing and minimising gambling harm and to reduce related health inequities. It is appropriate that I reproduce those objectives below:[65]

> Objective 1: There is a reduction in gambling-harm-related inequities between population groups (particularly Māori, Pacific and Asian peoples, as the populations that are most vulnerable to gambling harm).
>
> Objective 2: Māori have healthier futures, through the prevention and minimisation of gambling harm.
>
> Objective 3: People participate in decision-making about activities in their communities that prevent and minimise gambling harm.
>
> Objective 4: Healthy policy at the national, regional and local level prevents and minimises gambling harm.
>
> Objective 5: People understand and acknowledge the range of gambling harms that affect individuals, families, whānau and communities.

[62] Gambling Act 2003, s317.
[63] Strategy to Prevent and Minimise Gambling Harm 2019/20-2021/22 (Ministry of Health, June 2019) at 2.
[64] At 8.
[65] At 19 and 20.

Objective 6: A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm.

Objective 7: Services enhance people's mana and build life skills and resiliency to improve healthy choices that prevent and minimise gambling harm.

Objective 8: Gambling environments are designed to prevent and minimise gambling harm.

Objective 9: Services raise awareness about the signs and range of gambling harms that affect individuals, families, whānau and communities, and how to respond.

Objective 10: People access effective treatment and support services at the right time and place.

Objective 11: A programme of research and evaluation establishes an evidence base that underpins all activities to prevent and minimises gambling harm.

V. I endorse and support the MoH Strategy and the objectives put in place to reduce problem gambling, especially for Māori, Pacific and Asian peoples.

VI. I encourage people who are, or know of someone who they believe has, a gambling problem, to contact the Choice not Chance helpline on 0800 654 655 or by text message to 8006. This service is available 24/7. Choice not Chance also provide specific helplines which are as follows:

Support Service	Helpline
Māori Gambling Helpline	0800 654 656
Pasifika Gambling Helpline	0800 654 657
Youth Gambling Helpline	0800 654 659

VII. Choice not Chance also provide the contact information of a number of local problem gambling services.

Suicide intervention

VIII. I do not make, nor intend to imply, any criticism of anyone who Pologa had direct contact with and to whom Pologa had made comments about suicide. However, Pologa's death is a reminder of the need to take threats of suicide or self-harm seriously. The MoH offers the following guidance, which I endorse:

If someone has attempted suicide or you're worried about their immediate safety, do the following.

- 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.

IX. I do not make any recommendations pursuant to section 57(3) of the Coroners Act.

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 Pologa taken during the investigation into his death upon the grounds of personal privacy and decency.

Jay [2021] NZCorC 119 (3 August 2021)

CIRCUMSTANCES

Daniel Jay, aged 15, died 4 October 2019 at 9 Mistletoe Place, Browns Bay, Auckland in circumstances amounting to suicide.

Daniel, known as Dan, was a year 10 student at Long Bay College. In the weeks before his death, there had been a noticeable change in Dan's behaviour by his circle of friends. He did not seem particularly happy. At this time, he had experienced some bullying by a group of older boys. Furthermore, he and some of his friends, had gotten into trouble at school and were all on report. Subsequently, there was a falling out between Dan and his friends. Despite the above, he gave assurances to family that he was fine.

Dan and his friends tended to joke about self-harm and suicide. However, some of his friends were sufficiently concerned and spoke to the school guidance counsellor who spoke with Dan. He assured the counsellor that he was fine, that his comments were meant to be taken as a joke, and was unsure why others were concerned.

COMMENTS OF CORONER HO

I. Pursuant to s 57A of the 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 similar circumstances similar to those in which Dan's death occurred. 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.

II. I have decided not to make any formal recommendations but do however make the following observations.

III. Youth suicide is a topical issue and is one of which young people and those who work with young people are acutely aware. There are a number of support programmes in place to help prevent and educate around youth suicide. This case sadly shows that those programmes can be of limited benefit where the young person in question does not engage with such programmes or for whatever reason is reluctant to engage with such help when it is offered. This issue is further compounded when there is no outward manifestation of an intention to commit suicide until it is too late. In making this observation I record that I do not fault the Long Bay College counsellor's actions, which seem to me to be appropriate given Dan's responses and behaviour at the time.

IV. There was evidence that suicide was a topic of joking conversation within Dan's circle of friends. I acknowledge that some young people are sufficiently robust to engage in such banter without any ill effect. It may also be counterproductive to censor such conversation, especially given the prevalence of information about youth suicide on the internet and in popular media. However, it is also likely that such conversations could cause distress to anyone who was already feeling down or depressed and could also plant the seed of an idea in a vulnerable person's mind, even if they do not appear to be troubled by the conversation at the time.

