OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

# Recommendations Recap

A summary of coronial recommendations and comments made between **1 October** and **31 December 2021**

**Office of the Chief Coroner** | 2021 (4)

# 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 48 recommendations and/or comments issued by Coroners between 1 October and 31 December 2021.

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# Recommendations and comments

## 1 October to 31 December 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

### Bsaiso [2021] NZCorC 208 (10 December 2021)

**CIRCUMSTANCES**

Othman Mohammed Bsaiso, aged 18 months, died on 26 November 2017 at Epsom, Auckland as a result of drowning in a swimming pool on a residential property that was rented to his family.

The Bsaiso family had lived in the property in Epsom, which they rented, approximately two and a half years (since May 2015). At the rear of the house is a swimming pool, which the family did not use.

The pool area could be accessed from a deck, for which there were two entrances from the house. The pool was separated from the deck by a metal fence and gate. The gate had a pool lock and would automatically shut after being opened. The pool could also be accessed from a wooden gate on the side of the house, which was down a path next to the driveway.

On the evening of 26 November 2017, Othman was found floating face down in the swimming pool. He was unconscious and unresponsive and unable to be revived. Othman got into the swimming pool area through a wooden gate beside the house that had not closed properly.

Under the Building Act 2004, and previously the Fencing of Swimming Pools Act 1987, residential pools are required to have "physical barriers that restrict access to the pool by unsupervised children under 5 years of age". As of 1 January 2017, territorial authorities are required to inspect residential pools every three years to ensure compliance with the law.

An inspector for Auckland Council reported that the pool had last been inspected in 2015 and was due to be inspected in 2018. In the 2015 inspection, the barriers to the pool were compliant with the legislative requirements. Following Othman's death, the pool area was inspected and it was found the barriers to the pool were not compliant in the following ways:

a. the wooden gate failed to self-latch upon closing;

b. the gap underneath the metal gate from the deck to the pool area was greater than 100mm; and

c. horizontal rails on an adjoining boundary fence were less than 900mm apart.

These issues had not been discovered by the property manager during routine property inspections. It was not clear to the landlords, property managers, or the Bsaiso family where the responsibility lay for ensuring safety and compliance with the legislation. As a result of this lack of knowledge, the wooden gate was no longer compliant with the Building Act 2004 as it did not self-latch.

The Coroner consulted with the Ministry of Business Innovation and Employment (MBIE), Auckland Council, and the Real Estate Institute of New Zealand (REINZ) on actions that could be taken to effect change aimed at preventing deaths in similar circumstances. The actions taken by MBIE were incorporated into the formal recommendations.

Auckland Council advised the Coroner that their website contains a page on pool fencing, including a Pool Safety Area Checklist, with links to videos for in-ground, above-ground, and small heated pools:

https://www.aucklandcouncil.govt.nz/building-and-consents/building-renovation-projects/install-residential-small-heated-pool/Pages/restrict-access-pool-area.aspx

Auckland Council also carries out an annual campaign between December and February to remind Aucklanders to be vigilant around pools by closely monitoring young children and ensuring that pool barriers are secure. The campaign is also designed to reach people who may have pools that council is unaware of, such as portable/inflatable pools, or pools built without a building consent.

Auckland Council also considered the potential role it could play in highlighting the respective responsibilities of landlords and tenants, in light of its existing communications around pool safety, and its legislative obligations. The following areas were identified where it could target landlords and tenants to emphasise their respective obligations by:

a. Updating the relevant page(s) on its website to highlight the fact that both owners and occupiers are responsible for complying with pool fencing laws, and that tenants should advise their landlord if there are maintenance issues.

b. Including a link to the updated webpage in the Notice of Pool Barrier Inspection and developing a flyer to be included with the Notice, summarising the key pool safety messages (including responsibilities of owners and occupiers).

c. Undertaking a project by the Auckland Council's Proactive Compliance team to identify properties on the swimming pool register that are bought and sold each month, and to send a letter advising new owners of the pool fencing safety rules and their responsibilities. This in order to help educate owners who have never owned a swimming pool, and alert owners that intend to rent the property of their specific obligations.

d. Actively working with REINZ to assist with pool safety education for its property managers (at least in the Auckland region). This assistance is likely to take the form of a video or webinar.

REINZ is a membership organisation that represents more than 16,000 real estate professionals nationwide and is involved in all facets of real estate including residential property leasing and management. While REINZ is not an

industry regulator, it has a Residential Property Management Code of Practice. The code is explicit that properties are to be managed in accordance with relevant statutes, the tenancy agreement and a written management authority with the landlord that outlines all responsibilities, fees and charges to the landlord. Clause 6.2 of the code makes specific reference to swimming pool fences and gates – setting out the requirement that a property manager should:

> Make a tenant aware of the necessity to notify the Agency Member or landlord, as soon as possible after discovery, of any damage to the premises or the need for any repairs, including, but not limited to, swimming pools and their fences and gates (if any).

REINZ advised the Coroner that it has commenced work on a framework to raise awareness around pool safety in rented properties. In addition to working with Auckland Council, as mentioned above, REINZ has identified the following actions it can take:

a. REINZ will write a pool clause and promote its use in all Property Management Authorities. For example, the owner of the property will need to confirm and provide evidence to the property manager that their pool has been inspected by the Local Authority in the last three years and is currently compliant. REINZ needs to keep in mind that each Business will ultimately have its own internal policies, however feedback received is that many are looking for guidance on this very topic.

b. REINZ will also write a clause for Tenancy Agreements. For example, identifying if there is a pool, and whether it is classed as either a spa, or a pool. The clause will also state the spa/pool complies with the relevant Building Code and the date it was last inspected on. As well as the clause there will be a general information sheet for the tenant on their responsibilities as the occupier of the property.

c. REINZ has also tabled an educational webinar – that it is planning to work on in conjunction with the Auckland City Council for owners/landlords and tenants.

d. REINZ will promote this material via its regional networks – to disseminate it to its over 16,000 real estate members.

## RECOMMENDATIONS OF CORONER GREIG

I. Pursuant to s 57(3) of the Coroners Act 2006, I make the following recommendations:

**To the Chief Executive Ministry of Business, Innovation and Employment Hīkina Whakatutuki:**

II. That the tenancy agreement builder on the Tenancy Services website be updated to include a new optional clause relating to pool safety and maintenance.

III. That MBIE's Tenancy Compliance and Investigations Team (TCIT) investigates and addresses any gaps within its operating procedures in relation to pool maintenance and safety. For example, to allow TCIT to address any shortcomings discovered in the practices of Property Managers around swimming pool fencing, TCIT includes questions regarding pool safety compliance in its detailed assessment process of property managers.

IV. To highlight the importance of pool maintenance for tenants and landlords that MBIE:

a. Adds content to tenancy.govt.nz to ensure all parties are aware of their responsibilities for pool safety;

b. Ensures its Service Centre staff are equipped with information if customers call to ask who in the tenancy relationship is responsible for meeting requirements for pool fencing;

c. Shares information on pool maintenance and safety obligations with key stakeholders, including property manager organisations;

d. Includes information in its Tenancy Matters newsletter including regular reminders.

V. That MBIE's Building Assurance Team develops and sends a communication, attaching MBIE's guidance, to all Territorial Authorities reminding them to check that their public information on pool barriers is adequate and up-to-date.

VI. The above recommendations arise out of consultation with MBIE, with most being the result of proactive suggestions from MBIE as to how it could assist, across its organisation, to address the issues identified in these findings in an effort to prevent deaths in similar circumstances in future. MBIE's willing engagement and assistance during this inquiry has been constructive and most helpful.

**To the Chief Executive Auckland Council Te Kaunihera o Tāmaki Makaurau:**

VII. I recommend that Auckland Council complete all the proactive steps it has indicated the Council is currently putting in place, and that it continue to monitor whether there are further ways the Council can draw attention to the issues highlighted in these findings.

VIII. Again I note the willing engagement and assistance of Auckland Council. The steps it is putting in place are designed to enhance pool safety and to try and help prevent deaths in similar circumstances in future.

**To the Chief Executive Real Estate Institute of New Zealand**

IX. All the steps REINZ has identified it could do are helpful and positive initiatives designed to raise awareness of the obligations of property owners and tenants for swimming pool safety responsibilities in order to try and prevent deaths in circumstances similar to Othman's in future. I commend REINZ for the work it has started to undertake and recommend that it completes and implements the initiatives it has identified.

X. I note that REINZ has helpfully and proactively engaged in identifying a variety of steps the organisation can take to help to prevent deaths in circumstances similar to Othman's in future. It is to be hoped that other property managers also follow suit.

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

# Kamo and Orchard [2021] NZCorC 209 (22 December 2021)

## CIRCUMSTANCES

Hendrix Tamariki Russell Kamo, aged 28, and Shaun Logan Orchard, aged 23, died on or about 27 January 2019 of presumed drowning in the context of a rock fishing accident at Black Point.

On 27 January 2019 Messrs Kamo and Orchard and friends and family arrived at Black Point, a popular rock fishing spot approximately two kilometres south of the Slope Point Lighthouse on the south Catlins coastline. Messrs Kamo and Orchard left their group and went to fish on the rocks, out of sight of those in their group. The two were not wearing life jackets and had no access to floatation devices. About 20 minutes later their shouting alerted the others in the group that they were in trouble. Messrs Kamo and Orchard were seen in the water travelling further out and to the left (east).

Although a search was conducted, Messrs Kamo and Orchard were not found.

## COMMENTS OF DEPUTY CHIEF CORONER TUTTON

I. Water Safety New Zealand provides information on its website regarding staying safe while rock fishing. The website states:

> Rock fishing is an increasingly popular recreational past-time but it is also extremely hazardous. Being swept off rocks by large waves is a major hazard.
>
> Remember the following when rock fishing:
>
> - Always wear a lifejacket.
> - Pay particular attention to swell and tide information.
> - Never fish in exposed areas during rough or large seas.
> - Spend at least ten minutes observing the sea conditions before approaching the rock ledge.
> - Never turn your back on the sea.
> - Pay attention to warning signs.
> - Never fish from wet rocks where waves and spray have obviously been sweeping over them.

II. I endorse that advice. The deaths of Messrs Kamo and Orchard are a tragic reminder of its importance.

# Gollan [2021] NZCorC 178 (21 October 2021)

## CIRCUMSTANCES

Lucas James Gollan, aged four, died on 6 February 2019 at 689 Pioneer Highway, Brydone. The cause of death was drowning.

Lucas lived on a farm with his family. He was autistic, non-verbal and did not answer to his name. He enjoyed the outdoors and would frequently abscond from the main property to explore the farm.

On 6 February 2019, Lucas was spotted in the lounge of his house while his grandmother was outside gardening. Lucas' grandmother recalls closing the door of the house behind her when she went outside.

When Lucas' grandmother finished gardening, she found that the door of the house had been opened, and she could not locate Lucas. An extensive search was conducted by the family, neighbours and the Police and Lucas was later found lying face down in a creek behind the family's property. Despite emergency services attending, Lucas could not be revived.

The Police noted in their investigations that most of the creek was fenced off but there was a gap in the fence line on the eastern side. The gap led to a culvert across the lake. WorkSafe was advised of Lucas' death but found no breach to the Health and Safety at Work Act 2015 as there was no requirement to fence of waterways such as the creek in which Lucas drowned.

## COMMENTS OF DEPUTY CHIEF CORONER TUTTON

I. Farms are inherently dangerous places for children, with multiple potential hazards. WorkSafe New Zealand has published guidance entitled "Children and Young People on Farms" at:

https://www.worksafe.govt.nz/topic-and-industry/agriculture/keeping-safe-on-farms/children-and-young-people-on-farms/

II. Key points include that children want to explore, try new things and push boundaries, and water hazards are among the main risks for children listed. The importance of close, active adult supervision is recorded, and it is suggested that thought be given to having safety fences around areas such as play areas and water spots.

III. The evidence before me establishes that Lucas was an intelligent, enterprising and physically able child who loved the outdoors and found ways to access it, despite the extensive attempts of his parents, grandmother and others to keep him contained and safe. His death is a tragic accident.

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

# Gordon [2021] NZCorC 180 (27 October 2021)

## CIRCUMSTANCES

Taylor Paul Douglas Gordon, aged 23, died on 31 July 2019 at Butlers Bay of drowning.

During the evening of 31 July 2019, Mr Douglas consumed beer with his two brothers before the three of them went out to Butlers Bay to collect a fishing net they had set earlier that day. They went out to the water in a 10-foot aluminium dinghy. Neither Mr Gordon nor his brothers were wearing a life jacket and they did not have a waterproof means of communication.

After collecting the net, they started travelling back to shore. During the journey, Mr Gordon moved to the front of the boat to urinate, causing it to go under the water. Once in the water, the brothers began swimming towards shore. All three were struggling and when they stopped for a break, Mr Gordon sank beneath the surface.

When his brothers returned home, they reported that Mr Gordon was missing, and a search was commenced. Mr Gordon's body was found on 1 August 2019.

Toxicology testing on samples of Mr Gordon's blood confirmed the presence of alcohol at a level of 101 milligrams per 100 millilitres. For comparison purposes, the legal blood alcohol limit for a New Zealand driver 20 years or over is 50 milligrams per 100 millilitres. Tetrahydrocannabinol was also confirmed in the blood.

Maritime New Zealand completed a report which identified factors that may have contributed to Mr Gordon's death, as follows:

a. With three adults, the dinghy may have been overloaded and more susceptible to water entry by any sudden movements.

b. The lack of waterproof communication device meant the brothers could not call for help.

c. The lack of life jackets.

d. Consumption of alcohol, which is a risk factor associated with boating accidents.

e. The temperature of the Mangonui Harbour, which could have led to the rapid onset of hypothermia.

## COMMENTS OF CORONER BELL

I. Mr Gordon's intoxication, lack of life jacket and lack of communication device all contributed to his death. Maritime New Zealand provides online advice about staying safe when boating including:

a. Wear your life jacket;

b. Take two waterproof ways to call for help;

c. Check the marine weather forecast;

d. Avoid alcohol;

e. Be a responsible skipper.

II. Maritime NZ notes that alcohol can impair your ability to react, ability to perform simple tasks , judgment , and sense of direction. These factors put people at risk and also increase the likelihood of someone ending up in the water by accident. In particular maritime NZ refers to a number of cases in recent years where experienced mariners have fallen overboard and drowned after attempting to urinate over the side of a boat (especially at night).

III. I endorse the above information and make no recommendations under s 57A of the Coroners Act.

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

# Palmeira [2021] NZCorC193 (22 November 2021)

### CIRCUMSTANCES

Joel da Silva Palmeira, aged 45, died on 21 February 2020 at Waiau River, Monowai, Southland of drowning.

On 21 February 2020, Mr Palmeira and a group of friends were floating down part of the Waiau River using inflatables typically used in swimming pools. Mr Palmeira was in a dinghy inflatable with detachable oars, while the friends were in their own inflatables.

As the group approached the School House rapid (which is a Grade 2 rapid), Mr Palmeira came out of his inflatable and did not resurface. He was recovered later in the evening by the Fiordland Marine Search and Rescue, about 2 km downriver from where he had left his inflatable. Mr Palmeira was deceased.

### RECOMMENDATIONS OF CORONER MCKENZIE

I. I have considered whether any comments or recommendations are appropriate in this matter. Pursuant to s 57A of the Coroners Act 2006 I may make recommendations or comments in the course of, or as part of the findings of, an inquiry into a death. Recommendations or comments may be made only for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred. Recommendations or comments must:

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

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

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

II. I consulted Mr Palmeira's family, Water Safety New Zealand, and the other men on the trip regarding the following comments and recommendation:

> It is important that river-users use the correct equipment when travelling down a river. What is the right equipment will depend on the nature of the river and its conditions on the day in question. Relevant

factors will include depth, rate of flow, hazards such as rocks or willows, and any rapids. The person, their experience in the water, level of fitness, and age should also be taken into account. The inflatables the group were using appear to me to have been made for use in a swimming pool or calm/sheltered/flat water environment rather than for travel through a Grade 2 rapid(s).

I recommend that Water Safety New Zealand continue developing its educative resources to help promote safety in rivers and to reinforce the message to use appropriate equipment for the conditions.

III. I received no notice of any concerns about or amendments to my proposed comments or recommendation.

IV. I consider the recommendation is clearly linked to the factors that contributed to Mr Palmeira's death because it directly relates to safely in rivers. Is it based on evidence I have received, reviewed, and set out in these findings.

V. I consider that the recommendation may reduce the chances of further deaths occurring in similar circumstances because helping make river users aware of the safe equipment to use on a river might help reduce the chances of drowning. Accordingly, I am satisfied my recommendation satisfies the statutory requirements of s 57A of the Coroners Act 2006.

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

## Saunders [2021] NZCorC 198 (1 December 2021)

### CIRCUMSTANCES

Alan George Saunders, aged 76, died on 16 September 2017 at Shelley Beach Wharf, South Head of drowning.

On 16 September 2017 Alan took his 11 year old step grandson on a fishing charter boat owned and operated by Anthony Walles. There were six other passengers on board. A safety briefing advised passengers of the location of emergency equipment, the number of life jackets on board and the process to follow if someone fell overboard. Later, one of the passengers became seasick and put on a lifejacket. Another passenger offered a lifejacket to Alan which he declined.

While the boat was anchored at Poutu Bay, Alan stood up near the seats in the centre of the boat deck but stumbled and lost his balance, lurching forward. To steady himself he grabbed the edge of a plastic bait tray that was attached to the railing. However, the tray was collapsible, and it tipped over and flipped outwards over the top of the railing. This, together with Alan's forward movement, caused him to fall over the railing and into the water. He fell into the water headfirst, and then passed under the boat.

Mr Walles moved the boat down current, within range of Alan and, after several attempts, was able to lift him back onto the deck of the boat. Another charter boat arrived and rendered assistance. Resuscitation attempts were unsuccessful.

### COMMENTS OF CORONER ANDERSON

I. I do not consider that any recommendations are required in relation to Alan's death. It appears that he died as the result of an unfortunate serious of events. These included an accidental stumble or loss of balance in rough conditions; the unexpected movement of a bait tray that he grabbed at to steady himself; and difficulties in the resulting rescue procedure. It is also possible that his underlying health conditions may have contributed to some degree to his susceptibility in the water. It is clear that the other passengers on the Kaipara Cat, and the volunteer from the second charter boat, all did their very best to rescue Alan and then to resuscitate him. I acknowledge their actions in this regard, in what would undoubtedly have been difficult and stressful circumstances.

II. A number of steps were taken by Anthony Walles following Alan's death to secure the moveable bait boards on the Kaipara Cat and provide additional safety equipment. Importantly, Anthony also introduced a compulsory lifejacket policy on the boat. MNZ has either completed, or commenced, work on several systemic matters that will help ensure that the lessons learnt from these events are used to improve safety on other boats in the future.

III. In the circumstances, I do not consider that any additional recommendations are required in this case. However, I do note that Alan's death highlights the importance of wearing lifejackets at all times when out on the ocean. There is always a risk of an accident or unforeseen event while boating. Wearing a lifejacket maximises the chance of survival and reduces the risk of drowning in the event of unexpected entry into the water. Important information and advice about life jacket use can be found on the Maritime New Zealand website at https://www.maritimenz.govt.nz/recreational/safety/lifejackets/default.asp.

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

# Turagaiviu and Woolley [2021] NZCorC 213 (15 December 2021)

### CIRCUMSTANCES

Mitch Leigh Woolley and Sosiveta Camaiverata Turagaiviu, both aged 17, died on 3 February 2018 at Cascade Falls in the Waitākere Ranges as the result of accidental drowning. Mr Woolley's cause of death also included foreign bodies inhalation.

The two boys had decided to go swimming that afternoon, along with Mitch's brother Denver Woolley and their friends Jason Lee and Nathan Phillips. Cascade Falls are located along the Cascade Falls Track, which can be accessed from the Auckland City Walk Track. The track also has an upper and lower entrance from Falls Road. There are notice boards at each entrance stating "the weather can change quickly so be prepared", but no warning about the dangers associated with heavy rainfall. There is also no warning signage at the base of the Falls where the swimming hole is located.

The group arrived at around 4:00pm and walked the ten minutes down the Cascade Falls Track, crossing a stream over a footbridge to get to the Falls, where they began swimming. After about twenty minutes it began to rain heavily and the group decided to pack up and leave. To retrieve their bags, the young men had to walk across a log over a stream. As

the water had begun to rise quickly with increasing flow, Denver, Jason and Nathan formed a chain to pass their bags across the log to the track entrance side, where Mitch and Sosiveta (known as Sosi) were waiting to receive them.

Nathan, who was standing on a log in the middle of the stream, was pushed into the water by a sudden large wave from the waterfall. Mitch and Sosi were seen running along the streambed to try to assist Nathan. After about five minutes in the water, Nathan managed to pull himself out to safety, and ran back to the waterfall. He saw Sosi standing on a bank on the other side of the river, with a pool of fast-moving water between them. Sosi tried to jump across the water but fell in. Nathan attempted to grab hold of him but was taken into the water with him. After making it to the bank and running to the carpark, Nathan tried to call 111 on the emergency telephone phone box installed there but could not get through to anyone.

Jason managed to pull himself out of the water and eventually found a park ranger's house where he sought help. Denver clung to a tree for several hours and was rescued by the Westpac Helicopter.

Later that evening, Sosi's body was found on farmland down the Waitākere River near Bethells Beach. Mitch's body was found at the bottom end of the Waitākere Golf Course, having also travelled down the Waitākere River.

A MetService report noted a localised rainfall level of 43.5mm between 4:00pm and 5:00pm, described as "very intense". This had caused a dramatic increase in the water volume of the Cascade Stream, resulting in flash flooding over the Falls and further downstream. Data from NIWA showed that this level of rainfall at the location was extreme and rare, occurring about once every 40 years. There had been no Severe Weather Warning issued by MetService for the event, as such warnings are intended for events that cover areas greater than 1,000 square kilometres.

The Coroner was satisfied that water spilling from the Waitākere Reservoir did not affect the Cascade Falls or the Cascade Stream. However, the flooded and swollen Waitākere River, after its convergence with the Cascade Stream 150 metres downstream from the Falls, had provided an additional hazard close to the Falls swimming hole.

Denver Woolley raised concerns that there was only one walkway into Cascade Falls. Auckland Council advised that given the nature of the terrain, it does not consider that there to be any additional safe egress or exits from the area.

Auckland Council also advised that emergency phones in the regional park are set up to connect to its contact centre as soon as the receiver is lifted. It is not possible for calls to be made directly to emergency services, although the phones have a standard numeric dial pad. It was not known why Nathan's call did not connect to the contact centre when he tried to dial 111, but it was possible that the conditions at the time had caused the line to become disconnected.

While the Coroner acknowledged that the young men were "desperately unlucky to be in the wrong place at the wrong time", she considered it was misguided to dismiss the weather event as so rare that there was no need to take preventative action to prevent deaths in similar circumstances. The potential danger in the area could manifest very suddenly and was difficult to escape from, and may not be obvious to the public.

## RECOMMENDATIONS OF CORONER GREIG

I. A Coroner can make recommendations for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death(s) the coroner is considering occurred. To that end I make the following recommendations. For each recommendation I consulted with Auckland Council and their response is set out in italics below the recommendation.

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

a. **Erects clear signage warning of the specific dangers at the start of the short track to the pool at the base of Cascade Falls (and in this context considers whether the proposed signage of "stream level can rise rapidly" is sufficient warning for people who may not be aware of the implications of proposed wording).**

*Council is committed to erecting clear signage at the start of the short track that will most appropriately warn the public of specific dangers associated with the pool at the base of Cascade Falls.*

*Council will engage Coastal Scientist Nick Mulcahy of Coastal Research Ltd to provide expert advice on the specific wording for the proposed signage. Council regularly engages Mr Mulcahy to provide advice in relation to aquatic signage and risk management in the natural environment.*

I also **recommend** that Auckland Council considers:

b. where else signage could be put in the area to warn of the specific dangers.

*Council will also take advice from Mr Mulcahy on where else to install additional signage along the track network warning of the specific dangers with rising stream levels.*

c. how the Council can raise public awareness of the safety issues identified in these findings – including on Council websites[1] and Council publications.

*Council is committed to raising public awareness around the dangers at Cascade Falls. Council is though mindful that by bringing the hazards at Cascade Falls to people's attention on Council websites and Council publications, it may inadvertently increase visitation to the location, which could in turn increase the public's exposure to the risks the area poses.*

*Council will seek advice from the Mountain Safety Council (MSC) and Drowning Prevention Auckland (DPA) on how to best educate the public around the risks of flash flooding in environments such as Cascade Falls.*

d. whether the emergency telephones in the regional park network have clear enough advice on how they work for people to comprehend in an emergency.

*Council has reviewed the information provided to the public on the use of telephone at Cascade Kauri and noticed that this should be improved to provide clearer instructions on how to use the phone in an emergency. This has prompted a wider review of the information provided on how to use the phones throughout the regional park network. As a result, Council has decided to plan an audit of the signage in relation to the emergency phones in the Regional Park as part of its work programme for 2022.*

III. Auckland Council has advised that Cascade Kauri track network remains closed and will not be re-opened until the improvements set out above are fully implemented.

[1] For example at: https://www.aucklandcouncil.govt.nz/parks-recreation/Pages/park-details.aspx?Location=204

IV. I also asked Auckland Council to reconsider, notwithstanding initial reservations it had expressed, erecting a barrier containing a safety notice across the track used to get to the swimming hole at the base of the Cascade Falls, to act as both a deterrent and a physical warning of the dangers. The Council's response, set out below, has persuaded me not to make this recommendation.

> *Council 's reservations regarding a barrier across the track to the base of the Cascade Falls stem from the practical difficulties in preventing members of the public from accessing this area and due to the nature of the terrain.*
>
> *Council considers that erecting a barrier along a board walk on the edge of the Auckland City Walk and the start of the unofficial short track to the falls is the best solution for deterring visitors to the falls and warning them of the dangers in this location. Council considers that this barrier with appropriate signage will send a clear message that access to this area is discouraged.*
>
> *Council is however aware that some members of the public may still try to access this area and in consultation with Te Kawarau a Maki it has considered the possibility of establishing a safe track for the public to use. At this time, it considers this is not feasible as this will likely require regulatory approvals and significant investment in the design and development. A safe track would include building an egress point through the bush to higher ground for access in the event of rising stream levels.*
>
> *Council is strongly of the view that it would not be practical to install a barrier at the base of the Cascade Falls given the nature of the rock surroundings, undulating uneven and variable ground conditions. Council also considers that a barrier in this location is unlikely to withstand flood events.*

V. On the basis of this response and the Council's acceptance that it is likely that members of the public will not be deterred by warning signage and will continue to access the swimming hole, I **recommend** that Auckland Council pursues the option it has identified of establishing a safe track for the public to use – including building an egress point through the bush to higher ground for access in the event of rising stream levels. Such an egress point may help to prevent deaths in similar circumstances to those of Sosiveta Turagaiviu and Mitch Woolley. As Mr Woolley noted to this inquiry, on the day of the boys' deaths, the one walkway into and out of the area was compromised because of the flooding.

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

# Drugs and Alcohol

## Burns [2021] NZCorC 197 (29 November 2021)

### CIRCUMSTANCES

Timothy Gerard Burns, aged 55, died at Auckland between 3 and 14 May 2018 of synthetic cannabinoid toxicity (AMB-FUBINACA).

Mr Burns had a long history of drug dependence along with several mental health conditions. He also had a criminal history. In early March 2018, he was released from a ten-month prison sentence with a condition to undertake an assessment for an appropriate alcohol and drug program, and to complete any programs or counselling as directed by his probation officer.

Mr Burns was last seen on 3 May 2018 by his probation officer. Despite struggling with homelessness and admitting to methamphetamine use since his release, he had completed an assessment with community alcohol and drug services and was due to start an 8-week program. At this time, he was from moved from weekly to fortnightly reporting.

On 14 May 2018, Mr Burns was found deceased in his room by the manager of the hostel where he was staying. It was clear that he had died some time ago. Evidence at the scene indicated that he had consumed cannabis products before his death, which was confirmed by toxicological analysis of his blood.

The Coroner considered there was insufficient evidence to establish whether Mr Burns' death was an intentional act or an accidental overdose due to the potency of the synthetic cannabis.

## COMMENTS OF CORONER TETITAHA

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

II. Synthetic cannabis is a smokable plant-based material containing one or more chemical compounds called synthetic cannabinoids that cause the user to get 'high'. Synthetic cannabinoids are manufactured in a laboratory and little is currently known about their effects on humans.[2]

III. Many synthetic cannabinoids are more potent than cannabis and have the ability to cause significant physical and mental harm. The risk of death associated with synthetic cannabis use is substantial, as the user will not know which type of synthetic cannabinoid they are consuming or how strong the dose is.[3]

IV. A public warning was issued by the Chief Coroner in 2017 about the potentially fatal effects of synthetic cannabis given the number of deaths where this was a contributing factor.[4]

V. There have been attempts at deterrence. At the time of Mr Burns' death, it was not illegal to possess or use AMB-FUBINACA. On 13 August 2019 the Misuse of Drugs Act was amended to classify AMB-FUBINACA as a class A drug for which police could in their discretion prosecute for possession and use of a controlled drug.

[2] Ministry of Health website https://www.health.govt.nz/our-work/regulation-health-and-disability-system/psychoactive-substances-regulation/synthetic-cannabis

[3] See above.

[4] New Zealand Police "Joint statement from the chief coroner's office and police on that the significant number of synthetic cannabis related deaths in Auckland" https://www.police.govt.nz/news/release/joint-statement-chief-coroners-office-and-police-significant-number-synthetic-cannabis

VI. At risk groups of users of synthetic cannabis are generally male Māori aged 40 or over being treated for mental health illnesses, and medical conditions usually including a heart-related illness as well as homelessness.[5]

VII. Another vulnerable class of persons are those recently released from prison such as Mr Burns. According to Community Corrections, ex-prisoners have a heightened risk of death soon after the release. The chief causes of prisoner and ex-prisoner deaths include substances abuse, namely drug overdoses and accidental poisonings as well as suicide, homicide and accidents/injury.[6]

VIII. A World Health Organisation report[7] commented that the rate of acute drug related mortality, or overdose deaths, among prisoners in the immediate post-release period is unacceptably high. Such incidents result from many factors, including decreased tolerance after a period of relative abstinence during imprisonment and the concurrent use of multiple drugs which, with every additional illicit drug consumed in combination with opioids, nearly doubles the risk of death from opioids found within synthetic cannabis such as AMB-FUBINACA.

IX. The report made several key recommendations including:

a. the close linkage of prison health and public health systems being essential for success;

b. service delivery and programs for prison populations adhering to principles of equity of care, evidence-based practice and continuity of care and stability;

c. building partnerships and networks between corrections based and external service providers to establish effective and continuous services for prisoners;

d. building healthy therapeutic relationships including a multifaceted team case-management partnerships, treatment plans and service options designed in consultation with service users and education for all stakeholders including prison staff, prisoners, the people that support them and external service providers about the risks of acute drug related post-release mortality;

e. providing a comprehensive, countrywide framework of drug treatment including diversion to an appropriate community treatment facility rather than being sent to prison for individuals with a substance use disorder;

f. determining which service or agency should be responsible for addressing the needs of individuals at risk of acute drug-related mortality after release from prison;

g. recognising addressing the specific needs of particular subgroups;

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[5] See Kidwell CSU 2017-UK-001438 for an analysis of 84 coronial cases (both open and closed) involving synthetic cannabis related deaths.

[6] Community Corrections "An exploratory analysis into the mortality of offenders" https://www.corrections.govt.nz/resources/research/journal/volume_4_issue_2_december_2016/an_exploratory_analysis_into_the_mortality_of_offenders

[7] World Health Organisation "Prevention of acute drug-related mortality in prison populations during the immediate post-release period" online publication https://apps.who.int/iris/bitstream/handle/10665/326483/9789289042048-eng.pdf

h. monitoring, risk assessment and evaluation of interventions.

X. The Ministry of Health has provided a report that sets out a number of initiatives around synthetic cannabis. However these were not specifically aimed at recently released prisoners. There was reference to amendments to the Misuse of Drugs Act 1975 to reclassifying AMB-FUBINACA and 5 F-ADB as class A drugs and the Police discretion to make a health referral to the AOD helpline and Te Pae Oranga if someone is found in possession of illicit drugs.

XI. The Department of Corrections report advised it lacked the power to undertake drug testing at the time. Corrections can now direct individuals who are subject to an abstinence condition at the time of release to undertake drug tests. It accepts this would not necessarily dissuade Mr Burns from using drugs. Although changes to the legislation have now addressed this gap, there was no assurance an abstinence condition (and presumably drug testing) would have had any effect on his drug use. It is inferred that a more comprehensive treatment approach is required.

XII. There is no information confirming Mr Burns undertook drug addiction treatment whilst imprisoned. From his notes he had been remanded in custody since December 2016.

XIII. From the probation officer's notes Mr Burns struggled to find stable and safe accommodation and remain drug free since his release from prison. He had no accommodation upon release from prison on 7 March 2018. He then moved to Auckland and was placed in emergency accommodation. He was refused supported accommodation and took a room at a boarding lodge. At the time he was motivated to make changes for his children.

XIV. By 21 March 2018 Mr Burns admits using methamphetamine. He then loses accommodation due to reports he was offering females drugs. He then moved to his last accommodation where he was robbed "by a friend of a friend" and his probation officer notes signs of drug use in April and on 3 May 2018.

XV. Upon release there did not appear to be any clarity around Mr Burns' post release conditions other than completion of a "AOD programme". How and when Mr Burns was to complete the AOD programme was largely constructed during the 3-month period after his release when he was most vulnerable.

XVI. The unavailability of stable accommodation delayed any treatment and resulted in drug relapse within days of his release. Even when drug abuse was strongly suspected, due to his compliance with release conditions no therapeutic intervention occurred and he was given reduced monitoring.

XVII. Better co-ordination of these services prior to Mr Burns' prison release would have ensured a seamless transition from prison to community addictions treatment. Written treatment plans could have been negotiated with Mr Burns prior to release. The plan could identify his accommodation, the dates and type of treatment to be provided post release, monitoring and reviews. These actions are consistent with the key recommendations identified in the WHO report as required to prevent similar deaths.

**Recommendations**

XVIII. I sought comment about the above comments and draft recommendations based on the comments from both the Ministry of Health and Department of Corrections.

XIX. I am pleased to receive advice about changes both the Ministry of Health and Department of Corrections have made to policy and legislation implementation since Mr Burns' death.

XX. The Department of Corrections advises it has:

- created the "regional accommodation manager" and teams as permanent roles with the purpose of identifying specific housing needs for the region, forming relationships with local housing and re-integrative providers, working with agencies such as MSD and Kainga Ora, and supporting corrections practitioners in the accommodation reintegration space.
- an AOD strategy: *Our alcohol and other drug strategy, Ara Poutama Aotearoa strategy 2021-2026* (the strategy). The strategy is said to have moved from deficit approaches, such as monitoring and attention, towards recovering well-being and centred on mātauranga Māori. Specific points in the strategy that are relevant to the above findings are:
    - working with drug treatment programs, intensive treatment programs and community treatment providers;
    - a single point of entry process to ensure all corrections community sites have clear referral and service pathways.
- commenced work upon medication and a release planning between practitioners in a custodial setting and those in the community for people sentenced to more than 2 years' imprisonment;
- commenced work updating and upgrading IT documenting and sharing of the release plan for ex-prisoners.
- it is working with the Ministry of Health to establish opportunities to "pre-arrange" assessments for AOD services prior to release from custody to ensure the community support can commence as quickly as possible after release;
- each person released from custody will have a plan that has been developed while they are in custody by a case manager. AOD support was identified and prioritised in Mr Burns' plan, however, it is acknowledged that actual access to the supports could have been achieved earlier if a referral to service was made prior to his release from custody.
- a process for staff to follow when alcohol and drug testing results indicate there may have been a relapse. The response gives emphasis on trying to engage or reengage people in treatment or other support.

- expanded the range of accommodation support available and the number of staff contracts that help to arrange and provide the support.

XXI. The Ministry of Health advises it:

- has a single point of entry service contracts for offenders to AOD assessment and treatment services have been established across 6 districts (Auckland, Waikato, Bay of Plenty, Midcentral, Hutt Valley/Capital and Coast; and Canterbury).
- has also contracted Waitemata District Health Board to provide an Auckland based "getting started" program for treatment of people serving custodial sentences and people serving community sentences with a particular focus on the transition between prison and release into the community.

XXII. Given the above changes in policy (and legislation) since Mr Burns' death, I see no further need for recommendations to be made. Both the Department of Corrections and the Ministry of Health are thanked for their responses.

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

# Schimanski [2021] NZCorC 190 (17 November 2021)

### CIRCUMSTANCES

Craig Anthony Schimanski, aged 40, died on 1 October 2018 on Mairehau Road, Christchurch of the toxic effects of synthetic cannabinoids.

At approximately 7:00pm on 1 October 2018 Craig and a friend purchased synthetic cannabis and went into a bush at the entrance to the Tumara Park subdivision, Christchurch. The friend then went to a nearby bus stop on Mairehau Road. At approximately 7:25pm, Police were flagged down by members of the public to attend to Craig's friend who had collapsed. While doing so they were alerted to Craig, who was found lying on a nearby footpath, in an agitated and disorientated state.

Emergency services attended the scene. However, whilst Craig was being assessed in the back of an ambulance he went into cardiac arrest and was unable to be resuscitated.

The Coroner noted that despite Craig having had several previous, and serious, adverse reactions after smoking synthetic cannabis, and having been advised by clinicians of the significant associated risks (including death), he continued to regularly smoke it.

### COMMENTS OF CORONER KAY

I. I make the following comments, pursuant to section 57(3) of the Coroners Act 2006, in the interests of public safety. These comments are directed to the public at large.

II. More than a year before Craig's death, the Chief Coroner's office and Police issued a joint statement following a significant number of synthetic cannabis related deaths in Auckland.[8] A further joint statement was released two months later, following further deaths that were potentially related to the use of synthetic drugs – the statement urged those using such drugs to stop doing so, and to reach out to services that might assist them.[9]

III. Since then, sadly, further deaths due to synthetic cannabis use have occurred, despite several Coronial inquiries reiterating the dangers associated with synthetic cannabis, and urging individuals not to use it. I repeat that advice. The nature and strength of synthetic cannabinoids are unknown to those who use them, and therefore they cannot predict how they will be affected by them - each time they consume the drug, they expose themselves to the very real risk of dying (and doing so rapidly).

IV. Currently, Coroner Alison Mills is conducting a joint inquiry into a series of deaths in Auckland relating to synthetic cannabis use. I make no recommendations in respect of Craig's death, as Coroner Mills's inquiry, with the significant quantity of evidence it will consider, will be better placed to make recommendations that may reduce the chances of further deaths in similar circumstances.

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

# Fire

## Bell, T [2021] NZCorC 196 (26 November 2021)

### CIRCUMSTANCES

Trevor William Bell, aged 75, died on 4 January 2020 at 10A Elizabeth Street, Orewa, Auckland. The cause of death was chronic obstructive respiratory disease and the effects of an accidental fire in the garage at his home.

At about 6:40am on 4 January 2020, one of Mr Bell's caregivers arrived at his home and thought she could smell gas. She became concerned when there was no response to her knocks and calls. Emergency services attended and found Mr Bell deceased on the floor of his garage, where a fire had already self-extinguished. There was extensive fire damage to Mr Bell's car and soot covering most of the garage's interior.

Police surmised that Mr Bell had been woken during the night by his smoke alarm and gone to investigate the source. After entering the garage he had shut the internal access door and walked towards the external roller door with the intention of opening it, but had quickly become overwhelmed by smoke fumes.

[8] https://www.police.govt.nz/news/release/joint-statement-chief-coroners-office-and-police-significant-number-synthetic-cannabis

[9] https://www.police.govt.nz/news/release/police-and-chief-coroner-reinforce-synthetic-drug-warning

The post mortem report noted that Mr Bell's severe emphysema would have made him "extremely susceptible" to the effects of fire and smoke, and that smoke can cause fatalities by displacing the environmental oxygen. The Coroner concluded that Mr Bell's death may have been prevented had he immediately left his home when he heard his smoke alarm, rather than entering his garage.

Fire and Emergency New Zealand (FENZ)'s investigation found that the driver's door of Mr Bell's car had been left partially open for an extended period. This appeared to have caused a failure/overheating and subsequent ignition of the interior centre light or its surrounding material, which had then dropped down onto the front passenger seat or centre console area. FENZ advised they do not have any data indicating that it is common for fires to start in this way.

### COMMENTS OF CORONER GREIG

I. Although it is unclear whether the fire had already self-extinguished at the time Mr Bell entered the garage, his death highlights an important safety message in relation to fires in the home: the need to take very prompt action to get out of a building that is burning or smoke-filled.

II. Fire and Emergency New Zealand advises that if there is a fire in your house, there is around three minutes to get out before the fire becomes unsurvivable. If there is smoke it will be hot and poisonous. The best thing to do is get on your hands and knees and crawl low and fast to escape smoke. Their message is: "Get down, get low, get out."[10]

III. FENZ's advice is clear: you should not go into, or back into, a burning house or area within a house. I endorse the importance of this message.

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

## Prasad [2021] NZCorC 174 (14 October 2021)

### CIRCUMSTANCES

Meena Kishor Prasad, aged 43, died on 28 October 2019 at 5 Dawood Place, the Gardens, Auckland as a result of smoke and soot inhalation.

Mrs Prasad lived with her husband, daughter and mother-in-law. Her death occurred while they were all celebrating Diwali, the annual 'Festival of Lights'. During the festival lamps, candles and 'diyas' are burnt throughout the day and into the night to ward off darkness and evil. Diya is a ceramic open topped oil burner usually made from clay, with a cotton wick dipped in ghee clarified butter or vegetable oils to keep the wick burning.

Mrs Prasad and her family had a diya situated in the third storey of their house in their Pooja (prayer room). At approximately 6:00pm, on 27 October 2019 the diya was lit. It was checked several times throughout the night and was noted to be burning slowly.

[10] https://www.fireandemergency.nz/in-the-event-of-fire/what-to-do-in-a-house-fire/

At approximately 6:50am on 28 October 2019, Mrs Prasad's mother-in-law awoke to smoke in her room. She alerted Mrs Prasad and then returned to her bedroom to open her window. Mrs Prasad exited the house with her husband and daughter and noticed that her mother-in-law was not there so she turned back and ran inside the house to find her. The family waited for the two women to exit the house, but they did not.

Fire and Emergency New Zealand (FENZ) arrived at the house and commenced a search. Mrs Prasad was found deceased in a bedroom at the top storey. Her mother-in-law was located in the hallway on the same level and transferred to hospital.

FENZ investigated the fire and determined that it was caused by the diya igniting a nearby combustible item. FENZ considered that either the wick from the burning diya fell onto the shelf while it was burning, or the ghee caused a flame large enough that it burned the shelving.

## COMMENTS OF CORONER GREIG

I. FENZ advises that fire moves incredibly fast – and that if there is a fire in your house, you will have around 3 minutes to get out before the fire becomes unsurvivable. FENZ advises that it there is a fire in your house shout 'FIRE, FIRE, FIRE!' to alert others in the house and then to "Get Down, Get Low (to avoid smoke) and Get out quickly. Its firm advice is that once you are out of the house to never go back inside.[11] Mrs Prasad's tragic death is a stark illustration of the importance of this message – no matter how much you may want to go back inside. You will not have time to safely search for someone still missing or to retrieve something important.

II. As Mr Gallagher of FENZ has pointed out, the use of open flame devices during Diwali increases the risk of fire and requires extra vigilance during the celebrations and there are important safety messages that all families celebrating Diwali (or using candles at any time at home) should observe. Particular care is required with open flames in the home to avoid deaths in circumstances similar to Mrs Prasad's tragic death.

*Fire and Emergency New Zealand Diwali Safety Recommendations*

III. Mr Gallagher advised that FENZ has developed a set of guidelines for fire safety at Diwali, based on internationally recommended practices. They are as follows:

a. Diya, oil lamps and candles should be always placed firmly in a proper holder, so they remain stable and are not prone to falling over. They should be placed on top of a heat resistant surface and clear of readily combustible materials.

b. Open flame devices such as Diya, oil lamps and candles must be kept out of the reach of children and pets to avoid them being knocked or disturbed. These items should also be placed out of draughts and away from curtains, other fabrics or furniture, which could catch fire. They must also be placed away from ribbons, greeting cards and other decorations which could serve as a method to communicate and spread fire.

[11] https://fireandemergency.nz/in-the-event-of-fire/what-to-do-in-a-house-fire/

c. These items should be extinguished before being left unattended.

d. Lighting devices such as cigarette lighters and matches must be secured from access by children who may not appreciate the danger they pose.

e. Consider using battery operated tea lights instead of traditional candles. While these offer less risk of fire, care is still required as the small battery-operated tea lights often contain a button cell battery and these can be very dangerous if ingested, so it is important to keep these also away from children.

f. Smoke alarms should be installed in every sleeping area, living area and escape path. For optimum protection of occupants these should be interconnected to enable alerting of the household simultaneously.

IV. FENZ has advised that it intends to share these safety messages in advance of Diwali. It is intending to put the information in the guidelines on its website and use social media channels to promote safety messages. It is currently considering how best to promote its message.

V. I commend this initiative by FENZ. The importance of reminding communities who celebrate Diwali of the safety messages identified in these findings is very important and they should be publicized as widely as possible.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mrs Prasad entered into evidence in this inquiry upon the grounds of personal privacy and decency.

# Leisure Activities

## McKenzie [2021] NZCorC 192 (22 November 2021)

### CIRCUMSTANCES

Peter John McKenzie, aged 57, died on 7 September 2019 near the Wairaurahiri River Mouth, Fiordland National Park of hypothermia occurring in the presence of elevated blood and urine alcohol levels, in the setting of a jet boat accident.

On 7 September 2019, Mr McKenzie was jet boating on the Wairaurahiri and Waitutu Rivers with friends. During the course of the day, Mr McKenzie had consumed around three or four beers.

Later in the day while Mr McKenzie was re-entering the Wairaurahiri River, his driving of the jet boat changed, and he appeared to become drowsy or dazed. As the boat approached the mouth of the Wairaurahiri River, the passengers of the boat (including Mr McKenzie) were thrown into the cold and rough waters. They swam to shore, but Mr McKenzie was very unwell. About half an hour later, Mr McKenzie passed away.

### COMMENTS AND RECOMMENDATIONS OF CORONER MCKENZIE

I. Pursuant to s 57A of the Act a coroner may make recommendations or comments in the course of, or as part of the findings of, an inquiry into a death. Recommendations may be made only for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred. Recommendations or comments must:

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

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

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

II. I have not made a finding that Mr McKenzie's driving was directly impaired by alcohol in and of itself, though have noted the clear possibility of this. I consider the most likely scenario is that alcohol contributed to hypothermia which in turn affected Mr McKenzie's driving and chances of survival once in the water. Accordingly, I do not make a recommendation relating to alcohol use and impaired jet boat driving as I am not satisfied the *Carroll v Auckland Coroner's Court* causative threshold would be met.

III. Alongside this I consider it likely that alcohol contributed to hypothermia, which in turn affected Mr McKenzie's driving.

IV. In turning my mind to whether to make any recommendations in these particular circumstances, I observe that the more general dangers of driving a jet boat after having consumed alcohol are the subject of broader safety campaigns or recent inquiries. For example, Maritime New Zealand has webpages relating to the risks of alcohol and boating[12] and has a publication titled *Managing risks: Alcohol and drugs – Safety guidelines for jet boat operators* (this is in a commercial context, however).[13] I also note the analysis and observations of the Transport Accident Investigation Commission (TAIC) in its Final Report into its inquiry into the fatal jet boat accident on the Hollyford River on 18 March 2019:[14]

> 7.2 The consumption of alcohol can impair a person's performance significantly. It can adversely affect their risk perception, reaction time and co-ordination. Alcohol was a contributory factor in this accident, and this emphasises the increased risk of attempting to operate a boat under its influence.

V. TAIC's Final Report included various observations regarding the consumption of alcohol and jet boating. It recommended that the Director of Maritime New Zealand continue to develop its fatal accident database to improve the quality of the data so that the maritime sector is better able to understand the risks of alcohol and drug use in recreational boating accidents.

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[12] Available at: https://www.maritimenz.govt.nz/recreational/safety/alcohol/default.aspx

[13] Available at: https://www.maritimenz.govt.nz/commercial/safety/safety-management-systems/adventure-activity/documents/Safety-guidelines-managing-risks-alcohol-drugs-jet-boat-operators.pdf

[14] Available at: https://www.taic.org.nz/sites/default/files/inquiry/documents/MO-2019-202%20Final_1.pdf

VI. Maritime New Zealand's general information about alcohol and water includes reference to reducing awareness of the onset of hypothermia:

> No matter the activity, alcohol affects balance, vision, coordination and judgement. In boating, factors like wind, sun, noise, motion and vibration can magnify the effects of alcohol and accelerate impairment.
>
> A momentary lapse that might pass unnoticed on shore can have dangerous consequences out on the water. Alcohol will:
>
> - decrease your coordination and ability to perform a simple task, such as putting on a lifejacket
> - increase your sense of disorientation
> - make it harder for you to stay afloat in the water
> - lower concentrations of blood going to your brain and muscles, contributing to muscle, heat and fluid loss
> - reduce your ability to hold your breath
> - suppress your airway protection reflexes and make it easier for you to inhale water
> - give you a false sense of your situation, causing you to attempt tasks beyond your abilities
> - reduce your awareness of the onset of hypothermia.[15]

VII. In this setting of existing campaigns educating about the dangers of alcohol and boating, which include reference to hypothermia, I do not make further recommendations or comments.

An order under section 74 of the Coroners Act 2006 prohibits the making public of photographs of Mr McKenzie entered into evidence, in the interests of decency or personal privacy.

# Tsygankov [2021] NZCorC 201 (2 December 2021)

### CIRCUMSTANCES

Aleksandr Tsygankov, aged 40, died between 13 and 14 April 2019 at Mount Lancelot, Arthur's Pass National Park (Arthur's Pass) from high energy impact injuries due to a tumbling fall from a height.

Mr Tsygankov was a relatively competent tramper and mountaineer. He had signed up for a trip in the Arthur's Pass for 13 and 14 April 2019 with two others, David Hegan and Edmond Allaway. The route included Mt Guinevere and Mt

[15] Available at: https://www.taic.org.nz/sites/default/files/inquiry/documents/MO-2019-202%20Final_1.pdf

Lancelot and involved technical terrain with exposed ridges and bluffs. The group had around nine hours in which to do the trip before they lost daylight.

At the beginning of the hike, it became evident that Mr Hegan had a higher level of fitness compared to Messrs Tsygankov and Allaway as they fell behind him during the hike. When the group reached the Crow Hut, Messrs Hegan and Allaway agreed that Mr Allaway would return to the Crow Hut if he felt he could no longer do the climb. Neither of the pair can recall whether Mr Tsygankov heard the discussion.

Mr Hegan continued climbing ahead and eventually lost sight of the other two hikers. At some point, Mr Allaway decided to return to the Crow Hut. He called out to Mr Tsygankov who turned around and gave him a nod and a thumbs up. Mr Tsygankov continued climbing and Mr Allaway returned.

When Messrs Hegan and Allaway returned to the Crow Hut, separately, they realised that Mr Tsygankov was not with either of them. They looked for him and activated a personal locator beacon. An aerial search began that night using infrared technology. The search continued the following morning, both aerial and on land. Mr Tsygankov was found at approximately 3:15pm on 14 April 2019 by the Alpine Cliff Rescue Team. He was declared dead at the scene.

Police found that Mr Tsygankov had left his warm clothes and most of his food back at the Crow Hut. They could not locate a map in his backpack. The Mountain Safety Council (MSC) completed a report and concluded that the most likely scenario was that Mr Tsygankov began his descent to the Crow Hut in the dark. While he had his head torch on, it was likely that he slipped and fell in the vicinity of a steep water course.

## COMMENTS OF CORONER MCKENZIE

I. I have considered whether it is appropriate to make any recommendations in this matter. Pursuant to s57A of the Act I may make recommendations or comments in the course of, or as part of the findings of, an inquiry into a death. Recommendations may be made only for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred. Recommendations or comments must:

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

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

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

II. In assessing the need for recommendations, I have kept in mind the points made in the MSC report which I consider are akin to recommendations, even though not specifically framed as such. The MSC encourages mountaineers to:

   a. Stick together. When setting off to move as a group, travel together for the entire journey, especially in technical terrain. Decisions to separate should only be made in an emergency situation, and even then, the risks should be evaluated and mitigated.

   b. Group equipment such as maps must be available to all members to access and use if required. Carry multiple copies.

c. Always be prepared to turn back or change plans if things do not go as expected (planned). Have a Plan B organised before you leave and regularly stop and evaluate your progress.

d. Stay in constant communication with each other. Decisions about a change of plans should be made as a group and agreed to by all group members, ensuring everyone understands the potential implications.

e. Any decision to try and move faster due to a lack of remaining time is frequently the wrong decision, particularly when identified early in the day. If the group's pace is not quick enough to achieve the objective within the time available, then the objective needs to change, not the group speed or group composition i.e. splitting up.

f. Finally, if you are not confident in your location, or cannot see your way out of high-consequence terrain, stop and consider your options. Stay warm by applying spare clothing, try to identify where you are if you are not certain, and use your emergency communication device to call for help. It is better to spend a few hours waiting in the cold than to risk serious injury or death.

III. In the particular circumstances of this case and bearing in mind that Mr Tsygankov's movements after Mr Allaway lost sight of him cannot necessarily be precisely ascertained, I can do no better in terms of recommendations than the advice already given by the MSC above.

IV. I put the relevant parties on notice of my intention to endorse the MSC's advice above and provided an opportunity for them to comment. I received no substantive comments in response.

V. Accordingly, I do not make any formal recommendations in this matter. I do however endorse the advice of the MSC.

Note: an order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Mr Tsygankov taken during the investigation into his death upon the grounds of personal privacy and decency.

# Medical Care

## Anderson [2021] NZCorC 185 (1 November 2021)

### CIRCUMSTANCES

Sarah Caroline Anderson, aged 46, died on 20 December 2017 at Wellington Hospital of multiple drug effects (gabapentin, baclofen, dantrolene and clonazepam) and aspiration pneumonia in a woman with end-stage multiple sclerosis.

Ms Anderson suffered from multiple sclerosis and required full assistance which was provided by Registered Nurses at the Karori St John of God care facility (Karori) where Ms Anderson lived. This facility was specifically designed to care for persons living with severe multiple sclerosis and is supported by doctors from the Karori Medical Centre. Ms Anderson was unable to take her own medicine which was administered by a Registered Nurse who would collect it from a medical

trolley. Also on the trolley was a medical folder containing signed charts showing when the patient was last administered their medication.

When the facility is short staffed it is supported by temporary agency employed Registered Nurses. On 19 December 2017, Ms X was asked by her agency to work a shift at Karori. It was the third shift she would have worked at that facility. The manager of Karori was assured by Ms X at the start of her shift that she had had an orientation of the facility. Consequently, the manager assumed Ms X had been shown where the policies and procedures were located.

While on shift, Ms X collected Ms Anderson's medications, checking them off on the chart and comparing them with the medication pack. Before she administered the medication, Ms X collected another patient's medication but that patient was not in his room. Instead of putting that patient's medication away Ms X placed it on the trolley and when she returned to Ms Anderson, administered it to her instead. Ms X realised the error when she returned to the trolley.

Ms X telephoned the facility manager to ask whether she should call a doctor. The manager said that, because of the time, she would not be able to speak with the doctor. Instead, the manager said to transport Ms Anderson to hospital if there was a sudden change in her condition. The manager also said to contact the Poison Control Centre, which Ms X did, and to review the Monthly Index of Medical Speciality (MIMS). The MIMS provides information about various medications' side-effects and contraindication. Ms X could not locate the MIMS.

Ms X advised Ms Anderson of the error and continued to monitor her. Ms Anderson remained stable. At around midnight Ms X handed over to the nightshift Registered Nurse, who was also from an agency, and said she could not locate the MIMS. The overnight nurse also could not locate the MIMS and continued to monitor Ms Anderson.

At around 10:30am on 20 December 2017 Ms Anderson had deteriorated and was transported to Wellington Hospital. On admission she was drowsy and appeared to have aspirated, she also had low oxygen. Doctors provided oxygen support but she continued to deteriorate and was intubated. After confirming Ms Anderson's wishes, she was extubated and passed away.

## COMMENTS OF CORONER FITZGIBBON

I. Due to the death of Ms Anderson, an internal investigation was conducted by St John of God Hauora Trust (SIGHT). As a result of this investigation, the following action has been taken to prevent a medication error occurring again. These steps include (but not limited to):

   a. Karori Medical Centre has provided one general practitioner to cover St John of God Hauora Trust's service and has provided a personal phone number for emergencies and urgent calls.

   b. A medication error flowchart has been designed for Registered Nurses to follow. Copies of the flowchart are on the Emergency clipboard in the Registered Nurses' office; and the Agency Orientation folder, and as an attachment in the Medication Policy. The chart identifies the General Practitioner and the process for calling after hours medical offices at both After Hours Medical Centre and Accident and Emergency.

   c. All agencies that SIGHT Karori use have been requested to send their Registered Nurses half an hour early to shifts so that a full and thorough orientation can occur. This includes being physically shown around the facility, completing and signing a check list, being shown the emergency

procedure and clipboard (with information on what to do in clinical situations) and all residents of concern being discussed.

d. A copy of the Medication Policy is now within the Agency orientation folder.

e. A new MIMS has been purchased and is available in the Registered Nurses' office.

f. Further support for Registered Nurses to locate information on medications has been identified including: Healthline (phone); NZ Formulary and Medsafe (online).

g. The appointment of a Nurse Unit Manager as an extra clinical support person for Registered Nurses. (This position was being recruited at the time of the incident).

h. Senior Support workers have been trained for Medication Competencies to support the Registered Nurse with medication administration if there are emergencies or there is an Agency Registered Nurse on duty. More Support workers will be trained for medication competency.

i. A Standardised Medication Administration procedure is being developed for Registered Nurses at SIGHT Karori to follow. This is to improve practice and will reduce the possibility for error.

j. A folder with Medication Information sheets for all the medications that SIGHT Karori residents are on is being developed.

k. Electronic Medication Software has been approved and is in the process of being purchased for SIGHT.

II. Ms X states that she now ensures she does not have more than one patient's medications out of their packets on the trolley at the same time, so there can be no repeat of the error that occurred with Ms Anderson. I consider that to be a practical step to avoid medication administration errors, and (if not included already) I recommend it be included in the St John of God Hauora Trust Standardised Medication Administration procedures.

III. I consider that appropriate steps have been taken by St John of God Hauora Trust to reduce the likelihood of incorrect medication being administered to residents at their facilities and accordingly I do not propose to make any formal recommendations.

An order under section 74 of the Coroners Act 2006 prohibits the making public of photographs of Ms Anderson taken by Police, in the interests of decency or personal privacy. An order under section 74 of the Coroners Act 2006 also prohibits the making public of Ms X's name and any particulars likely to lead to her identification in the interests of justice.

# Bell, I [2021] NZCorC 212 (15 December 2021)

### CIRCUMSTANCES

Ian Chauncey Bell, aged 72, died on 4 November 2017 at Christchurch Hospital of multiorgan failure from severe sepsis, following peritonitis secondary to a bowel perforation during a robotic prostatectomy.

On 1 November 2017 Mr Bell was admitted to Southern Cross Hospital for an elective robotic prostatectomy for an early prostate cancer. Following the surgery, Mr Bell returned to the ward in a stable condition but became uncomfortable and had low blood pressure. It was decided that doxazosin (a medication used to treat symptoms of an enlarged prostate, such as difficulties with urine flow but which can lower the blood pressure) be withheld. When reviewed by his surgeon at 2:55am on 2 November 2017 Mr Bell was thought to be experiencing bladder spasms. He was given fluid bolus, oxybutynin and midazolam and became more comfortable. Later that morning, Mr Bell was reviewed by the anaesthetist who also considered that Mr Bell's pain was most likely due to bladder spasms. At a surgical review at 6:00pm it was decided Mr Bell would be transferred to the urology ward at Christchurch Hospital for observation. The surgeon noted that if Mr Bell deteriorated, a CT scan should be organised. Mr Bell's condition deteriorated further but the surgeon was not informed of this and staff continued to arrange the transfer. Mr Bell was transferred via ambulance to Christchurch Hospital. He was not assessed in the Emergency Department.

After arriving to the urology ward at Christchurch Hospital, the urology registrar assessed Mr Bell and sought assistance from the Intensive Care Unit (ICU) as the urology registrar was concerned about Mr Bell's condition. Mr Bell was assessed and admitted to the ICU at 11:40pm with a presumptive diagnosis of sepsis. A CT scan was carried out at 5:00am on 3 November 2017. It revealed changes consistent with a bowel perforation. A laparotomy was performed at 9:00am and revealed bowel content throughout the abdomen secondary to a 1cm perforation in the distal ileum which was adherent to the pelvic sidewall. Unfortunately, Mr Bell's condition continued to deteriorate despite intensive support and, in consultation with his family, life support was withdrawn. He died at 4:50pm on 4 November 2017.

The issue of whether private patients being transferred to a public hospital should be assessed in the Emergency Department, or go straight to a ward was brought into sharp focus by this case. Noting that there was a deficiency in the transfer process, it was confirmed that, at the time of Mr Bell's death, there was no formal policy or process regarding the transfer of patients from private hospitals. Rather, each surgical specialty had their own process for managing such transfers.

As a consequence of Mr Bell's death, a Surgical Services review of the transfer process and in-hospital assessment was undertaken. The purpose of the resulting policy, Transfer of Private Patients to Christchurch Hospital, was to outline the expected responsibilities when a patient needs to transfer from a private hospital facility in the Canterbury region to Christchurch Hospital. The new transfer policy outlined the clinical staff responsibilities and confirmed that an assessment at the point of arrival to the Emergency Department was the most appropriate way to implement this process. The definition of unwell/unstable was also clarified in the new transfer policy.

The Coroner received evidence from several experts, including Andre Westernberg and Professor Frank Frizelle. The former noted that the diagnosis of post-operative bowel perforation can be difficult and requires a high index of suspicion. While Mr Bell had some of the classical symptoms of post-operative bowel perforation, he did not have a rigid abdomen with peritonism, which most urological surgeons would consider to be the most important diagnostic feature of a bowel perforation. Mr Westernberg concluded that the bowel perforation could have been identified 12 hours earlier. The Coroner accepted that there was a period of illusion whereby Mr Bell was treated for presenting symptoms while waiting for the "declaration" where the inflammatory process became clearer. That highlighted the need for a higher index of suspicion.

Professor Frizelle noted that urologists do not see small bowel injuries every day, whereas it was not uncommon to see it in general surgery, given that general surgeons see a lot of trauma. He supported the idea that there be a low threshold

for urologists seeking an opinion from a general surgeon regarding possible bowel injuries. His experience and evidence underscored the value of a review by a general surgeon in cases where a laparoscopic surgery patient does not progress.