V. There are no easy answers to these dilemmas. They are topics which the Suicide Prevention Office are better placed to address.

VI. One of the several factors I identify above as likely contributing to Dan's state of mind was the behaviour by the group of older boys. They described it as banter and friendly physicality. From the description of the effect that this behaviour had on Dan, I wish to be clear that it was not banter or friendly physicality. It was bullying. Calling people names or making threats, even without any intention to carry them out, is not acceptable behaviour. While there is no evidence that in this case the bullying was a direct cause of Dan's decision to end his life, it is likely that he would, to varying degrees, have felt on edge while at school. He may have taken conscious steps to avoid the group of boys and to not unnecessarily attract their attention. This type of mental grind, which would have been in the back of Dan's mind day in day out at school, takes its toll. It would have been mentally detrimental to Dan's emotional and general wellbeing.

VII. Schools are required under the Ministry of Education's National Administration Guidelines to provide a safe physical and emotional environment for students, including implementing bullying prevention and response policies. Dan's death is a timely reminder for all schools to review their bullying policies and procedures to ensure that they are fit for purpose; and to remind their students that bulling, whether it is verbal of physical, or "in fun" or not, is unacceptable.

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 Daniel taken during the investigation into his death upon the grounds of personal privacy and decency.

May [2021] NZCorC 114 (28 July 2021)

CIRCUMSTANCES

Tika Craig May, aged 34, died on 18 April 2018 at 2843 State Highway 12, Waima, Kaikohe in circumstances amounting to suicide.

Mr May was released from prison in February 2018. He was unable to return to his house as it had been extensively damaged. Although he had support from his probation officer, the Out of Gate programme and community mental health services, his mental health declined. Mr May described feeling isolated and lonely and was struggling with living in emergency accommodation and repairing his house.

COMMENTS OF CORONER GREIG

I. People who take their own lives usually do so as a result of a complex range of factors. The Ministry of Health has reported that "it is usually the end result of interactions between many different factors and experiences across a person's life". Dr Williams' evidence is telling in this regard.

II. I feel it important to acknowledge that in the last weeks of Mr May's life, after he was released from prison, those with responsibilities for different aspects of Mr May's life (his probation officer, his Out of Gate worker and the DHB community mental health team) were doing their best to support Mr May in what they all identified as difficult living conditions – including poverty, social isolation and loneliness. Mr May was also dealing with the added difficulty of social anxiety for which the most effective treatment option of psychotherapy was not available where he lived. The evidence shows the care demonstrated by those working most directly with him 'on the ground' – and the efforts made by those people to communicate with each other to try and ensure that the most effective support possible was in place in the face of limited resources and considerable challenges.

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 Mr May entered into evidence, in the interests of personal privacy and decency.

McKeagg [2021] NZCorC 128 (16 August 2021)

CIRCUMSTANCES

James Mita McKeagg, aged 18, died on 6 October 2018 at Birch Avenue, Tauranga. The circumstances of his death amount to suicide.

In recent years, two people James was very close to had taken their own lives. Although this had deeply affected him, and he had begun to self-medicate with alcohol and drugs, James had not taken up offers of help.

COMMENTS OF CORONER ROBB

I. For the young, for teenagers, the impact of a loved one or a close friend, having taken their own life is significant. Even for adults coping with such a tragedy presents real difficulties. The risk of self-harm is

recognised as being increased in those circumstances, particularly for the young. Self-regulation or self-medicating with alcohol and drugs is not uncommon, but seldom provides the assistance that professional mental health care can provide.

II. I acknowledge that help was offered to James, but he felt unwilling or unable to take up those offers. I make no criticism of those entities that offered help, nor of his general practitioner who he had not seen for a considerable period of time. However, I ask that copies of this Finding be provided to those entities as a further reminder of the impact that self-inflicted death can have on those people closely associated with the person who has taken their life. I also highlight the importance of seeking and recommending professional mental health support when an individual is endeavouring to cope with unusual and extreme life tragedies.

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 James taken during the investigation into his death in the interests of decency and personal privacy.

Pariyar [2021] NZCorC 158 (21 September 2021)

CIRCUMSTANCES

Aashik Pariyar, aged 25, died on 8 March 2018 at Waikowhai Reserve in circumstances amounting to suicide.

Aashik arrived in New Zealand on 9 February 2018. His wife was already living in New Zealand. They were both from Nepal and were married through an arranged marriage. Their relationship deteriorated and his wife requested that they separate. Aashik told his wife that she would regret her decision.

On the morning of 8 March 2018, Aashik attacked his wife with a large butcher's cleaver outside their house on Albrecht Avenue. This caused her serious injuries. He then ran away from the scene. He was later found deceased by a member of the public along the Waikowhai Park Track.

COMMENTS OF CORONER ANDERSON

I. I do not believe that any recommendations are required in the circumstances of this case. Aashik was solely responsible for the horrific and near fatal wounds inflicted on his wife and, shortly after the attack, he took deliberate steps to end his own life. The way in which these events unfolded during the morning of 8 March 2018 meant that there was no opportunity for any substantive intervention by other parties.

II. Marital separation and relationship breakdown are amongst the known risk factors for suicide. The period around the ending of a relationship is also a time when an individual can be at increased risk of violence or death from an abusive partner. Anyone who has concerns about the safety or wellbeing of themselves, or others, should seek advice and support from appropriate agencies. This includes contacting the Police in situations where there is an urgent threat to life or safety because of anticipated self harm or harm towards others. Information about risk factors, warning signs and support options can be accessed from a range of agencies such as the following:

For suicide:

- Lifeline https://www.lifeline.org.nz/services/lifeline-helpline or call 0800 LIFELINE / 0800 54 33 54 or text HELP (4357)
- Your local District Health Board Mental Health Crisis Team
- The Mental Health Foundation https://mentalhealth.org.nz/suicide-prevention#resources

For family harm and intimate partner violence:

- Women's Refuge https://womensrefuge.org.nz/get-help/ or call 0800 REFUGE
- http://www.areyouok.org.nz/family-violence/
- Shine: Making Homes Violence Free https://www.2shine.org.nz/ or call 0508 744 633

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 any of the photographs of Aashik entered into evidence, or any of the CCTV footage of the attack that occurred on Albrecht Avenue prior to his death, in the interests of personal privacy and decency.

Pool [2021] NZCorC 134 (23 August 2021)

CIRCUMSTANCES

David Andrew Pool, aged 50, died on 18 November 2017 at North Shore Hospital in circumstances amounting to suicide.

On 15 November 2017 Mr Pool was admitted to the North Shore Hospital after a severe panic attack whilst driving. He had shown intermittent confusion over the previous two days, including hyperventilation with palpitations. A psychiatric liaison consultant reviewed Mr Pool's case and provided medication advice. Following this he was discharged from the psychiatry service and admitted to the cardiac unit for ongoing assessment for chest pain.

On 17 November 2017 Mr Pool became paranoid and delusional. He ran from the ward to the Emergency Department where he smashed a fire alarm, resulting in cuts to his forearm. The following day, being 18 November 2017, he was moved to another ward and given a security watch. Mr Pool remained significantly paranoid. He wanted to leave the hospital as he felt it was unsafe. Following a visit from a friend Mr Pool asked a nurse if he could take a shower. He did so with a guard standing outside the cubicle. Mr Pool was found deceased in the shower about 45 minutes later.

COMMENTS OF CORONER TETITAHA

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

II. From the evidence there were issues about the assessment and communication between hospital staff regarding Mr Pool's health needs. Several recommendations were also made that are discussed below.

III. The content of the Waitemata District Health Board's adverse event report confirms his care fell below the standards provided for in its policies. The adverse event investigation report also made several recommendations:

a. admission assessments to include review of previous admissions and alert nursing staff as to potential risk of self-harm;

b. engage with mental health to assist in developing a collaborative care plan to manage patients with there are behaviours of concern;

c. create specific management plans to support nurses to include environmental risk assessment and managed care of similar patients;

d. using healthcare assistants or peer support workers instead of security guards for 1:1 watches;

e. review and replace or shower door locks of this type; and

f. educate nurses about behaviours of concern and what recommended care is required where a patient is being watched - especially 1:1 when showering.

IV. If the above recommendations had been in place at the time Mr Pool was admitted into North Shore Hospital, it may have prevented his death.

V. These comments are directed to Waitemata District Health Board.

RECOMMENDATIONS OF CORONER TETITAHA

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

II. The Waitemata District Health Board review and implement the above recommendations set out in the adverse event investigation report dated May 2020.

III. The Waitemata District Health Board have provided a response to the above comments and recommendations. The response confirms that "all but one of those recommendations have been implemented" and the writer has sought "to be updated regarding the one outstanding and will advise the coroner accordingly".

IV. The Waitemata District Health Board is thanked for their response. Coronial services shall follow up with the Board within 28 days of the release of this decision regarding implementation of the final outstanding recommendation.