Professor Frizelle further noted there had been a "series of small seemly unimportant delays around process which amounted to a substantial and clinically significant delay." He concluded that this was an example of "Failure to rescue (i.e. prevent a clinically important deterioration such as death or permanent disability) from a complication of an underlying illness or a complication of medical care." Professor Frizelle agreed with Mr Westernberg that a CT scan should have been undertaken earlier.

## 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. Bearing in mind that restriction, I make the following recommendation:

a. That the Ministry of Health be provided with the Transfer of Private Patients to Christchurch Hospital policy and encourage other District Health Boards to develop similar policies.

III. This finding is to be sent to the Urological Society of Australia and New Zealand for dissemination among its members to emphasise:

a. The need for a high index of suspicion of bowel injury (and atypical presentation of the same) in patients who do not progress following robotically assisted prostatectomy;

b. The value of review by a general surgeon if patients who fail to progress following such surgery;

c. Circumstances that can contribute to "failure to rescue".

IV. My provisional finding included a recommendation that Southern Cross Hospitals Limited review its transfer policies to ensure that it aligns with CDHB Policy. I have been referred to revised policies which obviate the need to such a recommendation.

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

# Miscellaneous

## Campbell, Campbell-Rodgers and Patterson [2021] NZCorC 191 (19 November 2021)

### CIRCUMSTANCES

Wendy Christine Campbell-Rodgers, aged 60, and her daughter Natanya Kelly Campbell, aged 37, respectively died from multiple gunshot injuries (head and neck) and multiple gunshot wounds (head and chest) on 26 July 2017 at 287 Mount Tiger Road, Whareora, Whangārei.

Quinn Lorne Patterson aged 55 also died on 26 July 2017 at 287 Mount Tiger Road, Whareora, Whangārei but in circumstances amounting to suicide. The evidence established to the standard required that Mr Patterson inflicted the fatal injuries upon Mrs Campbell-Rodgers and Ms Campbell before taking his own life.

Mrs Campbell-Rodgers worked as a property manager and, since April 2017, had been assisted by Ms Campbell. At that time Mrs Campbell-Rodgers began to manage two properties at 287 Mount Tiger Road. The primary dwelling was rented to Mr Patterson.

Mr Patterson and Mrs Campbell-Rodgers had a tense relationship from the outset, but it deteriorated further when Jeffrey Pipe was engaged to carry out property maintenance services at the address. The relationship continued to deteriorate when Mrs Campbell-Rodgers served notice on Mr Patterson to remove a structure he had built on the property. Mrs Campbell-Rodgers had earlier made a complaint to Police about the structure as it appeared to have been used as firearms target. Police visited the property and were satisfied by Mr Patterson's explanation that the target was used by his friend, Michael Hayes, to shoot pigs and targets.

Mr Patterson did not have a firearms licence and had been refused a licence on the basis that he was not a fit and proper person to possess firearms. Mr Hayes was a firearms licence holder. However, Mr Hayes possessed three military style semi-automatic (MSSA) weapons, the first of which was a rifle that had a folding stock, a free-standing pistol grip and was fitted with a suppressor. Mr Hayes had a 30-round magazine for that firearm. The second MSSA rifle had a flash suppressor, folding stock and a free-standing pistol grip. The third MSSA was a shotgun that had a collapsible stock and a free-standing pistol grip. Mr Hayes had a 10-round magazine for this shotgun. Mr Hayes never held the required endorsement to his firearms licence to possess these or any other MSSA weapons.

The evidence showed that Mr Hayes left some of his weapons at Mr Patterson's address. It also showed that both Mr Hayes and Mr Patterson purchased firearms and ammunition on the website TradeMe. Mr Hayes' firearms licence number was entered for those transactions but through Mr Patterson's TradeMe account. Mr Hayes' home address was also listed as an additional buyer delivery address on Mr Patterson's account.

At around 10:30am on 26 July 2017, Mrs Campbell-Rodgers, Ms Campbell, and Mr Pipe went to Mr Patterson's address to conduct a property inspection and complete some property maintenance. After a verbal exchange Mr Patterson retrieved a firearm which he used on Ms Campbell, Mrs Campbell Rodgers and Mr Pipe.

Mr Pipe managed to escape to his vehicle and alerted the Police who arrived at the address and attempted to negotiate with Mr Patterson. However, he engaged police in an exchange of gunfire before the dwelling became ingulfed in flames. After emergency services extinguished the fire, police located Mr Patterson's body.

## COMMENTS OF CORONER BELL

*Is the process of purchasing guns from TradeMe robust enough?*

I. Daniel Compton, a Senior Police Liaison Officer at TradeMe provided a report to my inquiry about Mr Patterson's purchases through the website. Mr Compton subsequently provided further information about the process of purchasing firearms through TradeMe.

II. Prior to October 2017, if a potential buyer wanted to interact with a firearm listing, they would be required to enter their firearms' licence number. The TradeMe system would check if the licence number entered by the user matched the makeup of a firearms' licence (i.e. one letter and seven numbers). The number was also checked against the TradeMe database to see if the licence number had been used on any other memberships, which could indicate multiple/duplicate use if confirmed.

III. The TradeMe system would generate an alert if the licence number entered:

a. Did not match the format of a firearms' licence;

b. Was sequential (e.g. F1234567);

c. Was repetitious (e.g. F1111111);

d. Only had two different numbers (e.g. F1212121);

e. Differed from the licence number previously used on the membership; or

f. Had been used previously by a different membership.

IV. If that licence number did generate an alert, a staff member would check it and take any necessary action which may include restricting a user's ability to interact with firearms listings on TradeMe. This may occur if the firearms' licence appeared on a new membership with no links to the original membership.

V. After Mr Patterson's death, in September 2017, TradeMe and Police implemented a firearms validation process known as the "Licence Check" whereby TradeMe can check the firearms' licence details entered by its members against a silo of the Police firearms' licence database (the database). The check is made in real time and ensures only the holders of valid firearms' licences are able to bid, buy or ask a question on firearms listings on the TradeMe website.

VI. Mr Compton advised that the process since October 2017 has been as follows:

a. TradeMe checks that the name on the licence matches the name registered to the TradeMe membership.

b. If the name on the licence matches the TradeMe membership, the details are checked against the database which confirms that the licence is valid or invalid. If valid, the action is able to proceed.

c. If the name on the licence that has been entered does not match the details registered to the TradeMe membership, the member is shown a general error messaging stating that they need to make sure the name entered matches the licence.

d. If the name on the licence that has been entered matches the TradeMe membership but does not match the database, the action is not allowed to proceed.

e. Where the action is not allowed, the member will receive an error message highlighting that a valid firearms' licence is required for the action to continue. They are not told the reason that it is invalid.

f. A system alert is also generated to TradeMe staff that an invalid licence has been entered.

VII. Mr Compton noted that TradeMe does not have access to the personal information held on the database at the time of the check, rather it is matching the provided firearms' licence number against what is stored on the database.

VIII. In response to my questions, Mr Compton advised that a TradeMe user is not required to attend a Police station to have their firearms' licence registered with a TradeMe account, nor is photo identification required to register a firearms' licence on the TradeMe site.

IX. Mr Compton did outline that the seller of a firearm is required to meet its legal obligations as a firearms retailer before it can proceed with a sale. Once a firearm or ammunition has been purchased, the seller must:

a. Sight the buyer's firearms' licence at the time of pick-up (if in person); or

b. Ensure that they receive a completed FRM43A (Mail Order) form before they post the firearm to the buyer.

X. I note that Mail Order form must be filled out by a member of the Police who has inspected the purchaser's firearms' licence and is satisfied they are a fit and proper person to purchase the item.

XI. Mr Compton further advised that when the potential buyer enters a firearms' licence number, they confirm that they are aware of their obligations under the Arms Act 1983 and that the licence and name provided will be checked against the database to confirm that the licence is valid.

XII. Additionally, when a firearm is listed for sale on TradeMe, the seller has to confirm via a tick box that the firearm they are listing can be legally purchased and used by "A" category firearms' licence holders in New Zealand and is not a semi-automatic firearm as per TradeMe's firearm's policy. They also confirm that they will ensure any buyer holds the licence required to own the firearm. When ammunition is listed for sale, the seller must confirm via a tick box that the ammunition that is being listed is for an "A" category firearm.

XIII. Mr Compton emphasised that the process that has been implemented between TradeMe and Police took a number of years to fully implement and is a strong gatehouse to ensure that a purchaser interacting with a firearm or ammunition listing is a valid licence holder. He also noted that there is still an offline process that individuals must complete before a firearm can be legally transferred to the new owner.

XIV. Police have advised that its inquiries did not establish any culpability for TradeMe sellers supplying firearms to unlicensed persons.

XV. I am satisfied that the process that has been implemented between TradeMe and Police since Mr Patterson's death are sufficient to ensure that a purchaser interacting with a firearm or ammunition listing is a valid licence holder.

*Do the 2019 amendments to the Arms Act 1983 prevent access to the guns used by Mr Patterson?*

XVI. Acting Superintendent Michael McIlraith and Police Armourer Terence Quirke provided information about recent gun law reform in New Zealand. Superintendent McIlraith was closely involved with the April 2019 legislative change including attendance at select committee hearings and advising Police policy on the changes.

XVII. As a result of the 15 March 2019 Christchurch shootings, the Arms Act 1983 was amended by the Arms (Prohibited Firearms, Magazines, And Parts) Amendment Act 2019 (the 2019 Amendment) which took effect from 12 April 2019.

XVIII. Both before and after the amendment, the Arms Act 1983 provided that:

a. A firearms' licence is required in order to lawfully possess a standard firearm (unless the person is under the immediate supervision of a licence holder). Standard firearms (commonly referred to in Police as "category A" firearms) can be obtained from a dealer or through private sale. The seller of a standard firearm needs to be satisfied that the purchaser holds a firearm licence. The transfer of standard firearms is not tracked, except that transfer through mail order requires a mail order endorsed by a member of the Police; and transfers through licenced dealers must be recorded in the dealer's book.

b. For restricted weapons and pistols which are separated out as categories of high-risk firearms and weapons, an endorsement (with an additional fit and proper person assessment and more stringent security requirements) and permit is required in order to lawfully obtain and possess them in one of the following capacities:

    i. As a member of a recognised target pistol shooting club.

    ii. As a bona fide collector of firearms.

    iii. As a person to whom the pistol or restricted weapon has special significance as an heirloom or memento.

    iv. As the Director or Curator of a bona fide museum.

v. As an approved employee or approved member of anybody being:

1. A broadcaster within the meaning of the Broadcasting Act 1989; or

2. A bona fide theatre company or society or cinematic or television film production company or video recording production company.

vi. As a licensed dealer or an agent or employee of a licenced dealer.

c. To take possession of a restricted weapon or pistol, a permit issued by Police is required. Accordingly, the transfer of possession of restricted weapons and pistols is tracked.

XIX. Prior to 12 April 2019, the Arms Act 1983 also provided for a category of firearm called military style semi-automatic firearms (MSSA). An MSSA firearm was a semi-automatic firearm (other than a pistol) that had one or more of the following features:

a. A folding or telescopic butt:

b. A magazine designed to hold 0.22-inch rimfire cartridges that-

i. Is capable of holding more than 15 cartridges; or

ii. Is detachable, and by its appearance indicates that it is capable of holding more than 15 cartridges:

c. A magazine (other than one designed to hold 0.22-inch rimfire cartridges) that-

i. Is capable of holding more than 7 cartridges; or

ii. Is detachable, and by its appearance indicates that it is capable of holding more than 10 cartridges:

d. Bayonet lugs;

e. A flash suppressor;

f. A component of a kind defined or described by an order under section 74 as a pistol grip for the purposes of this definition…

XX. Similar to pistols and retired weapons, an endorsement and permit was required in order to lawfully possess a MSSA, although the capacities in which the MSSA might be possessed were not specifically listed. So, for example, while a pistol held on an endorsement for target shooting can only be used on an approved range, an MSSA could be used on any range and also off a range. A restricted weapon had to be rendered inoperable and not used with live ammunition, while there was no such limitation on an MSSA.

XXI. In practical terms, a semi-automatic firearm could be relatively easily converted from a standard firearm without any MSSA features, into a MSSA firearm by the addition of a MSSA feature, for example, by the addition of a large capacity magazine. A person who wanted to acquire a standard

firearm, convert it to an MSSA firearm by the addition of an MSSA feature, and then continue to legally possess the firearm was required to obtain an endorsement for that MSSA that is specific to that MSSA.

XXII. The 2019 Amendment abolished the MSSA category and all endorsements issued in relation to MSSAs were made obsolete. New categories were created of prohibited firearms, prohibited magazines, and prohibited parts. Definitions of prohibited firearm, prohibited magazine and prohibited parts are contained in new sections 2A, 2B and 2C of the Arms Act 1983.

XXIII. The new category of prohibited firearm is much broader than the old category of MSSA firearm, and includes, for example, all centrefire semi-automatic firearms (that are not pistols) and no longer differentiates between those with the old MSSA features.

XXIV. The 2019 Amendment significantly restricts access to semi-automatic firearms and related parts to improve public safety. It effectively banned prohibited items to Police or through a dealer. A compensation regime could be established in regulation.

XXV. The only categories of people who can apply to lawfully possess a prohibited firearm or magazine are set out in the new section 4A of the Arms Act 1983. As with restricted weapons and pistols, dealers, collectors, museums and theatrical armourers can apply. The only additional capacities in which a person can apply relate to controlling wild animals and animal pests and only in particular roles (e.g. Department of Conservation employees).

XXVI. A person wanting to lawfully possess a prohibited firearm, or a prohibited magazine would need to obtain an endorsement under s 30A of the Arms Act 1983 in one of the capacities in s 4A. The matters to be considered by Police in deciding whether to issue the endorsement are set out in s 30B and include, whether the person is a fit and proper person to possess the prohibited firearm or magazine, and whether, in all the circumstances, it is reasonable to grant the endorsement.

XXVII. There are additional capacity-specific considerations set out there too, including, for example, for an endorsement for pest or wild animal control-related work, whether there is a genuine need to possess that prohibited item, whether a non-prohibited item could be used instead, and whether the decision-maker is satisfied that the prohibited item will be used solely for controlling wild animals and animal pests.

XXVIII. An endorsement application involves a further fit and proper assessment and referee checks. In addition, Police visit the person's home to check that the security in place meets the higher standard set out in regulation 28 of the Arms Regulations 1992.

XXIX. If the endorsement is granted it will be subject to conditions. Standard conditions are set out in s 33A (including that the person may only possess the prohibited item in the section 4A capacity they applied under).

XXX. The endorsement needs to be made specific to a prohibited firearm or prohibited magazine. This step occurs when the person applies for and is issued with a permit to import under s 18 or a permit to possess under s 35A.

XXXI. Mr Quirke advised that some of the firearms found at the Mt Tiger Road property would be categorised as prohibited firearms as a result of the 2019 Amendment.

XXXII. Video footage obtained of the weapon used by Mr Patterson to kill Ms Campbell and Mrs Campbell-Rodgers indicates that the weapon used was a Gevarn .22 calibre semi-automatic firearm. This weapon could still be lawfully obtained and possessed as a category A weapon by an appropriately licenced person after the April 2019 reform provided it was over 762mm in length and it did not have a magazine capable of holding more than 10 rounds (any such magazine would be within the current definition of a prohibited magazine).

XXXIII. Unfortunately, it was Mr Hayes who supplied Mr Patterson with firearms that were then used to kill Mrs Campbell-Rodgers and Ms Campbell. It is difficult to say that banning the weapons would have made a difference since they were unlawfully obtained/altered in the first place.

*Are there any associated risks in the Property Management industry that need addressing?*

XXXIV. WorkSafe New Zealand (WorkSafe) prepared a report for my inquiry. WorkSafe did not identify any practicable steps that should have been taken by either Mr Pipe as a self-employed contractor or Mrs Campbell-Rodgers' company Seek n Find.

XXXV. WorkSafe concluded that Property Management is not considered a high-risk industry. Mrs Campbell-Rodger, Ms Campbell and Mr Pipe were carrying out routine property maintenance and follow up on a Breach of Tenancy Notice.

XXXVI. The correct precaution was taken by attending the property together, which was reasonable to do so in the circumstances. The outcome was extraordinary and could not have been anticipated.

XXXVII. I concur with WorkSafe's conclusion. This was an extraordinary outcome.

Note: Orders under sections 71 and 74 of the Coroners Act 2006 (the Act) apply. Specifically, under section 71 of the Act no person may make public the method of Mr Patterson's death, or any detail that suggest the method of death. Pursuant to section 71(3)(b) of the Act, the death may be described as a suicide. Under section 74 of the Act, it is prohibited to make public any of the following that have been presented as evidence: photographs of the deceased taken by the Police; any footage or other photographic material of the deceased, and attending Police officers; and any audio communications or recordings of the deceased, any attending Police officers and the 111-call made by Mr Pipe. The orders under section 74 were made upon the grounds of personal privacy, decency, public order and interests of justice.

# Motor Vehicle

## Alletson [2021] NZCorC 207 (9 December 2021)

### CIRCUMSTANCES

David James Alletson, aged 69, died on 11 September 2019 at State Highway 1 near Moerewa from multiple severe injuries including pericardial tamponade arising out of motor vehicle collision.

At about 3:20pm, Mr Alletson was the driver and sole occupant of a Nissan Bluebird car travelling west on State Highway 1 in Northland. On a straight stretch of road, his car suddenly swerved across the centre line and collided head on with an oncoming vehicle. Mr Alletson died from his injuries at the scene.

The day prior, Mr Alletson had arrived in New Zealand from Australia, possibly to attend a family funeral. An investigation by the Police Serious Crash Unit noted that several factors indicating fatigue were present, such as a driver aged over 50 (suggesting increased disturbed sleep), straight segments of road, a single occupant, a head on crash and a lack of emergency action. The Coroner also noted that Mr Alletson may have been suffering emotional distress, which might have compounded any fatigue he was experiencing at the time.

The Coroner concluded that the most likely explanation for Mr Alletson's sudden swerve into the opposite lane was that he momentarily fell asleep at the wheel, involuntarily causing his car to travel across the road into the path of an oncoming vehicle.

### COMMENTS OF CORONER HO

I. Waka Kotahi New Zealand Transport Agency has a section on its website warning of the dangers of driver fatigue. Importantly, it states that fatigue is tiredness, weariness or exhaustion. A driver can be fatigued enough for it to impair their driving long before they 'nod off' at the wheel. Being tired can also cause drivers to drift in and out of sleep without knowing it, or "microsleep". Such drifts can last between three and five seconds and are the main cause of fatigue-related crashes where the driver runs off the road.

II. Previous coronial findings have also warned of the dangers of driving while fatigued. I endorse those comments and the warnings issued by Waka Kotahi. Mr Alletson's death is a reminder to all drivers to consider whether they are sufficiently rested before embarking on their journey. Risk factors particularly include, but are not limited to, those who have recently arrived from international flights or those who have not been sleeping well.

III. I address readers directly. Ask yourself whether you are sufficiently rested to handle the drive, and any possible delays, before setting out. Do not assume that fatigue and sleep-related crashes only happen to others.

IV. In the context of previous coronial recommendations and comments about the dangers of driving while fatigued, and the information publicly available on the Waka Kotahi website, I do not make any further recommendations or comment.

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

# Baume [2021] NZCorC 177 (19 October 2021)

### CIRCUMSTANCES

Heather Mary Baume died on 17 January 2018 on State Highway 15 at Nukutawhiti from neck and chest injuries sustained as a result of motor vehicle collision.

On 17 January 2018, Mrs Baume was travelling along State Highway 15 with two other cars in front of her. The lead car was travelling slowly along the highway. At Nukutawhiti, the cars reached a relatively straight section of road which had a temporary 50km/h speed limit in place for a chip seal patch repair in the southbound lane. The left edge line and centre line had not yet been repainted over the new patch.

At that point, the driver of the second car pulled into the opposite lane and overtook the front car. By the time the driver had completed the takeover, all three cars had traversed the straight section and reached a left-hand bend. The beginning of the bend coincided with the patch of new chip seal.

Approaching the bend, Mrs Baume pulled into the northbound lane to overtake the two cars in front of her. It is estimated that Mrs Baume was travelling between 79 and 104 km/h. Mrs Baume's vehicle drove on to loose chip and gravel and lost traction. It then slid across the southbound lane and veered off the road. The passenger side of Mrs Baume's car impacted a power pole which caused the car to overturn and land on its roof.

Mrs Baume died before rescue services arrived at the scene. Toxicological testing identified the presence of tetrahydrocannabinol (THC) in her blood.

### COMMENTS OF CORONER HO

*Use of illegal drugs while driving*

I. Previous coronial findings have warned of the risks of driving while under the influence of illegal drugs. I take this opportunity to remind those who consume cannabis and other illegal drugs should not drive under doing so. Those who drive under the influence of drugs create an unnecessary danger to themselves and other road users.

*"Overtaking" versus "passing" – consistency of language*

II. The Waka Kotahi website defines overtaking as when the "driver crosses the centre line and uses the opposing traffic lane to pass a slower vehicle" and passing as when "slower vehicles use passing

facilities, such as passing lanes, to let faster following vehicles pass".[16] In a separate section of its website Waka Kotahi uses passing as a generic term to encompass what it has defined as both passing and overtaking, including admonitions for "passing" drivers to be careful if entering part of the road used by oncoming vehicles (i.e. overtaking).[17] Having elected to discretely define the terms Waka Kotahi should ensure it uses them in a consistent manner. Unnecessary definitional inconsistencies such as these create confusion for the driving public.

III. Waka Kotahi acknowledges that this language could be improved. It will carry out a review to ensure a distinction is made between the intended meaning of the two terms and that they are used appropriately and consistently. Because there is no evidence in this case that the inconsistencies in Waka Kotahi's language contributed to the accident, I do not make a formal recommendation under s 57A that Waka Kotahi uses consistent definitions and terms throughout its communications with the public. I nevertheless encourage it to do so.

## RECOMMENDATIONS OF CORONER HO

I. This accident could have been avoided. I make the following recommendations pursuant to s 57A of the Act.

*Improving roadworks signage*

II. It was appropriate for a temporary 50 km/h restriction to be in place along that section of SH15 in light of the recent patch repair and consequent risk of loose chip seal. However, the way in which this was communicated to road users was not clear. It appears the temporary limit was posted with either only an orange "temporary" sign or a sign advising of roadworks, not a sign advising of loose chip seal. Yet it was the loose chip seal that was the risk at which the reduced speed limit was targeted.

III. It is important that the imposition of temporary restrictions be accompanied by signage which clearly communicates the reason why those restrictions are in place and matches the conditions physically present. There is otherwise a risk that road users will make assumptions which cause them to drive in an unsafe manner for the conditions. For example, leaving roadworks signage erected when there are no visible roadworks, particularly if such signs are left up for a prolonged period, could well lead to drivers to assume that site deactivation had been forgotten and cause them to revert to the regular speed limit – even though there might still be good reasons why temporary speed restrictions need to remain in place.

IV. The risk on the day of the accident was loose chip seal potentially causing loss of traction. The temporary speed restriction should therefore have been accompanied by signage warning of loose chip, not generic temporary signage or roadworks signage.

[16] https://www.nzta.govt.nz/roads-and-rail/road-engineering/passing-and-overtaking/frequently-asked-questions/

[17] https://www.nzta.govt.nz/roadcode/general-road-code/road-code/about-driving/key-driving-skills/passing/

V. For the same reason, I am concerned that the traffic management plan in place allowed the signs to be left in place until July 2018. I consider that Waka Kotahi has an obligation to inform road users of the reasons for temporary restrictions and the risk at which those restrictions are targeted. If those signs become out of date they should be promptly withdrawn or replaced. To do otherwise creates complacency among road users and increases the risk of driving behaviour unsuitable for the road condition.

VI. I recommend Waka Kotahi review and strengthen its processes to ensure appropriate, informative, signage is in place to advise road users of the risk at which any temporary restrictions such as lower speed limits are targeted. This will ensure that road users are better able to understand the reason for the restrictions and ensure a better match between the risk and the road users' perception of the road conditions.

VII. Pursuant to s 57B of the Coroners Act 2006 I advised Waka Kotahi of my intention to make recommendations and invited its comment. Waka Kotahi advised that it is in the process of reviewing its guidance in relation to temporary traffic management. It will incorporate my concerns into advice provided to the travelling public regarding reasons for temporary speed limits, most likely through supplementary information plates positioned below the speed limit.

VIII. I note the ongoing work being done by Waka Kotahi in this area and accordingly formalise my recommendation.

*Greater emphasis needed to educate slower drivers including by encouraging them to pull over and allow other vehicles to pass*

IX. The Waka Kotahi website includes a short section on slow drivers, subsumed within the general page on speed limits, advising those who are travelling slower than the speed limit that they must pull over as soon as it is safe to let following vehicles pass. I am not aware of any road signage to remind and educate drivers of this. Rather, Waka Kotahi road signage appears primarily targeted at speeders.

X. It is not only speeding drivers who create unnecessary risk on New Zealand roads. Drivers who travel below the speed limit also create unnecessary risk because their behaviour can incite other drivers into dangerous overtaking manoeuvres, particularly if (as here) that driver is at the front of traffic and the road layout affords few or no passing opportunities. All drivers must consider how their actions, including the speed at which they travel, affect the safety of others with whom they share the road. It is not illegal to travel below the speed limit, but excessive slowness can create a danger to other road users that would otherwise not exist.

XI. Drivers who travel below the speed limit should monitor traffic behind them and regularly pull over to let vehicles behind them pass. There is no stigma to this; on the contrary, it is the safest course of action for everybody. It allows the slow driver to travel at a speed at which they are comfortable and without inciting aggressive behaviour from drivers behind, thus reducing the risk of the slow driver becoming intimidated and driving in a manner beyond their competence; and allows drivers behind who wish to travel at the speed limit the opportunity to do so, thus reducing the risk of those drivers engaging in dangerous manoeuvres to get in front of the slow driver.

XII. I recommend that Waka Kotahi review its messaging around the risks posed by slow drivers to other road users. That review should include consideration of whether to erect road signage at appropriate locations reminding drivers who have a queue of vehicles behind them to pull over and allow those vehicles to pass. This is particularly relevant on roads such as SH15 where overtaking opportunities are limited. If the slow driver in this case had pulled over at the first opportunity, I consider it unlikely that Mrs Baume would have attempted to overtake in the manner she did.

XIII. Waka Kotahi responded to my proposed recommendation. It advises that it will review the information provided on its website and the New Zealand Road Code relating to slow drivers and their responsibilities to other road users. I note Waka Kotahi's action in this area and accordingly formalise my recommendation.

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

## Brick [2021] NZCorC 170 (6 October 2021)

### CIRCUMSTANCES

Glynn Fitzgerald Christopher Brick, aged 49, died at Maungatautari Road, near Karapiro, on 15 March 2020 from severe head injury sustained in a motor vehicle collision.

At about 9:00pm on 15 March 2020, Glynn was driving his Ford Focus east on Maungatautari Road, near Karapiro, Waikato. While negotiating a bend, he lost control of the Ford and struck an Armco roadside barrier before colliding with a signpost. Glynn died at the scene from injuries he sustained in the collision.

The Coroner concluded that the combination of alcohol consumption and entering the corner at too high a speed, was a significant contributor to the collision. There was no evidence that Glynn had applied his brakes, which indicated that he may have lost concentration or otherwise fallen asleep immediately prior to the collision. The extent of Glynn's injuries was due to the fact he was not wearing a seatbelt.

### COMMENTS OF CORONER ROBB

I. Considerable effort is made in New Zealand to promote the message that driving while intoxicated can result in serious injury as well as fatalities. The dangers associated with driving while intoxicated extend to endangering other road users. The messages about driving while intoxicated are coupled with regular campaigns to enforce the requirement to wear a seatbelt. Failure to wear a seatbelt increases the likelihood and extent of serious injury and can be the difference between surviving a collision or death. Our laws require the wearing of a seatbelt and forbid driving with excess blood alcohol for those safety reasons. This was another tragically avoidable death caused by driving while intoxicated and failing to wear a seatbelt.

II. Police, Coroners, and Waka Kotahi New Zealand Transport Agency have consistently highlighted these dangers. I have again highlighted these dangers and make no additional comment nor recommendations.

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

# Bedford [2021] NZCorC 183 (29 October 2021)

### CIRCUMSTANCES

Kenneth Edward Bedford, aged 81, died on 26 January 2020 on State Highway 29 (SH29) approximately 900 metres south of Taotaoroa Road of hypovolemic shock due to multiple fractures in the context of a motor vehicle accident.

On the afternoon of 26 January 2020, Mr Bedford was driving from Hamilton to his home in New Plymouth after attending a family wedding. While driving on SH29 Mr Bedford's vehicle suddenly veered across the centreline of the road on an easy left bend and collided with an oncoming vehicle.

The Waikato Serious Crash Unit (SCU) conducted an investigation of the collision and opined that fatigue was the likely causative factor in the crash.

### COMMENTS AND RECOMMENDATIONS OF CORONER BATES

I. I make the following comments and recommendations pursuant to sections 57(3) and 57A of the Coroners Act 2006. If drawn to public attention, these may reduce the chances of further deaths in similar circumstances:

*Initial Comments*

II. Crash Analyst, Constable Chris Johnston of Waikato SCU, made the following recommendations:

a. Continued education and enforcement in respect to driver behaviour on rural Highways.

b. Continued education and enforcement in respect of fatigue.

c. Addition of a centre wire barrier where the crash occurred.

d. Raised tactile profiling (rumble strips) added to the centreline and edge lines.

III. Waka Kotahi NZ Transport Agency ("Waka Kotahi") recently released their National Land Transport Programme for 2021-2024.[18] Waka Kotahi have developed a new activity class titled 'Road to Zero'. Examination of the nationwide Road to Zero class and the Waikato Regional Summary in the 2021-2024 programme confirms significant investment and improvements are intended and/or underway. Some extracts from Waka Kotahi's programme are as follows:

> Road to Zero is a new activity class in the 2021–24 National Land Transport Programme (NLTP). It is dedicated to investment in safe system responses to risk on our roads.

[18] 2021–24 National Land Transport Programme | Waka Kotahi NZ Transport Agency (nzta.govt.nz).

Over the next three years, $2.9 billion will be invested in Road to Zero activities throughout New Zealand. A priority in this period is to continue an infrastructure and speed improvements programme that will reduce deaths and serious injuries. These are on state highways and local roads that carry the highest risk to road users and the most traffic.

In 2021–24, we intend to install approximately 183kms of median barriers, 75 roundabouts and make speed changes on 16,500kms of local roads and state highways to prevent an estimated 213 deaths and serious injuries.

On state highways, we have work planned on 17 high risk corridors throughout New Zealand. This includes 51 intersection improvements, 25 new roundabouts, and 164kms of median barriers.

On local roads, working with local government, we plan to invest in more than 1074 projects. This includes 50 roundabouts, 19km of median barriers, and speed changes on 13,500kms.

In 2021–24 we'll be investing $1.24 billion in the Road Safety Partnership Programme to provide road policing activities approved by the minister which will maintain 1,070 dedicated road policing staff and about 20% of non-dedicated police staff time undertaking these activities. These activities are focused on restraints, impairment, distraction and speed (RIDS) and include almost doubling enforcement of speed and drunk driving.

We'll be investing about $197 million in national, regional and local road safety promotion and education campaigns supporting Road to Zero programmes. This includes a campaign to raise public awareness of Road to Zero.

Road safety remains a significant issue in the Waikato, with more than 20% of New Zealand's annual deaths and serious injuries occurring in the region. During the 2021–24 NLTP, we'll be focusing on speed management and infrastructure improvements to make journeys safer across the region.

Throughout Waikato during the next three years, we will invest to improve safety across 15 high-risk corridors to significantly reduce annual deaths and serious injuries in the region.