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 Mr Pool taken during this inquiry, in the interests of decency.

Scriven [2021] NZCorC 115 (28 July 2021)

CIRCUMSTANCES

Mary Jane Elizabeth Scriven, aged 20, died on 2 October 2017 at Beckenham, Christchurch in circumstances amounting to suicide.

Mary experienced a psychotic episode during her second year of university study. She was well supported by her family over the following months and received care from the local District Health Board ("DHB"). However, Mary continued to struggle with her mental health during the period prior to her death.

On 21 August 2017 Mary advised her case manager that she had stopped taking her anti-psychotic medication due to the side effects. In early September 2017 she stopped taking her anti-depressant medication. Mary's case manager was advised of this in an email from Mary's mother on 6 September 2017. Following this Mary met with her case manager on several occasions and a psychologist on four occasions. However, a follow-up review with her psychiatrist did not occur in the weeks after Mary stopped taking the anti-psychotic medication, or at any time after she stopped taking the anti-depressant medication.

During a review by the DHB following Mary's death, the psychiatric registrar involved in Mary's care advised that he could not recall any specific discussion regarding Mary's cessation of the antidepressant at Multi Disciplinary Team meetings ("MDT"). Mary's case manager advised the reviewers that the doctor "would have been told, and it would have been discussed at the twice weekly MDT meetings as it is important information". The DHB Review Team recognised that the documentation of the MDT was inadequate. Because of this, it was not clear that the MDT was informed that Mary had stopped taking her anti-depressant medication.

The DHB reviewers also noted that Mary's parents did not feel fully included in her care and that they felt that they were "on the edge". Although they attended a number of appointments with Mary, her parents experienced a lack of collaboration and active engagement in risk management. They attended a family support programme at Totara House and were given information about psychosis. However, they advised that they were not given information about suicide, or given advice about how to ask questions about Mary's mental state and whether she was having any suicidal ideation. Retrospectively, they believed they might have been able to identify indicators of risk if they had been given more information about suicide and what to look for. Instead Mary's parents thought that Mary was getting better as positive progress was being reported by Totara House. They did not perceive the level of risk and Mary's death came as a shock to them.

RECOMMENDATIONS OF CORONER ANDERSON

I. I acknowledge the steps that the DHB has taken to make improvements since Mary's death. In particular, the explicit expectations around documentation of Multi Disciplinary Review meetings and the work being done to improve engagement and communication with family members.

II. I note that the views expressed by Mary's parents following her death highlight, once again, the critical nature of the interaction between clinical teams and the families of mental health service users. I will provide a copy of these findings to the Ministry of Health Deputy Director General of Mental Health and Addiction Services. [Mary's parent's] experiences are a stark reminder of the importance of

family/whānau partnership and information sharing, and how crucial it is to progress this work at a national level.

III. I also make the following recommendation to Canterbury District Health Board:

> *That the DHB review the processes for planning/scheduling medical reviews for mental health service users to ensure that planned reviews take place within the expected timeframes. If a planned review cannot be scheduled when required, for example due to leave or unavailability, then this should be documented in the clinical record along with any appropriate interim measures or actions put in place to support the care of the service user pending the review taking place.*

IV. I have formed the view that this recommendation meets the requirements of section 57A of the Coroners Act 2006 and that by drawing the matter to the attention of the DHB it may reduce the chances of further deaths occurring in future.

V. I provided CDHB with an opportunity to respond to this proposed recommendation, but the DHB has chosen not to provide comment.

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 any photographs of Mary taken by Police in the interests of decency and personal privacy.

Smith aka McMurchy [2021] NZCorC 155 (16 September 2021)

CIRCUMSTANCES

Charmaine Mauriss Vicky Smith, also known as Charmaine Mauriss Vicky McMurchy, aged 50, died on 16 December 2019 at 82 Riverview Road, Huntly in circumstances amounting to suicide.

Charmaine had a history of mental health illness. In the week leading up to her death she had seen some gang members near her car, which had triggered post-traumatic stress for her. Charmaine sought medical assistance after this event and was engaged with a crisis homebased treatment team at the time of her death.

COMMENTS OF CORONER BATES

I. Although Charmaine had not given any indication that she was at imminent risk of suicide, her tragic death provides an opportunity to reiterate Ministry of Health advice for anyone concerned that someone may be suicidal, or who becomes aware of suicidal threats being made. This advice cannot be repeated often enough.

II. The Ministry of Health website provides the following information:[66]

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

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.

- 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 history of health website. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated.

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 Charmaine taken during the investigation into her death, in the interests of decency, personal privacy and public interest.