Work continues to improve safety along the existing length of SH1 between Cambridge and Piarere. We're installing flexible median barriers to reduce the number of crashes along this section of highway. More than 2.4kms of median barriers have already been installed and work continues finalising designs to extend this work to Maungatautari Road. This NLTP we'll invest $35 million to address safety along 26.3kms of the corridor.

On 12km of the East Tāupo Arterial, $13 million is being spent widening the roadside shoulders, and installing flexible median safety barriers and safety barriers where hazards cannot be removed.

Speed management reviews are already underway for Hamilton City (SH1, SH3 and SH26), West Waikato (SH23, SH31 and SH39) and Mangatarata to Katikati (SH2–SH25), with a number of additional routes planned for review during this NLTP period.

More than $2 million is being spent improving safety at six high-risk areas in central and eastern Waikato, with rumble strips, better roadside signage and long-life line markings. These areas are: SH5 Waiohotu Road to Oturoa Road; SH5 Webster Road to Waiohotu Road; SH25 Waitakaruru to Kōpū; SH27; SH 26 Tatuanui to Waharoa; SH2 Mackaytown to Waikino; and SH29 Matamata–Piako boundary to SH28.

*Recommendations*

IV. I recommend that Waka Kotahi consider the recommendations made by Crash Analysist Constable Chris Johnston of Waikato SCU.

V. I recommend that Waka Kotahi consider incorporating into their programme the section of road where Mr Bedford lost his life.

*Response from Waka Kotahi*

VI. I provided a provisional copy of my findings to Waka Kotahi and invited a response. Waka Kotahi's responded as follows:

- The Road to Zero strategy sets Waka Kotahi's 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 and driver behaviour is available at www.nzta.govt.nz/safety/.
- As part of the strategy, Waka Kotahi has implemented the Speed and Infrastructure Programme (SIP) to improve road infrastructure and set safe speed limits across the land transport network. Within SIP, feasibility design for improvements from SH29, Piarere to SH28 has been approved for funding, which will include the location where the crash occurred. While design is ongoing, a centre wire rope barrier is included as one of the possible options under investigation. If a median barrier is not installed at this location, it will be replaced by a wide centreline and supplemented with audio tactile profiled (ATP) markings (rumble strips). If a median barrier is installed, ATP markings will also be installed on the median shoulder marking.

VII. Waka Kotahi's programme of initiatives is significant, welcome and encouraging. I am pleased to see they incorporate the section of roading where Mr Bedford lost his life.

VIII. Unfortunately, according to the New Zealand Government Annual Monitoring Report released in July 2021, it appears that implementing some aspects of the Road to Zero programme has been delayed

and intended targets have not been met. This report covers the 2020 period.[19] Whatever the reason for delay, my sincere hope is that implementation of Waka Kotahi's significant and much needed initiatives gains traction and moves with increasing momentum towards completion. That would no doubt have the effect of saving a greater number of lives on our roads.

*Additional comments – driving while fatigued*

IX. Mr Bedford's death serves as a reminder of the dangers of driving while fatigued.

X. Waka Kotahi provides information about safe driving in New Zealand. Its 'Driving in New Zealand' guide, which is available in multiple languages, states:

**Fatigue**

- If you're tired you're much more likely to have a crash.
- Get enough quality sleep before you drive, especially if you've just arrived in New Zealand after a long flight.
- Take a break from driving every two hours. If possible, share the driving with someone else.
- Avoid driving during the hours when you would normally be sleeping.
- Avoid large meals, which can make you tired, and drink plenty of water.
- If you begin to feel sleepy, stop at a safe place and try to have a short nap for 15-30 minutes. If you're feeling very tired, find a place to stay overnight.

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

# Butler [2021] NZCorC 182 (28 October 2021)

### CIRCUMSTANCES

James Robert Butler, aged 84, died on 30 December 2018 at Auckland Hospital from complications of blunt force trauma sustained in a motor vehicle accident.

On 30 December 2018 Mr Butler was driving east along Tamaki Drive, a four-lane road, with two lanes for each direction of travel. There was a cyclist in the left eastbound lane, which required cars to move into the right lane to pass. Traffic flow was moderate to heavy and there was some bottleneck as cars in the left lane moved out to pass.

[19] https://www.transport.govt.nz/assets/Uploads/MOT-3833-Road-to-Zero_Annual-Monitoring-Report-2020_FA4_WEB.pdf

When Mr Butler attempted to overtake the cyclist, it appears that no one in the right lane would leave a gap for him. Mr Butler then swerved to the left to avoid hitting the cars in the right lane. He travelled in a straight line in front of the cyclist, before failing to negotiate a gentle bend and colliding with a tree.

Mr Butler and his wife, who was a passenger, were transported to hospital. Mr Butler rapidly deteriorated and died that day. His wife survived.

### COMMENTS OF CORONER HO

I. The evidence was that Mr Butler had to make a sharp manoeuvre back into the left lane because right lane traffic would not let him merge. Mr Butler's death is a reminder to drivers to ensure that they have appropriate room to pass, which includes assessing traffic flow in the lane into which they are moving; and that it is courteous to allow sufficient space to other drivers attempting to overtake so as to minimise the need for any abrupt manoeuvres.

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

## Cooper [2021] NZCorC 200 (2 December 2021)

### CIRCUMSTANCES

Jason Steve Cooper, aged 36, died on 4 June 2019 on a section of State Highway 3 at Mimi, North Taranaki as a result of injuries sustained in a motor vehicle collision (driver).

Mr Cooper worked as a heavy truck driver. In the week before 3 June 2019 he had been suffering from influenza. In the evening of 3 June 2019 he visited a friend for dinner in Edgecumbe, departing their address at 10:20pm. He told his friend that he was tired but would have a sleep in his car when he got to Hamilton before beginning his shift at 1:00am on 4 June 2019. The journey from Edgecumbe to Hamilton is a distance of 181 km and would have afforded Mr Cooper very little time to sleep before starting work.

Mr Cooper started his shift at 1:00am driving his truck and a back trailer filled with building materials. At approximately 3:45am, Mr Cooper was travelling southbound along Mokau Rd, State Highway 3, at Mimi when he failed to negotiate a slight right-hand bend and collided with an embankment on the left-hand side of the road. The force of the impact ejected Mr Cooper through the truck's windscreen and he died at the scene.

### COMMENTS OF CORONER BORROWDALE

I. Tragically, the factors that led to the collision that killed Mr Cooper were avoidable.

II. There is good evidence to suggest that Mr Cooper was starting work as a heavy truck driver in a state of sleep deprivation. He said that he was tired and needed sleep, but he had not allowed himself sufficient time to sleep before starting work. Waka Kotahi, the New Zealand Transport Agency, has publicised the risks of driver fatigue. The agency's publicly available resources include advice to shift

workers, like Mr Cooper, on how to avoid fatigue while working shifts. They also include advice targeted to employers and employees. I commend these resources to the driving public.[20]

III. Aside from his sleepiness, Mr Cooper was also driving while unwell with the flu. His post mortem examination disclosed that he had developed pneumonia secondary to the flu. There is no evidence that Mr Cooper knew the extent of his illness, but drivers should be aware that illness can make you a risk when behind the wheel. Those who drive professionally may feel inhibited from calling in sick, and may not wish to inconvenience their employer or customers. However, driving is a cognitively complex task. Drivers who are unwell pose a risk to themselves and to others.

IV. Additionally, it was confirmed by toxicology testing that methamphetamine had been used by Mr Cooper. The dangers of driving while under the influence of drugs has been widely publicised. At the end of 2019 the Government announced an intended law change that would see roadside drug testing rolled out in New Zealand. The proposed law change will give Police enhanced powers to conduct drug tests and run roadside testing stations. This law can be expected to have a significant, and welcome, deterrent effect.

V. Finally, Mr Cooper was not wearing a seatbelt while driving, and was ejected on impact from his truck cab, through the windscreen. Once again, the dangers of operating a motor vehicle while unrestrained by a seatbelt are well known. The protection provided by seatbelt use has formed the basis of road safety campaigns down the years. It is not only an offence – punishable by a fine - to fail to wear a seatbelt, it exposes the driver or passenger to significantly enhanced risk of serious injury or death. The impact force on a seatbelt can be as much as 20 times the occupant's weight; this is how hard the person would hit their vehicle without the restraint of a seatbelt.[21] Advice on the Waka Kotahi website states that wearing a seatbelt reduces the chances of being killed or seriously injured in a road crash by 40%.[22] Seatbelts should always be worn when in a moving vehicle.

VI. Given these general comments to the driving public, I do not consider that there are any recommendations that can usefully be made pursuant to section 57(3) of the Coroners Act 2006.

Note: An order under section 74 of the Coroners Act 2006 prohibits making public photographs of Mr Cooper entered into evidence during this inquiry, on the grounds of personal privacy and decency.

[20] Waka Kotahi "Driver fatigue" information is available at https://www.nzta.govt.nz/safety/what-waka-kotahi-is-doing/education-initiatives/fatigue/

[21] Waka Kotahi website: https://www.nzta.govt.nz/safety/driving-safely/seatbelts/

[22] https://nzta.govt.nz/safety/vehicle-safety/safety-belts-and-restraints

# De Bruin [2021] NZCorC 205 (8 December 2021)

## CIRCUMSTANCES

Albert Van Reenen De Bruin, aged 22, died on 20 March 2018 on Selwyn Road between Robinsons Road and Cross Road, Selwyn of multiple injuries due to riding his motorcycle into the back of a truck. He had used MDMA, cannabis and alcohol prior to his death. His death was accidental.

On 19 March 2018, Reenen attended a Limp Bizkit concert. At 11:00pm when the concert finished, Reenen and others, walked to a house in Wainui Street to continue partying. At 1:30am Reenen's friends convinced him to stay, which he agreed to. However, at about 2:30am on 20 March 2018, his friends heard Reenen's motorcycle start up. They saw the taillights of the motorcycle going down Peverel Street.

At approximately 3:29am Reenen was riding his motorcycle south west on Selwyn Road when he crashed into the back of a large truck in front of him that was slowly turning right into a driveway. Reenen died at the scene.

## COMMENTS OF CORONER JOHNSON

I. Coroners, Police, and Waka Kotahi NZ Transport Agency have consistently highlighted the dangers of driving when having consumed alcohol and drugs. The clear dangers of using alcohol and driving are well known and well publicised, but I note that this case Reenen was driving having used three recreational drugs; alcohol, cannabis and MDMA.

II. The New Zealand Drug Foundation reports that after cannabis, MDMA is the second most used illegal drug in New Zealand. On its website it provides the following advice

> **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).

III. Given the prevalence of the use of MDMA, it is appropriate to raise public awareness of the effects of the use of both these drugs and in particular educate drivers about the effects of these drugs and what was referred to by Senior Constable Isitt:

> **MDMA**
>
> When compared to a sober state, MDMA has a moderate effect on vehicle control, acceptance of higher levels of risk, acute changes in cognitive performance and impaired information processing ability.

> THC from cannabis has been shown to impair performance on driving simulator tasks and on open and closed driving courses for up to approximately three hours. Decreased car handling performance, increased reaction times, impaired time and distance estimation, inability to maintain headway, lateral travel, subjective sleepiness, motor incoordination and impaired sustained vigilance have all been reported.

IV. I also repeat what ESR advised in relation to the use of cannabis on driving:

> The dangers of driving after using cannabis are due to taking longer to respond to events, reduced ability to think clearly, and reduced ability to pay attention. The effects of cannabis may include distorted perception, difficulty in thinking and problem solving and loss of coordination.
>
> The combined use of cannabis and alcohol tends to accentuate the effects of alcohol

V. I recommend that these findings are brought to the attention of media agencies in the hope of raising further awareness of the dangers of driving when using MDMA and cannabis and alcohol. It is my hope that this will go some way towards preventing further harm to the public.

VI. 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 the deceased taken after their death in the interests of decency and personal privacy.

# Dykstra [2021] NZCorC 203 (7 December 2021)

### CIRCUMSTANCES

Frederick Dykstra, aged 54, died on 1 July 2020 at 513 Ohauiti Road, Tauranga from positional asphyxiation, sustained in a ride-on mower incident.

During the afternoon of 1 July 2020, Frederick was using his John Deere ride-on mower to mow lawns at his property. When Frederick had not returned by the evening, his wife went looking for him. She found him at the bottom of a steep slope on their property, pinned underneath the mower. Despite resuscitation efforts, Frederick was unable to be revived.

Attending police reported that there was evidence that Frederick was travelling up a zig zag track on a steep bank on his property. It was muddy and slippery at the time and at some point, the mower started to slide towards a drop-off. Frederick then turned the steering wheel to counter the slide, causing the mower to tip sideways and roll at least once before coming to rest on Frederick's back.

### COMMENTS OF CORONER ROBB

I. Similar to the operating of a quad bike on difficult terrain, there are dangers inherent in operating a heavy ride-on lawnmower when traversing steep and potentially slippery terrain. These dangers can on occasion be sadly underestimated. I reiterate those warnings. This machinery is heavy, a recognised

risk of operating a ride on mower on a slope or uneven terrain is the risk of roll-over. If roll-over occurs the user can become trapped beneath the ride-on-mower with the mower too heavy to dislodge. Tragically Frederick's death highlights the fatal consequences by way of asphyxiation that can occur as a result.

II. Safety warnings form part of the operator's manual on John Deere ride-on-mowers. The manual provides advice and warnings in respect of avoiding tipping the mower over when mowing on a slope, highlighting this as a "major factor related to loss-of-control and tip-over accidents, which can result in severe injury or death. Operation on all slopes requires extra caution." The safety advice in the manual also provides a warning to use the Mechanical Front Wheel Drive ("MFWD") when driving on slopes to increase traction and provide four-wheel braking. A sticker is also attached to the equipment providing advice on operating the mower on slopes.

III. Similar advice and warnings are provided with the sale of other brands of ride-on-mowers.

IV. Pursuant to s57(3) of the Coroners Act I repeat those warnings in the hope that bringing these dangers to the public attention will reduce the risk of death occurring in similar circumstances in the future.

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

## Francis [2021] NZCorC 171 (8 October 2021)

### CIRCUMSTANCES

Hannah Teresa Francis, aged 11, died on 28 July 2018 while being airlifted from Ohakune to Waikato Hospital following her involvement in a bus crash on Ohakune Mountain Road. Hannah's death was due to non-survivable injuries to her head and chest sustained in the bus crash.

On the morning of 28 July 2018, Hannah headed to Tūroa ski field with her father, stepbrother and a family friend. As the group did not have chains for their vehicle, they took a commercial shuttle bus to the ski field. At around 2:00pm that day, they boarded a return shuttle bus (the Bus) owned and operated by Ruapehu Alpine Lifts Ltd (RAL) and driven by RAL employee, Sung-Pil (Terry) Choi. Hannah was seated in the back row next to the left-side window, with her father beside her. The Bus did not have passenger seatbelts.

While descending Ohakune Mountain Road, approximately 7 kilometres down from the ski field carpark and 9 kilometres up from Ohakune township, the Bus failed to negotiate a bend, causing it to crash and tip onto its left side. Despite her father's efforts to restrain her, Hannah was partially ejected through the left-side window and suffered severe traumatic injuries. She was airlifted from the scene but died en route to hospital.

The cause of the crash was a loss of braking effort and control resulting from Mr Choi's driving technique. 2.5 kilometres down from the top of Ohakune Mountain Road are two very sharp and steep corners, roughly in the shape of a letter S, commonly referred to as the "hairpin". It is most likely that Mr Choi entered the hairpin in third gear. Evidence provided at inquest suggested that he should have been in a gear no higher than second in the leadup to the hairpin and, by the time Mr Choi sought to change down to second mid-hairpin, he was going too fast to do so. As a result, he was heavily reliant

on the service brakes to control his speed during the hairpin. The brakes overheated resulting in “brake fade” and a loss of braking effort, loss of control and ultimately the crash. Mr Choi gave evidence that he frequently approached the hairpin in third gear.

The Bus had an air-over-hydraulic service brake system which, while common in vehicles of its kind, was described as old technology by today’s standards. Evidence provided at inquest suggested that this particular braking system is broadly understood to be at risk of failure from overheating unless the vehicle’s braking resources are managed carefully. Evidence also provided that once brake fade sets in, there is little, if anything, the driver can do to recover braking function. The Bus did not have an independent emergency braking system and Ohakune Mountain Road did not have sand traps or other means of halting a vehicle in the event of brake failure.

The Bus also had a “flicker chain switch system”. If engaged, this unlabelled switch located next to the driver would cause the air which powered the braking circuits to vent into the atmosphere. The circuit connected to the switch would immediately become inoperative, and the other circuit would work for as long as it took the air in the relevant reservoir to become depleted. While the presence of this switch was noted to be extremely hazardous, it did not contribute to the crash.

At the time of the accident the Bus had a current licence and the Certificate of Fitness (CoF). While the Bus was not found to be fundamentally inappropriate for use as a passenger vehicle in the Ohakune Mountain Road alpine environment, the evidence did disclose that in doing so it was operating closer to the margins of its design envelope. In such circumstances, the need for robust vehicle maintenance and careful driver management of the service brake resource becomes critically important.

Mr Choi had worked as a bus driver for 16 years and was appropriately licensed to drive the Bus, including holding a Class 2 (medium rigid vehicles) licence. At inquest he reported that the driving course he completed as a requirement for obtaining his Class 2 licence did not teach him about different types of brakes on buses and did not cover air-over-hydraulic braking. Instead, he learnt about this type of braking “on the job”, having driven many types of buses, most with air-over-hydraulic braking systems, over the course of his career. RAL also ran initial driver training sessions, as well as refresher trainings for returning drivers (such as Mr Choi).

On or about 30 November 2018, RAL surrendered its Passenger Service Licence. In 2019 RAL partnered with a specialist contractor, Sand Safaris 2014 Ltd (Sand Safaris) to manage all aspects of passenger transport operations for both ski fields.

In early 2020, the Bus and Coach Association NZ (BCA) issued the Alpine Code of Practice (the Alpine Code), a voluntary industry code developed following three bus crashes in 2018. The Alpine Code outlines standards considered desirable by BCA, with the aim of collectively raising the safety bar for passenger transit in alpine environments.

In 2021 the National Ski Operation was renamed “Operation Hannah”. Operation Hannah took place between 27 July to 1 August 2021 and involved Police staff, dedicated road policing units, and rural areas, in partnership with Waka Kotahi. The stated focus of the operation is on ensuring that passenger service vehicle drivers operating in and around New Zealand’s ski fields are not driving fatigued, are within their worktime hours, that the vehicles being operated are roadworthy and that all passenger movements are being conducted in a safe manner.

## COMMENTS AND RECOMMENDATIONS OF CORONER WINDLEY

I. My approach to whether there are any comments or recommendations that I can make which may, if drawn to public attention, reduce the chances of future deaths in similar circumstances, has been framed by a simple fact: many of us could have been the Francis family on 28 July 2018, making what we assume to be a sensible and prudent decision to use RAL's commercial passenger transport between the Tūroa ski field and Ohakune. Doing so with the belief and blind trust that RAL, the driver it employs, and the bus on which we travel, can be relied upon to deliver us up or down the mountain safely.

II. Having found the operation of the Bus on Ohakune Mountain Road to be within, but at the margins, of its design envelope, with a braking system that while ubiquitous was on each and every downhill trip critically (and unforgivingly) reliant on the driver's careful management of the braking resource, can the public have confidence that these same circumstances will not arise again in the future and claim another life? More specifically, does the current regulatory regime, the overlay of health and safety duties, and a voluntary (and unaudited) industry Alpine Code adequately mitigate the risks that materialised on 28 July 2018 and cost Hannah her life? Those risks ought to have been understood and recognised, and not regarded as a series of unexpected failures.

III. The evidence before my inquiry is that passenger transport service regulations and legal standards related to vehicle entry requirements, in-service testing, and driver training and licensing are deliberately calibrated to set minimum requirements that have broad application without reference to the environment the driver ultimately operates in, or the particular characteristics of the brake system.[23] To the extent the environment or the bus the driver operates gives rise to specific safety risks, these are left to employers and employees to identify and manage, both being subject to statutory health and safety duties and obligations. Oftentimes, any deficiencies only come to be recognised in hindsight following an incident, or worse still, a fatality.

IV. Police report that heavy vehicle crashes are more likely to be fatal, accounting for over 20% of road deaths. Waka Kotahi makes clear that any need for further regulation of passenger service vehicles, transport operators, or drivers relies on research, data, and cost-benefit analyses. Yet my inquiry has not identified auditing or compliance mechanisms that provides any real insight into the extent to which the Alpine Code standards are currently being met by operators on a voluntary basis. The extent to which the industry is effectively self-managing the significant risks presented by alpine passenger service operations is simply not known. Certainly, some operators have expressed concern that compliance would put them at a commercial disadvantage. While Police crash investigations and initiatives like "Operation Hannah" suggest a good degree of compliance with current legal requirements, the Alpine Code standards deliberately set a higher bar that the industry recognises is both appropriate and necessary for optimising safety in that environment.

V. In its response to my provisional Findings the Ministry of Transport confirmed the Government has made road safety one of the highest priorities for transport investment, and has committed to giving effect to *"Road to Zero: New Zealand's road safety strategy for 2020-2030*." *Road to Zero* sets a target

[23] Other than buses utilised as school buses.

to reduce deaths and serious injuries on New Zealand's roads, cycleways and footpaths by 40 percent between 2020 and 2030. In its response, the Ministry of Transport reiterates that "*buses are the safest mode of transport in New Zealand*", and suggests this is in part due to the impact forces from a crash being absorbed by the larger mass of a bus, which in turn "*reduces the effect of a crash on the passengers, making it less severe and less likely to cause injury than would be the case in smaller, lighter vehicles*." The medical evidence of Hannah's traumatic injuries, and the expert evidence of Professor Raine with respect to the extreme forces that Hannah's body was subjected in the crash, is the cold reality of a bus crash involving unrestrained passengers. That Hannah was, at least statistically, safer travelling as an unrestrained passenger on the Bus than if she had been a car passenger, pedestrian, or cyclist is of little comfort to anyone, especially her family. No greater reason than Hannah's death in these circumstances should be needed for the Minister and Ministry of Transport to seriously and genuinely explore opportunities for tangible safety improvements through legislative reform.

VI. I am of the view that, for the most part, the industry already has a clear understanding of what modifications to the pillars of the system are required to mitigate the factors that caused this crash, and the risk of another loss of life in similar circumstances. The issue is whether there is the appetite and willingness of the industry to voluntarily make the changes and the investments that are necessary and, by doing so, collectively raise the safety bar for passenger transport operations in alpine environments. The Alpine Code is a highly considered and commendable step by the industry towards defining and documenting best practices and standards for optimal safe passenger transport operations in the New Zealand alpine environment. However, the Alpine Code's potential to truly deliver on improved passenger safety is seriously undermined by its current voluntary status and lack of any compliance auditing.

VII. The BCA itself has neither the mandate or resourcing to audit all passenger service operators in alpine environments for compliance with the Alpine Code.[24] Against that, there is a very real risk that consumers erroneously assume that an operator who is a participant in the Alpine Code meets all its standards. While I expect the vast majority of participating operators, of which there are a number, have the goodwill and good intentions Dr Borren [Chief Executive of the BCA] described, currently sentiment alone does not translate to practical implementation and adherence to all, or in fact any, of the Alpine Code standards by a participating operator. In reality the extent of current compliance is simply not known. The BCA commentary in the development phase suggested that industry practice had some way to go to meet the standards proposed under the Alpine Code. The BCA observed: "*the status quo methods of operating may need to change for many*", many operators were "*just running buses up and down mountains as opposed to taking a holistic view of their operations*", the BCA being "*fairly sure*" the "*less-risk-focussed*" operators were not adopting a risk-based approach to their operations.[25]

[24] Refer https://www.busandcoach.co.nz/communication/bca-alpine-code-of-practice and Mr Borren's Brief of Evidence, Bundle, at 1343-44.

[25] Bundle, at 946.

VIII. It would be naïve to ignore or dismiss cost as a barrier for some operators, particularly the smaller ones and in the COVID-19 economic environment, in making the kinds of changes and investment which will yield the greatest safety gains, such as retro-fitting seatbelts and selecting vehicles with better braking capability relative to loaded mass. It is clear that while the Bus was capable of getting people up and down the mountain safely, there are much better choices of vehicle to operate in this environment, such as the 4WD smaller passenger vehicles that Sand Safaris now use for Tūroa passenger transport.[26]

IX. To the extent an operator chooses not to operate to Alpine Code standards, as it currently stands, the only recourse is for the consumer to make an alternative purchasing decision. Mandating the standards set out in the Alpine Code would be an obvious means of levelling the playing field for commercial operators and ensuring compliance is not sacrificed in the name of commercial disadvantage. Cost should not be the single determinative factor and reason enough to avoid implementing practical means by which to reduce preventable deaths like Hannah's. Even less palatable would be doing nothing because of the apparent inflexibility of the current generic regulatory regime to accommodate safety regulation in a more refined and targeted way.

X. If the industry seeks to avoid the possibility of further government regulation, then it must demonstrate its commitment to giving the Alpine Code standards operational and practical effect rather than mere lip-service. If the industry and the Government is truly serious about passenger safety, and the Road to Zero, in my view that commitment must start, at the very least, with mandating seatbelts in commercial passenger transport vehicles that operate in alpine environments.

XI. I am conscious also of the fact that every day each of us puts our safety on the road in the hands of other road users. The privilege to drive comes with significant responsibilities that each of us relies on every other road user to uphold in order to maintain our collective safety. We must demonstrate our skill, knowledge and experience to drive a class of motor vehicle, and we are obligated on every journey to drive in a reasonable and prudent manner. As has been ultimately shown in this inquiry, passenger transport safety in alpine environments relies significantly on the competence and skill of the driver on each and every journey. The environment is unforgiving of complacency or bad driving habits. In vehicles like the Bus, the driver's ability to carefully manage the braking resource on a long downhill road with steep descents is, as this case tragically demonstrates, a matter of life and death.

XII. By Mr Choi's own admission, he considered himself competent to drive the Bus, and he said he was well familiar with air-over-hydraulic braking systems in passenger service vehicles and the need to manage his braking resource when descending a hill. He learned this on-the-job and not through any formal training, as was the common experience of those witnesses at inquest who are familiar with operating heavy vehicles. Even so, I was not convinced he appreciated just how narrow the margin for brake and gear selection mismanagement was, and the resulting knife edge between an uneventful

[26] Professor Raine stated in evidence that if he was asked to recommend a vehicle he would look for a vehicle that had very substantial braking capability in relation to it's loaded mass, and preferably had disc brakes, NoE, at 918.

journey and a catastrophic one down Ohakune Mountain Road in the Bus. He was also poorly equipped to respond in the event of brake loss.

XIII. Mr Choi was appropriately licenced to drive the Bus (or any other Class 2 or Class 4 vehicle) on any public road in New Zealand, from the quiet streets of Ohakune to the steep, alpine terrain of Ohakune Mountain Road. He was reliant on RAL's 'top-up' training to ensure he understood and was competent in the ongoing management of the driving risks associated with the Bus and Ohakune Mountain Road. For reasons I need not make a finding on, RAL's driver training failed to detect his self-reported usual driving practice that plainly gave rise to a foreseeable risk of brake fade.

XIV. This inquiry has shown that driver training must make clear the risks specific to the vehicle and the emergency response actions, recognising that drivers may make mistakes and that things can go wrong, albeit in this case brake loss was considered irrecoverable. Moreover, training must be ongoing and robust, not just a tick-box formality, or even worse, a sham, so as to protect against the risk of complacency by either the driver or the operator who employs them. I agree with RAL's submission that this type of training should not be left (at least only) to operators.

XV. My finding that the flicker chain switch played no role in the crash means I am precluded from making any comments or recommendations related to that highly concerning issue, by virtue of s 57A. For the same reason, I cannot formally comment on advice from VTNZ that it was not made aware of the flicker chain switch issue, which was a key focus of both the Police investigation, and my inquiry, until receiving notification of the inquest. As was recognised at the inquest hearing, the opportunity to raise industry awareness of the issue in a timely and targeted way through issuing an industry alert was lost by a lack of communication between agencies who share in ensuring vehicle safety compliance in New Zealand.

XVI. In any event I note, for completeness, the advice of VTNZ, that since becoming aware of the flicker chain switch issue, efforts have been made to review and ensure CoF training materials for new vehicle inspectors adequately address air braking systems and auxiliary devices, and that the need to check the little things that are out of the ordinary is promoted with inspectors.[27] In response to my provisional Findings, VTNZ advised that it intends to continue its efforts and training to focus on this type of issue in its operation for the future.

XVII. Following the inquest Police also reported that in partnership with Waka Kotahi, twelve Commercial Vehicle Safety Centres are being rolled out in strategic locations across New Zealand. Each centre will be equipped with RBM and the latest data and information collection technology to enable Police and Waka Kotahi to target effectively to risk and ensure brake compliance to CoF standard.

XVIII. Finally, and especially in the absence of increased regulation, where consumers have a choice of passenger transport service operators in alpine areas, they should endeavour to make an informed one. The BCA suggests*: If you are considering hiring or using passenger transport services in an alpine area, we suggest you look at the Code to compare the services you are offered with what we*

[27] NoE, at 501-504

*see as being 'optimal' for safe travel*.[28] That is easier said than done. As noted earlier, there is no current auditing or mechanism by which consumers can readily discern the extent to which a participating operator is compliant with the Alpine Code. And it should, but sadly doesn't, go without saying that if a bus is fitted with seatbelts passengers must use them.

XIX. On the basis of the preceding reasoning, I make the following recommendations:

> ***Recommendation 1: Legislating fitment of seatbelts in passenger service vehicles in alpine areas***
>
> *That the Minister and Ministry of Transport look to legislate a requirement that all passenger service vehicles operating in alpine environments, except those vehicles designed to carry standing passengers and travel no faster than 30 km/h, have passenger seatbelts fitted, and that all passengers are seated and wearing seatbelts during a journey.*

XX. In response to my proposal to make this recommendation the Ministry of Transport, as referred to earlier, took as its starting point the reported fact that statistically buses are the safest mode of road transport in New Zealand. This asserted risk profile must of course be understood as reflecting an overall statistical analysis. It appears to not distinguish between bus journeys in urban (most often travelled at lower speed) and those in non-urban (such as alpine) environments. Indeed, the Ministry's response recognised that operating buses in alpine areas, particularly in winter, presents additional and potentially unique risks. The Ministry's response goes on to explain its position in relation to this recommendation as follows:

> To mitigate these risks, operators and drivers should implement additional measures beyond those required on other parts of the road network and during other seasons.
>
> Te Manatu Waka's position is that transport regulation is not the most appropriate framework to specify the full suite of additional measures that might be required to address these risks. This is because transport regulation prescribes common minimum standards across all vehicles in a certain class and minimum standards across all operators for broad categories of transport service. In addition, transport regulation does not differentiate between the time of year or weather conditions – for example whether snow is present.
>
> We consider a risk management approach is a more appropriate way of dealing with these issues and would align better with health and safety regulation.

XXI. The Ministry's response identifies that it would be difficult to use transport regulations to mandate that seatbelts be fitted on buses operating in alpine environments without impacting on other types of bus operations, such as public transport services in urban areas. To introduce different vehicle standards between buses when they are used in different environments would, in the Ministry's view, "*create significant complexity in the system*". The Ministry notes that where seatbelts are mandated in vehicles, vehicle inspectors must check they are fitted and meet specified safety requirements before issuing a CoF or Warrant of Fitness. Vehicle inspection requirements are currently based on vehicle class and not on the purpose of a vehicle. The purpose of the vehicle is not recorded anywhere and

[28] Refer https://www.busandcoach.co.nz/communication/bca-alpine-code-of-practice

may change over time or even on a day-to-day basis, meaning a Vehicle Inspector would have no way of knowing if a particular bus under inspection was required to have seatbelts or not. The Ministry considers that because current transport regulation does not distinguish between the different purposes a bus may be used for, a requirement for buses operating in alpine environments to have seatbelts would necessarily extend to public transport buses in urban environments. This would mean that urban public transport services would be precluded from carrying standing passengers as the PSV Rule currently prohibits passengers from standing in any vehicle in which every seat must by law be fitted with a seatbelt. The Ministry identifies that this would adversely impact urban public transport bus capacity (in particular at peak times) when standing poses "*a low safety risk to passengers*".