Wood [2021] NZCorC 116 (29 July 2021)

CIRCUMSTANCES

Matthew Cameron Wood, aged 41, died on 25 January 2020 at 8 Chaucer Road South, Hospital Hill, Napier in circumstances amounting to suicide.

Mr Wood had significant involvement with mental health services over many years, and had a diagnosis of Bipolar Affective Disorder. He was being treated by his general practitioner with antidepressant medication and medication to assist with sleeping. He had been referred to the mental health service on three occasions by his GP since 2017. The last referral was on 18 January 2020. On that occasion, the referral was declined by the service, via a letter dated 21 January 2020.

Mr Wood's referral was declined as his presenting symptoms were considered to fit into the "mild to moderate criteria" which appeared to be managed by the GP. A report from the Hawke's Bay District Health Board ("DHB") stated that there was no evidence of increased risk to self or others in the GP's referral letter.

The Coroner considered that it would have been prudent for Mr Wood to have an in-person assessment as part of the triage process before a decision on the referral was made, given Mr Wood's history with the service, his deteriorating mental health state as described by the GP, his recent relationship break-up, his request for help from the service, his known gambling addiction, and the fact that the GP felt it necessary to refer him at that time.

RECOMMENDATIONS OF CORONER RYAN

I. Having given due consideration to all of the circumstances of this death, I proposed to make a recommendation pursuant to section 57A of the Act, for the purposes set out in section 4. I considered this recommendation was appropriate on the basis that there were factors pertaining to Mr Wood that indicated an in-person assessment may have been warranted at his last referral, and if this had been done, the referral may have been accepted and the outcome may possibly have been avoided. I note that Mr Wood's death occurred only 7 days after he was referred to the mental health service, and the letter declining acceptance was likely received 2 or 3 days before his death. There is therefore a very close temporal connection between the declination and Mr Wood ending his life.

II. The proposed recommendation was that the Hawke's Bay District Health Board consider amending its policy with regard to triaging referrals to the mental health services by GPs to include an in-person mental health assessment of the person by a clinician. A copy of this proposed recommendation was provided to the DHB, and they were invited to respond as to whether they considered this recommendation was appropriate. The DHB provided a response by way of a further report dated 20 July 2021. It is worth repeating a section of the report as follows:

> During the last 12 months, 32% of referred people were closed without being seen face to face. There are a variety of reasons (some more valid than others) to explain this number.
>
> …
>
> There are high volumes of referrals to secondary mental health services and it would be ideal for each referral to receive a face to face assessment. The reality unfortunately, would be the increasing pressure on an already stressed service to provide this for every person. The MHAS is largely funded on an FTE basis (personnel) and not on specific volumes of referrals received. The intention is for secondary MHAS to (at any one time) see three percent (3%) of the Hawke's Bay population; approximately 4900 people.
>
> To see every referred person would not be achievable with the current staffing resource. Recruitment has also proven difficult and we have a number of vacancies (similar picture nationally) impacting on our workload. There is also a lack of mental health staff coming through the New Zealand pipeline, a lack of available experienced mental health clinicians and COVID-19 restrictions has (sic) impacted on overseas recruitment.
>
> The Emergency Mental Health Service (crisis team) has years [sic] seen a 300% increase in contacts over the past few years; most presentation being for psychosocial issues such as homelessness. There is an escalating demand for specialist services, limited support for people in the community and there are challenges with the recruitment and retention of experienced staff.

III. The comments recorded above show that the DHB recognises the desirability of seeing every referral to the MHAS face to face, but that the financial constraints of the funding provided by the government does not enable the service to do this. In addition, but no doubt related to it, are the difficulties in recruiting experienced staff.

IV. In its report, the DHB lists a number of initiatives that are being undertaken to improve the service offered to consumers, some of which are funded by the Police through its Proceeds of Crime process and others are financed by the Ministry of Health.

V. While the comments from the DHB explain the reason why Mr Wood was not seen face to face, they also support the oft-reported popular view that mental health services in New Zealand are under-funded and under-resourced. It is of great concern to me that financial and staffing resources preclude the MHAS from seeing face to face those people referred by GPs. It appears a reasonable assumption to make that GPs do not refer people to the MHAS lightly; there must be some sense by the GPs that a referral is appropriate, that it is in the best interests of the patient.

VI. I therefore intend to make the proposed recommendation, in the hope that the DHB can use it to demonstrate to the Ministry of Health the need for additional funding for mental health services.

VII. Pursuant to section 57A of the Act, I make the following recommendation:

> That the Hawke's Bay District Health Board considers amending its policy with regard to triaging referrals to the mental health services by GPs to include an in-person mental health assessment of the person by a clinician.