XXII. As I refer to above, s 57A permits a coroner to make comments or recommendations only in relation to factors found to be causative of the death under inquiry. Recommendations must also be capable of reducing the chances of future deaths in similar circumstances. My inquiry has therefore been properly focused on the specific circumstances and causative factors that resulted in Hannah's death. The fact Hannah was an unrestrained passenger in the Bus travelling downhill in an alpine environment are material causative factors. The evidence before my inquiry, while necessarily speculative to some degree, is that her death may have been avoided had she been able to be restrained in her seat on the Bus. It is indisputable that a means by which the death of others travelling in similar circumstances to Hannah may be avoided already exists, the only issue is whether passenger transport operators should be required, under law, to make it available to passengers.

XXIII. I accept that identifying the exact mechanism within the transport law framework to achieve this recommendation, that is necessarily targeted and constrained by the s 57A parameters of a coronial recommendation, is not straightforward and may lead to wider implications and practical difficulties of the type the Ministry identifies. However, the asserted inability of a generic transport law framework to accommodate the kind of targeted safety improvement this recommendation sets out, appears to be a case of current form prevailing over substance and frankly, good safety sense. Whether the New Zealand public and government has an appetite for making seatbelt restraints mandatory on all bus journeys is outside the scope of my inquiry. But I do not accept that the lowest common safety denominator, or fiscal implications to operators in retro-fitting or at least committing to progressive fleet upgrades, should dictate bus passenger safety. The *Road to Zero* safety strategy is ambitious in reducing preventable road deaths, and the Minster and Ministry of Transport should be equally ambitious in in looking for ways to achieve its targets. As I have said, no greater reason than Hannah's death should be needed for the Minister and Ministry of Transport to seriously and genuinely explore opportunities for safety improvements through legislative reform.

***Recommendation 2: Amendment to the Alpine Code***

*That the Alpine Code standard in relation to seatbelts be amended to remove the qualifier word "ideally" (the standard currently provides: "ideally all vehicle seats should have restraints, and all passengers should be seated").*

XXIV. The BCA's response to my proposal to make this recommendation was provided by the new Chief Executive of the BCA, Ben McFadgen. The BCA expressed concern that removal of the word "ideally" may hinder uptake and compliance with the Alpine Code. The BCA advised that prior to the COVID-19 pandemic investment in newer vehicles which are fitted with restraints was ongoing and it was predicted that older vehicles would be gradually replaced by vehicles with factory-fitted restraints. Reference was again made to concerns expressed by some operators during the development of the Alpine Code, that retro-fitting old buses was cost prohibitive, the BCA suggested in some cases costing more than the value of the vehicle itself. With the economic impact of COVID-19 the BCA considered retro-fitting to now be even more cost-prohibitive, estimating that 32% of tour bus operators have been forced to close their business or go into hibernation as a result. The BCA also noted that the Ministry of Education does not require restraints in school buses, many of which operate in 100km/h speed zones and rural areas. An alternative to this recommendation was suggested; that the qualifier "ideally" be replaced with "it is strongly recommended", and that the use of seatbelts be worked into the compliance rating system (Recommendation 5). The BCA considered this would sufficiently encourage operators to install restraints and buy vehicles that have restraints fitted, while not discouraging uptake and compliance with the Alpine Code.

XXV. I was disappointed with the BCA's response to strengthening its stance on seatbelts. The suggested amendment is essentially synonymous with the current wording. As I have said earlier, I fully acknowledge there are cost implications to retro-fitting an existing fleet, or investing in a modern replacement vehicle. I am genuinely sympathetic to the impact the COVID-19 pandemic has had on operators and the industry, and also recognise the BCA's position that, as a membership organisation, it must represent the interests of its members. But I suggest it is naïve to think that in the current economic climate and in the face of competing cost pressures, reluctant operators will voluntarily direct revenue to "ideal" or even "strongly recommended" safety upgrades. I am not persuaded that the fact that the Ministry of Education does not require seatbelts on school buses, some of which operate and travel at open road speeds, is the applicable benchmark measure of safety.[29] The Alpine Code is clearly directed at mitigating the combination of factors which increases the risk all passengers are exposed to while travelling on passenger service vehicles in the alpine environment.

XXVI. If the Alpine Code is to truly achieve its goal of raising the industry bar for passenger service vehicle safety, all vehicles seats should have restraints. I do not agree that the recommendation should be re-worded in the way suggested by the BCA. I do agree however that whether an operator is in fact compliant with such a requirement ought to be clearly reflected in the proposed rating system available to the public to inform their choice in transport provider.

***Recommendation 3: Audit to determine current compliance with Alpine Code***

*That within 24 months of this Finding the BCA, Waka Kotahi and WorkSafe in partnership with complete an audit of BCA member passenger service vehicle operators who undertake transport operations in alpine areas to ascertain the current degree of voluntary compliance of with the Alpine Code standards.*

[29] The Ministry of Education school bus service contracts stipulate a range of vehicle specification requirements, including maximum vehicle age. Where the contractor chooses to fit them seatbelts must comply with legislative requirements.

XXVII. The proposed recommendation in the provisional Finding set a timeframe of 12 months for the completion of the audit. In response, the BCA, Waka Kotahi and WorkSafe all confirmed their willingness to undertake the recommended audit. However the BCA noted that the 2020 and 2021 ski seasons had been significantly affected by the COVID-19 pandemic and considered it likely that an audit completed within the next 12 months "*will show a different level of compliance than we would have expected in normal years*". Presumably the BCA means that but for the COVID-19 pandemic, operators would have progressed their efforts to comply with the Alpine Code standards, and that to measure compliance in the near term would potentially reveal a greater departure from Alpine Code standards than would be expected if the 2020 and 2021 ski seasons had been 'typical'. While I consider it important to get a timely measure of the current extent of voluntary compliance, I accept that the current state of the industry is anything but typical. Extending the audit completion by a further 12 months will allow for an additional ski season to inform operator decisions and implement compliance changes in relation to the Alpine Code standards.

***Recommendation 4: Consideration to be given to legislating the Alpine Code***

*Following completion of the Recommendation 3 audit, Waka Kotahi and the Ministry of Transport give consideration, relevant to each agency's role and function, as to whether the identified extent of voluntary industry compliance is adequate to manage the risks of passenger transport operations in alpine environments, and whether mandating the full range of standards set out in the Alpine Code by way of subordinate legislation is indicated.*

XXVIII. In response to my proposal to make this recommendation Waka Kotahi expressed support and stated it "*believes there is potentially a case for mandating some of the Alpine Code standards and will work with Te Manatu Waka – Ministry of Transport to further consider this recommendation*."

XXIX. As noted above in relation to seatbelts, the Ministry of Transport does not consider transport regulation to be the most appropriate framework to specify the full suite of additional safety measures that might be required to address the particular risks that operating buses in the alpine environments presents, preferring instead a risk management approach as it says is reflected in the Alpine Code. Notwithstanding that, and the complexities and potential implications it identifies, the Ministry states:

> Following this audit, we are open to considering whether certain standards should be mandated through transport regulation, where prescription is considered necessary to increase compliance.

***Recommendation 5: Development of rating system for compliance with the Alpine Code***

*That following completion of Recommendation 3 audit, the BCA (with appropriate input and assistance from Waka Kotahi) look to devise a rating system that will provide guidance to consumers as to an operator's degree of compliance with Alpine Code standards.*

XXX. In response to my proposal to make this recommendation the BCA expressed support but identified that a rating system will take significant time and resources to develop. It advised that this will require input from Waka Kotahi to achieve. Waka Kotahi and WorkSafe also expressed support for this recommendation. Waka Kotahi committed to provide operational resources and analytical support towards the auditing task and together with the BCA and WorkSafe, to achieve a high level of industry "buy-in" to the process.

***Recommendation 6: 'Operation Hannah' enhancements***

*That in partnership with Waka Kotahi and WorkSafe, Police continue to undertake on no less than an annual basis, operations in the nature of Operation Hannah to target passenger service vehicles operating in alpine environments in New Zealand, to:*
*(a) educate participants, and to examine and test for legal compliance and safety of the vehicle's braking systems (including any overheating of brakes), safe driving technique; and*
*(b) extend compliance assessments and inspections to include (to the extent possible) assessments of compliance with the Alpine Code standards.*

XXXI. No response to this proposed recommendation was received from Police, Waka Kotahi or WorkSafe, although Waka Kotahi and WorkSafe both confirmed more broadly that all the recommendations proposed were appropriate and within the relevant responsibilities of each agency.

***Recommendation 7: Review Class 2 driver training***

*That MITO and Waka Kotahi review the Class 2 approved course training standards to ensure drivers receive specific and comprehensive instruction and practical training, and can demonstrate an understanding of the different types of braking systems, the means and importance of gear selection and management of braking resource relative to each system, and any emergency response that the driver might deploy in the event of a brake emergency.*

XXXII. In response to my proposal to make this recommendation, Waka Kotahi expressed support although, as noted earlier, on the basis that every driver participating in an approved Class 2 driver training programme is provided with the MITO Study Guide, it suggested I could be satisfied that specific aspect of this recommendation was already met. Waka Kotahi advised it would also consider including the content in all testing pathways for obtaining a Class 2 licence, as well as other heavy vehicle licence classes.

XXXIII. MITO advised it was supportive of this recommendation.

***Recommendation 8: Development of NZQA micro-credential in alpine passenger service driving***

*That together with the MITO and Waka Kotahi, the BCA look to develop an NZQA approved micro-credential in alpine passenger service driving, and encourage relevant industry operators to utilise that training programme for current and future drivers as part of Alpine Code compliance.*

XXXIV. In response to my proposal to make this recommendation MITO, the BCA, and Waka Kotahi all expressed support.

***Recommendation 9: Consideration of a new driver licence endorsement***

*That Waka Kotahi and the Ministry of Transport give consideration, relevant to each agency's role and function, to implementing a new licence endorsement directed to drivers seeking to operate a passenger service vehicle in New Zealand's alpine environment, reflecting the considerable driving challenges and skill required to safely operate such a vehicle in that environment, typically in winter conditions.*

XXXV. In response to my proposal to make this recommendation both Waka Kotahi and the Ministry of Transport expressed support for this recommendation, although they suggested it could effectively be combined with Recommendation 8 as both sought consideration given to enhancing driver training for the alpine environment.

XXXVI. Given the BCA has an identified role to play in Recommendation 8, I decline to combine the recommendations, but see the separation as immaterial to implementation by Waka Kotahi and the Ministry of Transport.

XXXVII. The Ministry of Transport advises it will be "*guided by any recommendation from Waka Kotahi on this matter*." Of particular note is that Waka Kotahi advised that it has " …*commenced consideration of potential recommendations and notes that in Australia, a Hazardous Area Authority is required for drivers of vehicles that have 13 or more seats (including the driver) and who wish to drive in declared "hazardous areas" for the Victorian alpine region during the snow season*."

> ***Recommendation 10: Industry and driver education***
>
> *That the BCA publish a summary of these Findings to its members to highlight the causative factors identified, the potential for deaths and serious injuries on every journey where these factors are present, and to encourage uptake in operator compliance with every Alpine Code standard; and*
> *That the Department of Conservation distribute a copy of these Findings to relevant concession holders operating passenger transport services in the National Park area; and*
> *That WorkSafe and Waka Kotahi together develop an educational campaign targeted at current Class 2 licence holders to educate and remind drivers of the risks involved in poor gear selection and mismanagement of air braking resources, and the emergency responses that may be required in the event of brake failure.*

XXXVIII. In response to my proposal to make this recommendation the BCA confirmed that it had plans to publish a summary of these Findings to its members to highlight the identified causative factors, the potential for deaths and serious injuries on every journey where these factors are present, and to encourage uptake in operator compliance with every Alpine Code standard. The BCA noted that while most bus and tour companies are members, the BCA does not represent the entire industry and its influence on non-members is limited.

XXXIX. As noted previously, RAL advises that in addition to Sand Safaris there are around five other transport operators who undertake passenger transport services (albeit generally on a smaller scale) in the National Park area under concessions issued by the Department of Conservation. While RAL no longer has involvement in passenger transport services it has confirmed that it will use the contractual provisions with Sand Safaris in respect of RAL staff transport to ensure audits of refresher training is carried out in relation to drivers providing that staff transport. RAL also suggested that given National Park passenger service transport operators are required to hold a concession from the Department of Conservation, that department would be well placed to ensure relevant concession holders are made aware of these Findings. While that recommendation has not been put to the Department of Conservation for response, I do not consider this aspect of this recommendation to be so onerous or contentious that further consultation on it is required.

XL. Waka Kotahi expressed support for this recommendation and undertook to pursue a targeted educational approach to increase driver awareness and provide reminder education to drivers. Waka Kotahi further advised it will consider extending the application of this recommendation across the wider spectrum of heavy vehicles where this type of crash sequence has been reported.

XLI. WorkSafe also expressed support for this recommendation.

***Recommendation 11: Ohakune Mountain Road improvements***

*That Ruapehu District Council, the Department of Conservation, and Waka Kotahi together consider the feasibility of roading and signage improvements to Ohakune Mountain Road including strategically placed run-off/layby areas to provide dedicated area for brake recharge and emergency stopping for vehicles that encounter a brake emergency while descending.*

XLII. In response to my proposal to make this recommendation Waka Kotahi and RDC expressed support and undertook to liaise to consider it further.

XLIII. RDC explained that it is part of a Joint Advisory Council with the Department of Conservation, Ngāti Rangi, Uenuku and RAL which has a mission to ensure the Ohakune Mountain Road is managed in a manner that meets the needs of the parties and the broader communities surrounding the mountain, now and in the future. The first objective is that the road is maintained and operated in accordance with Waka Kotahi Specifications and Guidelines – alluding to the need to keep users safe. RDC confirmed that, as noted in these Findings, it has carried out significant safety improvements to the road in the past ten years, including easing the gradient at the hairpins, and further vertical grade realignments at two sites is already programmed for the next three financial years, subject to funding. RDC advised that it will continue to work with the Joint Advisory Committee to maintain the objectives and uphold strong safety standards.

XLIV. I was pleased to learn that in furtherance of this recommendation RDC will commission a road safety audit for Ohakune Mountain Road to look into the feasibility of the suggestions. It noted that while road safety audits had been previously undertaken it was time to revisit this. RDC advised that it believes it will be possible to provide emergency stopping and lay-by areas but the topography may make creation of run-off areas more difficult. In addition, RDC will adopt the Alpine Code for any contracts it may let in future on behalf of Horizons Regional Council.

XLV. Notwithstanding my stated impression that additional road signage advising of the need to adopt a low gear on the descent down Ohakune Mountain Road was unlikely to have resonated with Mr Choi on this journey and changed the outcome, Waka Kotahi invited me to reconsider inclusion of relevant signage at the start of the descent within this recommendation. Waka Kotahi noted that "*Many long and steep descents in New Zealand have such a sign, and it serves as a good reminder to drivers of heavy vehicles that they need to guard against the possibility of brake fade*."

XLVI. RDC advised the road safety audit would include consideration of additional signage at locations of concern, in particular potential inclusion of low-gear advisory signage.

XLVII. Waka Kotahi advised it would also give consideration to whether to advise other Road Controlling Authorities to undertake a risk assessment on all ski field access roads and to consider the feasibility of the installation of run-off areas and laybys for each one, prioritised according to risk.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Hannah taken during the investigation into her death and the names, identifying particulars, and personal health information of those inboard the bus, other than those individuals named in the Finding, in the interests of decency and personal privacy.

# Hura [2021] NZCorC 179 (26 October 2021)

## CIRCUMSTANCES

Luscieana Marie Hura, aged 22, died at Hauraki Road, Turua on 25 June 2019, from severe chest and head injuries caused by a motor vehicle accident.

On 25 June 2019, Ms Hura was driving north on Hauraki Road, Turua towards Thames when she attempted to overtake a vehicle. As Ms Hura was travelling at an excessive speed for the overtaking manoeuvre, she lost control of her car and collided with an oncoming van. As a result of the collision, Ms Hura suffered fatal injuries and died at the scene.

The Waikato District Serious Crash Unit (SCU) investigated the collision. Their report to the Coroner included several recommendations.

## RECOMMENDATIONS OF CORONER BATES

I. Given the circumstances of Ms Hura's death, pursuant to s 57(3) of the Coroners Act 2006, I endorsed the recommendations contained in the Waikato District SCU report and referred them to the Hauraki District Council. Those recommendations are:

   a. That wire barriers are placed on the western edge of seal of Hauraki Road.

   b. That the posted speed limit in the area of the crash, from both directions on Hauraki Road as it approaches the intersection with Huirau Road, is reduced from 100 km/h to 80 km/h.

   c. Continued education and enforcement in respect to driver behaviour on rural highways.

II. Corresponding responses from Hauraki District Council are as follows:

   a. Recommendation not supported but alternative works proposed. Council is not satisfied the proposed treatment (barrier type and placement) is appropriate for the historical crash types. A road side barrier on the outer side of Hauraki Road may not serve to reduce a repeat of the risk of this specific crash type and severity. The Council have proposed geometric (widening) safety improvement to the Huirau/Hauraki Road intersection, and a design is well advanced. The implementation of this project will be subject to Waka Kotahi NZTA approval and financial support. Staging of physical works would follow. A land take is required for the project and that may delay progress.

   b. Recommendation supported. A review of the Council's speed management plan is well underway, and a specialist external consultant has been appointed to assist. Hauraki Road is part of the review. The triggers for Hauraki Road's inclusion are: crash history (deaths and serious injury); having childcare and school facilities; customer request history; and being a high risk road as identified by NZTA. While the Council cannot pre-empt the outcome of the review, a speed reduction to 80km/h is a likely outcome.

   c. Recommendation supported. The Council has an ongoing joint road safety programme with two neighbouring Councils (Matamata-Piako and Thames Coromandel), facilitated by the East

Waikato Road Safety Co-ordinator. Road safety is promoted through the East Waikato Road Safety Programme on an ongoing basis.

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

## Kereopa and Rewha-Lakau [2021] NZCorC 195 (24 November 2021)

### CIRCUMSTANCES

Te Rangatahi Kereopa and Hazein Rewha-Lakau died on 30 August 2020 at Great South Road, Huntly of probable mechanical/traumatic asphyxia and non-survival injuries to the abdomen and pelvis respectively, in the context of a motor vehicle collision.

At approximately 7:10pm on 30 August 2020, Te Rangatahi was seen driving a Toyota Altezza at speed, with Hazein as a passenger. They were travelling south on Great South Road, Huntly. On an easy left hand bend in the road Te Rangatahi lost control of the vehicle and over corrected the steering. As a result, he crossed the centreline through the northbound lane, and collided with an ARMCO barrier.

The subsequent investigation showed that Te Rangatahi was driving in disregard of his licence restrictions, and at a level of intoxication that placed him over the legal limit for operating a motor vehicle. He also drove through a red light, and in excess of the legal maximum speed limit. Additionally, neither Te Rangatahi nor Hazein were wearing seatbelts. Te Rangatahi was ejected from the vehicle during the crash as a result. Both men died following the crash.

### COMMENTS OF CORONER ROBB

I. These two deaths were avoidable deaths brought about by the actions of the driver. The most significant contributing factors in these deaths are the driver driving at excessive speed, while intoxicated, and without wearing a seatbelt. Coroners, Police, and NZTA have consistently highlighted the dangers of driving at excessive speed and under the influence of alcohol. Similarly, dangers about the increased risk of significant or fatal harm through not wearing seat belts has been highlighted on many occasions.

II. I again highlight those dangers and risks, which these two deaths graphically demonstrate, can result in entirely avoidable deaths.

III. There have been numerous publicity campaigns highlighting those risks. In that context I make no additional comment or recommendation.

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

# Ladd [2021] NZCorC 184 (29 October 2021)

## CIRCUMSTANCES

Antony Warwick Ladd, aged 25, died on 3 April 2019 on a section of Bainesse Road, Palmerston North from multiple serious injuries caused by the collision of the motorcycle he was riding with a cattle beast that had found its way onto the roadway.

At around 7:55pm on 3 April 2019, Mr Ladd was riding a motorcycle along Bainesse Road when he collided with a black cow. On arrival, emergency services confirmed that Mr Ladd had died from his injuries.

Post mortem testing confirmed that Mr Ladd had a blood alcohol concentration of 33 milligrams of alcohol per 100 millilitres. The legal blood alcohol limit for a driver over the age of 20 years is 50 milligrams per 100 millilitres. It also showed the presence of cannabis and confirmed THC (the active ingredient of cannabis).

The Police Serious Crash Unit investigated the collision and determined that Mr Ladd was travelling between 119km/h and 140km/h at the point of impact. The speed limit for the section of Bainesse Road was 100km/h. Police confirmed that Mr Ladd held a Restricted Class 6 (motorcycle) Licence which permitted Mr Ladd to ride a motorcycle with a maximum motor size of 250cc.

Police also identified the farm where the cow had escaped from and the likely area of fencing in which it escaped which was repaired.

## COMMENTS OF JUDGE THOMPSON

I. There can be no doubt that Mr Ladd was riding a motorcycle that he was not authorised, by the licence he held, to be using. That was because it had an engine with a cubic capacity greater than 250cc – it was a 750cc model.

II. Equally, there can be no doubt that he had alcohol and cannabis in his body systems. The blood/alcohol level was not above the legal limit for a motorist of his age, and the amount of cannabis had had used before setting off on his trip cannot be known. But I do note, as mentioned [by the toxicologist], that the combination of alcohol and cannabis is known to enhance the impairment caused by alcohol, and the cannabis alone may have caused impairment in his reaction times and coordination.

III. His speed was almost certainly well above the legal limit of 100km/h.

IV. That said, he was riding at night, on an unlit road, onto which a black (certainly dark) coloured cow had strayed from an adjoining farm. It cannot be said for certain that an entirely sober rider, riding a motorcycle which he was licensed to ride, at a speed within the legal limit, would not have suffered a similar accident. But it can, and should, be said that for the reasons noted Mr Ladd was at considerably greater risk than a compliant rider would have been.

V. I also do note, of course, that it is necessary for farmers and their staff to ensure that farm stock are securely confined and do not have the ability to get got onto public roads – the possible consequences for the stock, and for road users are very obvious, and there is an obligation in law for farmers to keep

stock safely confined. For this area, it is contained in the Manawatu District Council Animal Bylaw 2019, clause 6 of which provides that:

> Every person keeping Animals, must ensure that such Animals and their management:
>
> …
>
> (d) do not roam from the Premises or Rateable Property on which they are kept

# Leeson [2021] NZCorC 202 (3 December 2021)

### CIRCUMSTANCES

Jamie Peter Leeson, aged 43, died on 26 January 2018 at Waipapakauri in the Far North of severe head injury consistent with a motor vehicle accident.

On 26 January 2018, Mr Leeson was driving his Toyota Prado (the Toyota) at Ahipara beach. There were three passengers onboard. Around 9:00pm he was racing up and down the beach. The Toyota was skidding and turning sharply, doing what are known as “donuts” and “figure eights”. At some stage, it started to roll. Two passengers were thrown from the Toyota, as was Mr Leeson. He was deceased.

### COMMENTS OF CORONER TETITAHA

I. I make the following comments pursuant to section 57A of the Coroners Act 2006 for the purposes set out in section 4. There continues to be a need to reinforce existing public health and safety messages regarding the dangers of drinking alcohol in excess of the legal limits for driving to prevent similar deaths to Mr Leeson’s.

II. It is also necessary to reinforce when driving upon a non-urban road such as a beach it is recommended that you do not make sudden turns as wheels can dig in on the sand and (if you have a vehicle with a high centre of gravity like an SUV) roll it quite easily.

III. It is also important to note that there have been changes to the management of Ninety Mile Beach/Te Oneroa-a-Tōhe since this accident occurred. As part of the Te Hiku Iwi Treaty settlement, the Te Oneroa-a-Tōhe Board was formed to oversee the management of Ninety Mile Beach/Te Oneroa-a-Tōhe. Part of their activities included the drafting of a beach management plan.

IV. Part of this plan includes lowering the beaches speed limit to 30 km/h when motorists are within 200 m of any beach access points where activities such as boat launching people fishing. A 60 m/h speed limit is proposed for the remainder of the beach.

V. The reduction in speed limits to 30 km p/hr around the beach access points such as Waipapakauri ramp are more likely to prevent similar driving behaviour to Mr Leeson occurring in future. The slower speed limit is also likely to reduce the risk of roll-over by similar motor vehicles to Mr Leeson’s. The plan also provides for education of beach users regarding the spiritual importance of Ninety Mile Beach/ Te Oneroa-a-Tōhe.

VI. I congratulate the Te Oneroa-a-Tōhe Board and the Te Hiku Iwi for their beach management plan. In the circumstances I do not make any recommendation pursuant to section 57A of the Coroners Act 2006, for the purposes set out in section 4.

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

# Maaka and Sarsfield [2021] NZCorC 187 (3 November 2021)

### CIRCUMSTANCES

Tyrone Maaka, aged 19, and Santana Sarsfield, aged 20, died on 4 January 2018 at State Highway 16, Woodhill. Both died from multiple blunt force injuries sustained in a motor vehicle accident.

On 4 January 2018, Tyrone was driving north along State Highway 16. Santana was the only passenger in the car. As they navigated a curve near Woodhill, Tyrone lost control of the vehicle, which crossed the centreline and was impacted by another vehicle that was traveling south. Both Tyrone and Santana died at the scene.

There were no speed warning advisory signs on the curve where the crash occurred, and the road edges were marked with solid white shoulder lines and road markers situated at varying intervals. Police who investigated the crash did not identify speed as a contributing factor to the crash.

Tyrone had never held a driver's licence and inexperience was likely a factor in the collision.

### RECOMMENDATIONS OF CORONER HO

I. Pursuant to s 57A of the Coroners Act 2006 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 Tyrone and Santana's deaths 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.

*Road safety improvements*

II. Opus Fulton Hogan prepared a fatal crash report following the accident. It noted that a roadside barrier was proposed to be installed around the outside of the curve as part of an upcoming project. It identified that the curve had a maximum difference of 32 km/h between the maximum approach speed and the curve speed but there were no curve warning signs in place. It recommended that Waka Kotahi New Zealand Transport Agency review this and adjacent curves for curve warning signage appropriateness.

III. I sought information from Waka Kotahi about whether the recommendation had been implemented. Waka Kotahi responded on 30 July 2021 and advised that while it did consider curve warning signage at the location, it determined that the installation of a guardrail around the outside curve would be the most appropriate intervention. Waka Kotahi advised that in 2019 it also installed a motorcycle rub rail for further protection.

IV. In light of Waka Kotahi's response I do not consider it necessary to make any further recommendations under s 57A of the Act.

*Driver licensing*

V. Tyrone was unlicensed at the time of the crash. The New Zealand driver licensing regime serves a valuable purpose including to ensure that those who drive on New Zealand roads have the qualifications and necessary driving experience to do so. Driver licensing is a public good and is one of many tools used to ensure the roads are safe for all drivers. It is important that those who use the roads adhere to the driver licensing regime. To the extent that there are barriers to access (for example, cost) Waka Kotahi should consider how best to accommodate these issues within the framework of a robust licensing regime. I do not however consider it necessary to formalise this as a recommendation under s 57A.

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

# Ruddenklau [2021] NZCorC 211 (13 December 2021)

### CIRCUMSTANCES

Jeanette Helen Ruddenklau, aged 63, died on 25 August 2018 at Waimahaka River of drowning.

In the three to four days prior to her death, Mrs Ruddenklau and her husband had been working on a house they were building in Queenstown. On the morning of 25 August 2018 Mrs Ruddenklau left Queenstown, intending to return to her Tokanui home. When she failed to return, a search was commenced. Mrs Ruddenklau's car was located the following morning submerged in the Waimahaka River, with Mrs Ruddenklau trapped inside.

The Serious Crash Unit investigated the accident and concluded that there were a number of factors present that were consistent with fatigue related crashes, including that there was no evidence of emergency action being undertaken. As well, there was CCTV footage from 41 kilometres before the crash, which showed Mrs Ruddenklau driving with her window lowered. Her husband reported that she only drove with her window down when she was feeling tired.

Based on the CCTV footage it appears that Mrs Ruddenklau knew she was tired. Her husband reported that she usually pulled over to rest when she became sleepy while driving. It is unclear why she failed to take this course of action on 25 August 2018, however her familiarity with the road she was driving may have contributed to her decision to continue her journey.

### RECOMMENDATIONS OF CORONER HESKETH

I. Significant effort is made in New Zealand to warn people of the dangers of driving while fatigued. As part of this initiative, rest stops are made available along commonly travelled roads, and billboards and television advertisements are used to advise people to pull over when they feel tired or sleepy. On the evidence before me, Mrs Ruddenklau often followed these instructions. Her death is a tragic reminder of the importance of heeding these messages, even when drivers are very familiar with the route they are travelling.

Note: An order under section 74 of the Coroners Act 2006 prohibits the making public any of the photographs of Mrs Ruddenklau entered into evidence upon the grounds of personal privacy and decency.

# Tyler [2021] NZCorC 189 (17 November 2021)

### CIRCUMSTANCES

Mark Kelvin Tyler, aged 57, died on 8 May 2018 on a section of Hakataramea Valley Road from high impact injuries to his chest and spine sustained in a motor vehicle accident.

At approximately 11:00am on 8 May 2018, Mr Tyler was travelling along Hakataramea Valley Road when he lost control of his vehicle eventually causing it to roll. The force of the impact ejected Mr Tyler from the vehicle's sunroof and he died from the injuries he sustained. An examination of Mr Tyler's vehicle revealed that he was not wearing his seatbelt at the time of the collision.

### COMMENT OF CORONER KAY

I. The dangers of driving without a seatbelt are well-known and have been widely publicised for many years. However, I reiterate that if you sit in a seat with a seatbelt, you must wear the seatbelt. Wearing a seatbelt reduces the risk of being killed or seriously injured in a road crash by approximately 40%.[30]

Note: An order under section 74 of the Coroners Act 2006 prohibits making public photographs of Mr Tyler taken by Police following his death, in the interests of decency or personal privacy.

# Wiki Teoi [2021] NZCorC 181 (27 October 2021)

### CIRCUMSTANCES

William Wiki Teoi, aged 84, died on 12 March 2018 at Middlemore Hospital of cardiogenic shock with underlying cause of acute coronary syndrome on background of underlying heart failure and various comorbidities including injuries sustained as a result of a motor vehicle accident.

Mr Wiki Teoi mobilised using an electric wheelchair and had severe underlying medical conditions. On 11 March 2018, he wanted to cross East Tamaki Road from the south to the north. At the eastern end of East Tamaki Road there is a

[30] https://www.nzta.govt.nz/safety/driving-safely/seatbelts/

signalled intersection controlled by traffic lights. The lights manage merging traffic from Preston Road which joins East Tamaki Road from the south. Northbound traffic coming from the south along Preston Road have two options at the intersection. They can continue straight through the traffic lights and join East Tamaki Road travelling east. Or they can turn left into the westbound lanes of East Tamaki Road via a slip lane.