VIII. This recommendation is addressed to the Chief Executive and to the Chief Medical Officer, of the Hawke's Bay District Health Board.

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.

Sudden Unexpected Death in Infancy (SUDI)

Baby A [2021] NZCorC 103 (3 February 2021)[67]

CIRCUMSTANCES

Baby A, aged 3 months, died on 11 August 2019 at Avonside, Christchurch of Sudden Unexpected Death In Infancy (SUDI) in the context of an unsafe sleeping position, with a background of viral infection.

[67] While this finding was completed and dated in February 2021, it could not be published until the certificate of findings was signed several months later.

During the day on 10 August 2019, Baby A was not her usual self. During the evening she was “a bit wheezy” and her mother made a social media post which stated that she anticipated taking Baby A to hospital. During the post-mortem, the pathologist found that Baby A was suffering a viral infection.

Baby A would not settle in her cot that night, instead falling asleep on her mother. Sometime between 2:00am and 3:00am on 11 August 2019, Baby A’s father put her in her cot. He placed her on her stomach, as he wanted to mimic the position she had been in when she fell asleep on her mother. He also took a pillow from the couch to put in the cot, so that Baby A’s left cheek was resting on the pillow. He used a blanket to “help lay her on her side slightly to keep her from being face down”.

Baby A’s father checked on her and found her face down on the pillow. Despite resuscitation efforts, Baby A could not be revived.

RECOMMENDATIONS ENDORSED BY JUDGE ROBINSON

I. I endorse the Ministry of Health safe sleeping advice:[68]

Make sure that your baby is safe

To keep your baby safe while sleeping, make sure:

- they always sleep on their back to keep their airways clear
- they are in their own bassinet, cot or other baby bed (eg, a pēpi-pod® or wahakura) – free from adults or children who might accidentally suffocate them
- they are put back in their own bed after feeding – don’t fall asleep with them (to protect your back, feed your baby in a chair rather than in your bed)

Make sure that your baby’s bed is safe

Baby’s bed is safe when:

- it has a firm and flat mattress to keep your baby’s airways open
- there are no gaps between the bed frame and the mattress that could trap or wedge your baby
- the gaps between the bars of baby’s cot are between 50 mm and 95 mm – try to get one with the gaps closer to 50 mm if you can
- there is nothing in the bed that might cover your baby’s face, lift their head or choke them – no pillows, toys, loose bedding, bumper pads or necklaces (including amber beads and ‘teething’ necklaces)

[68] https://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/6-weeks-6-months/keeping-baby-safe-bed-6-weeks-6-months

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Baby A entered into evidence upon the grounds of personal privacy and decency. It also prohibits the publication of any details that might tend to identify Baby A's parents, including Baby A's name, on the grounds of interests of justice, privacy and decency.

Faulkner [2021] NZCorC 123 (6 August 2021)

CIRCUMSTANCES

Ezra Mikaere Roy Faulkner, aged 5 months, died at Durham Street, Hamilton on 12 June 2020 due to sudden unexplained death in infancy (SUDI).

Ezra was in the care of his father, Jesse Faulkner. Although Ezra would usually sleep in his cot, he had recently started waking up in the middle of the night and crying. When Ezra would wake up, Mr Faulkner would take him to his bed in order to calm him down. This happened on the night of 11 June 2020. On 12 June 2020, Mr Faulkner woke up and found Ezra unresponsive. Despite efforts to revive him, Ezra sadly passed away.

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. Although it is not clear that the safe sleep message was given to Ezra's family, it is clear that Ezra had only recently began co-sleeping with Mr Faulkner. Ezra's death is tragic and serves as a reminder that every sleep should be a safe sleep.

III. I note that the Ministry of Health launched a SUDI prevention programme in August 2017, directed at significantly reducing the number of deaths of babies. A key focus of the programme is to target the two key modifiable risks of SUDI: exposure to tobacco smoke during pregnancy and unsafe bed sharing. Such measures are clearly desirable to reduce the instances of infant deaths. In the present case there was bed sharing. I record that Ezra's mother stopped smoking immediately when she found out she was pregnant and Ezra's father, although he estimated he still smoked anywhere from 2-10 times a day, seems to have had a practice of smoking outside or in the garage, away from Ezra.

IV. In the circumstances of the present case, I do not consider that formal recommendations are necessary.

V. 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 Ezra taken during the investigation into his death in the interests of decency or personal privacy.

Hemara-Graham [2021] NZCorC 108 (12 July 2021)

CIRCUMSTANCES

George Trupa Te Aroha Hemara-Graham, aged 8 months, died on 5 July 2019 at 16 Kamaka Road, Mangere, Auckland, of Sudden Infant Death in death associated with unsafe sleep.

George was born at 27 weeks gestation. He was eventually discharged 91 days later after birth, on 19 January 2019, at a corrected gestational age of 40 weeks and two days.

During a discharge planning meeting at the hospital, George's family were educated on the risks of cot death and the safe sleep philosophy (no bed sharing with siblings or adults and baby put on their back for sleeping). George's parents were taught CPR prior to George's discharge and they were also given signs of developing illness to watch for and advised to seek medical attention early for George if signs of illness were noticed.

On 3 July 2019 George was taken to see his GP by his mother, for a two to three day history of cough, wheeze and ear discharge. He did not have a fever and was not in respiratory distress. George was diagnosed with bronchiolitis and was prescribed antibiotics.

At about 3:00am on 5 July 2019, George woke up and was fed by his father, Daz. George was then put back to sleep on top of his parents' bed at about 4:00am. George was placed on his tummy with his head facing the wall.

At about 7:00am, Daz was woken up by a family member coming into the room at which point he noticed that George's face looked pale. George was on his front with his face away from the wall. George was then taken into the lounge area and CPR was commenced. Emergency services attended, but George could not be revived.

It was noted in the Finding that George's mother smoked during her pregnancy and after George was born. Daz and others living in the house also smoked.

COMMENTS OF CHIEF CORONER JUDGE MARSHALL

I. The Ministry of Health Safe Sleep message for babies includes:

- make sure that your baby is in their own bed for every sleep
- make sure that your baby is on their back for every sleep
- have a smoke free home

II. A New Zealand study published in 2017, showed that infants of mothers who smoked during pregnancy were at a six-fold increased risk of Sudden Infant Death compared to infants of non-smokers. Bed-sharing increased the risk five-fold and for infants exposed to both these risks there was a 32-fold increase. A prone sleeping position increased the risk 3.8-fold.

III. These risks are well established. It is vital that parents and other family members adopt the Ministry of Health guidelines and make every sleep a safe sleep.

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

Mita [2021] NZCorC 154 (15 September 2021)

CIRCUMSTANCES

Lucia Taylah Johanna Stacey Mita, aged 4 months, died at 6A Wha Street, Frankton, Hamilton overnight on 1 – 2 May 2018. The cause of Lucia's death is unascertained in the context of Sudden Unexplained Death in Infancy (SUDI).

On 1 May 2018, Lucia was put to bed in her bassinet. There were no issues when Lucia's mother checked on her at around midnight. However, when she woke at 3:30am, she found Lucia unresponsive. Unfortunately, despite all efforts, Lucia was unable to be revived.

A cause of death was unable to be ascertained, however Lucia's mother smoked tobacco throughout her pregnancy and after Lucia was born.

COMMENTS OF CORONER BATES

I. The Ministry of Health launched a SUDI prevention programme in August 2017, directed at significantly reducing the number of deaths of babies. A key focus of the programme is to target the two key modifiable risks of SUDI: exposure to tobacco smoke during pregnancy and unsafe bed-sharing.

II. I record that Lucia's mother continued to smoke tobacco during and after the pregnancy. Her two flatmates also smoked tobacco. I have no doubt that Lucia was exposed to tobacco smoke. It will remain unknown to what if any extent regular exposure to tobacco smoke contributed to Lucia's death. Exposure to tobacco smoke continues to be a known SUDI risk and should be avoided. I make no additional comment on this point.

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 Lucia taken during the investigation into her death in the interests of decency or personal privacy.

Pomare [2021] NZCorC 161 (23 September 2021)

CIRCUMSTANCES

Karais Pomare, aged 5 weeks, died at his home on 24 August 2020. The cause of death was unascertained in the context of an unsafe sleeping environment.

Karais lived with his parents, Freda Paul and Bronsyn Pomare, and other family members. He was born about 3 weeks early with a low birth weight, but appeared to be progressing well. During post-natal home visits, Freda's midwife discussed concerns that the house was cold and reiterated the importance of keeping the baby's room warm. Concerns

that the home was not smoke-free were also raised. Freda was strongly advised not to smoke in the house, to change outer clothes and to sanitise before returning to care for the baby after smoking. Safe sleeping advice was also provided. Freda advised that Karais usually slept in a bassinet in their bedroom on his back.