The traffic signals also allow pedestrians to cross East Tamaki Road. However, because of the slip lane, the signalled crossing does not provide an uninterrupted path between the south and north sides of East Tamaki Road. Pedestrians coming from the north side of the road cross to a traffic island on the south side. From that island they can then either cross the uncontrolled slip lane to reach the south side of East Tamaki Road/west side of Preston Road; or cross Preston Road via a signalled crossing to another traffic island from which they can cross an uncontrolled slip lane to the east side of Preston Road.

Because Mr Wiki Teoi's mobility chair did not permit him to cross the non-accessible uncontrolled slip lane to get to the traffic island and the signalled crossing, he instead travelled a short distance west, down the south side of East Tamaki Road where there was a driveway allowing access on to the road. His intention appeared to be to cross the two lanes on the south side of the road, pass through a turning bay and then cross the three lanes on the north side of East Tamaki Road where he could remount the footpath by using carpark entry access.

When Mr Wiki Teoi reached the turning bay, both lanes two and three on the north side had stationary cars. He started moving through the stationary traffic towards lane one that was free flowing at the time. As he exited lane two he came into the path of an on-coming vehicle which collided with the front of his wheelchair. The force of the impact knocked him to the ground and he sustained a number of rib fractures. He was transported to Middlemore Hospital but suffered profound heart failure that was unable to be treated and he subsequently passed away.

**RECOMMENDATIONS OF CORONER HO**

I. Auckland Transport conducted a Road Death Site Investigation Report following Mr Wiki Teoi's death. It provided a copy of the report to the Counties Manukau Police Serious Crash Unit. In the cover letter, which was signed by AT's Walking, Cycling & Safety Manager, AT wrote that the report "highlights that the road was not the primary contributing factor to the crash". AT nevertheless identified two general road improvement recommendations, being to: (a) investigate for active road user connectivity improvements along East Tamaki Road, observing that there were no pram crossings or crossing facilities on the slip lane; and (b) to renew the road markings in the area. The improvements were expected to be completed by January 2019.

II. On 3 October 2019 AT provided an update on those recommendations. It advised that its Operation Planning and Performance team was undertaking concept designs which included pedestrian safety improvements across the existing slip lanes by providing signal crossing and footpath connectivity at the slip lane corner from Preston Road on to East Tamaki Road. AT noted that the concept plan would be progressed to scheme design subject to further feasibility and modelling outcomes.

III. On 24 September 2021, following a request from the Coroners Court for an update, AT provided scheme plans dated 29 March 2021 showing, among other changes, the proposed pedestrian safety improvements. It advised that consultation with the community would "be undertaken in the very near future when Covid-19 restrictions allow businesses to return to work" and that "depending on the

feedback received during the consultation process, the project will proceed to the detailed design stage this financial year and programmed for construction during the 2022/23 financial year, subject to funding".

IV. Therefore, even on AT's best-case scenario, there will be no safe, signalled, mobility-accessible crossing from Preston Road across East Tamaki Road until late 2022 at the earliest – over four years after Mr Wiki Teoi's accident and subsequent death.

V. Mr Wiki Teoi's accident was preventable. I do not accept AT's conclusion that the road was not the primary contributing factor to the crash. It was. The only reason why Mr Wiki Teoi was navigating through uncontrolled traffic was because AT did not provide a safe signalled crossing for mobility users to cross a busy arterial road.

*Recommendation 1*

VI. I recommend that AT undertake the necessary works to ensure that mobility and other carriage users have access to a safe and accessible signalled crossing across East Tamaki Road in the same manner that able-bodied pedestrians presently enjoy.

VII. Pursuant to ss 57B(1) and 58 of the Coroners Act 2006 I provided AT with a copy of my findings in draft so that it could make any comment on my proposed recommendation or to be heard on any part of my finding which could be construed as adverse comment. Mr Garratt, AT's Team Leader Road Safety Engineering, responded on 22 October 2021:

> Unfortunately, progress of the improvements at East Tamaki Road intersection with Preston Road has not been as quick as we wanted. This scheme is important and we will do what we can to ensure that it is funded and once constructed, it will fully comply with mobility requirements. However, given that the scheme could be constructed in late 2022/early 2023 I will look at introducing an interim measure to assist pedestrians and those with mobility issues, to access the traffic island from the footpath on the south western corner of the intersection.

VIII. Mr Garratt did not elaborate in his response the reasons for the delay and whether the cause of the delay was funding or some other resourcing constraint. I have no power under the Coroners Act to mandate the implementation of any recommendations that I make. It is up to AT to determine its own priorities.

IX. The risk factors that led to Mr Wiki Teoi's accident are still present. I can do no more than reiterate, with the strongest possible force, the recommendation that I have made above. There has already been one unnecessary fatality as a result of mobility users being unable to access the signalled crossing. It is desirable that this accessibility issue be promptly remedied.

*Recommendation 2*

X. I also recommend that AT review all signalled crossings across its network to ensure that they comply with access requirements for mobility and other pedestrian carriage users and if they are not compliant that there are safe alternative crossings for such users within a reasonable distance.

XI. Mr Garratt responded:

> AT currently has two programmes aimed specifically at addressing access requirements at intersections. One is focussed on safety deficiencies based on historical vulnerable road user crash information, while the second is focussed on improving pedestrian experience at signalised intersections based on facilities. With over a thousand traffic signals across the Auckland road network this is a challenging task resulting in this programme needing to address those locations located within busier pedestrian activity areas such as the City Centre, metropolitan centres, town centres, local centres as well as outside schools, rest homes and public transport hubs. Both programmes are ongoing and continue to make ground despite the growing network and travel activities across the network and limited resourcing made available.
>
> All improvements, and all new installations are very much compliant with the requirements of mobility and other pedestrian users with ongoing consultation and focus-group engagements with key walking advocacy groups.

XII. I note AT's ongoing work in this area and formalise my recommendation accordingly.

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

# Self-Inflicted

## Aidney [2021] NZCorC 199 (2 December 2021)

### CIRCUMSTANCES

Mitchell Francis Aidney, aged 21, died on 31 December 2016 at his home in Red Beach of self-inflicted injuries in circumstances amounting to suicide.

In his mid- to late-teens Mr Aidney began suffering from ulcerative colitis. He experienced significant physical difficulties and interruptions to his daily life. In addition, the condition visited upon him a number of losses in terms of the social interactions and experiences characteristic of someone his age. His ulcerative colitis also affected his mental health. When his physical illness flared up, his mental health tended to deteriorate.

In 2016, Mr Aidney made a planned attempt to end his life. He spent several days in North Shore Hospital (NSH). Following this, he was treated in the community by the Rodney Area Mental Health Services (RAMHS) before being discharged to his general practitioner (GP) on 13 October 2016. On 2 January 2017, Mr Aidney was found deceased by his mother.

### RECOMMENDATIONS OF CORONER MCKENZIE

I. I have turned my mind to whether any recommendation(s) are appropriate in this setting with the features below. I set out these features because any recommendation(s) I make must be made in a setting where they may reduce the chances of further deaths occurring in similar circumstances.

II. In considering recommendations, I have kept the following factors in mind:

a. In 2018, the Waitemata DHB turned its mind to the issue of psychiatric/psychological support for ulcerative colitis/IBD patients, identified a gap in services, and made recommendations in relation to this. These matters are recorded in the 2018 SIR Report. I do not have a current update.

b. NSH staff and Mitchell's treating clinicians were aware of the interaction between Mitchell's ulcerative colitis and his mental health.

c. NSH staff knew Mitchell acted more positively than he in fact felt to get out of hospital, after which he had indicated he would end his life. He was known to say what he thought others wanted to hear and could possibly be overly-agreeable. Community-based staff were also aware of this dynamic to Mitchell's care. Mitchell's family thinks that in hindsight his purported future plans were a bluff towards others

d. Mitchell's care was not impacted by a lack of mental health funding or him being in a general medicine ward at NSH.

e. On the expert review evidence before me from Professor Mellsop, Mitchell received standard evidence-based care.

f. Mitchell had follow-up mental health care in the community for approximately one month following his discharge from NSH. His discharge back to his GP on 13 October was considered appropriate and agreed to by Mitchell, his family, and his treating team.

g. Mitchell was not seeing his GP regularly in the period before his death. Dr Whittaker stated that the last time he saw Mitchell was on 13 October.

h. Mitchell's mental health difficulties did not solely stem from his ulcerative colitis. On 5 September 2016 Mitchell told Liaison Psychiatry that he had started feeling suicidal/low since the age of 13 to 14 and "felt his symptoms preceded the symptoms of ulcerative colitis, and implied that it may be a separate issue." There is also some reference to this in the notes Mitchell left his family when he died as he refers to matters "even without this disease …"

i. Various clinicians had discussed psychotherapy with Mitchell and his family. Mitchell's family wished for him to have this, but Mitchell did not and he declined.

j. Mitchell was in the adult system and could not remain under the compulsive regime of the MHA when he no longer met the threshold. Mitchell was generally mentally competent (and was placed under the MHA when it was deemed he was in need of compulsive treatment). A competent and informed person in the adult system has the right to determine his or her own healthcare (and indeed to prevent the sharing of health information, except in limited circumstances). Section 11 of the New Zealand Bill of Rights Act 1990 (BoRA) provides that everyone has the right to refuse to undergo any medical treatment and similarly Right 7 of the Code of Health and Disability Services Consumers' Rights concerns the right to make an informed choice and give informed consent.

k. In Professor Mellsop's view, Mitchell's unhappiness with the issues his illness brought about was not a manifestation of seriously impaired intellectual functioning or of a primary mood disorder such as MDE.

III. Alongside these points, and taking a longer view of the potential trajectory of Mitchell's mental health, I note that on the information before me, Mitchell does not appear to have had formal mental health referrals or contact before he attempted to take his life in September 2016. Dr Whitaker stated that Mitchell had not made any previous suicide attempts to his knowledge or expressed suicidal thoughts to him. Dr Whittaker was not aware of any other mental health history apart from what he described as a "depression apparently brought about by the use of prednisone." The gastroenterology team was not aware of suicidal ideation before the September 2016 incident.

IV. I consider that earlier mental health intervention might have made a difference to Mitchell – or could do so to a person in his position as is suggested by the SIR Report and Dr Scott's annexure. In my view it is reasonably possible that with earlier intervention – which Mitchell would have needed to have accepted and engaged with – Mitchell might have developed the skills to better live with what can be a debilitating illness. Dr Frankish referred to a body of evidence that young men aged 19 to 25 suffering from IBD can benefit particularly from cognitive behavioural therapy. That is, Mitchell's mental health might not have deteriorated to the point it did in early September 2016 when he made an organised attempt to end his life. Previous flare ups of his illness might not have left such a negative impact on Mitchell going forward had he developed the coping tools (and support network) to better handle them.

V. I appreciate that I cannot have evidence on these matters because Mitchell did not engage with mental health services before September 2016. When he did engage, the materials before me suggest he did so rather reluctantly, even if giving an impression otherwise. However, I consider it reasonably possible that if Mitchell had had input at an earlier time, his mental health trajectory could have been different. Or, it could be different for someone else living with a serious physical illness such as ulcerative colitis which directly impacts areas of life that go to wellbeing such as social interaction and work.

VI. With this in mind, in my view there is value in practitioners continuing to be educated about the effects that a serious physical condition can have on a person's mental health and wellbeing. I note for example that Starship Hospital has a Child Consult Liaison Psychiatry team. Its website records that it "provides psychological and emotional assessment and support to children and adolescents who have medical or surgical problems. It also provides a service to parents and brothers and sisters."[31] The sorts of issues the service helps with include adjusting to and coping with illness or injury.

VII. More directly on the specific factual setting of this case, I also consider that there would be benefit in the Waitemata DHB's IBD group including a psychologist or a psychiatrist.

VIII. I initially sought information from the Royal New Zealand College of General Practitioners (RNZCGP) on several related questions. I summarise the RNZCGP's responses below.

[31] At: https://www.starship.org.nz/directory-of-services/child-consult-liaison-psychiatry/

a. What guidance is available for GPs (or other relevant practitioners) on the psychological impacts of a physical health condition?

    i. GP Pulse –GP Pulse is a monthly publication available to GPs. It is a source of evidence, ongoing clinical educational material, and expert opinion on a range of topics to support ongoing learning, and raise awareness of current issues, and inform clinical management of health, wellbeing, and equity.

    ii. The RNZCGP COVID-19 mental health support webpage. The webpage refers people to the Ministry of Health (MOH) wellbeing support and resources. MOH has a comprehensive list of mental health and wellbeing resources, including digital and online. The list includes helplines, agencies, media, where to seek urgent help.

    iii. Health Navigator NZ: The Health Navigator NZ website is the recognised 'go to' site for GPs when referring patients to an online source of reliable and trusted health information and self-care resources. The non-profit community initiative combines the efforts of a wide range of partner and supporter organisations and is overseen by the Health Navigator Charitable Trust. The website is endorsed by the RNZCGP.

    iv. Equally Well: People accessing mental health services have more than twice the mortality rate than the general population. The Equally Well initiative is a collaboration to address physical health inequities for people with mental health and addiction issues.

    v. Te Pou, RNZCGP, Wellbeing Wellington: The RNZCGP is a signatory to the Equally Well initiative and has collaborated with Te Pou and Wellbeing Wellington to develop the Equally Well prescribing toolkit.

    vi. General Practice Education Programme – The educational goal for a GPEP registrars in The General Practice Education Programme to transition from a hospital-based episodic, reductionist model of providing treatment for sickness, to a community-based, continuous, holistic model of health care. In this model of learning, the emphasis is on health promotion and prevention or the earliest possible intervention. GPs also have access to a variable range of contact with regional mental health services and can seek potential advice on mental health issues from psychiatrists. The ability to access services in the secondary-community interface is very dependent on services available in each DHB area.

b. How is this guidance popularised and are GPs reminded of it?

    i. Mental health is applied specifically under domain 6 in the Curriculum.

    ii. It is covered in developing skills as a GP Specialist in the General Practice Education Programme (this is a three-year post-graduate training course to become a GP Specialist).

iii. It is addressed by fellowship and Continuing Professional Development. Specialist GPs are expected to complete 130 hours of Continuing Medical Education, every three years, and this covers a variety of skills. It may include a mental health component although this is not mandated.

c. Summary of how the brief intervention service works.

i. There are multi-providers of Brief Intervention Services (BIS) throughout NZ and access is different across DHBs, Health Networks, and communities, e.g. WellSouth. GPs are not always able to access these services and they are not always free or available when needed. Patients may not always be receptive to accepting a referral.

d. Summary of best practice of how the decision by a GP to refer a patient to a specialist service (here a mental health service) is made?

i. A referral would be dependant on the assessment of the patient and the specific clinical situations in conjunction with the patient's wish to be referred, and the availability of secondary mental health services. A range of services can be available from direct referral, advice by phone or e-mail for a psychiatrist or case conferencing with secondary services. However, services are variable and access to secondary services is often very restricted depending on the circumstance and specific referral criteria in a particular area. Referrals are not automatic and are very dependent on individual need.

ii. The other thing to note is that there is often a long waiting time for secondary assessment in which time the GP would be expected to manage the issue with the patient. Funding is also often restricted dependant on differing DHB funding models.

iii. Regarding mental health referrals and best practice processes around this, RNZCGP does not have any guidance and relies on providers who specialise in mental health to provide guidance. RNZCGP is currently working with Te Pou who works alongside mental health and addiction services to provide guidance to health practitioners, but it is up to each individual practice to be aware of which services are available so they can refer appropriately in their locality. Self help web sites are also very useful, e.g. Beating the Blues.

IX. I consulted the RNZCGP, NCNZ, Waitemata DHB, and MOH on the following recommendations:

That the RNZCGP, NZNC, and Ministry of Health continue to develop and popularise amongst clinicians educative material on the interaction between a consumer's chronic medical condition and his or her psychological and mental wellbeing. I would anticipate that such educative material would include referral of a consumer – including at a young age – to mental health services in appropriate cases, working with reluctant mental health services consumers, being cognisant of particularly vulnerable groups (for example due to age and gender), and advice on how to best achieve an integrated health response.

That the Waitemata DHB's IBD Group be expanded to include a psychologist or psychiatrist.

That the Waitemata DHB continue to work it has started on helping improve access to psychological support for people with chronic medical conditions as an integrated part of service provision for their chronic medical condition.

That the Waitemata DHB share its learnings from the work it is doing in this area with other DHBs and/or medical specialities within its own DHB.

X. I consider that such educative focus would reiterate to practitioners the potential link between a client's chronic medical condition and his or her psychological and mental wellbeing. It would, in my view, help place this in the front of practitioners' minds. This in turn might lead to referrals to mental health services at an earlier stage rather than in response to a serious event; and as such might help prevent the deterioration in mental health, possibly across years, that can lead to serious events occurring. Accordingly, it might help reduce the chances of deaths occurring in similar circumstances to that in which Mitchell died.

XI. With respect to those recommendations directed specifically at the Waitemata DHB, I consider progress on the provision of integrated care might likewise help reduce the chances of deaths occurring in similar circumstances because patients within their system with a chronic serious medical illness might be able to more readily access support, earlier, and before their mental health has deteriorated to the extent an adverse event occurs. Sharing learnings could ultimately help patients with IBD in other DHBs get support. The IBD group including a psychologist or psychiatrist could make such a clinician a more readily available (and visible) resource. Where a consumer is reluctant, having resources visible and readily available might help normalise engagement and assist in uptake.

XII. Mitchell's family raised the possibility of compulsory referral for someone in his position to counselling or for formal mental health support. In my view a recommendation for a compulsory referral would encounter difficulty for reasons including that it would dilute a doctor's discretion and the requirement to act in the best interests of his or her patient. There will be some consumers who have support networks and/or adequate coping tools and therefore will not be in need of such referral. Or, they plainly would not engage with a referral and might state this clearly. Not all consumers with chronic medical illnesses might experience a decline in mental health. On the other hand though, consumers with an objectively more minor illness might experience a strong adverse psychological reaction and be amenable for referral to mental health specialist help but a prescriptive tool for referral might see them not eligible/ "miss out."

XIII. In these circumstances, I consider it important and most beneficial that doctors retain their discretion as to what is in a consumer's best interests at a particular point in time, recalling too that this can change. A fixed, compulsory referral tool would need to be anchored to measurable or specific criteria and might see people miss out. Further educating practitioners about the interaction between a medical condition and mental health would, in my view, help bring the issue more centrally into consideration of the care their consumer needs at a particular point in time.

XIV. The Ministry of Health commented on the following proposed recommendation:

> That the RNZCGP, NZNC, and Ministry of Health continue to develop and popularise amongst clinicians educative material on the interaction between a consumer's chronic medical condition and his or her psychological and mental wellbeing. ….

XV. The Ministry submitted that the reference to the NZNC should be altered. It considered it more appropriate to work with the National Nursing Leadership Group sponsored by the Chief Nurses Office as this Group is a collection of relevant professional groups rather than the NZNC which is regulatory only and not a professional body.

XVI. The Ministry of Health's website provides that the Chief Nursing Officer leads the Office of the Chief Nursing Officer Business Unit within the Ministry of Health.

XVII. The website relevantly goes on to record:

> The Chief Nursing Officer is part of the Executive Leadership Team, reflecting the importance of clinical leadership in the health system.
>
> The Chief Nursing Officer:
>
> - provides expert advice on nursing to Government and helps to develop, implement and evaluate Government health policy, leading on nursing policy and strategy in support of the Government's objectives
> - provides professional leadership to the nursing profession in New Zealand working closely with nurse leaders within the health sector, the professional statutory bodies, professional and staff associations and unions, DHB Chief Executives and managers, and the voluntary and independent sectors
> - ensures an effective New Zealand contribution to nursing and health policy in international fora, including the World Health Organisation, the Western Pacific Region, and close association with Australian colleagues through the ANZCCNMO (Australian and New Zealand Council of Chief Nurses and Midwifery Officers).

XVIII. In the light of the above information and of the Chief Nurse's Office (which sponsors the National Nursing Leadership Group) being part of the Ministry of Health, I amended the recommendation to remove reference to the NZNC.

The Ministry of Health also noted in its response to the recommendation (footnotes omitted):

> The Ministry recognises the link between chronic physical health conditions, illness and pain with suicide and suicidal thinking and behaviours.
>
> Chronic pain and a wide range of physical health conditions are important risk factors for suicidal thinking, behaviour and death by suicide. While most research has been done in older adults, the evidence of an association has been found across age groups.

> Studies have found that in older adults, functional disability as well as a range of specific physical health conditions including pain, arthritis, chronic obstructive pulmonary disease (COPD), cancer, neurological conditions are associated with suicidal behaviour. Suicidal behaviour has been found to be 2 to 3 times higher in those with chronic pain compared to the general population. Similarly, there is an increased risk of suicide in range of physical health conditions, for example stroke and COPD.
>
> There is a growing body of evidence that shows the same association between physical health conditions and chronic pain conditions like back pain and migraine and suicide in adults.
>
> The association between suicidal thoughts and chronic illness, particularly in those with comorbid mood disorders has also been shown in young people. Similar to adults, in a systematic review of 25 studies, pain was shown to double the suicidal behaviours and suicide in adolescents.

XIX. I thank the Ministry of Health for its assistance with the proposed recommendations.

XX. For all of the reasons I have variously set out, I consider these recommendations meet the statutory criteria.

XXI. Accordingly, I make the following recommendations:

> That the RNZCGP and Ministry of Health continue to develop and popularise amongst clinicians educative material on the interaction between a consumer's chronic medical condition and his or her psychological and mental wellbeing. I would anticipate that such educative material would include referral of a consumer – including at a young age – to mental health services in appropriate cases, working with reluctant mental health services consumers, being cognisant of particularly vulnerable groups (for example due to age and gender), and advice on how to best achieve an integrated health response.
>
> That the Waitemata DHB's IBD Group be expanded to include a psychologist or psychiatrist.
>
> That the Waitemata DHB continue the work it has started on helping improve access to psychological support for people with chronic medical conditions as an integrated part of service provision for their chronic medical condition.
>
> That the Waitemata DHB share its learnings from the work it is doing in this area with other DHBs and/or medical specialities within its own DHB.

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 Aidney entered into evidence in the interests of decency and personal privacy.

# Aifa [2021] NZCorC 206 (9 December 2021)

### CIRCUMSTANCES

Anesi Nuulua Aifa (aka Anesi Aifa), aged 20, died between 11 and 12 October 2019 at Mangere, Auckland in circumstances amounting to suicide.

On 11 October 2019, Mr Aifa had an argument with a family member over the phone about his girlfriend visiting him at the address he was staying at. This was not allowed due to bail conditions. Mr Aifa became upset and threatened suicide. The family member ended the call. The following day Mr Aifa was found deceased.

### COMMENTS OF CORONER BELL

I. One role of the Coroner is to make comment or recommendations that may prevent deaths in similar circumstances in the future. In this case the issue of how best to deal with a person talking of taking their own life requires comment. This is not a circumstance most people are faced with. Knowing how best to respond if confronted with such a situation is important.

II. There are key things to bear in mind. The first is that if someone expresses thoughts and feelings about suicide take them seriously. Urge the person to obtain help and if you are concerned, get help immediately, by contacting a doctor or mental health service. If you need to, call emergency services on 111. If the person is feeling unsafe, or you think they are at high risk, do not leave them alone. People in this situation need someone with them.

III. I note the Ministry of Health gives the following advice for people who are concerned about suicidality in others: https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal#urgenthelp

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 making public any of the photographs of Mr Aifa entered into evidence, in the interests of personal privacy and decency.

# Grant [2021] NZCorC 214 (21 December 2021)

### CIRCUMSTANCES

Cody Sean Grant, aged 19, died between 9 and 10 February 2020 at Papamoa in circumstances amounting to suicide.

On 2 February 2020, Cody joked about committing suicide and self-harming.

### COMMENTS OF CORONER HESKETH

I. From the evidence gathered in this inquiry it is apparent that Cody had voiced suicidal ideation in the past, albeit briefly and on occasion it was masked by his dark humour. He was able to mask his feelings of depression and anxiety from most, including those who were closest to him.

II. Help is available to anyone who is struggling and thinking of harming themselves. Help is also available to anyone who is concerned or aware that a friend, family member or anyone else feeling that way.

III. Information about the ways a person can support someone who is thinking about harming themselves is available at:

a. The Ministry of Health website on suicide prevention, the signs to watch for and ways of supporting someone who is suicidal at: https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide

b. The website contains information about what to do if you think someone needs urgent help. That information is:

i. Call your local mental health crisis assessment team or go with them to the emergency department (ED) at your nearest Hospital.

ii. If they are an immediate physical danger to themselves or others, call 111.

iii. Remain with them and help them to stay safe until support arrives.

iv. Try to stay calm and let them know you care.

v. Keep them talking, listen and ask questions without judging.

IV. Some options and the contact details of some agencies that can help are listed below. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated:

a. For Counselling and Support:

i. Need to Talk? Free call or text 1737 any time

ii. Lifeline -0800 543 354

iii. Samaritans -0800-726 666

b. For Children and Young People

i. Youthline -0800 376 633, free text 234 or email talk@youthline.co.nz (for young people, and their parents, whānau and friends).

ii. What's Up -0800 942 8787 (for 5 – 18 year olds; 1pm to 11pm).

iii. The Lowdown – visit their website, email team@thelowdown.co.nz or free text 5626 (emails and text messages will be responded to between 12 noon and 12 midnight)

iv. SPARX -an online self-help tool that teaches young people the key skills needed to help combat depression and anxiety.

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 making public any of photographs of Cody entered into evidence, in the interests of personal privacy and decency.

# Jellyman [2021] NZCorC 186 (2 November 2021)

### CIRCUMSTANCES

Simon Richard Jellyman, aged 25, died on 7 May 2019 in circumstances amounting to suicide.

Simon had longstanding issues with pain and had been diagnosed with depression. In March 2019 he was admitted to hospital as he had attempted suicide. He was referred to the Crisis Assessment Homebased Treatment (CAHT). Following an improvement in mood and additional medication, Simon was discharged from CAHT's care. His personal doctor, Dr Watson, was not notified of Mr Simon's admission to hospital or the reason for the admission.

### RECOMMENDATIONS OF CORONER ROBB

I. In Lynda's [Simon's mother's] statement to police, she commented that a family group conference, after the March 2019 suicide attempt, would have assisted them with supporting Simon's mental and physical health. She also believes there could have been better communication between CAHT and Dr Watson.

II. What is borne out in Lynda's concerns is a sense that she did not have a full picture of what was occurring for Simon leading up to his death, coupled with concern that the family were not placed in a position to both understand Simon's mental health difficulties nor what the professional advice for supporting him was.

*Mental health care*

III. It is certainly unfortunate that Simon's near suicide attempt on 15 March 2019 and subsequent mental health assessment was not conveyed to Simon's personal doctor. The personal doctor had the closest and longest professional relationship with Simon. It was important for the doctor to know the detail of that event close in time and any mental health care that was being provided to him, and to be in a position to evaluate what other mental health support Simon might need in the community.

IV. Having regard to the seriousness of that 15 March 2019 incident and then Simon's suicide on 7 May 2019 it is unfortunate that he did not continue to receive formal mental health care from the CAHT. I understand that there was difficulty in contacting Simon, but in his mental state, and ultimately in his expressions of despair, it is clear that he did not have an understanding or appreciation of the benefit that he had could receive from ongoing formal mental health support. His apparent reluctance to engage, proving difficult for CAHT to reach him likely reflects his depressed state, his feeling of being in a dark place. His feeling of being 'way beyond help' may well have been a reflection of his mental

state. However, my concern is that this also likely reflects his lack of understanding of how mental health support may have enabled him to transition through his feelings of darkness and his journey to ensure his physical pain was appropriately managed.

V. Simon's involvement with formal mental health care support was limited to an assessment by a nurse for the mental health and addiction service, he was not the subject of formal assessment by a psychiatrist. This was despite a planned suicide in March 2019 and his discussing thoughts of suicide thereafter.

VI. I recommend in circumstances where there has been a suicide attempt, or significant steps taken to plan a suicide that:

a. information concerning a suicide attempt and any triage or mental health assessment be provided to a patient's personal doctor as soon as is practical, and,

b. attempts are made to communicate and engage with both the general practitioner and the family of young adults who have been subject to a mental health assessment. To communicate the circumstances of a potential suicide attempt, the ongoing risks that the patient presents, and the care plan for the individual. This provides the opportunity for family to be in the best position to assist the individual in the community, and,

c. CAHT care remain in place, as far as is practical, until the patient is assessed by a psychiatrist as suitable for discharge.

VII. In accordance with section 57B of the Coroners Act 2006 an opportunity to comment on the above proposed recommendations was provided to the Waikato DHB. A response from Dr Rees Tapsell, Director of Clinical Services, Mental Health and Addiction Services, included the following:

> "We accept and agree with all of these recommendations. I can confirm that in our current processes, there is a team discussion with the psychiatrist in such cases and where possible this occurs in real time. However, all cases are discussed in a clinical review meeting each day, including Psychiatrists and other team members. There is a protocol for registrars to follow out of hours.
>
> In addition, communication with family is an expectation of service delivery and is improving. A recent audit indicated that whilst we are seeing improvement overall in whanau engagement, we can continue to improve in this area. A document which is now completed in all acute assessments includes a prompt around whanau engagement.
>
> GPs are now routinely notified about CAHT assessments. Whilst this is currently a manual process, in November the assessment form will automatically be sent to the individuals GP. This is a part of our ongoing work to improve and strengthen linkage with primary care providers and support a more joined up approach across secondary and primary care services."

VIII. I acknowledge this response and the positive progress that was already being taken by the Waikato DHB to address those concerns set out in the recommendations above.

*Ministry of Health advice*

IX. I do not make, nor intend to imply, any criticism of anyone who Simon had direct contact with and to whom Simon had made comments about suicide. As noted above, these were comments that were made a number of times, but not acted upon. Those close to Simon appeared to successfully manage his mental health distress on numerous occasions and had no reason to believe that he was about to take the drastic steps that he took on 7 May 2019. However, his 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.

X. The Ministry of Health website provides the following information:[32]

> **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.

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

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

**Help them find support**

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

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

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

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

**How to be supportive**

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

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

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

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

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

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

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

**Services that offer more information and support**

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

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 publications of photographs taken of Simon during the investigation into his death, in the interests of decency and personal privacy.

# Pay [2021] NZCorC 194 (23 November 2021)

## CIRCUMSTANCES

Paul John Beban Pay died on 17 April 2020 at Hawkes Bay Regional Prison in circumstances amounting to suicide.

On 17 April 2020, Mr Pay was found deceased in his cell when officers opened his cell to give him breakfast.

He had been received at Hawkes Bay Regional Prison on 22 November 2019. On his arrest he indicated that he was feeling suicidal, and advised prison staff of the same on his incarceration. It was noted that Mr Pay suffered from multiple sclerosis and chronic pain.

Between November 2019 and February 2020 Mr Pay would move between being considered at risk of self-harm and being safe. After February 2020, no concerns were documented with Mr Pay's health until his death in April 2020. However, on 14 February 2020, Mr Pay advised an education tutor that he was considering ending his life. This information was not passed on to prison or medical staff.

The prison inspectorate reviewed Mr Pay's death and provided a report which recorded several recommendations including developing: practice guidance for health staff to ensure that prisoners who express concern about pain are assessed for suicidal ideation and a work programme to support identification and removal of potential suicide tools in cells. It also recommended that "Education Tutors" should receive training on suicide awareness.

## COMMENTS OF CORONER RYAN

I. Having given due consideration to all of the circumstances of this death, I endorse the [first two] recommendations referred to [above], paraphrased in the Prison Inspectorate report but set out more fully in the review of prison suicides.

II. I also endorse the recommendation in the Prison Inspectorate report that Education Tutors should receive training on suicide awareness, discussed [above].