In the two weeks prior to Karais' death, everyone in the household had been ill with a cold and cough, including Karais. On the day of his death, Karais had been feeding as usual, with his last feed at about 10:00pm. Freda then placed Karais on their queen-sized bed to sleep, on his back with no pillow under his head. After some time Bronsyn returned to the bedroom and fell asleep in the bed up against the wall, while Karais slept on the side facing the bedroom door.

Sometime between 11:00pm and midnight, Karais' grandfather entered the bedroom to check on him. He found Karais lying face down on the bed, still warm but unresponsive. Freda commenced CPR and emergency services were called, but sadly Karais was unable to be revived.

A forensic pathologist advised that the cause of death was unable to be ascertained because an inadequate investigation had been undertaken. There was no evidence of injury. Toxicology testing undertaken as part of the lesser post-mortem found THC (cannabis) in Karais' blood, but it was considered this did not play a physiological role in his death.

COMMENTS OF CORONER MILLS

I. The evidence is that Karais was a dearly loved baby who had made good weight gains since his birth. While the cause of his death was unascertained Karais was found in an unsafe sleep safe environment.[69] There were a number of other factors present in Karais' life that are associated heightened risk of a sudden unexplained death (SUDI) including:

   a. Smoking. Research undertaken in 2017 found that the combination of maternal smoking in pregnancy and bed sharing leads to a greatly increased risk of SUDI. Bed-sharing increased the risk five-fold and for infants exposed to both these risks there was a 32-fold increase.

   b. While Karais was not technically "low birthweight" (defined as under 2500 grams)[70] or premature (defined as being born before 37 weeks)[71], he was small at birth weighing only 2800 grams and born early at 37+1 days. This may have increased his risk.

   c. The house Karais and his whānau lived was noted to be damp and cold by both the midwife (who encouraged the whānau to keep the bedroom warm) and by Freda. Poor housing is recognised as a systemic factor contributing to increased health problems and increased risk of SUDI.[72]

   d. Cannabis is the third most popular recreational drug in New Zealand after alcohol and tobacco (excluding caffeine).[73] At the time Karais died he had THC/cannabis in his blood.

[69] The Combination of Bed Sharing and Maternal Smoking Leads to a Greatly Increased Risk of Sudden Unexpected Death In Infancy: the New Zealand SUDI Nationwide Case Control Study; NZMJ 2 June Vol 130 No 1456. www.nzma.org.nz/journal
[70] https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators/infant-health
[71] https://www.healthnavigator.org.nz/healthy-living/p/premature-labour-and-birth/
[72] Child and Youth Mortality Review Committee, Te Rōpū Arotake Auau Mate o te hunga Tamariki, Taioho, 2017. Sudden unexpected death in infancy (SUDI) special report June 2017 https://www.hqsc.govt.nz/assets/CYMRC/Publications/CYMRC_SUDI_Report.pdf
[73] https://www.health.govt.nz/system/files/documents/publications/food-and-nutrition-guidelines-preg-and-bfeed.pdf

There is no evidence before me to explain how this occurred. However, ESR advised that, given the level detected, it was most likely either through breast milk or through direct exposure. While the pathologist advised that exposure to THC did not contribute directly to Karais' death, I note that Medsafe (New Zealand's Medicines and Medical Devise Safety Authority) recommends that lactating mothers should avoid using cannabis when breast feeding as the long term effects on babies are unknown.[74]

II. In summary, given the cause of Karais' death was unascertained, and he was found in an unsafe sleeping position, I simply reinforce the key messages from the Ministry of Health:

- make sure that your baby is in their own bed for every sleep;
- make sure that your baby is on their back for every sleep; and
- have a smoke free home.

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

Tapuaiga [2021] NZCorC 141 (30 August 2021)

CIRCUMSTANCES

Inah May Tapuaiga, aged 6 weeks, died at 6 Clyro Place, Mangere East, Auckland on 10 July 2020. The cause of death was unascertained in the context of co-sleeping.

After Inah's birth, her parents were provided safe sleeping advice. It was noted that the household was not smoke-free. Advice was given that there should be no smoking inside and that the smokers should change their clothing before being close to Inah.

About 4:30am on 10 July 2020, Inah woke up and, after having her bottle, stayed in bed with her parents. Her mother woke up about 6:00am and picked Inah up but noticed she was not moving. Despite resuscitation attempts, Inah passed away.

COMMENTS OF CHIEF CORONER JUDGE MARSHALL

I. The Ministry of Health safe sleep message has been consistent.

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

b. Eliminate smoking in pregnancy and protect baby with a smoke-free home.

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

[74] https://www.medsafe.govt.nz/profs/puarticles/lactation.htm

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of the deceased taken by Police upon the grounds of personal privacy and decency.

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