III. I note that the Department of Corrections (DoC) has commenced a number of different programmes to address some of the factors identified in the circumstances of Mr Pay's death. In submissions provided after receiving a draft copy of the Finding, the DoC informs that more work has begun and significant progress made in some of the areas identified above. I therefore do not consider there are any other comments or recommendations that could usefully be made pursuant to section 57A of the Act, for the purposes set out in section 4.

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.

# Poulter [2021] NZCorC 173 (13 October 2021)

## CIRCUMSTANCES

Hayden Tyrone Poulter, aka Haydon Tyrone Poulter aka John Leon Lorenzo, aged 57, died on 22 September 2018 at Whanganui Prison of self-inflicted injuries in circumstances amounting to suicide.

Mr Poulter had a long history of serious offending and had served several terms of imprisonment in the past. On 14 June 2018 he was released from prison on lifetime parole with special conditions and went to reside with family. In August 2018 Mr Poulter's Probation Officer (PO) received information that Mr Poulter had been using cannabis and had obtained methamphetamine. The PO was also told that Mr Poulter planned to fake his own death to avoid his special conditions on life parole.

On 27 August 2018 Mr Poulter had been readmitted to Whanganui Prison after the PO lodged an application with the Parole Board to have Mr Poulter recalled on the grounds that he posed an undue risk to the safety of the community or specific individuals, had breached his release conditions, and had committed an imprisonable offence.

Whilst back in prison, on 29 August 2018 an Initial Health Assessment Form was completed which included a mental health screening tool. The screen identified that while Mr Poulter denied having current thoughts of self-harm or suicide, he had a previous history of self-harm. In response, Corrections Officer (CO) Kayla How was responsible for making an "improving mental health" referral for Mr Poulter to an external Mental Health Services provider, PACT. However, CO How was unable to access the referral system on 2 September 2018 so she asked a colleague, CO Suzanne-Michele Ryland, for assistance.

CO Ryland then sent the referral on CO How's behalf. One week later, however, she received an automated alert that the referral was still in the system waiting to be sent. A referral was finally received by PACT on 10 September 2018. However, Mr Poulter was not seen by any mental health service providers prior to his death.

In the meantime, on 4 September 2018, Mr Poulter was assessed by Justice Liaison Nurse (JLN) Sue Bastion of the DHB Mental Health Addictions and Intellectual Disability Service who conducted a Risk Assessment and did not find him to be at risk of self-harm. He was found deceased in his cell on 22 September 2018.

## COMMENTS AND RECOMMENDATIONS OF JUDGE THOMPSON

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".[33]

II. Mr Poulter's final letters disclose his feelings of sadness, depression, failure and hopelessness at finding himself back in prison and facing the prospect of a further period of incarceration. Even when looking to a time in the future when he could potentially be again released, Mr Poulter expressed disheartened and pessimistic thoughts about his ability to reintegrate and live a satisfying life under the restrictions of lifetime parole.

[33] Ministry of Health, A strategy to Prevent Suicide in New Zealand 2017: A draft for public consultation.

III. The evidence before my inquiry identifies that following his recall to prison Mr Poulter was assessed by Department of Corrections staff to be at either no or only low risk of self-harm. While Mr Poulter's final letters suggest he was acutely mentally distressed following his recall, it would seem that his disclosures to Department of Corrections staff did not reveal the full extent and acuity of his distress. An historic [suicide] attempt in 1997 was noted but subsequent assessments were noted to have not raised any concerns. In addition, risk assessments undertaken upon Mr Poulter's return to prison on 27 August and when reviewed by the Forensic Mental Health Service nurse on 4 September expressly asked whether Mr Poulter had any thoughts or plan of self-harm. Mr Poulter's recorded responses consistently deny such and he was therefore assessed as not at current risk of self harm.

IV. At most, on 2 September 2018, 20 days before his death, prison staff (namely CO How) found Mr Poulter to be … *anxious, uncertain* … of having a feeling of …*betrayal*. He had agreed to CO How's suggestion that he speak to a counsellor about how he was feeling in relation to his recall to prison. Even at that time his recorded risk of self-harm on the counselling referral was stated as "low". CO How's statement does not detail the basis upon which she made that risk assessment at that time, but of note is JLN Bastion's clinical assessment two days later on 4 September evidently did not find Mr Poulter to be at risk of self-harm.

V. Mr Poulter recorded in his letter to his mother that he was very depressed and that no-one in the prison cared. CO How's statement asserts that she had developed a good rapport with Mr Poulter. While I consider CO How (assisted by CO Ryland) to have acted appropriately in suggesting and then seeking to make a referral for Mr Poulter to the external provider for improving mental health services, it would seem that the systems and processes to effect that referral were either inadequate, not functioning, or poorly understood by staff. Regardless of the cause, the referral was not in fact transmitted until eight days after CO How's discussion with Mr Poulter. Clinical records identify the referral was approved the following day but there is no recorded action in response to the referral in the following 12 days before Mr Poulter's death. Whether this was the result of PACT triaging with reference to the recorded low level of risk, or some other reason, ultimately Mr Poulter was not provided with mental health counselling support that he had been referred for prior to his death. The evidence before my inquiry does not address whether this timeframe aligned with that agreed or anticipated in the contractual arrangements between the Department of Corrections and PACT.

VI. With the obvious benefit of hindsight, had counselling been made available to Mr Poulter in the nearly three weeks between his discussion with CO How and his death, it may have provided an opportunity to have at least discerned the extent and acuity of Mr Poulter's distress, to re-evaluate his level of risk of self-harm with more insight, and identify any need for review by the forensic mental health service. Beyond that, it is simply not possible to say if counselling would have ultimately changed Mr Poulter's intention and actions taken to end his life.

VII. In light of the circumstances relating to the Improving Mental Health Services referral, I recommend that the Department of Corrections review the mental health services referral process and practice and ensure that:

a. the systems and processes required to effect a referral to improving mental health service providers are supported by adequate staff training and technology systems;

b. that Corrections Officers are provided with appropriate training and guidance in making assessments as to the risk of self-harm/suicide in prisoners which are recorded in such referrals; and

c. that PACT (or any other external provider of mental health services) response timeframes are clear and are understood by staff making referrals.

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 and photographs of Mr Poulter, in the interests of decency and personal privacy.

# Smythe [2021] NZCorC 172 (8 October 2021)

### CIRCUMSTANCES

Dayna Jayne Smythe, aged 14, died on 28/29 September 2019 at 24 Mawake Place, Turangi in circumstances amounting to suicide.

Despite there being numerous indictors that Dayna's mental health was suffering, no professional mental health support was provided nor sought for her.

### COMMENTS OF CORONER ROBB

I. The benefits of appropriate psychological support are professionally well recognised despite the importance of seeking help not being readily understood by everyone in the community. Seeking help also brings with it a level of discomfort that an individual may experience in endeavouring to engage with this type of support.

II. There is no certainty that this would have prevented Dayna's death, but it was likely to have provided her with the best prospect of living with, and potentially overcoming, the mental health difficulties she had developed. Difficulties that appear to have become deeply entrenched for her.

III. I do not make, nor intend to imply, any criticism of anyone who had direct contact with Dayna and who was aware of her having thoughts about suicide. However, Dayna'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.

IV. The Ministry of Health website provides the following information:[34]

**If you're worried someone may be suicidal**

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

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

**For children and young people**

*Youthline* – 0800 376 633, free text 234 or email talk@youthline.co.nz

(for young people, and their parents, whānau and friends)

*What's Up* – 0800 942 8787

(for 5–18 year olds; 1 pm to 11 pm)

*The Lowdown* – visit the website, email team@thelowdown.co.nz or free text 5626 (emails and text messages will be responded to between 12 noon and 12 midnight)

*SPARX* – an online self-help tool that teaches young people the key skills needed to help combat depression and anxiety

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

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Dayna taken during the investigation into her death, in the interests of decency and personal privacy.

# Stanley [2021] NZCorC 168 (5 October 2021)

## CIRCUMSTANCES

Samuel (Sam) John William Stanley, aged 27, died on 27 April 2019, at Foleys Road, Teddington in circumstances amounting to suicide.

Mr Stanley was a resident at Sarona House (Sarona) in Christchurch from February 2019 until the time of his passing. Sarona is contracted by Canterbury District Health Board (CDHB) to provide supported accommodation for adults recovering from mental illness.

Mr Stanley had separate information sharing settings with Sarona and CDHB. He permitted CDHB to provide full disclosure of information to his parents from 24 January 2019, however, he did not permit disclosure from Sarona to his parents until 14 March 2019.

Mr Stanley had periods of deteriorating mental health. On the evening of 1 March 2019, he went missing from the care facility. He returned the following morning and self-reported to staff that he had attempted to end his life. He was taken to Christchurch Hospital for clinical assessment and treatment and was discharged back to Sarona. Mr Stanley's parents were not informed about the attempt until he disclosed it to his mother in late March/early April.

On Tuesday 23 April, Mr Stanley's mother contacted Sarona as she was concerned about his wellbeing. Staff reported that they had not observed any major changes in his behaviour and suggested that the parents contact Mr Stanley's Registered Nurse Care Worker (RN Care Worker). Mr Stanley stayed with his parents on 23 and 24 April and returned to Sarona on the evening of 25 April.

Mr Stanley's parents remained concerned about his low mood and behaviour. They attempted to contact his RN Care Worker on 26 April 2019 but she was on leave. Mr Stanley's parents advised that they subsequently got in touch with Sarona and asked the facility to take Mr Stanley's car keys away from him as they had concerns about his wellbeing. Sarona advise that they have no record of this conversation.

On the evening of 27 April 2019, Mr Stanley again went missing from Sarona. On the morning of 28 April 2019, he was found deceased.

## COMMENTS AND RECOMMENDATIONS OF CORONER MCKENZIE

I. Section 57A of the Coroners Act 2006 enables a coroner to make comments or recommendations for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which a death occurred. Recommendations or comments must:

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

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

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

II. Any comments or recommendations I would be minded to make would relate to:

a. Family involvement in a resident's care.

b. The ongoing monitoring of a resident's suitability to remain at Sarona or whether they need a more intensive level of support.

c. The issue of Sam's keys not being taken from him again by Sarona on or about 23 April.

d. The disclosure by the CDHB or by Sarona to Sam's parents of details of the incident on 1 to 2 March.

III. I address each area in turn.

IV. *Family involvement in a resident's care*: [Sam's parents] have communicated their concerns about this to the CDHB and to Sarona, and I am satisfied that these entities have heard their concerns. Both providers have advised me of steps taken to try and better integrate a family and their voice into a client's care.

V. Involvement in care becomes more difficult when an adult client does not wish for family to be involved. Furthermore, in Sam's case there were different disclosure settings with the CDHB to those with Sarona which further complicated his care and integration/communication of this across providers. Maintenance of the therapeutic relationship is important on a day-to-day level.

VI. In terms of making any recommendations that would be workable within the current law and its practical application when a client does not consent to disclosure, I am satisfied that the parties have taken steps to address this within their structures and settings and do not make any recommendations.

VII. *Ongoing monitoring of suitability to remain at Sarona*: I am satisfied that Sarona and the CDHB had in place processes for monitoring a client's suitability to remain at Sarona and applied them to Sam's care. There is evidence before me that Sarona advised SMHS [Specialist Mental Health Services] of concerns about Sam at the times they arose and that SMHS in turn took action. Examples include the 1 to 2 March incident and concerns in mid-March which prompted a review. In Dr Chow's assessment, Sam did not reach the threshold for hospital admission. Sam had also said he felt safer at Sarona than in hospital.

VIII. *Not taking Sam's keys on or about 23 April*: there is conflicting evidence before me as to the reported request to take Sam's keys from him. Sam's parents say they asked for this to occur, Sarona has no record of this. An email from Sarona's then Manager to the Ministry of Health on 7 May 2019 recorded however that "Hindsight asks should he have been asked if he was safe to continue holding his keys following his mother's call."

IX. In my view, Sarona has reflected on the appropriateness of its decision-making and I do not consider I need to make a formal comment or recommendation. It has also provided information on the holding of items and the changes it has made. I note that Sam's keys were held for approximately one month following the 1 and 2 March incident and were not given back to him in mid-March when he asked for them. That is, the ability to hold a resident's keys and the risk they could present were issues already recognised at Sarona and had been acted on before in relation to Sam.

X. *Disclosure of the 1 and 2 March event to Sam's parents*: the CDHB and Sarona have provided information as to steps taken with respect to disclosure to families of health information. Sarona's information includes a wider review of how it involves and corresponds with families, going back to when a client begins his or her residence and how it can best learn from a family about a client and keep them involved in care.

XI. Issues relating to balancing an adult client's privacy and self-autonomy on the one hand, and the involvement of family and disclosure of health information on the other, cut across the health system. This intersection can be very difficult to navigate in a practical sense. Sam's experience highlights the complexities involved where there are different disclosure settings across different providers and a patient's real-time preference might be in contrast with his or her formal settings. For example, until about mid-March Sam did not wish for Sarona to disclose information to his parents but he had a full disclosure setting with the CDHB from 24 January; and as at 1 to 2 March and despite the full disclosure setting with the CDHB, he did not wish for the CDHB to give his parents details of the incident the precipitated his visit to the Emergency Department.

XII. Sam's parents say they were not given details of the 1 and 2 March attempt which took place on a road near Governors Bay, in a similar location to where Sam was found deceased on 28 April. In my view there could have been an opportunity for the CDHB to discuss this in more detail with Sam's parents from the date it occurred (Sam's full disclosure settings pre-dated the incident) and for Sarona to discuss it with them from mid-March when he changed his disclosure settings to full with Sarona.

XIII. Examples when more detail could have been provided include when Sam was assessed at the Emergency Department on 2 March (or following this via communication between his Case Manager and his parents), at clinical reviews attended by CDHB and Sarona staff and Sam's parents, in day-to-day conversations between Sam's parents and Sarona (not in the presence of Sam), and when Sam went missing on 27 April. I note again that Sarona advised police of the previous location when reporting him missing.

XIV. I appreciate the subtle and interrelating considerations at play with respect to disclosure of details of the 1 to 2 March incident (most acutely at the time of the incident). This is an example where, to return to the CDHB's words, the practical situation with disclosure can be somewhat fluid and dependant on an individual's presentation and degree of engagement with services at the time. The disclosure situation with Sam was not straightforward, he did not at that time wish for his parents to be told any detail about the 1 to 2 March incident (whether by the CDHB or Sarona), and there were the different settings as between the CDHB and Sarona.

XV. After consultation with the CDHB and Sarona, I make the following recommendation:

> That clinicians and other relevant mental health workers operating within CDHB areas (including at Sarona House) give closer and ongoing attention to the disclosure of information to nominated family members within the bounds of the Health Information Privacy Code 2020 (Code). The Code relevantly permits disclosure of information when it is necessary to prevent or lessen a serious threat to the life or health of the individual concerned (Rule 11(2)(d)).

XVI. I consider this recommendation is clearly linked to the factors that contributed to Sam's death because it directly relates to enhancing the support available to unwell people from nominated family members by them being more informed, and thus potentially improving their wellbeing. The recommendation is based on evidence I have received, reviewed, and set out in these findings. It also follows the required consultation.

XVII. I consider that the recommendation may reduce the chances of further deaths occurring in similar circumstances because if nominated family members are more informed, they might be able to better assist in their loved one's daily care or have insight if an emergency occurs. It also appears to me that it is inherently a good thing for nominated family members to be as fully informed as permissible of the status and care of a loved one.

XVIII. Accordingly, I am satisfied my recommendation satisfies the statutory requirements in s 57A of the Coroners Act 2006.

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Sam entered into evidence upon the grounds of personal privacy and decency.

# Thomas [2021] NZCorC 167 (4 October 2021)

### CIRCUMSTANCES

Conrad a'Beckett Thomas, aged 24, died in Tauranga on 17 July 2018 in circumstances amounting to suicide.

Conrad was first referred to Adult Community Mental Health at Tauranga Hospital (MHAS) in December 2017 by his GP, Dr Churchill. He was seen by a psychiatrist at MHAS in February 2018 and, at his request, referred to a psychology service.

On 21 March 2018, a MHAS psychologist urgently referred Conrad for psychological assessment. However, by the time of his death this had not progressed due to a high waitlist.

### COMMENTS OF CORONER DUNN

I. When taking into account the circumstances leading up to Conrad's death, I do not consider that there are any recommendations that could usefully be made pursuant to section 57(3) of the Coroners Act.

II. I do however comment that delay in access to mental health services is a feature of this inquiry. Sadly, this issue is all too common for deaths by suicide. Conrad wanted to see a psychologist. He was referred to urgently see a psychologist in March 2018, at the time of his death he was still waiting for four months for an appointment. That delay is unacceptable.

III. Conrad's mother has written to me outlining the stress of waiting for an appointment. She was so concerned about this aspect of Conrad's care that she met with Conrad's mental health providers

following his death to ascertain if waiting lists and access had improved since Conrad's death. She reports that it appears that nothing has changed.

IV. I can only reiterate what has been said by other coroners and by myself in recent findings - delay in access to mental health services for vulnerable unwell members of the community is not good enough. Timely access to experienced mental health professionals is crucial to ensure support and assistance is provided when needed. I appreciate this is a resourcing issue however it is a very real issue for unwell patients and their families. This needs to be addressed to ensure the safety of patients who place their care in the hands of our mental health system.

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 Conrad taken during the investigation into his death, in the interests of decency and personal privacy.

# Whalley [2021] NZCorC 169 (5 October 2021)

### CIRCUMSTANCES

Michael James Whalley, aged 41 years, died between 6 and 7 August 2017 at Caversham, Dunedin in circumstances amounting to suicide.

Mr Whalley had a lengthy mental health history and frequently developed depressive symptoms and suicidal thoughts in response to stress. During the evening of 6 August 2017, Mr Whalley expressed suicidal thoughts to a family member. These comments occurred in the context of Mr Whalley's financial stress.

### COMMENTS OF CORONER HESKETH

I. The following comments are made pursuant to section 57(3) of the Coroners Act 2006, for the purpose of public education aimed at avoiding further suicide by anyone in circumstances similar to those in which Michael James Whalley died.

II. Help is available to anyone who is struggling and thinking of harming themselves. Help is also available to anyone who is concerned or aware that a friend, family member or anyone else is thinking that way.

III. Information about the ways you can support someone who is thinking of harming themselves is available at https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide.

IV. The website contains information about what to do if you think someone needs urgent help. If someone has attempted suicide or you're worried about their immediate safety, do the following:

a. Take them seriously. Thank them for telling you, and invite them to keep talking. Ask questions without judging.

b. Call your local mental health crisis service or go with the person to the emergency department at the nearest hospital.

c. If they are an immediate danger to themselves or others call 111.

d. Remain with them and help them to stay safe until support arrives.

e. Try to stay calm and let them know that you care.

V. Some options and the contact details of some agencies that can help are listed below:

a. For counselling and support - these are free and generally available anytime: Lifeline - 0800 543 354 Samaritans - 0800 726 666

VI. For children and young people:

a. Youthline - 0800 376 633, free text 234 or email talk@youthline.co.nz (for young people, and their parents, whānau and friends)

b. *What's Up - 0800 942 8787 (for 5-18 year olds; 1 pm to 11 pm)

c. *The Lowdown - visit the website, email team@thelowdown.co.nz or free text 5626 (emails and text messages will be responded to between 12 noon and 12 midnight)

d. *SPARX - an online self-help tool that teaches young people the key skills needed to help combat depression and anxiety.

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 making public of photographs of Mr Whalley entered into evidence upon the grounds of personal privacy and decency.

# Sudden Unexpected Death in Infancy (SUDI)

## Cassidy [2021] NZCorC 175 (15 October 2021)

### CIRCUMSTANCES

Kohatu Whakamanawanui Whaikaha Maia Cassidy, aged 7 weeks and 3 days, died on 14 April 2018 at 3/24 Routley Avenue, Kaikohe, the cause of his death being unascertained, in an unsafe sleeping environment (likely asphyxiation).

On 13 April 2018, at approximately 8:00pm, Kohatu was fed and changed by his father. His father then wrapped him in a blanket and watched television with Kohatu lying on his chest. Sometime after 9:30pm, Kohatu's father fell asleep. When he woke up at approximately 2:00am, he realised that Kohatu was no longer on his chest and was lying face down on the sofa, wedged between two sofa cushions under his left leg.

Kohatu's father attempted CPR and then ran to his neighbours to ask them to call emergency services. Despite emergency services attending, Kohatu could not be revived. Kohatu generally slept safely in a pēpī pod.

### COMMENTS OF CORONER GREIG

I. Since Kohatu's death his parents have expressed the view that if he had been placed to sleep in the pēpī pod on the night of his death it is likely that he would not have died. This is a heart-breaking realisation for his parents who most times had used the pēpī pod for Kohatu to sleep in.

II. Kohatu's death sadly illustrates that every sleep for a baby needs to be a safe sleep. Babies are safest when they sleep face-up (on their back), with the face clear (plenty of space in front of their face and no pillows), in their own safe sleep space and are smoke free from conception.[35] There are key safety messages to keep a baby safe while sleeping. These include making sure that babies:

   a. Always sleep on their back to keep their airways clear;

   b. Are in their own bed such a bassinet, wahakura or pēpī pod for every sleep;

   c. Are put back in their own bed after feeding – don't fall asleep with them;

   d. Have someone looking after them who is alert to their needs and free from alcohol or drugs.[36]

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

## Wira-Raharaha [2021] NZCorC 210 (10 December 2021)

### CIRCUMSTANCES

Te Orewai Manuera Wira-Raharaha, aged five weeks, died on 25 September 2019 at his home at Raumanga, Whangārei. The cause of death was sudden unexpected death in infancy (SUDI).

According to Northland District Health Board (NDHB) records, his mother did not receive any prenatal or antenatal care for Te Orewai, although he was born at Whangārei Hospital. She also did not receive any safe sleeping or smoking cessation advice, although she was a regular smoker.

Te Orewai lived with his mother and five other siblings in a rental home which showed evidence of dampness and a lack of warmth. He slept in a queen-sized bed with his mother and, at times, two other siblings. There was no safe sleeping device in the house.

On the evening of 24 September 2019, Te Orewai was changed, fed and winded at about 9:00pm before being placed down to sleep next to his three-year-old sister, with his mother lying down next to him. At some point during the night, his sister moved to a single bed in the room to sleep with another sibling.

[35] https://www.hqsc.govt.nz/assets/CYMRC/Publications/Protecting-Infants-from-SUDI.pdf

[36] https://www.healthed.govt.nz/resource/keep-your-baby-safe-during-sleep

Te Orewai's mother woke at around 2:30am and realised that he felt cold to touch. When she turned on a light, she realised that he was not breathing and called emergency services. Despite resuscitation efforts, Te Orewai was sadly unable to be revived.

The Coroner noted that even if the family had been provided with a safe sleeping device like a wahakura or pēpī pod, which are available free for infants up to six months of age, Te Orewai had outgrown the dimensions of these by the time of his death. She also noted the difficulties involved in providing a cot or separate bed for families like Te Orewai's.

## COMMENTS OF CORONER TETITAHA

I. I make the following comments pursuant to section 57A of the Coroners Act 2006. These comments are directed to the Ministry of Health and Te Hapai Hauora.

II. This is the fourth sudden unexpected death in infancy (SUDI) decision[37] I have issued involving a Māori or Pasifika infant living in circumstances of poverty, overcrowding and damp housing. None of these whānau (including baby Te Orewai's) were to blame for their impoverished circumstances. Improved housing and increased financial support might improve these infants' survival rates.

III. The provision of prenatal and antenatal care to baby Te Orewai's mother might have prevented this death by reducing the risk factors associated with SUDI. This includes providing access to smoking cessation services. Academic researchers have commented upon the effect of social factors of poverty resulting in the marginalisation of Māori including disengagement with mainstream health services.[38]

IV. Further investigation by the Ministry of Health into the reasons for Māori mothers disengaging from prenatal and antenatal care health services and identifying solutions including the use of culturally appropriate health providers should be explored.

V. However a larger safe sleeping device capable of use within a crowded living situation might have prevented this death. Baby Te Orewai outgrew the dimensions of a wahakura and pēpī pod by 5 weeks of age. There is a need to consider providing Māori infants with larger safe sleeping devices to accommodate them up to 12 months of age. These also need to be flexible enough to fit within crowded living situations. This may require consideration towards the development of a suitable product if one is not currently available.

VI. To ensure SUDI prevention advice and devices are reaching Māori mothers such as baby Te Orewai's, consideration should be given to their distribution through iwi and hapū health providers.

VII. Prior to issuing this decision I sought comments from the Ministry of Health (the Ministry). The Ministry is thanked for their reply.

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[37] Similar SUDI deaths include Vahnah-Faith Abigail Salt CSU-2018-AUK-000728; Elizabeth Dianna Isabella Hepoto-Vailahi Vuna CSU-2018-AUK-001356 and Halo-Seianna Leeshaye Ranapia CSU-2018-AUK-000567.

[38] C Houkamau, D Tipene-Leach and Kay Clarke "Discussion paper: the high price of being labelled "high risk": social context as a health determinant the sudden unexpected infant death in Māori communities" New Zealand College of Midwives Journal Issue 52 2016.

VIII. The Ministry acknowledges they are aware that "the impacts of colonisation and institutional racism result in a health service that is not engaging for many wahine Māori and their whānau." The Ministry has been implementing projects through the maternity action plan (MAP) 2019-2023 including:

- Te Ara ō Hine-Tapu Ora: a national program to provide financial and pastoral support to Māori and Pacific undergraduate midwifery students to ensure the future workforce better represents the birthing population.
- Updating and increasing funding to the Primary Maternal Services Notice 2021 to more effectively remunerate primary maternity care provided to women with complex social or clinical care requirements as well as those living in rural areas. This will support midwives to provide care to women and whānau with complex needs through additional care visits.
- Partnering with the Health Research Council on a funding initiative to invest in health research and knowledge translation projects. This will inform the development of policy and practice in New Zealand maternity services to achieve equitable maternal and infant health outcomes, and supporter quality improvement culture within maternity services.

IX. The Ministry advised that the Northland District Health Board (NDHB) provides kaupapa Māori pregnancy, birthing, parenting and early years services through Ngā Tātai Ihorangi and Ngā wānanga o Hine Kōpū.

X. The Ministry noted they would also fund cots, mattresses, bedding and so on "if they are what the whānau need". The Ministry indicates it will work to ensure the SUDI prevention portfolio managers in every district health board are providing the appropriate infant safe sleep beds that whānau require.

## RECOMMENDATIONS OF CORONER TETITAHA

I. Access to the NDHB antenatal and postnatal programs and resources require Internet connectivity and a cell phone to register and maintain contact with the NDHB health provider and the midwife. Impoverished whānau may not have access to the internet and cell phones. This might have been a barrier for baby Te Orewai's whānau engaging or disengaging with prenatal and antenatal healthcare services.

II. This is the fourth decision I have made where whānau did not have access to these resources despite the above advice regarding availability. This indicates there are barriers for these whānau accessing those resources which are currently not being addressed.

III. Some of the issues of discrimination might be overcome by strategic use of cultural resources such as iwi and hapū health providers who work within these communities and could provide increased engagement with health programs and services.

IV. Although the Ministry may fund safe sleeping devices, I remain unclear whether there are safe sleeping devices available that can be used in damp crowded sleeping situations such as baby Te Orewai's.

V. This issue could be addressed by further investigations into the production of a safe sleeping devices for larger Māori and Pasifika babies that are warm, portable and can be used in crowded sleeping situations.

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

VII. That the Ministry of Health:

a. investigate the barriers for Māori mothers accessing prenatal and antenatal healthcare services provided within Tai Tokerau;

b. investigate alternative solutions towards lowering barriers for Māori whānau accessing antenatal and prenatal healthcare services and resources. Resources such as iwi and hapū health providers might be a solution for further investigation;

c. investigate the funding and production of safe sleeping devices for larger Māori and Pacific Island babies that can be used in damp, crowded sleeping situations.

An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Baby Te Orewai taken during this inquiry, in the interests of decency.

# Workplace

## Anderson and Solouota [2021] NZCorC 176 (18 October 2021)

### CIRCUMSTANCES

Robert Solouota, aged 36, and George Peter Anderson, aged 49, died on 12 December 2016 near Bushy Knoll Station, East Coast, near Gisborne as a result of multiple injuries sustained from a light aircraft accident.

Mr Anderson was a topdressing pilot and Mr Solouota was a trainee topdressing loader for Gisborne Farmers Air (GFA). He was under the supervision of Mr Anderson and Josh Maddock, another senior loader operator. On the morning of 12 December 2016, the topdressing aircraft left Gisborne Aerodrome with all three men on board. The original work plan was for them to attend the first task at Tauwharetoi Station, after which Mr Solouota would return to the Gisborne Aerodrome with a loader truck while the other two would continue topdressing at Waimaha Station.

As a result of another staff member at GFA falling ill, Mr Anderson was asked to stop at the Pembroke Station before going to Tauwharetoi Station. As a result the plan changed and after finishing at Tauwharetoi Station, Mr Maddock returned to Gisborne Aerodrome with the loader truck, while Mr Anderson and Mr Solouota proceeded to fly to the Pembroke Station at 6:00am. Mr Anderson was familiar with the area he was flying in, although the specific area was not one of his primary clients.

During that time, another topdressing plane was operating at the Bushy Knoll Station just north of Tauwharetoi Station. At about 6:15am Mr Anderson had a radio conversation with the pilot of that plane, Peter Blake, and they talked of their locations and intentions.

Near the Bushy Knoll Station was a set of 110kV high-voltage power lines consisting of six wires which supplied electricity to Gisborne and the East Coast Region. The wires span the valley in an approximately east-west direction and the height above terrain at the mid-span of the bottom two conductors (the lowest point of the span) was approximately 200 feet (or 61m). The wires were marked on the relevant visual navigation chart but conductors and supporting structures are not required to be physically marked in accordance with Civil Aviation Rules (or CAR). According to Mr Blake, who was aware of these powerlines, they were higher than normal and almost always impossible to see at topdressing height.

When Mr Blake finished topdressing he saw Mr Anderson's plane over his right shoulder and noticed that it was trailing wires from its left wing. He transmitted this information to Mr Anderson but there was no response. Mr Blake then saw the plane continue down the valley, roll to the left, and impact the terrain, resulting in post-impact fire. Mr Anderson and Mr Solouota were confirmed deceased at the scene.

It was established later that the plane had struck the wires spanning the valley approximately 24 nautical miles west of Gisborne, at approximately mid-span between two supporting towers. That is, at the lowest point of the conductors or wires when they were about 200 feet from the ground. However, according to CAR, when transiting between jobs, a pilot is prohibited from flying at a height of less than 500 feet above the surface or at a height of less than 500 feet above any obstacle, person, vehicle, vessel, or structure within a horizontal radius of 150m from the point immediately below the aircraft.

The Civil Aviation Authority (CAA) carried out an investigation into the crash and raised a number of safety actions. These included matters specific to GFA, such as implementation of a Team Resource Management approach to provide pilots the support required when plans change and hiring an Operations Manager.

The CAA Report included commentary on human factors in aviation, particularly:

- The risks associated with agricultural aviation operations which include flying at a low level and having high workloads. Given the risks, pilots must conduct a hazard briefing to know what they might confront. While Mr Anderson had done a briefing for the three stations outlined in the work plan, he had not conducted a hazard brief for the Bushy Knoll Station.
- Mr Anderson was "likely" to have experienced inattentional blindness due to his attention being on the other aircraft nearby.
- It is "likely" that Mr Anderson was aware of the power lines in the area. Research suggests that pilots usually strike a wire that they are aware of following an operational change. In the current instance, Mr Anderson changed the plan with respect to Mr Solouota remaining in the vehicle, he also detoured via Bushy Knoll Station rather than travel directly to Pembroke Station.
- It is likely that a number of human factors influenced Mr Anderson's decision to deviate from the original plan.

- Mr Anderson was experienced in low-level operations and was not known by the CAA to have been involved in any previous aviation accidents. However, pilots with little to no previous exposure may be vulnerable to certain decision making.
- Without having conducted a hazard identification for flying at low level over Bushy Knoll Station, it is likely that Mr Anderson's mental model was not as accurate or as well-informed as it could have been.

## COMMENTS AND RECOMMENDATIONS OF CORONER MCKENZIE

I. Pursuant to s 57A of the Act I may make recommendations or comments in the course of, or as part of the findings of, an inquiry into a death. Recommendations may be made only for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred. Recommendations or comments must:

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

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

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

II. I consulted the following parties on an initial set of recommendations: Mr Anderson's and Mr Solouota's families, the CAA, Ministry of Transport, WorkSafe, Federated Farmers, NZ Agricultural Aviation Association (NZAAA), GFA, Transpower, Vector, Horizon Energy Group, Electricity Networks Association, Marlborough Lines Limited, Electronet, PowerNet, and Aurora Energy.

III. The initially proposed recommendations that I consulted on regarded the CAA resuming its work on Rule Part 77/ the wire markings rules project with a focus on the best way(s) to help ensure agricultural pilots perceive wires to help lessen the chances of wire strike; refresher educative campaigns regarding wire strike and how to avoid this by the CAA and WorkSafe; and the voluntary installation of visual markers irrespective of any rule or law change.

IV. I received detailed responses to my initially proposed recommendations from the CAA and Transpower in particular. I thank them for their engagement with this inquiry.

V. The CAA advised that it is not looking to undertake further policy or rule work in the area of wire strike. Previous analysis had identified that marking wires is not always effective or feasible. The CAA's focus remains on encouraging operators to actively manage risks.

VI. As part of that, the CAA is continuing to monitor for other potential technological solutions, such as the fixed warning system OCAS. There are challenges with these technological solutions which can be expensive and impractical for some wire installations (especially on farms). The CAA is actively monitoring and communicating with a range of companies to help promote and encourage collision avoidance technology.

VII. The CAA further noted that agricultural aircraft operators are now required to have a SMS under Part 100 of the Civil Aviation Rules. In its view, these systems ought (if working) point to risks/hazards for operations and ensure appropriate mitigations are in place.

VIII. With respect to lines owners or their operational agents voluntarily installing visual markers, visual markers are deemed a passive measure. Under the Health and Safety at Work Act's hierarchy of controls, the CAA would expect farmers/landowners to eliminate the hazard where possible (remove wires), minimise exposure (pilots not fly in the vicinity of wire where possible), and then consider defences such as wire cutting equipment / visual markers.

IX. The CAA supports an ongoing education focus, involving aviation, agricultural, and electricity transmission industries.

X. Transpower outlined work it has already undertaken with respect to the issue of wire strike, primarily around being involved in a working group(s) and marking its seven of the twenty highest risk spans in New Zealand. It also identified difficulties with marking wires and newer technologies that might be more effective, including OCAS and technology using GPS and drawing on the GIS mapping that already exists of wires. I have already outlined this.

XI. Transpower recommended that a working group of relevant electricity and aviation industry participants be reconvened to consider the issue again, review the most recent technological developments, and propose an approach that considers a variety of solutions to address wire strike issues in a New Zealand context.

XII. WorkSafe advised that since December 2016 it has not conducted and does not plan to conduct any educative campaigns or other action regarding agricultural aviation and wire strikes. This is because in its view the CAA is the most appropriate agency in the area.

*Discussion regarding recommendations*

XIII. With all of this in mind, the relevant background to making my recommendations became more refined. I set out the primary features of this background below:

a. I have viewed the Police photographs and two from Mr Blake of the area and of the wires. The wires are very difficult, to me, to see in the photographs taken from a distance. I note that Ms Noad and Mr Blake also considered the wires to be difficult to see.

b. The issue of marking wires has received CAA and industry attention for a number of years.

c. Markings on wires could provide an effective day-time visual indicator of wires. They would not appear to be effective at night-time (however I do not understand agricultural, low flying to occur at night-time). However, a pilot could still experience inattentional blindness even with markers.

d. There are practical constraints regarding marking wires, including hazardous installation, weight and wind loading, and maintenance. There is also cost involved. I think it is reasonable too that not all wires where planes might be flying across New Zealand could practicably be marked.

e. Various educative campaigns have been undertaken for pilots regarding wire strike. More generally, the CAA emphasises SMS, hazard management, and TEM in its training. Its focus is on active risk management.

f. Educative campaigns have taken place with respect to farmers taking down unused wires.

g. SMS is now mandatory. I am satisfied that SMS working correctly would help mitigate against inattentional blindness and, as a separate issue, wire strike accidents.

h. There are technological ways to alert pilots to lines without physically marking them such as the OCAS system or other mapping using GIS layers and/or GPS. This technology appears to be developing.

i. While technological solutions might not tell pilots how to avoid wires, a key benefit in my view is that solutions such as OCAS would push an alert to a pilot in close proximity. This would be an active "push" alert rather than the passive alert of markings.

j. Wire strike incidents continue to occur. Some of New Zealand's worst spans have already been marked. I consider there is room for further activity and consideration in this space, especially in a setting where I consider it reasonable to assume that technology will continue to develop and, as it does, potentially become more accessible.

XIV. With these points in mind, I refined my proposed recommendations to the following five:

a. A working group of relevant industry participants be convened to assess the most effective way to mitigate wire strike for agricultural pilots who fly in areas where wire strike is a hazard. I anticipate such a working group would include the CAA, Transpower/ lines companies, landowners who have wires, WorkSafe (on the basis that power lines could be in a pilot's workplace), and independent agricultural aviation and collision avoidance technology experts.

b. The CAA continue to emphasise active hazard identification and management as this applies both in the SMS planning phase of a pilot's daily operations and while flying in dynamic or real time.

c. The CAA continue to actively investigate and encourage the use of collision avoidance technology amongst relevant stakeholders, irrespective of the progress of any working group. I appreciate that the CAA, as a Crown entity, cannot endorse or promote a particular product.

d. The CAA and WorkSafe to undertake further and regular educative campaigns for pilots and landowners regarding wire strike and removing unused wires.

e. Lines owners or their operational agents and/or landowners consider voluntarily installing visual markers on lines which are hazards in navigable airspace, such as Transpower has done in relation to its seven worst spans.

XV. I consulted further with the parties by circulating provisional draft findings, which included the refined recommendations. I also invited the parties to correct any errors or omissions given the length and at

points technical nature of these findings. Below I set out the responses of those parties who replied, omitting information that I have already referred to elsewhere.

XVI. Aviation New Zealand made comments on its behalf and on behalf of the NZAAA which is a wholly owned subsidiary. Aviation New Zealand commented:

a. It suggested I enlarge recommendation (a) to include a representative from the NZAAA be added to the working group.

b. It noted the two potentially valuable tools in the 'Down to the Wire' and 'Let's Get Em Down' educative campaigns and advised that both were developed at industry instigation and by the NZAAA and pilot Mr Lithgow following a fatality with input from the CAA; and that industry also funded the development work. Therein lies the challenge: "in simple terms, industry lacks the resources to fund these programmes on a serious basis. Covid-19 presents further challenges."

c. While industry has the "feet on the ground" to promote educative campaigns to farmers, it does not have the financial resources to produce the advertising material and wire markers to be put permanently on wires as warnings. Financial and "in kind" assistance from relevant government agencies would make a significant contribution to improved safety in Aviation New Zealand's view.

d. With respect to recommendation (a), the CAA, WorkSafe, and Transpower could endorse, potentially help resource, and champion a programme based on the 'Down to the Wire,' 'Let's Get Em Down,' and WorkSafe's wire avoidance sheets.

e. The 'Down to the Wire' campaign's "fundamental" aims are to get wires down, or where they must remain, suitably marked.

f. Some material suggests an onus on individual aviation companies to manage risk. There is a limit however, as to what companies can do on their own. They can manage the risks identified to the best of their ability but there is a bigger question around education and the need for farmers, electricity companies, and other companies that put up wires to be aware of their responsibilities too. This is where an education programme can come in.

XVII. With respect to Aviation New Zealand's comments as they relate to the recommendations, I consider that a programme based on existing educative campaigns with respect to recommendation (a) is provided for in the current wording of that recommendation as such programme would help "mitigate wire strike for agricultural pilots who fly in areas where wire strike is a hazard."

XVIII. With respect to funding, I note the point and reiterate my hope at [4] that the matters raised in these findings might further serve as a current starting or reference point for ongoing dialogue and action.

XIX. WorkSafe responded to recommendations (a) and (d). It maintained its position that the CAA is the best placed regulatory agency to lead any investigations involving aviation fatalities and pilot behaviour.

XX. WorkSafe further advised that it has no future work programmes planned regarding agricultural aviation or wire strikes and that the CAA was the most appropriate regulatory agency to lead work in this area. WorkSafe will consider any requests if invited to provide input or to be involved in educative campaigns.

XXI. Mr Blake expressed the view that the agricultural aviation industry in New Zealand is not well regulated.

XXII. The CAA responded to the recommendations as follows:

a. It observed that recommendation (a) could partially duplicate industry campaigns such as 'Down to the Wire.' It invited me to confine the first recommendation to refreshing and running ongoing campaigns to assess the most effective way to mitigate wire strike for agricultural pilots who fly in areas where wire strike is a hazard.

   The CAA stated that this amendment would reflect that it is "happy to continue to support and participate in the work being conducted to assess the most effective way to mitigate wire strike for agricultural pilots who fly in areas where wire strike is a hazard, such as this down to the wire campaign."

b. With respect to recommendation (c), there are some promising developments in regards to collision avoidance technology. However, it is unclear whether the cost of such systems in the near future will be such that it is reasonable for operators to adopt. To reflect this, the CAA suggested the draft recommendation be amended to: "I encourage the CAA and industry bodies to monitor the development of wire-collision avoidance technologies, and where practical and feasible, encourage use."

c. The CAA submitted recommendation (d) be restated to: "I encourage the CAA, WorkSafe, industry organisations, to refresh and run ongoing educative campaigns for pilots and landowners regarding wire strike and removing unused wires."

XXIII. Regarding the CAA's response to recommendation (a), this recommendation is deliberately wider than a working group only being concerned with educative campaigns. Recommendation (c) is a more active recommendation than "monitoring the development" which is passive. I adopt the CAA's changes to recommendation (d) but retain the aspects that the campaigns are regular and "further" which deliberately implies new campaigns being developed rather than re-stating existing campaigns. I consider that addition of industry organisations aligns with Aviation New Zealand's comments about the campaigns being industry-led.

XXIV. At about the same time as I consulted on the recommendations, I received further correspondence from Mr Moreton, a Notary Public who was a power supply authority chair ex officio his position as the Heathcote County Council Chairperson. Mr Moreton did not seek standing as an interested party.

XXV. However, he has corresponded with this inquiry across time, including forwarding various information or points to consider, as well as relevant media articles. Most if not all of the points Mr Moreton has variously raised have been considered or are otherwise before me in these inquiries. I thank Mr

Moreton for his engagement with this inquiry across the years in his capacity, as Mr Moreton put it, as a “senior citizen with experience in the electricity lines industry.”

XXVI. In particular, in September 2021 Mr Moreton pointed out that there could be multiple reasons why a pilot might need to deviate from their planned flight path, including an emergency. In my view this observation is helpful when considering a pilot’s mental model and how and why this can change in real or dynamic time.

XXVII. Mr Moreton also observed that undergrounding of wires removes hazards such as power poles which still kill motorists, for example. I do not understand Mr Moreton to necessarily be suggesting the undergrounding of wires in remote and rugged countryside, which could encounter considerable practical difficulties as well as unintentionally visit a different hazard on a different group of people with live wires being underground. However, consideration of this possibility would in my view fall within the scope of the first recommendation I make below.

XXVIII. Following the consultation, I have made the recommendations below:

a. A working group of relevant industry participants be convened to assess the most effective way to mitigate wire strike for agricultural pilots who fly in areas where wire strike is a hazard. I anticipate such a working group would include the CAA, a representative from the NZ Agricultural Aviation Association, Transpower/ lines companies, landowners who have wires, WorkSafe (on the basis that power lines could be in a pilot’s workplace), and independent agricultural aviation and collision avoidance technology experts.

b. The CAA continue to emphasise active hazard identification and management as this applies both in the Safety Management System planning phase of a pilot’s daily operations and while flying in dynamic or real time.

c. The CAA continue to actively investigate and encourage the use of collision avoidance technology amongst relevant stakeholders, irrespective of the progress of any working group. I appreciate that the CAA, as a Crown entity, cannot endorse or promote a particular product.

d. The CAA, WorkSafe, and industry organisations undertake further and regular educative campaigns for pilots and landowners regarding wire strike and removing unused wires.

e. Lines owners or their operational agents and/or landowners consider voluntarily installing visual markers on lines which are hazards in navigable airspace, such as Transpower has done in relation to its seven worst spans.

XXIX. In my view, recommendations (b) to (e) will help give practical effect to recommendation (a).

XXX. I consider these recommendations are clearly linked to the factors that contributed to Mr Anderson and Mr Solouota’s deaths because they directly relate to mitigating against wire strike. They are based on evidence I have received, reviewed, and set out in these findings. They also take into account the responses I received to my two rounds of consultation.

XXXI. I consider that the recommendations may reduce the chances of further deaths occurring in similar circumstances. This is because helping make pilots aware of wires that can be very difficult to see and educating/ re-engaging with pilots about wire strike would help reduce the chances of wire strike and the accidents that occur because of it.

XXXII. In these circumstances, I am satisfied my recommendations meet the statutory requirements in s 57A of the Act.

XXXIII. I reiterate that it is my hope too that these findings and their recommendations will further serve as a current reference point for dialogue and action to mitigate against wire strike in New Zealand's agricultural aviation industry.

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

# Brooking-Hodgson [2021] NZCorC 204 (8 December 2021)

### CIRCUMSTANCES

Niko O'Neill Brooking-Hodgson, aged 24, died on 22 August 2016 in the Esk Forest at the Pohokura Block, Te Haroto, near Napier. He died from non-survivable head and chest injuries sustained in a forestry incident while undertaking a line retrieval operation.

Niko was employed by DG Glen Logging Limited as Head Breaker Out. At approximately 10:50am on 22 August 2016, he was undertaking a line retrieval operation in order to move a hauler to another landing site. As the line was being hauled, a D-shackle attached to the line became snagged on an obstruction. Niko moved position to inspect the situation. As he did so, the line spontaneously became free, releasing the tension and sending the line and gear with speed towards him. Niko was hit by the line, D-shackle or block (or a combination of all three) and received fatal injuries to his head and chest.

Following an investigation by WorkSafe NZ/Mahi Haumaru Aotearoa, an inquest hearing was held on 22 and 23 July 2021 in Gisborne District Court.

The inquest established that the rigging and set up for the line retrieval had been unusual in that the backline was at a higher elevation well above the hauler, with approximately 300 metres between the hauler and the backline. The hauler driver had advised Niko by radio transmitter that the tail rope was snagged but would soon be clear. Niko did not acknowledge or communicate in response before tension was applied to the snagged rope.

It was found that Niko had moved into an unsafe area while the rope was still moving, potentially within the bight of the rope, when the sudden release of tension had caused the D-shackle to fly up the hill and inflict the fatal injuries. Niko was described as very capable, qualified and experienced, with exemplary results in the appropriate Unit Standards required to undertake the role, and it was unknown why he had moved into an unsafe location.

It was considered the only way to have completely avoided Niko's death would have been for the tail rope to be stopped where the snag occurred. In the absence of clear communications and confirmation between Niko and the hauler driver, tension should not have been kept on or further applied to the rope.

One of the primary issues investigated at inquest was whether use of a "straw line" (a light-weight line used to lay out or shift working ropes) would have prevented Niko's death. Whether it is suitable for use in all terrain was the subject of extensive evidence, and with differing conclusions reached regarding its use in Niko's situation. It was noted that WorkSafe had identified the practice of using a straw line as a specific industry learning and recommendation for the task of line retrieval in their investigation report.

Evidence was unanimous from all parties at inquest that there was no policy or guidance about line retrieval in the Approved Code of Practice for Safety and Health in Forestry Operations 2012 (ACOP). Following Niko's death, the Best Practice Guide for Breaking Out in a Cable Harvesting Operation was published by the key forestry sector training organisation. A WorkSafe representative who was aware of the circumstances of Niko's death ensured the specific risks associated with line retrieval were discussed and guidance issued to industry for that operation.

## RECOMMENDATIONS OF CORONER LLEWELL

I. Under section 57A of the Act, I must consider whether it is appropriate to make any recommendations or comments to reduce the chances of further deaths occurring in similar circumstances to Niko. The threshold is the "potential reduction" of similar deaths, not complete avoidance.

II. Having regard to the submissions of the parties, evidence heard at inquest, the determination of the issues set out above and other matters raised during the course of the inquest, I consider there are sound reasons to provide formal recommendations.

III. With competing evidence, we cannot say for sure whether the use of a straw line might have led to a different outcome. However, it is more probable than not that a straw line would have given the hauler driver more flexibility and manoeuvrability for the ropes which could have avoided the obstruction or provided an avenue to clear it.

IV. I am satisfied that the benefits of a straw line are real and tangible and outweighed by the time and expense involved. The hazard and risks of its use can be mitigated by astute use and the proviso not to overload the straw line.

V. Accordingly, I draw the attention of WorkSafe New Zealand/Mahi Haumaru Aotearoa and the Ministry of Business, Innovation & Enterprise (MBIE) to the following recommendations made under section 57A of the Act:

   a. Amend the ACOP to include the operation of line retrieval as a distinct operational risk separate from line shifting;

b. Introduce standards for line retrieval within the ACOP that may include the controls set out in the Best Practice Guide for Breaking Out in a Cable Harvesting Operation[39] and should also include:

   i. Competency requirements for line retrieval and associated Unit Standards that are required to be achieved to undertake that operation;

   ii. Identification of a safe retreat distance and exclusion zone (with methodology for calculating and marking said distance and zone);

   iii. Address management and control of the line retrieval operation; and

   iv. A procedure for clearing an obstruction, including consideration of the release of tension on the ropes to avoid recoil, collaborative and informed decision-making between a head breaker out and hauler driver on the best manner to clear an obstruction, and confirmation that crew are in a safe position before applying tension to the ropes.

c. Incorporate the mandatory use of a straw line for line retrieval (in the ACOP and/or regulations) but subject to identifying the optimal conditions for deployment of a straw line that mitigates other health and safety risks (e.g. elevation, distance or other environmental factors);

d. Promote and support the development of new Unit Standards with competency requirements, training and accreditation for line retrieval;

e. Give urgent priority to the development of the next phase of the Health and Safety at Work regulatory framework with specific reference to the forestry sector (i.e. hazardous work regulations);

f. The Best Practice Guide for Breaking Out in a Cable Harvesting Operation[40] is to be publicised and linked prominently on both the Safe Tree and Competenz websites; and

g. In giving effect to these recommendations, have particular regard to importance of greater engagement and participation of affected forestry personnel, with an aim to produce an ACOP which is accessible, meaningful and fit for purpose.

VI. In accordance with section 57B(1) of the Act, WorkSafe New Zealand/Mahi Haumaru Aotearoa and the Ministry of Business, Innovation & Enterprise (MBIE) were provided with my provisional findings (dated 1 November 2021) for the opportunity to comment on my proposed recommendations.

VII. My provisional findings were provided to Niko's whānau. Having regard to one concern raised by Mr Christeller on their behalf, amendments have been made to paragraph [16] of these final findings. A courtesy copy of my provisional findings was also provided to the two forestry companies that participated during the inquest and to the hauler driver.

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[39] Competenz Best Practice Guide for Breaking Out in a Cable Harvesting Operation (September 2017) at page 26 (Inquest Bundle Document 17).

[40] Ibid.

*Feedback from WorkSafe New Zealand/Mahi Haumaru Aotearoa*

VIII. I received feedback by way of written response dated 25 November 2021 which was positive and appreciated. WorkSafe noted that recommendations (a), (b), (c) and (g) related to amending the ACOP and affirmed (as previously outlined at the inquest[41]) that WorkSafe has decided that a review of the ACOP can occur alongside the work to be done by MBIE on the hazardous work regulations (with potential for the review process to feed into those regulations).

IX. It was indicated that the WorkSafe team has taken on board the evidence from the inquest concerning the need for greater engagement and participation of forestry workers on the ground and will endeavour to ensure that their voices are heard as part of the guidance review and ACOP amendment process. They are also desirable for an ACOP (and other guidance) which is accessible, meaningful, and fit for purpose. Accordingly, they had no difficulty with recommendation (g).

X. WorkSafe is committed to comprehensive engagement with interested parties as part of the review, including forestry workers, unions, forestry contractors, forestry companies, forest owners, union organisations, Competenz, the Forestry Industry Safety Council and the Forestry Industry Contractors Association.

XI. WorkSafe had no difficulty with recommendation (a) requiring the identification of the operation of line retrieval as a distinct operational risk separate from line shifting.

XII. WorkSafe noted that recommendations (b)(i) – (iv) and (c) set out prescriptive requirements for inclusion in an amended ACOP. They undertook to ensure that those recommendations are fully discussed, however, it was considered premature to unequivocally commit at this point to those matters being included in an amended ACOP. This concern was based on their statutory responsibility under s222(2) of the HSWA to implement a consultation[42] process with relevant parties.

XIII. For the avoidance of doubt, a coronial recommendation is just that. It is premised on the issues and evidence at inquest as an avenue to reduce further deaths in similar circumstances. I appreciate that a recommendation cannot undermine or determine the outcome of a subsequent consultative process, but it should be respected as an indication of a discrete subject matter that warrants free, frank and open consultation with affected parties.

XIV. With reference to recommendation (d) about new Unit Standards, WorkSafe noted that the primary responsibility for developing these for the forestry industry now rests with a newly established entity Muka Tangata Workforce Development Council (formed as part of the Reform of Vocational Education). They suggested that my final findings also be provided to that entity. WorkSafe indicated a

[41] Evidence of Ms Hanson-White (pages 130 – 131) and noting that compliance with regulations is mandatory, in contrast with an ACOP.

[42] In *Wellington Airport Ltd v Air New Zealand* [1993] 1 NZLR 671, the Court of Appeal endorsed dicta from *Port Louis Corporation v Attorney-General of Mauritius* [1965] AC 1111, 1124 where Lord Morris of Borth-y-Guest, delivering the judgment of the Privy Council stated: "The requirement of consultation is never to be treated perfunctorily or as a mere formality. The local authority must know what is proposed, they must be given a reasonably ample and sufficient opportunity to express their views or to point to problems or difficulties: they must be free to say what they think".

commitment to raise the lack of any Unit Standard covering the line retrieval operation with the Council, to engage and support the Council to address this matter.

XV. With reference to recommendation (f) about improving the publications of the 2017 Best Practice Guide, WorkSafe advised that work is already underway for implementation of this recommendation.

XVI. WorkSafe advised that given the statutory obligation for the development of regulations[43] sits with MBIE's Health and Safety Policy team on behalf of the Minister for Workplace Relations & Safety, accordingly they would revert to MBIE to provide feedback on my recommendations (e) and (c) on advancing the regulatory framework and mandatory use of a straw line being included in regulations.

XVII. In relation to the scope of the ACOP review, WorkSafe advised that they were conscious that the suite of guidance material for the forestry and arboriculture industry will need to be examined as a whole rather than piecemeal, so that informed and consistent decisions can be taken about matters that require updating, replacement or revocation, new guidance material and appropriate forms for updated or new guidance. I have already acknowledged in paragraph [97] of these findings that it may not be feasible for everything to go into the ACOP and there will need to be a balance struck between the detail of the ACOP and other forms of control and information.

XVIII. In addition to the ACOP, WorkSafe's feedback recorded ten other regulatory instruments for the forestry industry (i.e. other ACOP's, Guidelines, Best Practice Guidelines and Fact Sheets ranging in date from 1995 – 2016). I note that only one of those instruments was admitted as evidence for this inquest.[44]

XIX. This listing was provided to support the proposition that "a comprehensive approach for review" is required to ensure there is a consistent approach; streamline the consultation process (so that interested parties can be consulted on all proposed areas for change or development within one process, rather than sequential processes for different topics within the industry (or indeed the same topics but included across different guidance materials)); to allow an assessment as to current divisions of topics between different guidance materials is sensible and effective; and to permit a fresh assessment of the best form for updated or new guidance to take (whether that be incorporation within regulations, within ACOP's, Guidelines etc.).

*Feedback from the Ministry of Business, Innovation & Enterprise (MBIE)*

XX. I received feedback by way of letter from the Manager, Health and Safety Policy dated 26 November 2021 which was appreciated. MBIE confirmed their role to advise the Government on the operation of legislation and support the development of legislation, including regulations made under the HSWA. MBIE's feedback was limited to those aspects of my recommendations.

[43] Outlined in paragraph [37] of these findings.

[44] Best Practice Guidelines for Safe Retreat Positions in Breaking Out (July 2014) (Inquest Bundle Document 16).

XXI. With reference to recommendation (c) about the mandatory use of a straw line when carrying out line retrieval in cable logging operations (to be achieved by inclusion in the ACOP and/or regulations), MBIE stated that they do not consider regulations would be the best means of requiring such detailed requirements of work methods or equipment. Their view was that level of detail is better provided in an ACOP or guidance developed by WorkSafe in consultation with the forestry sector.

XXII. MBIE's position is that incorporating the proposed additional requirement (for use of a straw line) in the ACOP would be consistent with current industry practice and expectations. In their view, because the requirement would only apply in certain circumstances (which need to be determined by the duty holder), a regulatory requirement is likely to be challenging to enforce and less effective than an ACOP might be. In other words, regulations are most effective only where they impose clear mandatory controls that apply in all situations.

XXIII. With reference to recommendation (e) to give urgent priority to the development of the next phase of the Health and Safety at Work regulatory framework (i.e. hazardous work regulations), MBIE advised that they are currently giving effect to Cabinet policy decisions to develop new regulations for plant and structures.

XXIV. Those regulations feature significantly in cable logging and other aspects of forestry operations, and will provide for mandatory design registration, item of plant registration, inspection of cable logging equipment and traction control equipment used in steep slope harvesting. MBIE expects these regulations to be passed in 2022 and that they will improve the standards of inspection and maintenance of equipment, and support improvements in work methods in all aspects of cable logging.

XXV. MBIE's work programme provides that after those regulations are completed, they will then begin consideration of new regulations for hazardous work. They anticipate that may include licensing of classes of workers or imposing mandatory controls on critical aspects of certain high-risk work (such as working at heights or excavations).

XXVI. The scope and content of new regulations for hazardous work will be a matter for the Government to decide and subject to Cabinet approval.

XXVII. MBIE confirmed their intention that the process will begin with consultation of the types of work that will be subject to regulation, rather than ACOP's or guidance. In preparing a consultation document, MBIE will have regard to (among other matters) coronial recommendations and the 2014 report of the Independent Forestry Safety Review.

XXVIII. Regretfully, no indication of a potential timeframe for proposed hazardous work regulations was provided to me. My recommendation for urgent priority to this phase of regulatory work stands as it related to evidence at the inquest (i.e. that promises of a comprehensive review of the ACOP, along with strengthening the associated regulatory framework for the forestry sector, have not been implemented as contemplated in 2014 and 2016).

Orders under section 74 of the Coroners Act 2006 prohibit the making public of photographs of Niko obtained during the investigation into his death, in the interests of decency and personal privacy; the specific information contained in

paragraphs [20] and [22] of the findings, in the interests of justice and decency; the name of the hauler driver involved in the incident that led to Niko's death, parts of evidence of Ms Armstrong in response to questions put to her at the inquest on 22 July 2021 (as outlined in more detail in the finding), and a photograph of Mr Scurr taken from the public gallery at the inquest on 23 July 2021, all in the interests of justice, decency, public order and/or personal privacy.

# De Lautour [2021] 188 (16 November 2021)

### CIRCUMSTANCES

Harry George Bayly de Lautour, aged 33, died on 28 September 2020 at Te Whangai Station, in Flemington, near Waipukurau. The cause of his death was consistent with drowning.

Mr de Lautour was the owner and operator of his family sheep farm. He lived on the property with his wife and their children. His farm comprised of around 3000 acres of steep rolling hill country with numerous gullies and steep embankments.

Quad bikes were the primary means of transportation on the farm. Police report that it is common for exposed areas of the farm to experience high winds with such winds known to be strong enough to flip motorbikes.

At approximately 7:00am on 28 September 2020, Mr de Lautour was seen by the farm stock manager, Duncan Kerr, on his quad bike with his safety helmet on. It was the lambing season, which involved locating new lambs, checking their ear tags and docking them. At around 10:00am, Mr Kerr noticed that Mr de Lautour's dog was not tied up by the woolshed, which he thought was strange. He immediately attempted to contact Mr de Lautour via the farm radio but received no response. Mr Kerr contacted other farm staff and they all commenced a search. Mr de Lautour was found at the base of a steep 10 metre bush covered gully embankment, lying face down in a one metre wide shallow stream of approximately 200mm depth. He had his safety helmet on. Staff commenced CPR however Mr de Lautour was unable to be resuscitated.

Police found that Mr de Lautour's quad bike was in neutral gear with its ignition turned on. They further noted that the quad bike's park brake system was not engaged. WorkSafe noted that Mr de Lautour had been interrupted while tagging the lamb.

### COMMENTS OF CORONER WINDLEY

I. Pursuant to s 57(3) and 57A of the Coroners Act 2006 a coroner may make comments or recommendations to reduce the chances of similar deaths in the future. Such comments or recommendations must be clearly linked to the factors that contributed to the death under inquiry.

II. Police concluded that an omission to engage the quad bike's rear brake locking plate meant that a strong gust of wind, not uncommon in such exposed areas of the farm, was sufficient to dislodge it from its stopped position on the knoll and set it off on a downhill trajectory which encountered Mr de Lautour as he was busy undertaking lambing procedures. Senior Constable Rowe interpreted the scene evidence as most likely supporting an attempt by Mr de Lautour to redirect the quad bike away from the embankment, but in doing so the momentum was sufficient to carry him over the embankment with the quadbike where he sustained head injury, not of itself fatal, but which likely had a concussive

effect. Tragically, it appears that the location where Mr de Lautour came to rest, face down in the shallow creek water, combined with his inability to self-rescue likely due to concussion, meant that the outcome of the incident was fatal.

III. WorkSafe concluded that there were no health and safety failings. While it is true that death or serious injury in the exact manner as I find to have transpired would not be a reasonably foreseeable risk, that sequence of events was causally related to Mr de Lautour's failure to engage the brake locking plate. Whether a reasonable and prudent person in Mr de Lautour's position ought to engage the quad bike brake locking plate on every occasion the ignition is turned off and the rider dismounts to undertake other tasks is beyond the scope of my inquiry. While the gradient of the knoll was less than the hillside, and the knoll was considered to be reasonably sheltered from wind gusts, it would seem that the latent risk of the wind being powerful enough to "flip motorcycles" was nevertheless well known. In those circumstances, I consider best practice would have been for Mr de Lautour to have engaged the brake locking plate when he went to undertake lambing procedures in that location.

IV. While noting what I consider would have been best park brake practice in these particular circumstances, the specific nature of this location and environment, in particular the exposure to strong wind gusts and the shallow creek, does not easily lend itself to comments or recommendations of broader application. The most that can be highlighted is that quad bike operators should be vigilant in assessing the risk of an unattended quad bike becoming mobile and resulting in harm in every environment they operate in, and where there is such a risk, appropriately engaging the brake locking plate.

Note: an order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Mr de Lautour taken during the investigation into his death upon the grounds of personal privacy and decency. I am satisfied that such interests outweigh the public interests in the publication of that evidence.

OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND