OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments made between 1 January and 31 March 2022

Office of the Chief Coroner | 2022 (1)

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 54 recommendations and/or comments issued by Coroners between 1 January 2022 and 31 March 2022.

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

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

Aviation

Shadbolt [2022] NZCorC 32 (9 March 2022)

CIRCUMSTANCES

Trevor Lawrence Shadbolt, aged 60, died on 25 July 2020 near Lake Pukaki of very high energy impact injuries to his face, chest wall and contents, limbs, pelvis, and spine due to a microlight in collision with the ground.

On 25 July 2020, Mr Shadbolt departed the Pukaki Aerodrome in a private flight Taylor Monoplane Class 1 Microlight. He was an experienced pilot and advised others of his intention, which was to practice stalling. He radioed when he was climbing through 6100 feet and carried a personal locator beacon on him.

When Mr Taylor had not returned from the flight, family and friends initiated a search with the assistance of emergency services. The aircraft was found with Mr Shadbolt in the cockpit at 5:11pm that day. A rescue helicopter attended but unfortunately Mr Shadbolt was deceased.

The Coroner found the crash to be accidental. It was not contributed to by any ascertainable mechanical defect or failure in ZK-DKQ. However, Taylor Monoplanes has advised the Civil Aviation Authority that it will include a covering letter with a caution to stick to the dimensions stated. This is due to a concern that Taylor Monoplanes were being built and operated well above their original design weight.

COMMENTS OF CORONER MCKENZIE

I. I have turned my mind to whether any recommendations or comments, including adverse comments, are appropriate in this matter pursuant to ss 57A and 58 of the Coroners Act 2006.

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

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

b. based on evidence considered during the inquiry; and

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

III. I do not make any adverse comments in relation to Mr Shadbolt. As I have set out, Mr Shadbolt was an experienced pilot, advised others of his intentions and appeared to follow them, had the appropriate safety gear including a personal locator beacon, had waited until the weather was suitable, and chose an area with emergency landing options. He radioed his position as he climbed through 6100 feet. He knew the characteristics of the aircraft.

IV. In terms of recommendations, I am mindful that these must be clearly linked to the factors that contributed to the death, yet in the particular circumstances of this case the precise cause and mechanism of the accident cannot be established. I endorse the CAA's observation and recommendation:

> This accident serves to remind all pilots that a lack of pilot currency is a well-known contributing factor to many accidents. The CAA recommends pilots to obtain dual instruction if they are not current in specific exercises or an aircraft type.

V. I also note that the RAANZ has revised pilot currency and renewal requirements in its exposition to include:

> Where privileges within a particular group have not been exercised for a period of more than 24 months then practical competence is required to be demonstrated to an instructor before use of the group is continued.

VI. Taylor Monoplanes has advised that it will caution customers to keep to the dimensions stated.

VII. In all of these circumstances, I make no further comments or recommendations in this matter.

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

Child deaths

Goraya [2022] NZCorC 50 (29 March 2022)

CIRCUMSTANCES

Jayzhan Singh Goraya, aged 4 months, died on 20 December 2017 at Houhora, Pukenui, of extensive bronchopneumonia against a background of extreme prematurity.

Jayzhan had been unwell with bronchiolitis since 18 December 2017. Medical staff at Kaitaia Hospital had instructed his caregivers to keep him upright to help ease his nasal congestion.

On the morning of 20 December 2017, Jayzhan was wrapped in a blanket and put in his pram to sleep. Sometime after being put in the pram to sleep, Jayzhan coughed and then stopped breathing. An ambulance was called, and emergency services attended but Jayzhan was not able to be resuscitated.

The Coroner sought advice from Dr Louise Finnel, an Emergency Medicine Specialist in the Middlemore Hospital Emergency Department about:

a. Whether the care provided to Jayzhan by the doctor at the Kaitaia Emergency Department was reasonable?

b. Whether the medication given to Jayzhan was appropriate?

c. Whether the discharge plan was appropriate?

Dr Finnel opined that the care, diagnosis and medication given to Jayzhan on 18 December 2017 was all appropriate. However, the decision to discharge Jayzhan after half an hour in the emergency department at Kaitaia Hospital was not appropriate. In Dr Finnel's opinion, Jayzhan needed a prolonged period of observation given his age and that he had more than one risk factor that predisposed him to more severe bronchiolitis. In light of that information, Dr Finnel considered it would have been prudent to admit Jayzhan to hospital for closer monitoring.

Dr Finnel also considered that the quality of the discharge advice given was poor. It was nonspecific about when to return, with no documented information about his social set up in case he needed to return to the Emergency Department urgently. Dr Finnel advised that specific return advice should have been given, which would be to return if any of the following signs occurred:

a. Feeding less than half of normal over 12 hours;

b. Periods of irregular breathing or pauses in breathing;

c. Nasal flaring, grunting or marked chest recession during breathing;

d. Signs of cyanosis like blue lips or tongue; and

e. Difficulty waking or not responding normally to cues.

Dr Finnel also considered that a suggested review by Jayzhan's GP in two to three days was longer than recommended for this type of baby given his various risk factors. Dr Finnel advised that generally a baby with these risk factors would be advised to attend the GP for a review within 24 hours.

COMMENTS OF CORONER WOOLLEY

I. I accept the opinion of Dr Finnel that the decision to discharge Jayzhan from the Kaitaia Hospital on 18 December 2017 after half an hour in the Emergency Department and that the quality of discharge advice given was poor. While Jayzhan presented in the mild category for bronchiolitis, he also presented with several risk factors that predisposed him to developing more severe bronchiolitis and that he could experience a more rapid respiratory deterioration. Given this, hospital admission should have been considered, or at least offered to Jayzhan's whānau, and a period of observation far greater than half an hour should have occurred prior to considering that Jayzhan could be discharged.

II. I also accept Dr Finnel's advice that the discharge advice given to Jayzhan's carers was poor because it:

a. lacked specificity about when to bring Jayzhan back to the Emergency Department;

b. did not contain any guidance about the type of symptoms that Jayzhan's carers should look out for that would warrant a return to the hospital; and

c. advised his carers to take him to the GP for a review in two to three days, rather than 24 hours, which would have been a more appropriate timeframe for a baby presenting in the early onset of bronchiolitis.

III. I agree with Dr Finnel's observation that had Jayzhan's carers been told specifically what symptoms to look for, it seems very likely that they would have taken him back to the hospital the night before he died given they observed him looking lethargic, less active and yellow.

RECOMMENDATIONS OF CORONER WOOLLEY

I. In my provisional findings, I had included recommendations that the NDHB:

a. adopt for use in its Emergency Departments the Starship Children's Hospital Bronchiolitis Guidelines (which I appended to the provisional findings) and a paediatric vital signs reference chart (an example was appended to the provisional findings); and

b. develop standard written patient advice sheets for common paediatric presentations such as bronchiolitis.

II. I provisionally made these recommendations to ensure consistent and comprehensive guidance is given to parents/caregivers about the red flags to look out for and when to bring a child back to the hospital or to see a doctor. It would also ensure that parents have a written resource to refer back to in the event that parents/caregivers are unable to recall all advice given orally at the time that they were seen in hospital. However, given the NDHB have advised me that they have already implemented these changes following their internal reviews, I do not need to make any formal recommendations. I commend the NDHB for taking these steps proactively.

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

Iro-Tulikaki [2022] NZCorC 51 (29 March 2022)

CIRCUMSTANCES

Evana-Jade Anarihi Iro-Tulikaki, aged approximately 8 hours and 25 minutes, died on 27 February 2017 at Middlemore Hospital, Auckland, of unascertained causes.

Evana-Jade was born at the Botany Downs Maternity Unit on 27 February 2017 at approximately 4:15am, under the supervision of Lead Maternity Carer (LMC) Shannon McCourt. After her birth, Evana-Jade was placed on her mother's chest in the birthing pool. Her mother, Brooke Himiona, remained in the birthing pool for about 20 minutes with Evana-Jade resting on her chest, with her chest down in the water. Ms Himiona then moved onto a bed to deliver the placenta, keeping Evana-Jade on her chest. Ms McCourt put a baby hat onto Evana-Jade and got a warm towel for her, and a blanket to put over both mother and baby.

Ms McCourt said she continued to assess Evana-Jade's position and colour and did not notice anything that caused her any concern during this time. As there were no concerns about either mother or baby, Ms McCourt left the room briefly at around 5:00am to prepare toast and milo for Evana-Jade's parents. When she returned, all appeared well, and she left the room again between approximately 5:14am and 5:19am to complete some paperwork.

Evana-Jade's parents said they thought she sounded wheezy during this time and advised Ms McCourt of this when she re-entered the room. Ms McCourt noticed that Evana-Jade's skin tone had dramatically paled, and that she appeared to be having trouble breathing. Staff at the Maternity Unit commenced resuscitation procedures, and an ambulance was called at approximately 5:33am via an 0800 professional healthcare line. At 5:55am, Ms McCourt called 111 as no ambulance had arrived.

At approximately 6:04am, a neonatal team arrived by ambulance and transported Evana-Jade to Middlemore Hospital, where she was treated in the Emergency Department before being transferred to the Neonatal Intensive Care Unit in a critical condition. At around midday, Evana-Jade's parents were advised that further resuscitation efforts were futile. She died at 12:40pm.

The post-mortem report noted Evana-Jade's vulnerability due to her gestational age of 37 weeks and considered two possible reasons for her early post-natal collapse. One was persistent pulmonary hypertension of the newborn (PPHN), which can result in respiratory compromise in an infant who otherwise appears well. However, as PPHN is diagnosed clinically and there are no histological indicators, it could not be confirmed during the post-mortem examination. The other possibility was an asphyxial event, which may have resulted from the positioning of Evana-Jade on her mother's chest, wrapped in towels and attempting to feed.

Counties Manukau Health (CMH) undertook a comprehensive review into the circumstances leading to Evana-Jade's death. Their report noted that Ministry of Health (MOH) Guidelines were not followed in that Ms Himiona and Evana-Jade were left without medical supervision several times in the first hour after birth.

The CMH Report also noted that the information displayed at the Maternity Unit for calling St John Ambulance Service advised calling the professional 0800 number rather than 111. This led to the non-urgent phone number being used to initially request an ambulance, potentially delaying the transfer to hospital by up to 26 minutes.

Additionally, there was a miscommunication to St John regarding the type of ambulance required. This miscommunication and the use of jargon such as "air puff" and "baby bus" led to the wrong type of ambulance being sent in the first instance, which was designed to provide patient transfer only and not medical treatment.

COMMENTS OF CORONER WOOLLEY

I. The outcome in this case is utterly tragic, and, unfortunately, despite a thorough investigation into Evana-Jade's death, there is no one clear answer about what medically caused her to die. The

investigation has, however, identified some issues that could have contributed to this outcome. I have found the following contributed:

a. The initial temperature of the bath water, at 38 degrees Celsius, was too hot.

b. Evana-Jade may have got cold in the bath after birth.

c. Mother and baby were left alone in the first hour after birth while skin to skin contrary to the MOH Guidelines.

d. There were delays in calling an ambulance and, when called, a non-urgent 0800 number was called rather than 111. Further, it was not clearly conveyed to St John that there was a life-threatening emergency situation.

CMH Report

II. In respect of the issues identified by CMH in the CMH Report, I recognise that the CMH Report also contained a number of recommendations to address those issues. In the table below I set out those recommendations, alongside the advice that I have received from CMH about its progress in implementing those recommendations:

Recommendation	**Advice on implementation of the recommendation as at 26 November 2021**
The National Observation Guideline regarding the observation of the baby and the frequency of vital signs in the immediate postnatal period be reviewed to include any assessment of vital signs requires good lighting; and the vital signs should be plotted on the Neonatal Early Warning Score.	CMH advises that on 13 April 2017, CMH introduced a Neonatal Observation Guideline which introduced the Neonatal Early Warning Score (NEWS), an escalation pathway for new-borns of concern. It also defined the criteria for, and frequency of, observations for new-borns to ensure they are appropriate to their clinical need. These observations are documented on a specific NEWS chart. CMH also advised that it had implemented the Ministry of Health consensus statement for the observation of mother and baby in the immediate postnatal period.
The CMH Guideline Fetal Heart Rate Monitoring in Labour be circulated to DHB and LMC midwives emphasising the guidance to “Listen for 60 seconds at a time, starting during a contraction: at least every 15 minutes in the active first stage of labour; at least every 5 minutes during pushing (with every 1-2 contractions); Duration 30-60 seconds”.	I am advised by CMH that these documents are circulated to all Women’s Health clinicians and LMC Access Holders.

Recommendation	Advice on implementation of the recommendation as at 26 November 2021
Professional follow up with Ms McCourt as appropriate.	I am advised by CMH that the Director of Midwifery Practice spoke with Ms McCourt.
Communicate to all midwives and LMCs CMH's Guideline (2015) Water Immersion during Labour and Birth.	CMH advises that this document was updated in 2019 and is circulated to all Women's Health clinicians and LMC Access Holders.
Ensure that the Primary Birthing Units have on display the St John Ambulance Services Inter Facility/Hospital Patient Transfers flow chart. Provide education and orientation to core midwives and LMCs to ensure that urgent requests for ambulance transfers are made utilising the 111 system to ensure appropriate ambulance response resourcing.	CMH advises that the flowchart is now displayed at all primary birthing units and all primary birthing unit charge midwives' managers had confirmed that updated resources and education have been implemented as recommended. CMH further advised that it also now has guidelines that describe the process and expectations around an emergency transfer from a CM Health Primary Birthing Unit to Middlemore Hospital.
Explore the practicality of teaching Laryngeal Mask Airway insertion in neonates to CMH midwifery and nursing staff as part of the neonatal resuscitation education.	CMH advises that the use of LMA in neonates was reviewed and its use in primary birthing units was assessed. Following careful consideration, CMH's preference in the primary birthing units is to promote the use of IPPV with a bag valve mask, or IPPV or Continuous Positive Airway Pressure (CPAP) with a T-piece device. CMH advised that LMAs would be suitable for use on rare occasions but only in experienced hands and that it would be difficult for midwives to maintain their skills in using these if it is rarely used.
Consider developing criteria for the use of a thermal wrap when transferring babies requiring resuscitation from the primary birthing units to Middlemore Hospital.	CMH advises this has not been developed further.
Explore whether any progress has developed regarding developing a sustainable regional neonatal/paediatric transport system.	CMH advises this is being discussed at a regional level and that the Auckland region is currently introducing a regional neonatal cot coordinator role that will facilitate the use of neonatal cots across the region. Once this rile is established the natural progression will be to establish a regional neonatal transport system.
Discuss with Neonatal SMO staff strategies whereby their acute advice could be obtained before or during a transport of a critically unwell neonate.	(a) CMH advises that the CMH Guidelines entitled Emergency Transport during emergency transfer from a Primary Birthing Unit to Middlemore Hospital Birthing and Assessment Unit incorporates guidance for the LMC or relevant midwife to consult with the on-call Neonatal Consultant so a joint decision can be made to determine the emergency ambulance transport required. CMH advises that the on-call Neonatal Nurse Practitioner is always available for staff to contact for advice and

Recommendation	Advice on implementation of the recommendation as at 26 November 2021
	a neonatologist is available through the hospital operator as required.

III. I note that almost all of the recommendations have been acted upon, or are in progress, with only one recommendation not developed further. Given the action already taken by CMH, and the action still in progress, I do not consider it necessary to make any further recommendations to CMH.

Ms McCourt (LMC) and the core midwives

IV. I recognise that Ms McCourt identified that changes in her practice were required, in particular with regard to the advice she gives to parents about how to recognise a baby becoming unwell and to ensure she closely watches a mother and baby in the first hour following birth. I commend Ms McCourt for this self-reflection and endorse these changes to her practice, in particular the need to remain in the room with mother and baby in the first hour following birth. However, I would also draw Ms McCourt's attention to the other issues that I have highlighted above and recommend that:

a. For any water birth for which she is LMC, she ensures the temperature of the bath water is never any warmer than 37.5C; and

b. In emergency situations, she seeks help from other midwives and/or emergency services as quickly as possible, without any delay.

V. I also recognise that some of the issues that I highlight above are not solely concerned with Ms McCourt's actions on the morning of 27 February 2017. I also recommend that core midwives also ensure that in emergency situations, help from emergency services is sought as quickly as possible, without any delay.

VI. Further, when calling to request an ambulance, it is crucial that the exact nature of the situation is made clear to the St John phone operators. I appreciate that situations such as the one in this case are extremely difficult and distressing, however, it is critical that health professionals retain the ability to clearly communicate the exact nature of the emergency on hand.

General observation about resuscitation procedures

VII. I acknowledge the existing compulsory requirement for midwives to complete ongoing resuscitation education and, therefore, a recommendation to this effect is not necessary.

Ambulance delays

VIII. With respect to the delay with an ambulance attending the Maternity Unit, I do not consider it necessary to make any formal recommendations about this because the issues have been identified and addressed by St John's own review. I commend St Johns for their proactive approach to investigating the cause of the delay and making appropriate changes to their Operating Procedures.

However, I record that, in my view, the delay in an ambulance attending the Maternity Unit was not due to any fault of St Johns, as they responded to the information they were given in the first phone call from the Maternity Unit. I have made comments above regarding the need for health professionals to ensure they give clear and accurate information to St Johns when requesting emergency ambulance assistance.

Rationale for the recommendations made

IX. I consider that the recommendations I have made above may reduce the chances of future deaths occurring in similar circumstances because:

a. As noted above, if the temperature in the bath is too hot, this can cause fetal hyperthermia and made any subsequent resuscitation more difficult. Therefore, ensuring the correct bath temperature assists to avoid these risks.

b. The LMC remaining in the room with mother and baby in the first hour post birth ensures that if the baby does show signs of decline, that can be addressed immediately and reduces the risk of a baby deteriorating to the point where resuscitation is necessary. It would assist to identify the cause of the decline and, therefore, identify the appropriate medical treatment required in response.

c. Calling quickly for assistance from emergency services can expedite urgent resuscitation assistance or transfer to the relevant hospital, and any urgent hospital treatment can be administered as soon as possible, assisting with the preservation of life.

X. The circumstances of Evana-Jade's birth and subsequent death could, in my view, provide a valuable learning tool in midwifery training, in particular in the importance of following the Guidelines. I propose therefore, to send a copy of this finding (in anonymised form) to the College of Midwives for its potential use in this respect.

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

Maru-Walker [2022] NZCorC 11 (27 January 2022)

CIRCUMSTANCES

Korowai-Aroha McKeilah Maru-Walker, aged 4 ½ months, died on 21 March 2020 at 130B Tramway Road, Hamilton of asphyxia due to smothering by an overlying dog.

On the evening of 20 March 2020, Korowai-Aroha was staying at her kaumātua (grandparents') home for the night. Living on the property was a bulldog named Wairua, who usually slept on a three-seater couch in the lounge.

As Korowai-Aroha had outgrown her Pēpi-Pod, she was put down to sleep on a reclined lazy boy chair in the lounge at approximately 9:00pm that night. At around 10:00pm her kaumātua went to sleep on an air mattress on the floor of the

lounge. Korowai-Aroha awoke at 2:00am, was bottle fed and then put back to sleep on the lazy boy chair. She immediately fell asleep.

At 7:00am on 21 March 2020, Korowai-Aroha's aunt, who also lived on the property, entered the lounge and saw Wairua asleep on top of Korowai-Aroha. The dog was pulled off Korowai-Aroha, who was unresponsive. Despite resuscitation efforts, Korowai-Aroha could not be revived.

COMMENTS OF CORONER BATES

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

II. Although it is not clear that the safe sleep message was given to Korowai-Aroha's whānau, it is clear that Korowai-Aroha had only recently begun sleeping on a recliner chair at her kaumātua's home when she stayed. Korowai-Aroha's death is tragic and serves as a reminder that every sleep should be a safe sleep.

III. I note that the Ministry of Health launched a SUDI prevention programme in August 2017, directed at significantly reducing the number of deaths of babies. A key focus of the programme is to target the two key modifiable risks of SUDI: exposure to tobacco smoke during pregnancy and unsafe bed sharing. Such measures are clearly desirable to reduce the instances of infant deaths. I record that Korowai-Aroha's mother very responsibly stopped smoking immediately when she found out she was pregnant. In the present case there was no bed sharing with whānau, but the chair Korowai-Aroha was sleeping on was known to be used on occasion by the dogs of the kaumātua. This presented a risk of smothering akin to risk associated with co-sleeping, as tragically realised in Korowai-Aroha's case.

IV. The above being said, I wish to emphasise that Korowai-Aroha was clearly loved and well cared for by her whānau.

V. In the circumstances of the present case, I do not consider that formal recommendations are necessary.

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

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

Drowning

Bao [2022] NZCorC 20 (11 February 2022)

CIRCUMSTANCES

Hanbo Bao, aged 44, died on 25 December 2019 at Kai Iwi Lakes of drowning.

On 25 December 2019, Mr Bao, a Chinese national, visited Kai Iwi Lakes camping ground in the Kaipara District with his family. Mr Bao entered the water to snorkel in an area where there is a sudden drop into a deep area of the lake. After half an hour, Mr Bao had not returned to shore and was unable to be found. He was eventually located deceased at the bottom of a shelf in the water about 20 metres below the surface.

The Kai Iwi Lakes area has water safety warning signs in English. The signs warned of the sudden drop in the water and noted that individuals are less buoyant in lake water than in seawater. The evidence indicated that Mr Bao did not have sufficient English language proficiency to understand the water safety warning.

COMMENTS OF CORONER TETITAHA

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

II. I am concerned Mr Bao may not have understood the hazards of swimming at Kai Iwi Lakes. The only signage was in English.

III. I made enquiries with the Kaipara District Council about the adequacy of the signage and the availability of water safety patrols. The Council have replied as follows:

IV. The current signage is located on the main office noticeboard and at the main exist points to Pines Beach (main swimming location) Promenade Point and Lake Waikare entrances.

V. The current signage was installed in 2018, there was a discussion on what languages these should be in but due to the many nationalities that visit the Lakes, we decided to use pictures instead.

VI. There is an AED at the main office, 3 life preservers, one at Pines Beach, Promenade Point and Lake Waikare.

VII. The lakes have no lifeguards on patrol, this is due to not being able to get qualified lifeguards and the amount that would be required to patrol the area.

VIII. Recommendations to prevent similar deaths would be more signage in multiple languages, advising the freshwater lakes do not have the same buoyancy as salt water.

RECOMMENDATIONS OF CORONER TETITAHA

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

a. The Kaipara District Council consider installing signage in multiple languages including Chinese warning that the freshwater lakes do not have the same buoyancy as salt water and to take care whilst swimming.

b. The Kaipara District Council consider employing qualified lifeguards during peak periods such as December/January.

II. I provided a copy of the above comments and recommendations to the Kaipara District Council. The Council have provided the following reply.

III. The Council agrees to the recommendation regarding installing supplementary signage in multiple languages including Chinese.

IV. Further the Council has agreed to consider employing qualified lifeguards over the December/January. The Council will commission a report assessing options for employing lifeguards at different locations at the lakes over December/January. It is anticipated that this report once completed, would be presented to the Mayor and Councillors for discussion endorsement of identified practical options.

V. The Kaipara District Council are thanked for the above replies.

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

Deng [2022] NZCorC 18 (8 February 2022)

CIRCUMSTANCES

Zhongyu Deng, aged 40, died on 25 December 2019 at Uretiti Beach of drowning.

On 25 December 2019 Mr Deng travelled to Uretiti Beach to go crab fishing with a friend. When he went out to retrieve one of the crab pots, he disappeared under a wave. Mr Deng was later located at one of the crab pots with his arm tangled in a rope.

COMMENTS OF CORONER TETITAHA

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

II. According to Water Safety New Zealand, 74 New Zealanders drowned in 2021 despite Covid-19 lockdown restrictions.[1] There were 8 preventable drownings in Northland in 2021, a reduction from 9 preventable drowning fatalities and Northland in 2020. Four of the preventable drownings in 2021 occurred at local beaches.[2] The figures indicate that more is needed to be done to prevent further drownings.

III. Uretiti Beach is a popular spot with swimmers during the peak summer season between December to January who also camp at the local Department of conservation campsite.

IV. Surf Lifesaving New Zealand have provided a report including a fatality brief regarding this death (the report). The report confirms that Uretiti Beach is not patrolled by surf lifesaving. This is despite it being known as hot spot for drownings over December - January (peak holiday season).

1 Water Safety New Zealand "2021 Provisional Drowning Report" online publication https://watersafety.org.nz/2021-Report-Provisional.
2 Water Safety New Zealand "2021 Drowning Toll Regional Breakdown-Northland" online publication https://cdn.fld.nz/uploads/sites/watersafety/files/Drowning_Report/Drowning_Fact_Sheets_2021/2021_Northland_Statistics.pdf

V. By contrast Ruakākā Beach and Waipu Cove beaches have weekday professional life guarding services over the Christmas period (10:30 am and 6:30 pm) by contract lifeguards and during labour weekend to Easter on weekends (11:00am to 4:00pm to 5:00pm) by volunteer lifeguards.

VI. Both patrols are regularly tasked to incidents occurring at Uretiti Beach. The approximate response time for lifeguards to reach Uretiti Beach from Ruakākā is 5 minutes during patrol hours, and 15 minutes outside of patrol hours. A rescue watercraft (Jet ski) is located at Ruakākā and does do roving patrols along the Bream Bay coastline, however this is not the same as a regular patrol presence.

VII. Uretiti Beach is exposed to moderate wave energy from the North, North East, East, and Southeast; high-energy waves are produced at times, particularly associated with subtropical depressions. Rip currents can develop anywhere along the beach. Rip currents shift frequently and are stronger during large surf and/or an outgoing tide. I understand this information is intended to indicate how unpredictable the currents are at Uretiti Beach.

VIII. An inquest into the death of a man crab fishing on Christmas day 2014 at Uretiti Beach recommended signage in multiple languages warning of the risks and dangers at beaches.[3] There is safety signage located at two main beach access ways to Uretiti. The signage has warnings in multiple languages, indicating the presence of strong currents and that the beach is not patrolled by lifeguards. It does not appear the signage was effective in preventing this death.

IX. The report provided a table of previous drowning records along the Ruakākā, Uretiti and Waipu Cove stretch of coastline between 1 July 2010 and 30 June 2020. The majority of drownings occurred at Uretiti Beach.[4] I have surmised this may be due to the lack of patrols.

X. Surf Lifesaving New Zealand confirm they have made applications to local councils to provide a paid lifeguard patrol service at Uretiti Beach over the peak period but have been unsuccessful due to insufficient funds.

XI. Given the numbers of drownings at the beaches, including Uretiti Beach and the increased numbers of residents as well as holidaymakers in this area, consideration should be given to funding a lifeguard presence during peak holiday periods. A lifeguard presence should prevent similar deaths occurring at Uretiti Beach.

XII. These comments are directed to the Kaipara, Whangārei and Northland Regional Councils. The Councils were given an opportunity to reply but have not provided any response to these comments or the below recommendation.

RECOMMENDATIONS OF CORONER TETITAHA

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

3 Wu [2018] NZCorC 100 (20 December 2018).
4 During this period there were 8 drownings in total, 4 occurring at Uretiti Beach.

II. That the Kaipara, Whangārei and Northland Regional Councils consider funding surf Lifesaving New Zealand to provide a lifeguard presence during the peak holiday period (December to January) at Uretiti Beach.

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

Park [2022] NZCorC 17 (4 February 2022)

CIRCUMSTANCES

John Park, aged 51 years, died on 11 August 2018 at sea off the Tutukaka coast from drowning.

On 11 August 2018 Mr Park set out for a solo paddle on his surf ski. He was wearing a thin rash top, thermal long johns and compression shorts. He was also wearing a life jacket and had a handheld VHF radio and a LED distress flare.

The sea conditions were moderate-to-rough and, after approximately 45 minutes on the water, Mr Park capsized twice within the space of four minutes. After his second capsize, he was unable to remount and instead stayed in the water holding his craft. Approximately 53 minutes later, Mr Park set off his distress flare. A rescue vessel was sent, however as Mr Park did not have a locator beacon, rescue crew had to navigate visually in the rough sea conditions. Approximately 45 minutes after he set off his distress flare, Mr Park was pulled into the rescue vessel and was subsequently pronounced deceased.

Mr Park did not attempt to use his VHF radio to call for help. It is possible that he was not able to access this device, either because it was secured to his craft out of his reach, or because it had been loose and was washed away when he capsized.

RECOMMENDATIONS OF CORONER HO

I. Mr Park's death was avoidable. I make the following recommendations to recreational paddlecraft users under s 57A of the Act:

a. Do not go out in rough conditions unless you are absolutely confident of your ability, in those conditions and any worsening conditions indicated by the marine forecast, to remount your craft on multiple occasions in quick succession. Assume the worst and consider whether you would be able to make it back to shore. If in doubt – do not go out.

b. Carry multiple, and at least two, emergency communication and signalling devices, of which at least one should be an emergency position-indicating radio beacon (EPIRB) or personal locator beacon (PLB). Ensure that communication devices such as VHF radios and mobile phones are either waterproof or secured in a waterproof bag and that they are secured to your person. Ensure that distress flares are working.

c. Wear clothing that is appropriate to the sea temperature and the risk of capsizing. When assessing the risk of capsizing, take into account your level of experience on the craft in

question and the sea conditions, including any conditions which might likely arise during your time on the water and as indicated by the marine forecast.

II. A lifejacket is only one of the several essential items that should be worn or carried while out on the water. As Mr Park's death demonstrates, a lifejacket will help in the event of a capsize, but it is not a guarantee of safety.

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

Zheng [2022] NZCorC 43 (18 March 2022)

CIRCUMSTANCES

Biao (also known as Bill) Zheng, aged 40, died on 19 January 2019 at Mangawai Surf Beach, Mangawhai Heads, as a result of salt water drowning.

Mr Zheng had gone to the beach with his family for a picnic and to go swimming. At around 10:30am, he got into the water with two of his children in an area that was not patrolled by lifeguards. His daughter said that they did not go very far out but that the waves were big. After around 20 minutes, Mr Zheng's son ran ashore to tell his mother that Mr Zheng was missing.

Mr Zheng's wife took a surfboard and searched for him without success in the water, before running to seek help. A member of the public who had observed Mr Zheng floating past him face down in the water had already alerted a lifeguard.

Shortly afterwards, lifeguards found Mr Zheng unresponsive in waist deep water and brought him to shore, where CPR was undertaken but was ultimately unsuccessful.

The Coroner concluded that sadly Mr Zheng's death was preventable. While Mr Zheng and his family had chosen a lifeguarded beach, their safety was not being monitored as they were swimming outside the flags. The evidence was that Mr Zheng was not a strong swimmer, and it was possible that he overestimated his ability to cope in the conditions, which included some waves and a rip current in the area.

COMMENTS OF CORONER GREIG

I. Surf Lifesaving New Zealand suggested the following beach safety messages to help prevent another drowning in similar circumstances:

- Choose a lifeguarded beach and swim between the flags.
- Do not overestimate your ability or your children's ability to cope in the conditions.
- Get a friend to swim with you – never swim or surf alone.

- Watch out for rip currents, they can carry you away from shore. If caught in a rip current, relax and float, raise your hand to signal for help, ride the rip until it stops, and you can swim safely back to shore. Remember – nobody is stronger than a rip.
- If in doubt, stay out.
- If you see someone in trouble, call 111 and ask for Police.

II. I endorse these comments.

Note: An order under section 74 of the Coroners Act 2006 prohibits the making public of any photographs of the body of Biao Zheng entered into evidence in this inquiry upon the grounds of personal privacy and decency.

Drugs

Redfern [2022] NZCorC 35 (12 March 2022)

CIRCUMSTANCES

Katarina Tracey Redfern, aged 53, died on 14 July 2021 at 81A Smeaton Drive, Raumanga, Whangārei. The cause of death was accidental multiple drug toxicity, with hypertension and coronary atherosclerosis significant contributing conditions.

Ms Redfern had been prescribed substantial amounts of codeine and morphine (both types of opioids) for her chronic back and hip pain between 2016 and 2021. However, her husband reported that her pain was becoming worse.

After eating dinner on 13 July 2021, Ms Redfern told her daughter that she had taken venlafaxine and three morphine tablets for pain. When Ms Redfern went to bed later that evening, she told her husband that she had taken more pain medication. Unusually, she slept through the night and did not move much, and remained sleeping throughout the following morning. Ms Redfern's husband checked on her at around midday and saw that she was still breathing, before leaving the house for an appointment.

At around 2:00pm, Ms Redfern's daughter arrived home and found her unresponsive in bed. Emergency services attended and confirmed that Ms Redfern had died. Police located a large amount of codeine tablets and an empty package of sevredol morphine sulfate, with an expiry date of June 2020. No written advice to Ms Redfern regarding the dosage of sevredol was found, and no other written advice warning about combining sevredol and codeine together or with other drugs was produced in evidence.

The Coroner noted that when people take high doses of opioids, it is accepted that this can lead to overdose, with the slowing or stopping of breath and sometimes death. This is estimated to account for around half of all drug-related deaths.[5] There was no clear evidence that Ms Redfern had deliberately taken toxic levels of her prescription drugs with the intent of ending her life.

5 Drug Information and Alerts Aotearoa New Zealand "high alert" website https://www.highalert.org.nz/articles/overdosing-on-opioids/

COMMENTS OF CORONER TETITAHA

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

II. From the evidence it appeared Ms Redfern had been taking large amounts of codeine for pain. It appears she may have been combing this with morphine as well.

III. Educational messages are needed to better inform the public about the potential harms of chronic codeine use, especially in the context of polypharmacy where patients are taking a large number of medicines. Written advice regarding preventing opioid overdosing should be distributed to the patient and their whānau at the time medical practitioners are prescribing these drugs.

IV. Medical practitioners should be encouraged to review previous prescriptions and provide advice on appropriate use and/or disposal of opioids when no longer needed.

V. Education and strategies to deliver this advice to patients and their whānau about possible opioid overdosing might have prevented this death from occurring.

VI. These comments and a draft recommendation were directed to Ministry of Health and the Medical Council of New Zealand. The Ministry of Health (the Ministry) have provided a written reply as set out below.

VII. The Ministry consider that it may be appropriate for written advice on preventing opioid overdosing for patients and whānau to be produced. They believe that the Health Quality and Safety Commission (HQSC) is better placed to provide advice on preventing opioid overdosing in patients and whānau, especially given that HQSC are taking a lead on the consumer safety/communications action of the safer person-centred prescribing and dispensing work.

VIII. Work is also underway to scope system level support for clinical pharmacists in primary care team roles. This work is led by the Clinical Advisory Pharmacists Association and the Royal New Zealand College of General Practitioners. Multi-disciplinary medication reviews that involved clinical pharmacists have the best evidence for addressing inappropriate polypharmacy. This includes addressing potential harms of chronic codeine use in the context of polypharmacy.

IX. The Ministry have also indicated a willingness to work with Coroners to develop a system of circulating anonymised reports (decisions) to relevant stakeholders for learning purposes. They further suggest it may be beneficial for generalisable learnings as well as anonymised reports to be available in the public domain.

X. The above paragraph requires further discussions between the Chief Coroner, Ministry of Justice and Ministry of Health to determine if and how this may occur. A copy of the Ministry's reply and this decision have been provided to the Acting Chief Coroner for consideration.

RECOMMENDATIONS OF CORONER TETITAHA

XI. Having taken into account the above reply I make the following recommendations pursuant to section 57A of the Coroners Act 2006:

XII. The Ministry of Health facilitate the production of written advice on preventing opioid overdosing for patients and whānau. This may include working with other agencies to develop advice regarding opioid overdosing for patients and their whanau and strategies to deliver this advice appropriately and effectively. The advice might include reviewing unused opioid medications including seeking disposal.

Note: An order under section 74 of the Coroners Act 2006 prohibits the making public of any photographs taken of Ms Redfern during this inquiry (being photographs of a deceased person), in the interests of decency.

Wilkinson [2022] NZCorC 44 (21 March 2022)

CIRCUMSTANCES

Steven Robert Wilkinson died on 30 October 2018 at Auckland of alcohol, lorazepam, quetiapine, sertraline and venlafaxine toxicity.

On 30 October 2018, Mr Wilkinson was found collapsed and unresponsive by his parents at their family home. Despite medical assistance, Mr Wilkson was declared deceased. Subsequent toxicological testing undertaken as part of the post-mortem process found that Mr Wilkinson ingested alcohol, lorazepam, quetiapine, sertraline and venlafaxine prior to his death.

The evidence indicated that Mr Wilkinson was self-medicating by combining different medications and not following medical advice about the need to not take these drugs with alcohol.

COMMENTS OF CORONER HESKETH

I. This is another example of a life ended prematurely by someone on prescribed medication choosing to ignore Medical Practitioner advice as to dosage and frequency. Furthermore, taking other suppressant medication that was not part of the treatment plan has increased the danger of respiratory depression.

RECOMMENDATIONS OF CORONER HESKETH

I. I recommend that people on prescription medication/s comply with the advice provided to them by their Medical Practitioner or Pharmacist where appropriate regarding dosage and frequency

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

Fall

Zeitler [2022] NZCorC 37 (14 March 2022)

CIRCUMSTANCES

Rolf Paul Christian Zeitler, aged 75, died at Auckland Hospital on 7 February 2021 of pulmonary embolus due to complications of blunt trauma to the head due to fall from height.

On 6 February 2021, Mr Zeitler was cleaning the roof with a water blaster when he fell from the roof. He did not have a safety harness or safety equipment.

COMMENTS OF CORONER TETITAHA

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

II. There are numerous resources setting out how to safely work at height including upon roofs.[6] These resources identify the need for safety equipment and clothing to be used when working at heights including at home. If appropriate safety equipment and clothing such as a safety

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

Fire

Ratahi [2022] NZCorC 46 (22 March 2022)

CIRCUMSTANCES

Ely D Ratahi, aged 31, died on 30 March 2018 at Middlemore Hospital from multi-organ failure as a result of self-inflicted injuries, in circumstances not amounting to suicide.

Mr Ratahi's childhood was difficult, and he suffered from abuse. At the age of 10, after three years in foster care, he was adopted by Nigel and Beverly Marshall. During his childhood, Mr Ratahi achieved well academically and in sports.

Mr Ratahi had a significant mental health history and experienced his first psychotic episode in 2004, when he was 18. He was treated by the Taylor Centre Community Mental Health Centre under the Auckland District Health Board (ADHB) from 2004. Mr Marshall described Mr Ratahi as very perceptive and conscious of his health but noted that he enjoyed the social side of using alcohol and drugs, which he started while he was at university.

In 2011 Mr Ratahi had a confirmed diagnosis of schizophrenia. He was under the care of the Māori Mental Health Team at Manawanui from 2012 until his passing. He had various keyworkers but had a stable relationship with his psychiatrist until a changeover in June 2016. His new psychiatrist reported that he engaged with her in a "needs must" way.

In mid-2017, Mr Ratahi's clinicians and his family noticed that his presentations had changed. He missed his clinical appointments and withdrew from his family. Manawanui staff contacted Mr Marshall in November 2017 to relay concerns

6 Worksafe NZ website https://www.worksafe.govt.nz/topic-and-industry/working-at-height/roofs/working-on-roofs-gpg/

and obtain his contact details. When Mr Ratahi continued to refuse medication, Manawanui staff contacted Mr Marshall to discuss any proposed treatment plans.

On 2 February 2018, Mr Ratahi applied to move into a boarding house at 17/21 Middleton Road, Remuera. Residents described him as “staunch”, although he kept to himself.

On 24 March 2018, Mr Ratahi was found severely injured in his room. Emergency services attended, and Mr Ratahi was transported to Middlemore Hospital. Sadly, Mr Ratahi’s condition deteriorated, and he died in hospital on 30 March 2018.

COMMENTS OF CORONER BELL

I. Mrs Marshall opined that the current mental health system in New Zealand operates from a regime of ‘exclusivity’ not ‘inclusiveness’ which is negatively fostered by the Privacy Act 1993. She enlarged on that opinion stating information that could be available in saving a person’s life, is not allowed to be shared, nor is it widely available. She and her husband knew Mr Ratahi better than anyone but there was little dialogue between them and his mental health team. She provided a number of examples where communication with her, Mr Marshall and the mental health team may have altered the approach to Mr Ratahi’s care. One example being that the information sharing would have provided greater understanding that Mr Ratahi’s condition may have been inherited.

II. I sought comment from ADHB regarding the concerns raised by Mrs Marshall. ADHB responded that there were specific times when Mr Ratahi specifically stated he did not want them to contact his parents. ADHB also stated that ‘there are times when we are prohibited by tangata whai te ora from involving whānau. Aroha/mai we apologise if the Privacy Act has at times prevented us from involving Ely’s whānau in his care”. ADHB explained that its privacy obligations in these circumstances may have meant that it was prohibited from disclosing Mr Ratahi’s health information without his authorisation, except in specific circumstances, such as a serious threat to his life.

III. I direct a copy of this finding together with Mrs Marshall’s letter be forwarded to Ministry of Health - Mental Health Services as part of the ongoing considerations of these issues.

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.

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

Leisure Activity

Sangsirichat [2022] NZCorC 14 (28 January 2022)

CIRCUMSTANCES

Pitiphong Sangsirichat, aged 25, died on 29 January 2018 at Auckland City Hospital. The cause of death was head injuries following a fall while skateboarding.

Mr Sangsirichat would skateboard most days and was confident in his abilities. On 27 January 2018 Mr Sangsirichat went to the Victoria Park skate park. He was not wearing a helmet.

At the northern edge of the skateboard park, adjacent to Beaumont Street, was a building used to service the Victoria Park tunnel (known as the Northern Egress Structure or NES). The function of the building was to provide egress stairs from the tunnel below, services control and the housing of fire boosters. The structure was approximately 3.85 metres high, 10 metres long and 5.3 metres wide. The concrete roof is flat with a membrane waterproofing layer. One side of the NES building contained a stainless-steel fenced wall. The other side had a steep concrete skate ramp attached to it. CCTV footage has showed adults and children used the stainless-steel fenced wall to climb up onto the NES' roof.

Mr Sangsirichat climbed up to the rooftop of the NES building. He intended to 'drop in' to the skate ramp from the roof-top. He stood there for a while. A crowd gathered at the bottom to watch him. Most were telling him "to do it" and started to record him on their cell phones. Others, including his partner, told him not to do it. Mr Sangsirichat dropped off the edge of the roof-top towards the skate ramp. Partway down, the skateboard went out from underneath him and continued down the ramp. Mr Sangsirichat fell backwards at the bottom of the ramp and hit the back of his head on the ground. There was a loud cracking noise as he hit the concrete. He lay unmoving on the ground.

Emergency services were notified and Mr Sangsirichat was taken to Auckland Hospital, where he died two days later.

COMMENTS OF CORONER TETITAHA

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

II. From the inquiries made to date, several concerns regarding this death have arisen. These are:

- The lack of any legal requirement for safety equipment to be used by skateboarders;
- The skate ramp attached to the NES building;
- The NES was not designed for skaters to access the roof and drop off onto the skate ramp attached to the building.
- Confusion regarding responsibility for the health and safety of users of the skate ramp attached to the NES building. The skate ramp is the property of the Auckland City Council. The NES building is the property of the New Zealand Transport Agency (NZTA).
- Adults and children climbing onto the roof of the NES building to use the skate ramp. NZTA have CCTV footage and there are several YouTube videos showing children climbing the NES using the stainless steel fence wall and being taunted to use the skate ramp.
- The insensitivity of persons taking photographs of an injured (and possibly dying) person.

III. Following Mr Sangsirichat's death, Auckland City Council advised they have installed razor ribbon around the top perimeter of the structure and erected signs on the building warning people not to climb

it. In addition, a security guard was stationed at the skate park from 7:00am to 10:00pm to dissuade people from attempting to climb the structure.

IV. NZTA advised they had commissioned a report from Opus regarding other options for modifying the cladding the building and installing anti climb roll bars. NZTA confirmed an agreement had been reached with the Auckland Council to install one anti-climb roll bar above the ramp to add a further deterrent to people climbing the building to drop onto the ramp.

V. If there had been a design standard regarding the placement of skateboard ramps alongside buildings including ensuring they were not climbable, this death may not have occurred.

VI. Mr Sangsirichat was not required by law to wear a helmet whilst skateboarding. If he had been wearing a helmet whilst skateboarding, he may not have died due to head injuries.

VII. Consideration should be given to whether there should be a law change to require helmets to be worn by skateboarders. Unlike cyclists, skateboarders do not have to wear a helmet. However, like cyclists' skateboards can be ridden on the road, although without requirement for a helmet or any other protective gear.

VIII. Mr Sangsirichat's whānau have raised concerns about near misses or other serious injury accidents at the Victoria Park skate park. They also sought answers to whether there had been concerns raised about people climbing the structure and experience of the designers in designing skateboarding facilities. The family also wants to know about any monitoring of its use following the opening in 2011 or any review about the park functionality to identify flaws or potential risks. These concerns were forwarded to the Council for consideration.

IX. The Auckland City Council provided a reply as follows:

- from a review of the records there is nothing to indicate that Council was made aware of any near misses or serious incident injuries that occurred at skate park between 2011 and prior to this death;
- at the design stage, Council sought advice from Isthmus group and a skate park advisory group made up of a small number of local great park users about the suitability of the ramp on the base of the building. Council was advised by Isthmus and the skate park advisory group that given the height of the egress structure, combined with the angle and shape of the ramp, it was virtually impossible for people to jump onto the ramp, on a skateboard from top of the building and land to track. In their view this would dissuade users from attempting this. Council relied on this advice.
- Council received a tender from Isthmus for the design of the skate park upgrade but cannot locate this. Isthmus was evaluated by Council as the most suitable vendors. They had previously designed Barry Curtis skate park and the Otara skate park amongst other projects. The subcontractor for the physical works, P&M Civil Ltd also had extensive streetscaping experience.

- Once opened, Council occasionally receives feedback from local skateboarders who are part of the skate park advisory group on potential safety risks for users. Where those issues related to the NES building, it was passed on to the owner NZTA. Maintenance subcontractors inspect the skate park for damage/safety concerns amongst other issues. Any issues are recorded in the risk manager. Once a month, subcontractors carry out an operational inspection of the play equipment. On an annual basis Council engages contractors to carry out a full condition assessment of its facilities including skate park.
- Since September 2019 the Council has evolved a 2021 Practice Note requiring each skate park design have a Safety in Design Compliance Report completed at the design stage as well as post installation. At the end of a project the design team is to record the lessons learned throughout the project. These design lessons can then be included in the Practice Note and used in future design.
- There are no specific design standards for skate parks.
- The Auckland design manual (the manual) provides guidance for delivering built environment project in Auckland to meet the Auckland plan 2050 objectives and has a section on skate parks. The manual encourages the involvement of local skateboarders and young people in the design process and suggests these skate parks should be located away from sources of debris which could compromise user safety.
- The council has a “corporate standard” for managing health and safety risks associated with external contracts.

X. The Ministry of Transport (Ministry) has also provided a reply in respect of the comments and recommendations. The Ministry has previously considered mandating helmets for skateboarders when riding on the road. However, the Ministry submits that any changes to the transport rules need to be underpinned by evidence that such a change is beneficial and justifiable. The evidence referred to is from 2000 to 2009 where there were 3 fatal collisions, 39 serious injuries, and 95 minor injuries involving a skateboarder and a motor vehicle. At that time, it was determined due to the costs and implementation challenges, mandating skateboarders to wear a helmet on the road was not an appropriate response to the risk.

XI. The Ministry has considered international examples and states many jurisdictions do not mandate helmet use for cyclists, skateboarders or any scooters. It believes New Zealand is an “outlier” by mandating helmets be worn by cyclists. There are different views about the safety benefit of helmet requirements - on one hand the helmets provide a level of protection to individual users in the event of some pressures but on the other, there is evidence that the mandatory requirement serves as a deterrent to the uptake of active travel which is likely to reduce health and other benefits, although the magnitude of this is debated.

XII. I thank the Council and the Ministry for their above replies and information.

RECOMMENDATIONS OF CORONER TETITAHA

I. I have considered the information that has been provided including the above replies. I remain of the view Mr Sangsirichat's death and similar deaths could have been prevented if the skate park design incorporated safety standards prevented or restricting the building of skate ramps on the sides of buildings that are not intended to be used for skaters to 'drop in' on the skate ramp.

II. The evidence that the Ministry has relied upon regarding skateboard injuries including death is historic. In 2019 ACC recorded 8083 claims for skateboarding injuries that increased to 9692 in 2020 and reduced slightly to 8950 in 2021. These would now appear to be a substantially greater number of skateboarding injuries than in 2000 to 2009. Compensation claimed for skateboarding injuries was $9,636,176 in 2018. These facts indicate the Ministry ought to (at least) review the current data pertaining to skateboarding injuries and consider law changes to require the wearing of helmets while skateboarding. There remains little doubt that if Mr Sangsirichat had been wearing a helmet he may not have died from head injuries.

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

IV. The Ministry of Transport review the current data pertaining to skateboarding injuries and consider law changes regarding the wearing of helmets while skateboarding.

V. That the Auckland City Council consider a design standard for skate parks that prevents or restricts the building of skate ramps on the sides of buildings that are not designed for skaters to drop in onto the skate ramp.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Mr Sangsirichat during this inquiry and photographs taken by bystanders at the scene where Mr Sangsirichat was injured on 27 January 2018, in the interests of decency.

Medical Care

Hazners [2022] NZCorC 30 (7 March 2022)

CIRCUMSTANCES

Aivars Hazners, aged 76, died at Palmerston North Hospital on 25 June 2020 of septic/endotoxic shock secondary to multiple sites of suppurative necrosis of the colonic wall, and emboli from an undetermined source (intracardiac vs aortic valve vs atheromatous complicated aorta). The manner of death was natural causes.

Mr Hazners had a history of ischaemic heart disease and was also diagnosed with cardiomegaly (an enlarged heart as a result of his heart valve problem heart disease). He took a range of prescription medications for other co-morbidities. He had also had surgery for bowel cancer in October 2019.

On 16 June 2020, Mr Hazners had loop ileostomy reversal surgery (to remove his colostomy bag), which had been delayed by approximately six months. The ileostomy reversal was an elective surgery and was not expected to go wrong.

He was discharged home on 22 June 2020, but three days later his condition deteriorated, and he was re-admitted for an emergency laparotomy. An ischaemic colon was found and resected. Increasing inotropes were required throughout surgery but Mr Hazners' blood pressure dropped, and he died nine hours after his admission to hospital.

The reporting surgeon did not know what had caused the colon to be ischaemic (lack of blood to the organ) and did not know what caused Mr Hazners' blood pressure to lower. She reported finding lots of old blood in the colon, and did not know what, if anything, had gone wrong with the ileostomy reversal.

Mr Hazners' family expressed a number of concerns about his care with MidCentral District Health Board (DHB), particularly questioning why the infection was not treater earlier, why Mr Hazners was discharged when he was still sick, and why the reversal procedure was not done by the same colorectal surgeon who undertook his previous operation.

The Coroner sought an independent report from Mark Omundsen, a Consultant Colorectal/General Surgeon employed by Bay of Plenty District Health Board. Mr Omundsen noted that when Mr Hazners was readmitted to hospital on the day of his death, his risk of operative mortality would have been predicted as 80% or greater. This should have been recognised earlier and triggered aggressive fluid resuscitation, the administration of intravenous antibiotics and an early senior surgical review (preferably a Consultant or Senior Registrar), as well as an urgent CT scan (ideally within two hours of request) with the report being fast tracked. A CT scan was not performed until over five hours after Mr Hazners' presentation, and his surgery likely commenced around seven hours after his presentation, just outside the ideal six-hour window. However, given his co-morbidities, Mr Omundsen considered it unlikely that an earlier delivery of surgical care would have changed the outcome for Mr Hazners,

Mr Omundsen was also satisfied that Mr Hazners was appropriately monitored and discharged following the ileostomy reversal surgery, and that his death was not related to any deficiency in the care he received. It was not possible to determine exactly when the emboli formed, although it was most likely as a result of his surgery on 22 June 2020.

The Coroner accepted the conclusion that Mr Hazners' death was not preventable.

COMMENTS OF CORONER HESKETH

I. Upon completion of my draft finding I recommended MidCentral District Health Board review their acute care system with the aim of having a Consultant available to cover acute care with no elective commitments. I directed my draft finding be sent to Dr Billinghurst the Chief Medical Officer, Primary Public and Community Health Executive at MidCentral District Health Board for consideration.

II. Dr Billinghurst responded to my draft recommendation on 7 March 2022 after reviewing all the current documentation. His observations from that review and from getting feedback from my draft finding include:

   a. Currently the acute care system does have a consultant available for surgical admissions without elective commitments. This has been in place now for over 12 months.

   b. He observes the delays occurring in ED reflect the general challenges (volume and space) of that unit. He records the total number of cases per day was 138 above the typical average of the unit on this day. Several reviews and improvement initiatives within the ED are already underway or happening at the level of the Ministry (of Health).

c. He notes the Early Warning System for Mr Hazners was at the highest level on his admission, but this doesn't seem to have translated through to urgent responses that might have been needed at the time. Dr Billinghurst will have Mr Hazners' case summarised and used as an educational case within the Emergency department to consider this point.

d. MidCentral DHB remain committed to continually improving their services and Dr Billinghurst appreciated the Coroner's findings.

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

Jimpson [2022] NZCorC 3 (19 January 2022)

CIRCUMSTANCES

Gwenda Jimpson, aged 90, died on 9 November 2018 at Selwyn Sunningdale Care Home, Hamilton of intracranial bleeds sustained in an accidental fall.

Gwenda was a resident at the Selwyn Sunningdale Care Home in Hamilton. On 22 October 2018 she was admitted to Waikato Hospital due to diarrhoea and vomiting. Whilst in hospital Gwenda was assessed as being at a 'high falls risk'. As a result of this classification, falls risk measures were put in place by the hospital. These were: a low bed, clutter free environment, 1-hour intentional rounding (which required a nurse to check on Gwenda every hour), grip socks, assistance with mobilising and a call bell within reach.

At around 5:00am on 28 October 2018, Gwenda had an unwitnessed fall in her hospital room and sustained an inoperable subdural haemorrhage. Gwenda's family were advised that her prognosis was poor. Gwenda was returned to her rest home for comfort cares, where she later died.

Her family laid a complaint with the Health and Disability Commissioner (HDC). That complaint was investigated, and a report dated 27 September 2019 as well as a supplementary report dated 14 November 2019 were provided to the family. The reports outline that there was no fault in the process or care taken by either the Selwyn Sunningdale Rest Home or Waikato Hospital. Accordingly, the HDC investigation file was closed.

However, Gwenda's family remained critical that the hospital did not consult them regarding Gwenda's fall risk and what precautions could be used to minimise this risk, and that a sensor mat was not used by the hospital to ensure Gwenda was kept as safe as possible from a fall. Coroner Dunn found that it was incumbent upon the hospital to utilise all tools available to them to ensure Gwenda's risk of a fall was reduced. In Coroner Dunn's opinion, the measures utilised for Gwenda did not adequately ensure that she was kept as safe as reasonably possible from a fall.

COMMENTS OF CORONER DUNN

I. Pursuant to section 57A of the Coroners Act I can make recommendations or comments as part of my inquiry if those recommendations or comments are for the purpose of reducing the chance of further deaths occurring in other circumstances similar to this one.

II. A hospital is required to provide a safe and caring environment. They have the responsibility of caring for unwell and injured patients. Many of those patients are vulnerable. I consider that Gwenda was vulnerable both due to her age and her frailty.

III. Had Waikato Hospital consulted with Gwenda's family and the rest home they would have been aware she had a tendency to act impulsively. Such a tendency is not uncommon for elderly persons who often fail to appreciate their own physical limitation. Falls by the elderly within their own homes, rest homes and hospitals are sadly common. These falls impact the quality of their lives and can have tragic results.

IV. In these circumstances I intend to make recommendations in an endeavour to ensure that vulnerable patients classified at 'high falls risk' are provided with adequate safeguards to reduce the risk of a fall. Those recommendations are as follows:

- Following a 'high falls risk' classification the hospital discusses with family/next-of-kin the individual patient's risk and consults with family what precautions are being taken by the hospital to avoid a fall.
- For elderly patients classified as 'high falls risk' the hospital is to provide, unless impracticable, a sensor mat.

V. I hope that my recommendation can provide some comfort for Gwenda's family and reduce the chance of a similar fall happening to any other person.

VI. Following the release of my finding to the Waikato District Health Board they have advised me that their policy was updated on 9 March 2020. This policy refers to maintaining a safe environment with particular reference to inpatients, regardless of their identified risk. Furthermore, that patients and their carers are routinely involved with care planning activities and that fall risk management must be discussed as part of usual care. They also advise that Gwenda's case will be referred to their falls committee that meets quarterly. It is hoped that sensor mats are utilised by the hospital to safely protect their elderly and vulnerable patients in their care.

Takimoana [2022] NZCorC 25 (23 February 2022)

CIRCUMSTANCES

Ruth Takimoana, aged 71, died on 25 September 2019 at Whangārei base Hospital. The cause of her death was a traumatic intracerebral haemorrhage.

Mrs Takimoana underwent surgery at Auckland Hospital on 8 September 2019. On 24 September 2019 she weas transferred to Whangārei Hospital where she was admitted to the surgical services ward. After she had settled into her room, Mrs Takimoana asked to call her family. A nurse assisted Mrs Takimoana to the phone in the hallway. During the phone call Mrs Takimoana became wobbly on her feet and fell. An hour after her fall, a CT scan showed a small intraparenchymal haemorrhage. Sadly, Mrs Takimoana succumbed to this injury and died the following day.

Following Mrs Takimoana's death, a serious event analysis ("SEA") was undertaken. The SEA report acknowledged that there was no cordless phone available for patient use in bed or at the bedside nor was there a call bell situated next to the phone in the hall.

COMMENTS AND RECOMMENDATIONS OF CORONER MILLS

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

Transfer process

II. Mrs Takimoana had numerous and complex comorbidities, however, the fall that led to her death was preventable. I have reviewed the post fall assessment undertaken by the hospital and the serious event analysis. I note that, as Mrs Takimoana had only just been transferred to Whangārei Hospital, no fall assessment or fall management plan was in place. While Mrs Takimoana's transfer documentation came with her, there does not appear to have been any specific communication prior to her arrival from Auckland Hospital about her care needs, including her mobility needs, meaning staff were not able to prepare prior to her arrival. No faxed or electronic handover was received and the telephone call from Auckland Hospital to Whangārei was focused on the delay and timing of her arrival, not her care or mobility needs.

III. The serious event analysis recommended that Whangārei Hospital review the process for transferring patients between facilities to ascertain the most effective and efficient way for handover. I sought an update from the DHB who advised that unfortunately, due to lack of resources and time, an in-depth review pertaining to the patient transfer handover process was unable to be fully completed. They had however been communicating with the Integrated Operations Centre (IOC) Manager in Auckland and brought this matter to her attention and asked that it be discussed with the Flow Coordinators and Wards.

IV. The Northland DHB's explained that the Northland DHB's IOC team accepts referrals from Auckland Hospital and hands these on to the accepting ward with an expected time of arrival and whenever possible additional information is sought to provide to the accepting ward. The accepting ward is aware of the Auckland ward where the patient has transferred from and should contact them directly if they have not had a handover of relevant information.

V. The Northland DHB also advised that the transfer process between hospitals was escalated and discussed at the reportable events committee who had asked for confirmation that the event and recommendation had been forwarded to the IOC Manager in Auckland for discussion. The reportable events committee also asked that Northland DHB's serious events analysis report relating to Mrs Takimoana be sent to the reportable events committee equivalent in Auckland. The Northland DHB advised these recommendations have been actioned but it is not aware of the outcome of discussions or reviews by Auckland Hospital's IOC or their Reportable Events Committee equivalent.

VI. I acknowledge and thank the Northland DHB for the steps it has taken to date to improve their transfer systems. I encourage them to seek a response from Auckland Hospital's IOC and to continue to work with the Auckland DHB on improve transfer processes.

Call bell

VII. I acknowledge that the serious event analysis report considered that a call bell may not have prevented Mrs Takimoana's fall. However, in my view, a call bell (or similar device to call for assistance) next to the phone provides patients with an easy and practical way to request assistance. I acknowledge that the phone was visible to the nursing station, however staff are often busy and not always present. Some patients may also feel uncomfortable personally calling out and drawing attention to themselves.

VIII. A call bell or similar device provides an alternative means of seeking assistance and I recommend that the Whangārei Hospital consider installing call bells or a similar device by phones used by patients. This could reduce the risk of patient falls (and consequential injuries such as sustained by Mrs Takimoana) in the future.

IX. The Northland DHB was provided with the opportunity to comment on this recommendation and advised that they accept the recommendation for a call bell to situated adjacent to telephone (in the corridor) provided asbestos building restrictions do not preclude this. They also advised that it has been agreed that a cordless or mobile telephone would also be made available for patient use.

X. I would like to thank the Whangārei DHB for engagement with this inquiry and commend them for accepting my recommendation and the action taken to improve the transfer process.

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

Medical condition

Williams [2022] NZCorC 49 (24 March 2022)

CIRCUMSTANCES

Rikurangi Reihana Omeka Williams, aged 32, died between 7 and 8 April 2018 at 4 Cunningham Place, Conifer Drive, Takanini. The cause of death was sudden unexpected death in epilepsy.

Mr Williams had been diagnosed with a seizure disorder and schizophrenia. He was prescribed an antipsychotic medication.

Mr Williams' non-compliance with medication had led to multiple hospital admissions between 2006 and 2010. Mr Williams again stopped taking his medication in August 2017. He was admitted to hospital in September 2017 following

Police intervention due to aggressive behaviour and neglect. When Mr Williams was discharged on 19 September 2017, he was placed under an indefinite order per section 29 of the Mental Health (Compulsory Treatment and Assessment) Act 1992 (MHA). A psychiatric follow-up appointment was scheduled for June 2018.

Mr Williams attended a consultation at Community Mental Health Services on 6 March 2018. His history of non-adherence to prescribed medication was discussed in relation to his valproate treatment for epilepsy.

On 8 April 2018 Mr Williams was found lying face down on his bed. He was deceased.

Toxicological analysis identified the level of antipsychotic drugs in Mr Williams' blood was too low to confirm and less than expected from a recent normal dose.

COMMENTS OF CORONER TETITAHA

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

II. Given the history of medical non-compliance and the noted concerns of Mr Williams' psychiatrist upon discharge, it is concerning his medical notes provide no evidence for review. This is particularly given the toxicology results regarding the low levels of antipsychotic medication in his blood.

III. It is clear the point of the indefinite section 29 order was to ensure medical compliance given his known medical conditions. At his last review it was known he was medically non-compliant. There does not appear to have been any checks made thereafter to ensure attendance at his GP and medication compliance. If checks had been made following the concerning results of his last medical review, his medical non-compliance may have been addressed. If he had been properly medicated, it is likely Mr Williams might not have died as the result of a sudden unexpected epileptic seizure.

IV. This indicates problems with follow-up by mental health services of patients such as Mr Williams once they are released into the community. This might indicate the need for an audit about the effectiveness of the discharge planning for patients such as Mr Williams. The Health and Disability Commissioner may be the most appropriate body to conduct such an audit to ensure there are adequate systems to support patients such as Mr Williams within the community.

V. These comments are directed to Counties Manukau District Health Board and the Health and Disability Commissioner.

VI. The Counties Manukau District Health Board have replied advising in summary:

a. s29 pertains to psychiatric conditions and ensuring compliance of psychiatric medications only. The Mental Health Act does not apply to medical conditions or physical medications such as epilepsy. He was under the care of his GP and the MHA order could not be applied to his treatment for epilepsy

b. There is currently a Ministry of Health Audit (MH02) underway which looks at discharge letters and wellness plans. This will be beneficial when considering how to improve the quality of transition in patients like Mr Williams.

RECOMMENDATIONS OF CORONER TETITAHA

I. Having taken the above reply into account I have determined to refer this matter to the Health and Disability Commissioner (HDC) pursuant to section 119 of the Coroners Act 2006 for further investigation.

II. This is because:

a. There is evidence in the toxicology that Mr Williams was medically non-compliant with both his psychiatric and epilepsy medications;

b. There was a s 29 MHA order that provided for Mr Williams to, at the very least, comply with treatment for his psychiatric conditions;

c. There is public interest in ensuring authorities empowered to act under s29 MHA orders are providing consumers such as Mr Williams with the treatment required in terms of the Code of Health and Disability Services Consumers Rights.

III. The Health and Disability Commissioner may also wish to work in conjunction with the existing MH02 audit being undertaken at Counties Manukau District Health Board mental health services.

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

Miscellaneous

Nath [2022] NZCorC 4 (20 January 2022)

CIRCUMSTANCES

Sherine Sandhya Nath, also known as Sherine Sandya Narayan, aged 32, died between 29 and 30 December 2019 at her home in Sunnyside Crescent, Papatoetoe. The cause of death was the combined effects of blunt force head injury and neck compression.

Sherine was born in Fiji and was of Indian descent. She had been married to Riki Nath for 14 years. There was significant and serious physical and emotional abuse from the start of the marriage. Following an assault by Riki in February 2019, Sherine visited her GP who gave her the phone numbers for the Women's Refuge and Shine.[7] Sherine and her son moved out of the home she shared with Riki. She also laid a complaint to the Police.

On the morning of 30 December 2019, Sherine was found unresponsive face down on her bed. She had been badly beaten and showed signs of trauma to the rear of her head and of strangulation. Riki was found deceased in circumstances amounting to suicide.

7 Shine is a national organisation committed to addressing domestic violence and offers a range of services.

Shakti provided the Coroner with a copy of a briefing paper prepared for the Family Violence Court in Auckland and Manukau in 2017. This briefing paper identified specific cultural and legal difficulties facing immigrant women of Asian, African and Middle Eastern communities. The purpose of the briefing paper was to raise awareness of the complex cultural factors that exacerbate family violence within these communities. Relevant to this matter the report noted:

a. Abuse is culturally sanctioned in almost all ethnic communities. Abuse is part of life for many and as a result, women are unable to identify abuse as such;

b. Physical assault with hands or objects is considered normal and often take place in front of other family members who do not intervene;

c. Marital rape is not considered abuse and most often is not reported as such;

d. Women who break away from abuse and get justice are stigmatised and isolated by the respective communities and struggle to rebuild their lives;

e. Mother-in-law abuse is common in some ethnic cultures and this is an outcome of deeply entrenched patriarchal norms as well as the mother-in-law herself having gone through abuse as a wife and daughter-in-law;

f. Women who do manage to secure protection orders are under constant pressure and threats to withdraw them, not just by the perpetrator and his family but also in some situations, her family, as her family are also put under pressure by the perpetrator's family;

g. Divorce continues to be highly stigmatised within ethnic communities.

COMMENTS OF CORONER MILLS

I. The circumstances of Sherine's tragic death, which caused such loss and ongoing grief to Sherine's family and friends, is not such that I am in a position to make recommendations that may prevent deaths in similar circumstances in future.

II. However, I do consider there are comments I can usefully make pursuant to section 57A of the Coroners Act 2006. These comments are made to raise greater awareness of the difficulties facing migrant women who experience domestic violence and to raise awareness of the signs that indicate a woman may be in serious danger from their partner. It [is] also hoped that these comments may help others respond to and help those who are in abusive relationships.

Culturally sensitive services

III. Domestic violence is predominantly perpetrated by men.[8] There are many complex reasons why women living in abusive relationships stay or return to their abuser. For migrant ethnic women this is

8 https://www.justice.govt.nz/assets/Documents/Publications/Domestic-violence-prog-evaluation-report-Nov2018.pdf; Murphy, C., Paton, N., Gulliver, P., Fanslow, J. (2013). Policy and practice implications: Child maltreatment, intimate partner violence and parenting. Auckland, New Zealand: New Zealand Family Violence Clearinghouse, The University of Auckland.

exacerbated by a range of complex cultural factors.[9] These may encompass individual (language barriers, isolation), household (migration factors, employment conditions), community (gender norms, patriarchal values), and systemic (racism, colonisation, capitalist structures) factors.[10]

IV. Sherine and Riki were both of Fijian Indian descent and many of the cultural factors noted in the briefing paper provided by Shakti to my inquiry applied to her situation. At the age of 17 she married, became dependent on Riki and was isolated for some years from her family.

V. Sherine was lucky that her mother and sisters supported her decision to leave Riki, however the cultural gender norms and expectations she had grown up with still placed her in a position where she felt extreme pressure to return to live with Riki despite her fears.

VI. Sherine did not report or disclose the full extent of the abuse she was experiencing for nearly 14 years. The underreporting of family violence is well known. Research suggests that 87% of women who had experienced physical or sexual violence from a partner had not reported this to the Police.[11] For migrant women, disclosure and reporting of violence can be even more difficult and they report at a lower rate than other women living in Aotearoa New Zealand.[12] In part, this silence may reflect shame and fear of the stigma from and towards their communities that may be associated with disclosing violence.[13]

VII. The Family Violence Death Review Committee 2020 report also noted that migrants often hold onto the cultural traditions of the communities they come from.[14] In the South Asian[15] relationships included in the committee's reviews, the men often continued to hold tightly to the view that they had a right to control the movements of the female family members and that any potential disruption to the family unit brought shame on the wider family.[16] Riki's behaviour and the control he exerted over Sherine suggests he also may have held these views.

VIII. Increasingly, there is recognition that services to support woman cannot be 'one size fits all' across ethnic and non-ethnic communities. Specific culturally sensitive approaches and techniques, such as those provided by organisations like Shakti, are needed to address the unique profiles of violence against ethnic and migrant women. I therefore encourage the ongoing support and development of such services.

9 See: Briefing paper for Judge Fraser Family Violence Court: Auckland and Manukau towards raising an awareness of the complex cultural factors that exacerbate domestic/family violence within Asian, African and Middle Eastern immigrant communities in New Zealand presented by Shila Nair, For Shakti May 5, 2017; and Simon-Kumar, R. (2019). *Ethnic perspectives on family violence in Aotearoa New Zealand.* Issues Paper 14. Auckland, New Zealand: New Zealand Family Violence Clearinghouse, University of Auckland.
10 Simon-Kumar, R. (2019). *Ethnic perspectives on family violence in Aotearoa New Zealand.* Issues Paper 14. Auckland, New Zealand: New Zealand Family Violence Clearinghouse, University of Auckland.
11 Ibid.
12 https://www.mbie.govt.nz/dmsdocument/12138-recent-migrant-victims-of-family-violence-project-2019-final-report
13 https://nzfvc.org.nz/sites/default/files/NZFVC-issues-paper-14-ethnic-perspectives.pdf. Family Violence Death Review Committee. 2020. Sixth report Te Pūronga tuaono: men who use violence/Nga Taāne ka whakamahi i te whakarekereke Wellington: Health Quality And Safety Commission. April 2020.
14 Ibid.
15 Ibid at page 50. The report notes that men of Indo Fijian ethnicity have been grouped with South-Asian men due to their ties to Indian rituals and faith.
16 Ibid.

IX. As required under s 57B of the Coroners Act 2006, I provided a copy of my draft findings to the Ministry of Justice and the Ministry of Social Development who fund many of the domestic violent programmes. The Ministry of Social Development has not responded to this comment. The Ministry of Justice did not respond directly to the comment above, however noted that, once the Protection Order was made permanent in October, Mrs Nath (Sherine) would have received, by post, the offer of a free safety programme which would have resulted in a further referral to Shakti if she had wished to take this up.

X. Having considered this response, I reiterate my comment regarding the need for the ongoing support and development of culturally sensitive services to address the unique profiles of violence against ethnic and migrant women.

Supporting woman in abusive relationships

XI. It is important to realise the women who are subjected to abuse, coercive control and violence do resist even if the stay in or return to a relationship. Just because they could not stop the violence, does not mean they 'let it happen' and they are not to blame for the violence inflicted on them.

XII. It is often difficult for family and friends to know how to respond and support someone trying to leave an abusive relationship. Sherine's mother and sisters found it frustrating and confusing that Sherine continued to have contact with Riki and did not understand why she returned to live with him. This is by no means a criticism of them. Sherine's family are to be commended for the support and encouragement they gave her to leave Riki.

XIII. Organisations like Shine,[17] Follow my Lead Aotearoa[18] and the website "are you ok"[19] provide useful guidance on how family and friends can respond to disclosures of abuse or concerns that someone is experiencing abuse. This includes:

a. If you suspect abuse – start the conversation, find a time and place that is appropriate.

b. Build trust with the person and offer non-judgemental support. Listen to what they have to say. Believe what they tell you. It will have taken a lot for them to talk to you. People are much more likely to cover up or downplay the abuse, rather than to make it up or exaggerate

c. Use safe communication – do no harm, set up a code or a safe word, make sure it is safe for them to talk.

d. Honour dignity and resistance – It is important to realise the women who are subjected to abuse, coercive control and violence do resist even if they stay in or return to a relationship. Acknowledge what she has done to resist. Tell her you think she has been brave in being able to talk about the abuse, and in being able to keep going despite the abuse.

17 https://www.2shine.org.nz/help-others/help-someone-you-know/.
18 https://www.insightexchange.net/follow-my-lead/ and https://www.insightexchange.net/wp-content/uploads/2021/04/Follow-My-Lead-Aotearoa-NZ.pdf
19 https://www.areyouok.org.nz/home/supporting-someone/how-to-support-someone/how-to-talk-with-someone-experiencing-family-violence/.

e. State that violence and abuse is not ok and help her to understand that the abuse is not her fault and that no-one deserves to be abused, no matter what they do.

f. Take the abuse seriously. Abuse can be damaging both physically and emotionally. Do not underestimate the danger she may be in. Check her safety, ask if she feels safe and encourage and offer to support her to make contact with agencies that can help.

g. Offer support but respect her right to make her own decisions, even if you don't agree with them. Respect her cultural or religious values and beliefs. Give support and information not advice.

h. Provide information of about support services and where to get help.

XIV. For further details and information go to https://www.2shine.org.nz/help-others/help-someone-you-know/ and https://www.areyouok.org.nz/

Serious risk factors

XV. Increasing the knowledge and understanding of domestic violence and the behaviours that are associated with greater risks may help women who are in danger from their partner. It may also help others identify potentially dangerous relationships. The website www.areyouok.org.nz identifies a number of behaviours that indicate that a person maybe in serious danger from their partner.[20] This includes if a partner:

- Strangles, chokes or cuts off your breathing (if you have been strangled/choked you may need medical help)
- Threatens to kill you
- Displays worsening or more frequent violence, or both
- Controls what you do and who you can see
- Shows intense jealousy or possessiveness
- Intimidates you or uses others to intimidate you
- Stalks you

XVI. These danger signs should be taken seriously. Riki exhibited many of these behaviours. In addition to physical violence, he had previously threatened to harm himself, and harm Sherine and [their child] if she left him. He was controlling, and jealous, and tracked Sherine's movements.

XVII. It is also important that those who are in danger know help is available. For those who are experiencing an abusive relationship:

20 https://www.areyouok.org.nz/home/understanding-unsafe-relationships/is-your-partner-making-you-feel-unsafe/ This website contains valuable information, resources and help for those affected by domestic violence. It is managed by the Social Campaigns Team within the Ministry of Social Development.

a. if you are in immediate danger, please call 111;

or seek support and help from:

b. Shakti 24-hour crisis line with multilingual staff: 0800 SHAKTI/0800 742 584

c. Women's Refuge National Helpline – Crisis line: 0800 REFUGE/0800 733 843

d. shine* Domestic Abuse Helpline: 0508 744 633

e. Worried about a child? Call: 0508 FAMILY or 0508 326 459 (Oranga Tamariki—Ministry for Children)

f. Rape Crisis: National call line: 0800 88 33 00

g. Safe to talk – Kōrero mai, ka ora 24/7 sexual harm helpline: 0800 044 334 or text 4334.

XVIII. I also direct that a copy of these Findings be sent to the office of the Minister for the Prevention of Family and Sexual Violence who leads the whole of government response on family and sexual violence.

Note: To the extent that the findings refer to the death of Riki Nath, 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.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Sherine Nath, Riki Nath and their son entered into evidence during the inquiry in the interests of personal privacy and decency; the name of Sherine Nath's son in the interests of personal privacy and decency; the Facebook live post and photos made by Riki Nath on 29 December 2019 and published on his Facebook page at about 4:00pm on 30 December 2019 and 1:30pm on 31 December 2019 in the interests of justice, personal privacy and decency.

D [2022] NZCorC 34 (11 March 2022)

CIRCUMSTANCES

D died on 6 May 2016 as a result of stab wounds inflicted by W.

D's death is one of five homicide deaths that occurred in the Wellington region over an 18-month period. Each of the five deaths resulted in an individual being charged with murder. Each murder prosecution was concluded with either a finding of not guilty due to being deemed insane at the time they killed, or a finding that the person charged was unfit to stand trial due to mental impairment to such an extent that they were unable to plead or to adequately understand the nature and purpose of the court proceedings.

Each of the five deaths was the subject of a separate inquest.

RECOMMENDATIONS OF CORONER ROBB

I. To reduce the risk that an individual such as W could become so psychotically unwell so as to act in the way that W did on 6 May 2016 I recommend:

a. Training to ensure that there is appreciation of the different perspectives that a care manager compared to a psychiatrist bring to the care of a client. Recognising that a care manager may have a focus on support and client's functionality in the community and may not recognise or see their role as identifying, probing, challenging or otherwise enquiring into psychotic symptoms.

b. That training of care managers in identifying psychotic symptoms and the significance of re-emergence of symptoms be undertaken.

c. Sufficient allocation of time and psychiatric resource, and/or training, and/or expectation setting, be provided to psychiatrists to ensure;

    i. that there is full documentation of an individual's ongoing diagnosis,

    ii. long-term and short-term care plan,

    iii. precisely what should occur if psychotic symptoms re-emerge.

    (Essentially those matters that were in large part documented in the brief of evidence provided by the psychiatrist and set out in this finding).[21]

d. Where any individual, who has suffered from psychosis and is believed to be in remission, has a recurrence of a psychotic symptom, they be assessed by a psychiatrist.

e. Where any individual suffers from a psychotic illness or has otherwise experienced a psychotic episode, they are not discharged from the care of a community mental health team without a psychiatric assessment, and without a detailed handover to a general practitioner explicitly identifying what should lead to re-engagement with the mental health service.

f. Where any individual under the care of Community Mental Health Team (CMHT) has suffered from a psychotic illness/episode resulting in antipsychotic medication being prescribed and:

    i. the dosage is reduced by the CMHT, and/or

    ii. is stopped;

    the individual should remain under the care of the CMHT until such time as the effects of the stopping of the medication can be determined by the CMHT, and the individual should then only be discharged from CMHT care following a final assessment by a psychiatrist.

II. In accordance with the requirements of the Coroners Act,[22] a copy of proposed recommendations, were provided to the Mental Health, Addiction and Intellectual Disability Service ("MHAIDS") inviting an opportunity to respond to those proposed recommendations.

21 At paragraph 68 of the findings.
22 Section 57A.

III. MHAIDS response to recommendations concerning training:

"Training

i. *MHAIDS would support a recommendation that there is training which ensures an appreciation of the different perspectives that different members of a Multi-Disciplinary Team bring to the care of a client (including, but not limited to, those of a care manager compared to a psychiatrist).*

ii. *It would also support the recommendation that training of care managers in identifying psychotic symptoms and the significance of re-emergence of symptoms be undertaken.*

iii. *It is submitted that there should be development and standardisation of such training for mental health professionals on a national basis, especially those working in services addressing the needs of those with serious mental illness and psychotic disorders in particular, and that any such training should be evidence-based and focused on skill development. In particular, such training ought to specifically address the management of psychotic disorders-engagement strategies and working with clients and whānau, motivational interviewing, early warning signs, relapse prevention plans and responses, role of medication and integrated psychosocial interventions with biological interventions, and being inclusive of culture throughout all aspects of delivery."*

IV. I welcome those responses and adopt the above suggestions as part of my recommendations.

V. In respect of the recommendations concerning documentation MHAIDS provided this response:

"*Documentation*

i. *It is submitted that psychiatrists should not hold responsibility alone for developing relapse response plans or crisis response plans. Care planning is a collaborative effort by the MDT. The MDT brings medical, nursing, social, occupational, and cultural perspectives to the discussion and endorsement of the care planning.*

ii. *MHAIDS is currently in the process of finalising its Service Exit procedure. The purpose of this procedure is to: 'provide a clear and consistent process to both Mental Health, Addictions and Intellectual Disability Services (MHAIDS) staff and service users when someone is exiting from MHAIDS. In particular it will provide a collaborative process with the person/ whānau which will summarise the treatment provided and give clear guidance as to the pathway for people who might re-enter MHAIDS.'"*

iii. *Service Exit is the final stage in a person's care in MHAIDS Client Pathway. It is generally a planned and coordinated transition to either another DHB, the person's primary health provider or other non-DHB health care provider.*

iv. *The proposed procedure is:*

Following a discussion with the person/ whānau to exit MHAIDS:

- *the primary clinician will present to the MDT to ensure that the MDT is an agreement to exit.*
- *The primary clinician communicates with the GP regarding the*
- *primary clinician will support the person to update their wellness plans include things that they can do to maintain well-being once they have exited MHAIDS.*
- *The primary clinician reviews and updates the person's digital client record including:*
  - *Comprehensive Plan.*
  - *Wellness Plan.*
  - *Digital Notes.*
  - *Other digital information including persons demographics, GP details and legal status.*
- *A service exit plan is prepared by the primary clinician that includes:*
  - *A brief summary of the treatment received in the progress on the identified goals.*
  - *Final diagnosis.*
  - *Recommendations for maintaining recovery, including relapse prevention strategies.*
  - *Any unmet needs and suggested actions.*
  - *Agreement as to what is to be shared with whānau (and whom).*
  - *A clear statement of how the person might re-enter MHAIDS in the future.*
- *The Service Exit checklist is completed which indicates that all tasks have been completed and the person has been discharged.*
- *Referral is closed.*

v. *It is expected that the Service Exit Plan will:*

a) *identify any unmet needs/treatment goals particularly for those who might not have engaged or completed their treatment goals;*

b) *provide enough information to give clear guidance about the process for a person should they need to return to MHAIDS in the future; this will be for both the person, their whānau and the service and include guidance about the most appropriate service to provide in the future; and*

c) *automatically be sent to the person's GP once finalised (along with the Wellness Plan, if the Wellness Plan box is checked). (In terms of medication that is the responsibility of the prescriber to ensure that there is a written handover to the GP of the current medication. This is usually by completion of the Note to GP)."*

VI. The response from MHAIDS in respect of documentation is a comprehensive response and reflects the genuine efforts they have made to take steps to ensure documentation best serves the care needs of clients and in doing so addresses the recommendations I have made.

VII. In respect of recommendations concerning management of a client with psychotic symptoms (my recommendations I(d), (e) and (f) it out above) MHAIDS submitted:

i. *Resources in New Zealand would not allow for the proposed recommendations to be implemented, due to the shortage of psychiatrists.*

ii. *It would be more appropriate for a recommendation that, as is now the case within MHAIDS, all cases under the care of a team ought to be reviewed on a regular, planned or scheduled roster by the MDT, as well as in circumstances where the client becomes acutely unwell or is in crisis; and that clients are also reviewed by the MDT prior to discharge. It is noted that psychiatrists are involved in the MDT meetings, discussions and review.*

VIII. I acknowledge those submissions, they reflect what became clear in the course of the inquest, psychiatrists are a limited resource in New Zealand which directly impacts on the role they are able to fulfil. I also acknowledge the teamwork put in place by MHAIDS, however I maintain my original recommendations on psychiatrist involvement, while at the same time recognising that resourcing may place practical limitations on implementation.

Note: High Court and Court of Appeal suppression orders remain in force. In addition, an order under section 74 of the Coroners Act 2006 prohibits the publication of: D's name, address at the time of these events, and occupation; C's name address and occupation; the name, address, and occupation of D and C's immediate family; any information that would lead to the identification of those matters detailed in (i-iii) above, this includes any reference to the address or suburb in which any of those individuals were living prior to, at the time of, or subsequent to these events and any religious or other affiliations of those individuals; any information, beyond that set out in the Addendum to this finding, of W's physical health and/or mental health prior to, at the time of, or subsequent to these events and any reference to W's child A, (this includes A's physical health and hospital care and any reference to either of A or B's actions or involvement attending to

A's health or care needs) and the names and identifying details of any past and present MHAIDS/CCDHB staff involved in the provision of care to W or A.

Motor Vehicle

Bailey-Cropper [2022] NZCorC 27 (2 March 2022)

CIRCUMSTANCES

Joshua Sid Bailey-Cropper, aged 20, died on 28 February 2020 at State Highway 1, Piarere of extensive craniofacial, thoracic, pelvic and lower limb injuries sustained in a head-on collision of his van with a truck.

On 28 February 2020 Mr Bailey-Cropper left work at around 3:30pm. When he arrived at a friend's house around 5:00pm it was evident that he had been drinking beforehand.

Mr Bailey-Cropper drank a couple of beers while he watched a movie with his friend. At approximately 7:45pm Mr Bailey-Cropper left his friend's house, presumably to visit someone in Taupō.

It is unknown what Mr Bailey-Cropper did after leaving his friend's house. However, at approximately 11.45pm Mr Bailey-Cropper was travelling north on State Highway 1, Piarere. Witnesses recalled seeing Mr Bailey-Cropper's vehicle suddenly pull out to pass a Heavy Motor Vehicle (HMV). As he did so he crossed the centre lane and into the path of an oncoming freightliner. Despite evasive manoeuvres, the freightliner was unable to avoid a collision. Mr Bailey-Cropper was confirmed deceased at the scene.

Toxicological analysis detected alcohol in Mr Bailey-Cropper's blood at a level of 170 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.

COMMENTS OF CORONER BATES

I. Considerable effort is made in New Zealand to promote safe driving messages. Mr Bailey-Cropper's death serves as yet another reminder about the dangers of driving while intoxicated, which can easily lead to a fatal outcome.

II. Police, Coroners, and Waka Kotahi New Zealand Transport Agency have consistently highlighted these dangers. I again highlight them again but make no additional comment.

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

Barham and Brown [2022] NZCorC 7 (24 January 2022)

CIRCUMSTANCES

Dexter Morgan Barham and Burgundy-Rose Eden Brown, both aged 16, died on 18 March 2018 on State Highway 1, Amberley. The cause of their deaths was multiple injuries due to a motor vehicle collision in which Dexter was the driver and Burgundy-Rose was his passenger.

Dexter worked the night shift at a factory. He was determined to save money for a car. However, as he only held a learner's licence, his mother told him he had to get his restricted licence before he could purchase a car.

Dexter finished work at 10:00am on 17 March 2018. At about midday he told his mother that he and his friend were travelling to Nelson to stay at the friend's family bach. She checked his friend had a full licence and that Dexter was going to sleep during the journey, as he had not slept for 24 hours. However, that was not what was planned. Dexter had arranged with friends, including Burgundy-Rose, to go to Nelson to purchase a Nissan car he had seen online. Dexter slept for most of the trip to Nelson and woke up at about 10:00pm. While they waited for the owner of the Nissan, Dexter and his friend shared a joint. Dexter purchased the Nissan, and eventually the group left Nelson to return to Christchurch.

At the first rest break in Murchison, Dexter's friends in the other car told him he had been drifting within his lane and that his headlights were on high beam when other traffic was approaching him. They also told him that he needed to be alert and aware. Dexter accepted this and told them that he was feeling tired but wanted to continue.

At their second stop at Springs Junction, Dexter's friends again told him that he needed to stay in his lane and remember to dip his headlights for oncoming traffic. The group next stopped in Culverden, where Burgundy-Rose got into the back of Dexter's Nissan and soon fell asleep. Dexter continued to drive south on State Highway 1. To stay awake, Dexter talked to his friend in the front passenger seat, listened to music and kept his window down. At some stage the front seat passenger fell asleep.

At around 6:20am on 18 March 2018, a northbound motorist came to the top of the crest of a hill and saw two headlights on full beam directly in front of them in the northbound lane. Initially the vehicle was closer to the grass verge but appeared to move closer to the centre of the lane. The motorist saw the Nissan make a small correction immediately prior to the collision. Dexter's front seat passenger woke up and grabbed the steering wheel prior to the collision with the northbound vehicle. Paramedics attended and verified that Dexter and Burgundy-Rose had both died.

RECOMMENDATIONS OF CORONER JOHNSON

I. Coroners, Police, and Waka Kotahi NZ Transport Agency, and NZ Drug Foundation Te Tūāpapa Tarukino o Aotearoa, have consistently highlighted the dangers of driving when fatigued or when having consumed cannabis. A combination of both greatly increases the chance of an accident.

II. In one of my previous inquiries into the death of a male driver who crashed and died while having consumed cannabis, the Serious Crash Unit investigator stated:

> 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.

III. Waka Kotahi NZ Transport Agency highlights why fatigue is a problem for drivers:

> Fatigue is tiredness, weariness or exhaustion. You can be fatigued enough for it to impair your driving long before you 'nod off' at the wheel. …
>
> As a driver, fatigue can cause you several problems including:
>
> - Reduced attentiveness and alertness to dangers
> - slowing your reaction time and decision-making ability
> - poor lane tracking and maintenance of speed
> - decreasing your tolerance for other road users.
>
> Being tired can also cause you to drift in and out of sleep without knowing it. Sleep experts call this microsleep. If this happens while driving it can cost you your life.

IV. 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 having used cannabis and while fatigued. It is my hope that this will go some way towards preventing further harm to the public.

V. Given the prevalence of publicity and general information available regarding the harm that may result from driving while fatigued and/ or driving having used cannabis, 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 any photographs that show Dexter or Burgundy-Rose, taken after their deaths for evidential purposes, in the interests of decency and personal privacy.

Benecke [2022] NZCorC 23 (16 February 2022)

CIRCUMSTANCES

Douglas Benecke, aged 58, died on 14 July 2020 at the intersection of Selwyn Road and Springston Rolleston Road, Rolleston as a result of blunt chest trauma following a motor vehicle crash (driver).

At approximately 8:00am, Mr Benecke was driving east on Selwyn Road, heading towards Christchurch. At the same time, another driver in a sedan was heading north on Springston Rolleston Road, towards Rolleston. Both drivers were travelling within the posted speed limit. The weather was fine and dry that morning. However, there was a very high sun in the sky. At the intersection with Springston Rolleston Road, there were stop signs on Selwyn Road in both directions.

At approximately 8:10am, Mr Benecke entered the intersection of Selwyn Road and Springston Rolleston Road without slowing down. Mr Benecke's vehicle collided with the sedan driving north on Springston Rolleston Road. There was no evidence that either vehicle braked before the impact. The driver's side of Mr Benecke's door took most of the impact, causing significant harm to Mr Benecke. Emergency services arrived at the scene and attempted CPR. Unfortunately, Mr Benecke could not be revived.

Several witnesses provided evidence that was relevant to the driving conditions on these roads on the day of the crash. One witness noted that the sun would have been directly in Mr Benecke's vision. Another witness reported that the sun was extremely bright in the sky causing them to adjust their mirrors as they travelled along Selwyn Road.

A comprehensive investigation was undertaken by the Serious Crash Unit (SCU). The SCU found that at the time of year that the crash happened, the sun rises directly in line with Selwyn Road, adversely affecting the driver's vision when heading east on the road. Mr Benecke's sun visor was in the down position indicating that his vision may have been adversely affected by the glare from the sun. There was no evidence that he had been wearing sunglasses when he crashed.

Coroner Borrowdale was persuaded by the position of Mr Benecke's sun visor, and by the evidence of the Police and witnesses, that the sun glare was a contributing or causative factor in this crash.

COMMENTS OF CORONER BORROWDALE

I. I make the following comments pursuant to section 57(3) of the Coroners Act 2006. The purpose of the comments is to reduce the chances of further deaths occurring in similar circumstances to those in which Mr Benecke died.

a. Sunstrike can occur at any time of day, but is most common during sunrise or sunset when the sun's rays hit the driver's windscreen at a low angle. This can make it difficult, or even impossible, to see. This is a very dangerous condition in which to drive.

b. According to information published by the Automobile Association of New Zealand (the AA), most common crashes involving sunstrike occur at intersections, when motorists fail to identify an approaching vehicle. Rear-end crashes are the second-most common, when drivers are unable to see the vehicle in front slowing or at a standstill.[23]

c. Good vision is essential to safe driving. Guidance published by the AA and by Waka Kotahi NZ Transport Agency[24] recommends the following relevant safety precautions, which I repeat and reinforce:

i. Be prepared for possible sunstrike when driving at sunrise or sunset, especially when turning or driving towards the sun.

ii. Be especially careful in winter, when sunstrike is more likely to occur because the sun is lower in the sky.

iii. Keep your windscreen clean, inside and out. Dust and grime on the windscreen can make the effects of sunstrike much worse.

iv. Wear sunglasses when driving with the sun in your eyes.

v. Use your car's sun visors to block the sun.

23 Available online at https://www.aa.co.nz/membership/aa-directions/driver/sunstrike-beat-the-glare/
24 Available online at https://www.nzta.govt.nz/roadcode/general-road-code/road-code/about-driving/when-conditions-change/sunstrike/

vi. If you experience sunstrike, it may be best to pull over and wait for a few minutes until your eyes adjust or visibility improves.

vii. Early morning and afternoon are the highest-risk times, when drivers, cyclists and pedestrians should be extra cautious. Even if you are not behind the wheel of a car, be aware that someone driving towards you may not be able to see you.

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

Chen [2022] NZCorC 54 (31 March 2022)

CIRCUMSTANCES

Chen Fang,[25] aged 74, died on 18 June 2021 at Auckland Hospital as a result of multiple injuries sustained from being struck by a motor vehicle.

On the evening of 10 June 2021, Ms Chen was walking from Pakuranga Plaza to Reeves Road. At the time it was dusk and the traffic on Reeves Road was busy but free flowing. Ms Chen began to cross diagonally across the eastbound lane of Reeves Road towards Cortina Place and was struck by a car travelling in the westbound lane. Ms Chen was taken to hospital and passed away eight days later as a result of her injuries.

RECOMMENDATIONS OF CORONER HO

I. The Serious Crash Unit identified a number of safety issues at the location, not all of which were directly related to Ms Chen's crash, but which it referred to Auckland Transport (AT) for investigation. Specifically:

a. the high amount of vehicle and pedestrian usage for the driveway to Pakuranga Plaza;

b. the change in speed limit from 60 to 50 km/h for eastbound traffic just before the driveway access to Pakuranga Plaza;

c. the merging of two lanes to one lane for eastbound traffic just before the driveway access to Pakuranga Plaza;

d. the width of Cortina Place including the raised central grass berm and the high amount of foot and vehicle traffic;

e. the increase in speed limit from 50 to 60 km/h just west of Cortina Place;

f. the widening of the westbound lane from one lane to three lanes just west of Cortina Place; and

25 Where Ms Chen's full name appears in these recommendations, I adopt the Chinese structure of writing her surname first followed by her given name.

g. a tailback can be created past Cortina Place as traffic backs up at the controlled intersection with Ti Rakau Drive. As pedestrians cross from Cortina Place towards Pakuranga Plaza they are obscured from eastbound traffic until they enter the eastbound lane.

II. Auckland Transport completed an investigation report in August 2021. As a result of the investigation it resolved to:

a. conduct a pedestrian survey at Reeves Road and Cortina Place intersection and investigate if any additional crossing facilities were required, including investigating and considering the existing pedestrian crossing nearby;

b. review the condition of the road marking and signage at the site and action accordingly;

c. undertake a lighting assessment at the location of the crash; and

d. investigate and likely include Reeves Road as part of its speed limit review of Ti Rakau Drive.

III. In a response on 29 March 2022 AT advised that the recommendations had been actioned and completed; and the results of the survey were being analysed.

IV. There is heavy pedestrian traffic along both the Pakuranga Plaza driveway and Cortina Place, and across Reeves Road between the two locations. Unless physically prevented from doing so, pedestrians travelling between Pakuranga Plaza and Cortina Place are not going to walk 160 metres out of their way to cross at a marked crossing. This is especially so where, as here, they are likely to perceive that they can safely cross two lanes of 50 km/h (or slower) traffic without undue difficulty. That is basic human nature.

V. There accordingly needs to be a way to ensure that pedestrians can cross safely at this location or, if a safe crossing is not feasible, to stop them from crossing at all by way of a physical barrier in the middle of the road or otherwise. I acknowledge that the latter proposal would limit the ability of exiting traffic from Pakuranga Plaza and Cortina Place to turn across the centre line but it may be that that is an inevitable consequence of pedestrian improvements which are required to be made.

VI. I do not consider that installing another pedestrian or signalled crossing at this location would be appropriate without changes to the other proximate crossings. Eastbound traffic will have only just cleared an intersection 80 metres away. Installing another crossing so close to the signalled intersection may compound queues and increase the risk of accidents. It further increases the risk of accidents for pedestrians crossing at what would be a second crossing 90 metres further west, as it is likely drivers would accelerate having cleared the first pedestrian crossing not expecting to have to stop so soon again after.

VII. I note also that AT has received funding for the Eastern Busway project which will include a flyover over Reeves Road to carry traffic to and from Pakuranga Highway and the South Eastern Arterial Highway. This will likely remove some direct east and westbound traffic along Reeves Road, and alter the width of Reeves Road and the configuration of the road where it intersects with Pakuranga Plaza and Cortina Place. Construction requirements might also result in temporary changes to this area. It

would be appropriate for AT to consider pedestrian traffic patterns in this area as part of its redesign and construction and I am told by AT that it will do so.

VIII. Pursuant to s 57B of the Coroners Act 2006 I notified AT of my intention to make the proposed comments at [IV] to [VII] above. Auckland Transport's response did not specifically address the merits or otherwise of my proposals.

IX. The Eastern Busway project is likely some years away from being completed. This means that the Reeves Road crossing issues which I have identified above are likely to exist for some time yet, and possibly get worse as pedestrian and vehicle traffic increases. I have therefore determined that I will formalise my proposal at [V] as a recommendation under s 57A of the Act. To avoid unintended consequences of adding or removing another crossing, as I have tentatively identified at [VI], I leave it to AT to determine how best any safety improvements should be implemented.

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

Clayton [2022] NZCorC 12 (28 January 2022)

CIRCUMSTANCES

Jeremy Robert Clayton, aged 30, died on 22 March 2020 at Whitehall Road, Karapiro of severe head and neck injuries in the context of a motor vehicle accident.

On 22 March 2020, Mr Clayton went clay shooting with friends. He drank beers while clay shooting and while socialising with his friends afterwards.

At around 7:40pm, Mr Clayton left his friends to return home. While there were no witnesses to the crash, the evidence suggested that Mr Clayton was travelling on Whitehall Road when his vehicle crossed the centre line on a bend before colliding with a bridge abutment. His vehicle then dropped into the stream bed below and burst into flames. As a result of the crash, Mr Clayton suffered fatal injuries and died at the scene.

Toxicological analysis found alcohol in Mr Clayton's blood at a level of 204 milligrams per 100 millilitres. For comparison purposes, the legal blood alcohol limit for a New Zealand driver 20 years old or over is 50 milligrams per 100 millilitres.

COMMENTS OF CORONER BATES

I. The Waikato SCU made the following recommendations:

- Continued education and enforcement concerning driving free from impairment by alcohol
- Installation of painted edge lines on Whitehall Road
- Installation of a protective Armco barrier on the bridge abutments.

II. Waka Kotahi NZ Transport Agency ("Waka Kotahi") recently released their National Land Transport Programme for 2021-2024.[26] 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.
>
> 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, 19kms 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.

26 2021–24 National Land Transport Programme | Waka Kotahi NZ Transport Agency (nzta.govt.nz)

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 SH26 Tatuanui to Waharoa; SH2 Mackaytown to Waikino; and SH29 Matamata–Piako boundary to SH28.

RECOMMENDATIONS OF CORONER BATES

I. Mr Clayton's death serves as a reminder of the dangers of driving while intoxicated. Coroners, Police, and NZTA have consistently highlighted the dangers of driving at excessive speed and under the influence of drugs and alcohol.

II. I again highlight those dangers and risks, which Mr Clayton's death graphically demonstrates. I recommend that Waka Kotahi consider the recommendations made by the Waikato SCU regarding ongoing education and enforcement of driving under the influence of substances such as alcohol for their future campaigns.

III. Waka Kotahi's programme of initiatives are significant, welcome and encouraging. I also recommend that Waka Kotahi consider incorporating into their programme the section of road where Mr Clayton lost his life.

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

Davidson [2022] NZCorC 8 (26 January 2022)

CIRCUMSTANCES

Jarryd Brett Davidson, aged 24, died on 12 January 2019 at 72 Glowing Drive, Meadowbank, Auckland as a result of multiple injuries sustained from a car accident.

On 11 January 2019, Mr Davidson spent the evening drinking with his friends. At approximately 5:00am on 12 January 2019, he messaged a friend to ask him what he was doing. It is unclear whether he went to bed after this.

At approximately midday, Mr Davidson was driving a vehicle in the southbound lane of Gowing Drive, Meadowbank. A public bus carrying several passengers was travelling in the northbound lane. Gowing Drive is a designated bus route for Metro buses and school buses. It is approximately ten metres wide and has two lanes. Motor vehicles were legally allowed to park on either side of Gowing Drive, making the passing distance between northbound and southbound motor vehicles very narrow.

As the bus approached 72 Gowing Drive, it crossed the centreline by 30 centimetres. As Mr Davidson approached 72 Gowing Drive, his car crossed the centreline by one metre into the northbound lane. Mr Davidson's car collided with the bus. Mr Davidson died at the scene.

Toxicological analysis found alcohol in Mr Davidson's blood at a level of 257 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. Methylenedioxymethamphetamine (MDMA) and tramadol were also confirmed in his blood.

The Serious Crash Unit (SCU) completed an investigation. The SCU report found Mr Davidson's car was travelling between 83km/h and 94km/h. The posted speed limit for the area was 50 km/h. Mr Davidson's speed was a factor in the crash. Mr Davidson had consumed drugs and alcohol prior to driving which was also found to be a factor in the crash. Additionally, he was not wearing his correcting lenses, which was a condition of his licence.

Auckland Transport also carried out an investigation at the crash scene and provided a report. They found no faults in the road surface, pavement and lighting.

COMMENTS OF CORONER TETITAHA

I. There are already a number of public warnings and campaigns about not driving while intoxicated and obeying speed limits. However, there are measures that can be put in place to reduce speed and to make this road safer to drive by active road management of the area where this death occurred.

II. Auckland Transport have provided a report about this crash that identified several actions for further investigation to reduce similar motor vehicle accidents in this area including:

- Traffic calming measures on Gowing Drive
- Installing signs preventing parking around the bends

III. The above traffic management measures would prevent excessive speeding in this area and enable better visibility for traffic approaching the bend where this incident occurred.

IV. I sought further comment from Auckland Transport regarding making a recommendation as set out above. They provided an update regarding progress on the recommendations set out in their report. They have provided maps detailing the proposed traffic calming measures including commentary. From the maps and commentary Auckland Transport proposes:

a. On Dorchester Street leading into Gowing Drive and at the end of Gowing Drive leading onto Saint Johns Road, it is proposed to place red servicing with “slow” road markings at 3 and 12 Dorchester Street.

b. It is proposed having no stopping at all times areas marked by broken yellow lines in the following areas 32 to 42 and 44 to 48 and 56 Dorchester Street; on the northbound lane of Gowing Drive at numbers 40 to 48, 56 to 58, 68 to 74, 108 to 110, 146 to 150 and 178; on the southbound lane of Gowing Drive at numbers 15 to 27, 39 to 45, 57 to 61, 73 to 75, 83 to 85, 103 to 107, 123, 129 to 131 135 to 141.

c. It is also proposed to relocate the existing bus stop from 17 to 21 Gowing Drive in the southbound lane. This is presumably to improve visibility given this is an area where there is the intersection of several roads.

d. Relocating bus stops from 51 and 86 Gowing Drive to 72 Gowing Drive (northbound lane) and 41 to 43 Gowing Drive (southbound lane). As noted above it is proposed having no parking areas marked by broken yellow lines on either side of the bus stops at 41 to 43 and 72 Gowing Drive.

e. There are proposed kerb and channels on both sides of Gowing Drive to slow traffic. These are located at 55, 77, 86, 93, 112A, 119, 136 and 160 Gowing Drive.

f. There is also proposed additional speed signage on Gowing Drive stating the speed limit of 50 km/h.

V. I thank Auckland Transport for their report and reply updating the Coroner on progress.

RECOMMENDATIONS OF CORONER TETITAHA

I. It is my view if these traffic calming measures had been in place at the time of this crash, it might have prevented this death. I understand these measures are proposed and have not as yet come into effect.

II. There is merit in making recommendations that support these proposed traffic calming measures being put in place as soon as possible to prevent further deaths in this area.

III. Pursuant to section 57A of the Coroners Act 2006, I recommend and support the implementation of the above proposed Auckland Transport traffic calming measures set out in paragraph IV above including where this death occurred on Gowing Drive, Meadowbank, Auckland.

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

Evans [2022] NZCorC 9 (26 January 2022)

CIRCUMSTANCES

Colin Bryce Evans, aged 54, died on 27 January 2018 at Mill Road, Alfriston of the combined effects of cardiomyopathy and multiple blunt force injuries following a motor vehicle collision.

Mr Evans had several health concerns, including heart failure and a long-standing seizure disorder. Seizures in 2011 and 2012 resulted in a period where he was forbidden to drive by various medical practitioners, but his medical notes indicated that allowed to return to driving after a period of being seizure free. His last discharge from hospital was on 19 January 2018. As far as his family were aware, there was no suggestion he should not be driving upon discharge.

Just before 12:43pm on 27 January 2018, witnesses reported seeing Mr Evans' car slowly swerving on Murphy's Road, Flat Bush. As he approached an intersection at Redoubt Road, he appeared to be slumped over the steering wheel. When a witness stopped behind his car and got out a check on him, Mr Evans drove off towards Papakura. The witness continued to follow Mr Evans and described him as driving erratically.

As Mr Evans was driving southbound on Mill Road he crossed the centre line and into the path of a Mini Cooper (the Mini) traveling in the opposite direction. Despite the Mini driver braking and sounding her horn, Mr Evans continued to drive into her path without any evasive action and collided with the Mini.

Mr Evans died from his injuries at the scene. The Mini driver was 21 weeks pregnant at the time of the collision. She lost her unborn baby in the crash.

Counties Manukau District Serious Crash Unit completed a specialist report into the crash. The report could not rule out driver distraction or inattention or a cardiac event for Mr Evans as contributory factors to this crash. Mr Evans not wearing a seatbelt at the time of the crash was a factor in the severity of the injuries he sustained.

COMMENTS OF CORONER TETITAHA

I. I have determined to make comments arising from this death pursuant to section 57A. This is because of concerns about the clarity of advice being given to patients after they are medically assessed as unfit to drive.

Requirement to notify NZTA of persons unfit to drive

II. Section 18 of the Land Transport Act 1998 (LTA) sets out the requirements for notification by a medical practitioner to Waka Kotahi New Zealand Transport Agency (NZTA) regarding persons assessed as unfit to drive:

> **18 Doctors and optometrists to give Agency medical reports of persons unfit to drive**
>
> (1) This section applies if a medical practitioner or optometrist, who has attended or been consulted in respect of a driver licence holder, considers that—
>
> (a) the mental or physical condition of the licence holder is such that, in the interests of public safety, the licence holder—
>
> (i) should not be permitted to drive motor vehicles of a specified class or classes; or
>
> (ii) should only be permitted to drive motor vehicles subject to such limitations

as may be warranted by the mental or physical condition of the licence holder; and

(b) the licence holder is likely to drive a motor vehicle.

(2) If this section applies, the medical practitioner or optometrist must as soon as practicable give the Agency written notice of the opinion under subsection (1)(a) and the grounds on which it is based.

(3) A medical practitioner or optometrist who gives a notice under subsection (2) in good faith is not liable to civil or professional liability because of any disclosure of personal medical information in that notice.

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

How to apply section 18 LTA - Guidance for Medical Practitioners

IV. The Agency has produced a booklet titled Medical aspects of fitness to drive: A guide for health practitioners (the Booklet). The Booklet is self-described as being part of New Zealand's legislative framework, albeit as a guide to good practice and not legally enforceable criteria.[27]

V. The Booklet identifies two main legal obligations health practitioners have relating to fitness to drive. They are as follows:[28]

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

b. to consider the Booklet when conducting a medical examination to determine if an individual is fit to drive.[29]

VI. The Booklet also notes that:

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

VII. The Booklet outlines the procedure the practitioners should follow when notifying the Agency under s 18:[30]

- Inform the individual that they are unfit to drive and the reasons for this.
- If the individual accepts they are unfit to drive and advises they will not drive, take no further action.

27 NZ Transport Agency "Medical Aspects of Fitness to Drive. A Guide for Health Practitioners" (NZ Transport Agency, June 2014) at 1.1 [the Booklet]; This document can be located online at https://www.Waka Kotahi.govt.nz/resources/medical-aspects/.
28 At 1.1.
29 See Part 7 clause 41(4) of the Land Transport (Driver Licensing) Rule 1999.
30 The Booklet, above, n1, at 1.4.

- If the individual does not accept the advice and is likely to continue to drive, advise the Transport Agency (section 18 of the Land Transport Act 1998).

VIII. It also provides:[31]

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

Cardiac events and driving

IX. According to the Booklet cardiac failure is a medical condition that would make a patient unfit to drive:[32]

> 3.5 Cardiac failure and cardiomyopathy
>
> Cardiac failure is a predictor of risk of sudden death. Individuals with uncontrolled or recent (within the last two weeks) uncontrolled heart failure should not drive.

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

X. It is settled law that the meaning of "likely" and in particular the degree of probability it contemplates is best expressed as a "real and substantial risk that the stated consequence will happen".[33]

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

XI. I sought comment from Mr Evans' GP and Middlemore hospital about whether they assessed Mr Evans as fit to drive, what did they advise him about driving and whether there was a notification to the NZTA regarding his fitness to drive.

XII. Dr Marianne Lund, a cardiologist employed by Counties Manukau District Health Board (CMDHB), has provided a report. The report sets out his medical history including his diagnosis of cardiac failure in 2017 and an incidence of uncontrolled heart failure in January 2018. In respect of advice to Mr Evans not to drive, the report states:

> The current LTSA guideline states that individuals with uncontrolled or recent (within 2 weeks) heart failure should not drive. There are further guidelines that

31 At 1.4.
32 Waka Kotahi NZTA Medical aspects of fitness to drive: a guide for health practitioners July 2014. https://www.nzta.govt.nz/assets/resources/medical-aspects/Medical-aspects-of-fitness-to-drive-a-guide-for-health-practitioners.pdf
33 Port Nelson Ltd v Commerce Commission [1996] 3 NZLR 554 (CA) at 562-563 at 226 [Port Nelson].

pertain to arrhythmias, syncope and ischaemia, none of which are relevant here. I can find no notes to definitively state that this was communicated with Mr Evans during his admission and to 19 January 2018, and so I do not have evidence to confirm that this advice was given. This is, however, standard advice given by the cardiology team for all heart failure admissions.

XIII. The family dispute that Mr Evans was advised not to drive during his last hospital admission on 19 January 2018.

XIV. A report from his general medical practitioner (GP) confirmed he was last seen on 26 January 2018. The time focused upon the management of his end stage heart failure. There was no time spent on his fitness to drive. It was assumed he would not be driving because he lived alone and transport was provided by his siblings.

XV. From the evidence his medical practitioners agree Mr Evans was medically unfit to drive due to his heart condition. There is doubt raised by his family who attended with him at his medical appointments that Mr Evans received advice not to drive. Unfortunately there is no written form of this advice being given as recommended by the Booklet.

XVI. Both Mr Evans' early death and the death of the victim's unborn child may have been prevented if this advice had been clearly communicated at his medical appointments.

Should health practitioners be required to record advice not to drive and to notify NZTA under s18 LTA where cardiac failure?

XVII. If a medical practitioner assesses a patient as unfit to drive, this should be recorded and a copy of the advice provided to the patient. The advice could be in a simple format setting out the advice not to drive, the reasons and the length of time driving is forbidden together with conditions for the patient to resume driving could be considered.

XVIII. NZTA could draft a standard form for health practitioners to use that states the patient is unfit to drive. A copy of the form could be kept on the medical notes and a copy provided to the patient. If the patient is a commercial driver, the form could also include reference to the patient informing their employer of any disabling condition that may impact upon their ability to work in the transport industry. This form could also be translated into several languages. This ensures consistent and clear advice is given to patients about being unfit to drive.

XIX. However, where a driver has a permanently disabling illness such as cardiac failure, medical practitioners should be required to notify NZTA. The circumstances of this case illustrate the consequences of patients continuing to drive with cardiac failure. It cannot be left to medical practitioners to negotiate removal of these drivers from the road.

XX. Section 18 LTA should be reviewed to consider mandatory notification by medical practitioners of drivers with long term and/or permanently disabling medical conditions rendering them unfit to drive. This circumvents any issues with clarity or disputes regarding advice not to drive. There is no basis for

the continued holding of licences in circumstances such as Mr Evans. Public safety should be the primary concern.

XXI. These comments are directed to NZTA and the Ministry of Transport.

RECOMMENDATIONS OF CORONER TETITAHA

I. The NZTA consider:

a. providing health practitioners with a simple form setting out the advice regarding fitness to drive in various languages

b. amending the guidelines for health practitioners regarding medical assessments of fitness to drive to require them to:

i. give written advice to patients assessed as unfit to drive; and

ii. record the advice in the patients' medical records.

II. The Ministry of Transport consider amending s18 LTA to require medical practitioners to notify NZTA of drivers with long term or permanently disabling medical conditions affecting their fitness to drive.

III. The NZTA have provided a reply to the comments and recommendations. They confirm they have provided a range of templates and possible forms to be used by health practitioners. They are reviewing the booklet and will consider producing the forms in other languages.

IV. NZTA is limited in its ability to influence the way health practitioners carry out examinations or maintain health records as these will be dependent on the professional guidelines and legal requirements specific to the health profession. However, it is acknowledged the importance of appropriate record-keeping in relation to drivers who may not be fit to drive. NZTA would be happy to consider what further emphasis could be applied to the current guidance and placement of the information during the booklet review.

V. The Ministry of Transport has provided a reply to the above comments as follows:

> Ensuring that driver licence holders are medically fit to drive has important safety considerations, and aligns well with the Road to Zero strategy and our overall regulatory work programme. Work is underway to consider new priority actions for inclusion in the next Road to Zero Action Plan for 2023 – 2025. As part of this, we will consider reviewing the framework related to fitness to drive. Any review of the relevant provisions would need to consider the potential road safety impacts of any changes, as well as any costs or unintended consequences of any changes.

VI. Both the Ministry of Transport and NZTA/Waka Kotahi are thanked for their replies.

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

Hamilton [2022] NZCorC 21 (14 February 2022)

CIRCUMSTANCES

Andrew James Hamilton died at State Highway 25, Pipiroa on 18 June 2019 from multiple injuries sustained in a motorcycle collision with a cow.

The crash occurred at around 12:00, when Andrew was travelling west on State Highway 25 on his Aprilia motorcycle. At around the same time, Police were informed that a motorist had nearly hit some cows on the road approximately 300 metres west of Pipiroa Road. Shortly afterwards, Police found the Aprilia lying on its side in the westbound lane. A deceased male, later identified as Andrew, was found lying about 10 metres away from the Aprilia in the eastbound lane. A dead cow was located in a ditch on the side of the road.

Nearby, Police found the paddock from which the cow had escaped. The paddock was fenced by a two-wire electric fence inside a post and batten wire fence. Parts of this fence were covered in a hedge. A tree had fallen some time ago onto the fence wires, which made the electric fence inoperable and created a hole in the fence where the wires had been pulled down. This meant that only the hedge was preventing livestock from escaping.

The Serious Crash Unit (SCU) considered that the causative factor in the collision was that Andrew did not have enough time to react and avoid a collision with the cow. Andrew's inability to react would have been aggravated by his drug impairment (methamphetamine) and inexperience on a motorcycle of the size and power that he rode.

While the Coroner could not entirely discount speed, there was no evidence that Andrew was riding recklessly. The principal cause of the collision was the unexpected presence of a cow on an unlit rural road, which likely gave Andrew "limited if any realistic prospect" of avoiding the collision. The Coroner concluded this was an avoidable death brought about by the fact that a cow had been able to wander onto a public road.

COMMENTS AND RECOMMENDATIONS OF CORONER ROBB

I. The Police not only fulfil a law enforcement role but are the coroner's agents in gathering evidence for the coroner for coronial investigations under the Coroners Act 2006. The evidence before me identified limited and poor-quality photographic evidence of the fence through which the cattle escaped. Andrew's family have provided me with another photograph indicating that the fence was poorly maintained and a walk around the boundary by the farmer would have established this.

II. The farm owner was spoken to by the Police, but the Police did not take a formal witness statement from him. This was despite it being his responsibility to maintain the fence and the inadequate fencing having resulted in the death of a member of the public.

III. I understand that while the farmer accepts being aware of some damage being caused by a fallen tree, he had been unaware of the section of damage that allowed the cows to escape. I understand he had cattle in the paddock for some seven days prior to the cows finding a way out onto the roadway.

IV. Andrew's family are deeply concerned about how this event could have unfolded in the way that it did.

V. The reality is that the fence damage and the ability for the cows to wander, has resulted in an avoidable death. In that respect I am concerned on behalf of the public about dangers that are present when livestock are kept in roadside paddocks with inadequate fencing in place.

VI. I recommend that the rural community be reminded of the importance of ensuring that fencing is properly maintained on roadside paddocks in which stock, be it cows or any other large animal, is being kept. I remind those that are responsible for this fencing that the consequences of inadequate maintenance can be the loss of somebody's life. As a coroner I have dealt with a number of rural deaths caused by animals having wandered onto the roadside. Prioritising maintenance of roadside fencing is as a result important.

VII. Pursuant to s 57A of the Coroners Act, I make the following comment:

a. Andrew's death is a tragic reminder of the dangers posed by wandering livestock. It is the responsibility of livestock owners to ensure that their paddocks are properly fenced and secure, and that this is thoroughly checked regularly.

VIII. Pursuant to s 57A of the Coroners Act, I make the following recommendation to Waka Kotahi, the New Zealand Transport Agency:

a. That Waka Kotahi undertakes a public safety campaign on the dangers of wandering livestock and the responsibility of livestock owners to highlight the inherent risks posed to the public and highlights how members of the public can notify Waka Kotahi of potential hazards caused by fencing to road users.

b. That Waka Kotahi considers implementing an annual assessment of agricultural fencing that runs parallel to state-highways, notifying property owners of the potential liability where the fencing poses a risk to road users.

Opportunity to respond to adverse comments and recommendations

IX. The Coroners Act[34] mandates an opportunity be provided to any party who is the subject of what may be perceived as an adverse comment, and/or is the subject of recommendations, to respond. I have accordingly provided the Draft Comments and Recommendations to the farmer, who owned the fence and the cattle who escaped through the fence, advancing an opportunity to respond or to provide me with any additional information prior to my finalising of this Finding that he may wish to provide. I have also asked that this draft be distributed to Waka Kotahi and those entities that can fulfil a representative role for the rural community who are responsible for fencing next to public roadways.

Waka Kotahi

Response to recommendation (a)

34 S57B and s58 Coroners Act 2006.

X. Waka Kotahi acknowledge the opportunity to respond to the draft finding and in their response they conveyed their condolences to Mr Hamilton's family for detailing the following:

i. *Waka Kotahi sent out a media release in 2020 which reminded farmers to keep their livestock secure following an increase in the number of road incidents involving livestock. Farmers were encouraged to check all fences and to take care with temporary road grazing fences. Motorists were also encouraged to report any stock wandering on to state highways by phoning 0800 4 HIGHWAYS (0800 44 44 49).*

ii. *Our current marketing and education campaigns focus on key areas of concern in the Government's Road safety strategy to 2030: Road to Zero. The marketing program concentrates on the issues of driving at excessive speed, drink-driving, drug-affected driving, motorcycling, seatbelt use, distracted driving and safe vehicles. (More information on Waka Kotahi marketing programs can be found on the NZTA website).*[35]

iii. *As none of these programs and initiatives focus on the dangers of wandering livestock, we will look to address this issue as part of our Road Code social media campaign. This campaign will focus on areas of concern identified by the public, with posts appearing across all Waka Kotahi social media channels monthly in 2022.*

Response to recommendation (b)

XI. The Waka Kotahi response included:

i. *Waka Kotahi recognises the risk that wandering stock presents to users of the State Highway network and are supportive of actions to reduce this. There are a number of practical issues that would need to be considered when implementing a networkwide survey on over 11,000km of state highways and notifying individual owners of potential liability, due to poor or damaged fencing. We have recently carried out this type of exercise along much of State Highway 35 (SH 35) in the Gisborne region and have identified several issues that limited the success of the outcomes sought.*

ii. *Due to the scale of the State Highway network, it is not always practical to inspect all boundary fencing which are often set back some distance, making them difficult to see and access from the State Highway. Waka Kotahi supports a targeted approach to areas that have a history of wandering stock issues, and areas of high stock grazing, which may be more successful. A more general advertising approach through our Road Code social media campaign will support a change on the wider State Highway network.*

iii. *It has proved difficult in many cases to determine the ownership of land adjacent to the State Highway, particularly land blocks with multiple owners or that are not*

35 www.nzta.govt.nz/safety/what-waka-kotahi-is-doing/our-advertising/

operated by a known business entity. It has also proven difficult to define what an acceptable standard of fencing should be defined as. While standard eight-wire fencing is an industry norm, there is evidence that animals short of water or feed can jump or breach well-maintained fences to reach roadside verges. This is particularly evident in the summer months, and during periods of drought.

iv. *It would be necessary to reach clarity of potential liabilities for individual landowners and persons conducting a business or undertaking (PCBU's) in each region. While some Local Authorities have stock control by-laws, some do not, and it is rare for any action to result from by-law breaches.*

XII. Waka Kotahi noted that PCBU's may have potential liability under the Health and Safety at Work Act 2015 and suggested that it might be appropriate to consider this in the recommendations to ensure that any potential liability highlighted to landowners is credible and enforceable. I adopt that recommendation.

Response from owners of the farm

XIII. Included at the outset was an expression of regret and sympathy extended in respect of Mr Hamilton's death. The owner then outlined a number of matters which included, but was not restricted to, the following:

i. The owner provided me with a series of photographs of the area of land and section of fencing relevant to the events. It was explained that the information recorded by the Police was light on detail. He explained the circumstances in detail.

ii. The farm had been purchased relatively recently and had been purchased as, and had been previously utilised as, a grazing property. Stock had grazed the fence line for a number of years without incident.

iii. The boundary fencing had been walked and checked where necessary areas of fixing and repairing fences was being undertaken on a paddock by paddock basis as cows were reintroduced onto the property and were moved around the farm in order to ensure their containment.

iv. Together with multiple photographs the farmer provided an explanation of repairs of fencing that had been undertaken in a staged process. Concerned that photographic evidence that I had been provided could present an incomplete or inaccurate account he provided multiple photographs with distant then close-up photographs capturing the fence line. He explained that an area of fencing might appear to be problematic if viewed by a single photograph and without closer inspection or surrounding context explained. This explanation included multiple photographs of the same region which showed what may initially have appeared to be a fence in poor repair, on closer inspection and removing of foliage, subsequently revealing adequate fencing in reasonable repair. Other photographs highlighted the difficulty

that presents where even on relatively close inspection an area of fencing appears to be in good condition when it is not.

v. The area where the cow escaped on the occasion of Mr Hamilton's tragic death had been evaluated as in reasonable repair prior to the incident. This was in an area where cows had been grazing without incident for a number of days prior to the tragic events. The tree that provided an opportunity for the cow to escape had come down in one place over two fences, a boundary fence and an internal electric fence. The tree was relatively small and had compressed the wires down to a height of approximately 60 cm-with the standard fence pattern normally being in the region of 1.1-1.2 m. Whether the top wire had been broken, and if so when and how this occurred, he was unable to say. Growth of grass and shrubs in the area had inhibited the ability to observe this compromised area of fence.

vi. The area of damaged fencing has been repaired, and the boundary fencing has been monitored and repaired when necessary. The farmer explained that this area of boundary fencing has had the wires cut by someone in recent times, in one instance involving 16 separate cuts to the fence. He detailed vigilance in maintaining the fence line to prevent a similar tragedy.

XIV. As noted earlier in this finding the consequences of any large animal escaping onto a public road can be very serious and can on occasion be fatal. The inquiry evidence also reveals that the importance of maintaining fencing on a boundary with a public road is recognised by the farmer. Maintenance of boundary fencing is not without its difficulties but is an important ongoing obligation for any farmer.

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

Hunuhunu [2022] NZCorC 10 (27 January 2022)

CIRCUMSTANCES

Thomas Hunuhunu, aged 47, died on 11 October 2018 on Devon Street West in Rotorua. The cause of his death was severe head trauma sustained in a motorcycle accident.

At 1:50am on 11 October 2018 Thomas was found lying on the grass at the side of Devon Street West in Rotorua. His motorcycle was lying nearby. While there were no witnesses, it appeared that Thomas had collided with a concrete kerb and a small timber retaining wall. As a result of the collision, he sustained a significant head injury and died at the scene.

The Bay of Plenty District Serious Crash Unit (SCU) investigated the crash, which occurred on a right-hand curve on an uphill grade at the end of a short straight. The incline on approach to the right corner measures approximately three degrees. The road is centre crowned, which resulted in a grade of approximately four degrees. The centre crown continues into the corner resulting in a slight negative camber, which varies between one and two percent when progressing through the corner.

It was dark at the time of the crash. Streetlights were operating but were quite dim and not able to fully light the road. The streetlights are positioned on the eastern side of the road. The left side of the northbound lane was left in darkness.

Thomas held a learner driver car licence but had never held, or attempted to gain, a motorcycle licence. Thomas had purchased the motorcycle about three weeks prior to the crash. Thomas was probably inexperienced, untrained and unfamiliar with the motorcycle, having only recently acquired it.

Thomas' blood sample tested positive for cannabis and methamphetamine.

RECOMMENDATIONS OF CORONER DUNN

I. The SCU expert noted that there were aspects of the environment that could be improved, such as the negative camber of the curve, poor street lighting, faded road markings, and applying an advisory speed to the curve.

II. The expert also recommended that motorcycle riders exercise more caution in this type of environment, use correct safety equipment and clothing and be aware of the dangers of impaired riding.

III. It is accepted that no one definitive explanation can be given as to why Thomas' motorcycle left the road. It is reasonable that it was a combination of his impairment from drug use, speed, the motorcycle's condition and Thomas' inexperience with motorcycles.

IV. Nonetheless I am of the view that the recommendations made by the SCU expert are helpful and could in the future reduce the chances of further deaths occurring in similar circumstances. Accordingly, I remind motorcycle riders to exercise more caution in this type of environment, use the correct safety equipment and clothing and be aware of the dangers of impaired driving.

V. I directed that a copy of my draft finding be sent to the Rotorua Lakes Council regarding the SCU expert's comments about the environment on Devon Street West. The Rotorua Lakes Council have responded to my draft finding and recommendations in a helpful and clear manner.

VI. The Council advise that since Thomas' death they have upgraded the street lighting to LED lighting. The Council advise that the general lighting has improved along Devon Street West as a result of their upgrade and is compliant.

VII. It is anticipated in the future that there will be an upgrade to Devon Street West including speed humps. The Council intend to carry out an assessment to determine whether an appropriate curve advisory speed is warranted. The Council also assess annual remarking of streets and Devon Street West is part of the 2021-22 remarking programme.

VIII. I thank the Rotorua Lakes Council for their response and am hopeful their upgrading and anticipated changes will ensure the road is maintained in a condition that reduces the likelihood of any such accidents in the future.

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

Iese [2022] NZCorC 28 (4 March 2022)

CIRCUMSTANCES

Hinerangi Moana Iese, aged 12, died on 1 November 2019 at Bay of Islands Airport as a result of multiple injuries sustained on State Highway 1 as a result of being struck by a motor vehicle.

Hinerangi regularly used the school bus to travel home. The bus operator's policy was to drop children off on the same side of the road as their house so that they did not need to cross the road. Hinerangi lived on Subritzky Road which ends in a T-intersection with the southbound side of State Highway 1. Just after the Subritzky Road intersection southbound the road curves to the right. This section of State Highway 1 is a sealed two lane, one in each direction, road with a 100 km/h speed limit. As with all roads, that 100 km/h speed limit reduces by law to 20 km/h when passing or meeting a stationary school bus dropping off or picking up children.

On the afternoon of 1 November 2019, Hinerangi was travelling home on her regular school bus. The bus pulled into the Subritzky Road intersection and stopped. There was enough room for other southbound traffic on State Highway 1 to pass without having to enter the opposite northbound lane. Hinerangi got off the bus. Normally she would walk down Subritzky Road towards her house. However, for unknown reasons, on this afternoon she walked to the back of the bus and prepared to cross State Highway 1.

Just as Hinerangi got off the bus and started to move back onto State Highway 1, a large southbound truck and trailer unit ("Scania truck") slowed down to approximately 10 km/h to pass the bus. The bus driver, who was moving slowly, waved the Scania truck to pass by. The Scania truck rounded the corner of Subritzky Road just as it passed the bus. At the same time the Scania truck passed, a northbound Isuzu truck and trailer unit ("Isuzu truck") was travelling on the northbound lane at 80 km/h. The driver of the Isuzu truck did not see the school bus because it was obscured by the passing Scania Truck.

Hinerangi ran across the southbound lane towards the northbound lane, momentarily pausing at the centreline. The driver in the northbound Isuzu truck saw Hinerangi suddenly run across the northbound lane but was unable to brake in time to avoid colliding with her. Hinerangi was conscious after the collision but sadly passed away while being transported to hospital.

COMMENTS OF CORONER HO

I. Previous coronial findings have addressed safety issues arising from school bus deaths. I consider below these recommendations and whether, if implemented, they could have possibly prevented Hinerangi's death. I also review the specific factors that were unique to this accident, including:

   a. The school bus was moving at the time of the impact. Under the law, the Isuzu driver was not required to slow down to 20 km/h.

   b. The Isuzu driver's view of the school bus was obscured by an overtaking truck. Therefore, even if the Isuzu driver was legally required to slow to 20 km/h, the accident would likely still have occurred because the Isuzu driver did not know the school bus was there.

II. I then go on to consider whether any further recommendations ought to be made that might prevent future deaths from arising in similar circumstances.

Previous coronial recommendations

III. Hinerangi's death was the first instance since 2010 of a child dying as a result of a school bus related accident. There were eleven serious injuries sustained by children around school buses during that same time period.

IV. Previous coronial findings have made recommendations designed to minimise the risk of harm to children getting off or waiting to get on school buses. In summary:

a. flashing lights should be mounted on the front and rear of the school bus to alert drivers of school children;

b. other motorists should stop while children are getting on or off, possibly by use of pneumatic barrier arms such as the type typically fitted on dedicated school buses in the United States;

c. there should be safety awareness campaigns directed at both children to teach them of the dangers of traffic and to other motorists to educate them of the 20 km/h speed limit.

<u>Use of flashing lights</u>

V. In 2014 Waka Kotahi New Zealand Transport Agency undertook a trial in Ashburton whereby flashing LED signs displaying a 20 km/h speed limit were fitted to school buses. The signs were designed to activate 20 seconds before the bus stopped and remain activated until 20 seconds after the bus started moving again. Waka Kotahi coupled this trial with an awareness campaign through media and other local sources reminding drivers that "either way it's 20k" – a reference to the fact that the speed limit when passing a stationary school bus picking up or dropping off children, in either direction, is 20 km/h.

VI. The trial reported over a doubling of the percentage of drivers slowing down to the legal 20 km/h speed when the LED signs were activated. However, the trial also noted that when the signs were used in isolation, without an awareness campaign, there were high levels of speed variability which was linked to lower levels of safety. Of particular concern was some motorists overtaking vehicles that had correctly slowed down for the school bus. In a September 2017 briefing to its Minister, the Ministry of Transport stated:

> "The trials found that to reduce speeds past stopped school buses safely, flashing speed limit signs must be supported by an awareness campaign and targeted enforcement."

VII. The Ministry of Transport then went on to say:

> "Nationwide fitment of flashing speed limit signs on school buses has been considered, but would be very expensive. [The Ministry of] Education estimates that fitment and maintenance of the signs on Education provided buses alone

would cost around $18 million over ten years. The costs of the required supporting enforcement and education campaign have not yet been quantified.

We consider the cost of a nationwide rollout of the signs would not be justifiable given the current low road safety risk. However, community and interest groups remain concerned about this issue."

VIII. While quantification of cost and benefit is a matter for the responsible government department and their expert advisors, I note that the quoted section from the Ministry's briefing appears at odds with a February 2017 report prepared for Waka Kotahi New Zealand Transport Agency by TERNZ Transport Research, which was commissioned to investigate the effectiveness of the Ashburton trial. TERNZ relevantly stated in its report on the Ashburton signs trial that:

a. the "benefits of the signs and related activity are estimated to be greater than 3.5 times" the cost of installing the signs on all school buses in the country;

b. the costs were "relatively modest compared with other road safety countermeasures" and suggested that "the initiative would be cost-effective"; and

c. a targeted intervention focusing on rural school buses would have "lower costs and greater benefits due to the high mode share of school buses in rural communities" and that "school buses that pick up or drop off in 100 km/h zones would gain the most in terms of safety benefits".

IX. I agree that the implementation of any flashing signs on buses should be accompanied by an education campaign to remind drivers of the appropriate speed limit when passing stationary school buses. In light of the recorded observations that many drivers appear not to be aware of this requirement, it is my view important that the Ministry of Transport and Waka Kotahi prioritise a nationwide education campaign. Just as driving drunk is a danger to road users, travelling at more than 20 km/h past a stationary school bus is a danger to the children who are getting on and off it.

X. While I generally support the use of bus-mounted flashing lights or signs in conjunction with an educative approach, such lights or signs would not have made a difference here. The driver of the vehicle that struck Hinerangi did not see the bus because it was obscured by an overtaking truck, and so he would also have been unable to see any lights or signs on the bus itself. There is also a practical topography issue, not unique to Hinerangi's death, in that buses parked on or near a corner may not be visible to other drivers until it is too late for them to safely slow down.

XI. I considered whether the difficulties posed by bus-mounted lights or signs might be addressed in another way, including whether it was possible to mount interactive LED 20 km/h speed limit signs a calculated distance either side of likely rural bus stops, similar to the interactive 40 km/h speed limit signs that are mounted near schools. When activated the signs could display any or all of: the 20 speed limit, an illuminated "slow" warning, flashing yellow lights to warn of the speed limit change, and the reason for the speed limit change ("stopped school bus"). Such signs could activate when a bus passes it in either direction or by GPS tracker, and would warn both following and oncoming traffic of a

likely stopped school bus. The signs could de-activate after a set amount of time or after the other sign detects the bus having passed.

XII. Pursuant to s 57B of the Coroners Act I advised Waka Kotahi and the Ministry of Transport of my intended suggestion. In response, Waka Kotahi advised that interactive signs at rural bus stops were likely to require substantial funding and physical works to implement. Further, because rural bus stops are often not fixed and change from year to year depending on where the students live, both Waka Kotahi and the Ministry of Transport noted that it was difficult to signpost every rural bus stop. The Ministry of Transport added further that installing such signs would require setting a variable speed limit outside each school bus stop which would require either an action by the road controlling authority or a nationwide rule change.

XIII. I accept that the shifting nature of rural school bus stops would pose difficulties. However, stops which are situated at the end of driveways are unlikely to be as high risk as stops just on the side of the road. I consider there must be a way for the appropriate government agencies to develop and apply a risk matrix to assess likely school bus stop locations which are more dangerous than others, such as those along main high speed rural roads or state highways, where the installation of such signs would be appropriate. Even if the signs did not flash an adjusted speed limit, but merely to warn of a stopped or stopping school bus, that might sufficiently alert drivers to be alert for and ready to slow down for the bus in the same way that interactive signs flash to warn drivers to slow down for an upcoming pedestrian crossing.

XIV. Waka Kotahi also raised a resource issue. It advised me that it has a responsibility to invest funds where it can save the most lives and prevent the most serious injuries. It stated that while it fully endorsed the recommendation of improving speed compliance past school buses, the level of investment required for fixed flashing signs would be more effective in preventing deaths and serious injuries if utilised elsewhere. While I accept that agencies are constrained by the amount of funding they receive, there must nevertheless be some ability to explore possible improvements to existing practices. It is important that trials are conducted and new methods investigated even though, at first blush, they might not be able to be done to a perfect standard. It is possible for resources to be allocated in a restricted but appropriate manner. For instance, it could be that flashing signs could be installed near locations which are consistently used for rural bus stops and which are assessed as high risk, such as because the stop intersects with a side road or is close to a blind corner. There are compromises short of perfection which might still go some way to improving the safety of children getting on and off school buses in rural areas. They should be explored and, as technology advances, updated.

XV. Finally, I note from the Ministry of Transport's response that it is working with Waka Kotahi and the Ministry of Education to scope a research project to update their understanding of school bus safety. I am informed that the findings of this research could inform potential future actions under "Road to Zero", New Zealand's road safety strategy for 2020 to 2030, and which sets out an overarching vision where no one is killed or seriously injured in crashes on New Zealand roads and which sets a target of 40 percent reduction in deaths and serious injuries by 2030. While research is important, and admirable, it is not a substitute for actual trials and implementation of the lessons learned from those

trials. It is, for instance, surprising that the results from the Ashburton trial appear not to have been converted into any meaningful development around school bus safety in the eight years since the trial was conducted. I hope that the promised research project will translate into practical and meaningful changes to school bus safety.

Full stop laws / pneumatic barrier arms

XVI. School bus laws vary from state to state in the United States but in almost all states it is a legal requirement for drivers in both directions to stop for a stationary school bus. Many dedicated school buses are also fitted with pneumatic barrier arms which extend from the driver's side of a school bus to stop following vehicles from overtaking, and which also has the effect of requiring children to cross the road in front of the bus in the bus driver's line of sight.

XVII. I have considered whether a similar full stop requirement should be applied in New Zealand and whether the use of pneumatic barrier arms would be desirable or practical. At least in the case of rural buses, I have come to the view that they would not.

XVIII. In relation to a full stop requirement, TERNZ identifies that 200 metres of clear sight distance is required to safely stop a vehicle travelling at 100 km/h down to 20 km/h. More distance would be needed again to safely bring a vehicle to a full stop. If a full stop requirement became law in New Zealand buses would have to stop at locations which allowed a clear sight distance of that length. This is likely to be impractical given New Zealand's typical winding road topography and might require buses to stop away from existing stops such as students' driveways or intersections with side roads along which children live. Children would then have to walk along the side of a high speed road to access their house or side road. This would merely swap one risk for another. In addition, stopped traffic would reduce the sighting distance for following vehicles and possibly create tailbacks which could cause further accidents.

XIX. For the same reasons, I consider that requiring the use of barrier arms on rural school buses would be impractical and possibly dangerous.

Education campaign

XX. Education campaigns are directed at both motorists and school children.

XXI. There appear to be virtually no education campaigns, at a nationwide level, directed at motorists to remind them of their legal requirement to slow to 20 km/h when passing a stationary school bus embarking or disembarking children. While ignorance of the law is no excuse, that is of little comfort to a child who might be hit by a vehicle and their family. I consider that this issue is one of primary road safety importance and which should receive more attention that it currently does. I recommend that a nationwide campaign educating motorists on the rules around passing stationary school buses be developed and implemented.

XXII. In its response to my proposed recommendation Waka Kotahi advised that the present focus of the national road safety marketing programme is on those priorities identified in Road to Zero, being excessive speed, drink-driving, drug-affected driving, seatbelt use, motorcycling, distracted driving and

safe vehicles. However, Waka Kotahi indicated it would look at further opportunities to run a previous Road Code social media campaign, which presumably includes school bus safety, across all social media channels. Waka Kotahi advised that rules about passing stationary school buses are addressed in a website and online learning tool to help young people become safe, skilled and capable drivers; and that its education portal provides schools with resources and educational material on road safety which are specifically aimed at a young audience.

XXIII. While some resource is better than none, I do not consider Waka Kotahi's present approach to be sufficiently proactive to address the harm on which my findings focus. It seems to me that further education could be developed at very little cost and without distracting from the core priorities of Road to Zero. An education campaign limited to, for example, erecting signs along high speed high traffic rural roads reminding drivers of the need to slow down for stopped school buses would go a long way towards further driver education on this topic.

XXIV. It would also be beneficial to ensure that children are educated, and frequently reminded, about the importance of the role they themselves play in school bus safety. I am advised that such campaigns are delivered in school at the beginning of each school year. However, the beginning of the year can be an exciting and unsettled time for many children. The lessons to be delivered in such safety talks may be absorbed only temporarily and then quickly forgotten. I recommend that particularly in rural areas, refreshers on school bus safety be delivered at least every six months and that posters reminding children of key school bus safety principles, such as not crossing the road without a parent or guardian present, be mounted in prominent places within school grounds. School bus safety might also be a useful unit studies topic for children to explore as part of their curriculum.

XXV. In its response the Ministry of Education advised me that it "broadly supports an educative approach to improving student safety" and that while school bus safety and road safety are not currently part of the New Zealand curriculum, schools and kura are encouraged to emphasise the importance of these topics through effective policies and procedures. Regrettably, there was little in the Ministry's statement to indicate that actual, proactive, work was being done in this space and the impression I received was that any specific education being delivered on this topic is due to the initiative of individual schools rather than the result of any national co-ordinated approach.

Other comments

XXVI. I am also troubled by the limitation in the rule which requires vehicles to slow to 20 km/h when passing or meeting a stationary school bus. As Hinerangi's death illustrates, first, there is likely to be a short period, after the bus starts moving, where disembarked children are still in the vicinity of the road. Yet under the current road rules, because the bus is no longer stopped, there is no legal requirement for vehicles to slow to 20 km/h. Second, because of where a school bus might stop or due to other traffic, it may not be possible for vehicles to see a stopped school bus until it is too late for them to slow down. A 'perfect world' solution would be to ensure other motorists are aware well in advance of a stopped or recently stopped school bus and the presence of schoolchildren, thus allowing them to slow down in plenty of time – but the responses I received from Waka Kotahi and the Ministry of Transport indicate that they do not regard such a solution as feasibly, technologically or economically practical.

XXVII. It may be that the recommendations and comments I have made, when implemented in conjunction, might be enough to prevent further school bus deaths. Schoolchildren might be more aware of road dangers. Motorists might be more careful around corners or be more alert to the presence of possible stopped school buses, particularly during school pickup and drop-off hours. I hope that they are. I hope that no other coroner is required in future to refer to this finding and the recommendations I have made in it.

XXVIII. I formalise the recommendations and comments made in paragraphs [XV] to [XXV] above. In light of the Ministry of Education's advice that it presently plays no role in school bus safety at a nationwide curriculum level, I ask that the Ministry make a copy of these findings available to rural schools for their consideration.

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

Lolohea [2022] NZCorC 31 (7 March 2022)

CIRCUMSTANCES

Eliesa Jacob Osaiasi Tonga Faleola Lolohea, aged 20, died on 4 November 2019 at State Highway 36, Pyes Pa, Tauranga of a head injury secondary to a motor vehicle accident.

On 4 November 2019, Mr Lolohea was driving north on State Highway 36, Pyes Pa Road, Tauranga. He lost control of his vehicle on a sweeping left-hand bend. His vehicle crossed the centreline and the southbound lane and collided with a roadside tree. As a result of the collision, Mr Lolohea suffered fatal injuries and died at the scene.

The Coroner considered that the combination of speed, fatigue and driver inexperience contributed to Mr Lolohea's vehicle crossing the centreline then being overcorrected, leading to the crash. The severity of Mr Lolohea's injuries was affected by the speed he was travelling and by him not wearing a seatbelt.

COMMENTS OF CORONER BATES

I. I make the following comments pursuant to section 57A of the Coroners Act 2006: The dangers of driving while fatigued are evidenced by Mr Lolohea's death. Waka Kotahi, the New Zealand Transport Agency (Waka Kotahi) has identified the following warning signs of fatigue and I urge all motorists to be mindful of them:

a. Restlessness

b. Blinking frequently

c. Yawning

d. Excessive speed changes

e. Braking too late

f. Forgetting the last kilometres travelled

g. Drowsiness

h. Centreline drift

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

III. Clearly the risk of injury is heightened, and the extent of any injury suffered will be increased when the occupant of a motor vehicle involved in a crash is not wearing a seatbelt. In the present case, failure to wear a seatbelt resulted in the driver being ejected from the vehicle and colliding with a tree, no doubt significantly increasing the degree of trauma he sustained. While it is impossible to tell whether the driver would have survived the crash had he been wearing a seatbelt, his chances of survival would certainly have been increased. Waka Kotahi have run campaigns educating the public to always wear seatbelts. The message requires continued promotion.

IV. The dangers of driving at excessive speed are well known and constantly promoted. I simply reinforce the clear and constant message to drive within prescribed speed limits and posted advisory speeds, and always to the conditions.

V. In the circumstances of this case, I do not consider it necessary to make any further comments or recommendations pursuant to s 57(3) of the Coroners Act.

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

McColl and Wallace [2022] NZCorC 24 (18 February 2022)

CIRCUMSTANCES

William John Wallace and Tadhg Lewis Hugh McColl, both aged 18, died on 30 March 2019 on Glover Road, Hawera from injuries sustained in a motor vehicle collision.

At approximately 8:15pm, William was driving his Nissan vehicle west on Glover Road with his friend Tadhg in the passenger seat. William had just bought the vehicle earlier that day. Both young men held restricted licences, meaning that William should not have been driving Tadhg as a sole passenger. While travelling at excessive speed, the vehicle left the road and rolled several times. Both William and Tadhg were thrown from the vehicle, and died at the scene from their injuries.

The Coroner accepted the evidence of the Serious Crash Unit (SCU) that the critical factor causing the crash, and William's and Tadhg's deaths, was the speed at which William was driving. The posted speed limit in the crash area was 70km/h. William was driving at a speed estimated between 118-146km/h.

The SCU also noted that William's driving speed exceeded what was appropriate for the conditions. Relevantly, these included that the weather was drizzly and the road wet; the road was gently undulating; and that the road was dark with no street lighting.

William was not wearing a seatbelt, which may have contributed to his injuries and to his ejection from the vehicle. However, Tadhg was wearing a seatbelt when he was also thrown from the vehicle and fatally injured.

COMMENTS OF CORONER BORROWDALE

I. I make the following comments pursuant to section 57(3) of the Coroners Act 2006, with a view to public education and the avoidance of further tragedies such as the motor vehicle crash that claimed the lives of these two young men, William and Tadhg. My comments are particularly directed to teenagers and young drivers, and reinforce safety messages made publicly available by Waka Kotahi NZ Transport Agency:[36]

a. Newly-licensed drivers who hold **a restricted driver's licence** should drive only in accordance with the conditions applicable to their licence. These restrictions are imposed for the safety of the driver and of the wider public.

b. This is not the first coronial case in which I have dealt with a fatal crash caused by a young driver who has only just acquired **a new vehicle**. It takes time to become accustomed to the capabilities and characteristics of a new car. Owners of new cars should – whatever the permissions on their licence – avoid carrying passengers until they have had time to adapt their driving style to the new vehicle.

c. It is essential to **drive defensively**. Travel at speeds that enable you to stop or avoid disaster, if a hazard appears in front of you.

d. Avoid **aggressive driving**. It is courting danger for any driver – and especially the driver of an unfamiliar vehicle – to push their vehicle to excessive speeds or to perform stunts in it.

e. **Keep your speed down**. Do not exceed posted speed limits. Drive to the conditions. The posted limit is the maximum legal speed you can travel on a road in perfect conditions.[37] But road conditions are rarely perfect. The posted speed limit may be too high for safe driving on the road conditions on a given day. High speeds reduce your time to react if something goes wrong, and increase the distance that you will need to stop. To maintain control of your vehicle, you must control your speed.

f. A small change in **speed can make a big difference to the outcome of a crash.** When a vehicle crashes, it undergoes a rapid deceleration. However, the occupants keep moving at the vehicle's previous speed until they are stopped – either by hitting an object or by being restrained by a seatbelt or airbag. The faster the speed, the greater the injury.

36 https://nzta.govt.nz/safety/driving-safely/
37 https://nzta.govt.nz/safety/driving-safely/speed/

g. **Be alert** to your surroundings when you are behind the wheel: road conditions, your speed and position, applicable traffic laws and signs, road markings, following distances, the cars around you, pedestrians, the weather etc. Staying focussed on driving – and only driving – is critical to vehicle safety.

h. Always wear your **seatbelt**. Advice on the Waka Kotahi NZ Transport Agency website states that wearing a seatbelt reduces your chances of being killed or seriously injured in a road crash by 40%.[38]

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of William John Wallace and Tadhg Lewis Hugh McColl entered into evidence during this inquiry, on the grounds of personal privacy and decency.

Meldrum [2022] NZCorC 13 (28 January 2022)

CIRCUMSTANCES

James Robert Meldrum, aged 20, died on State Highway 1 at Morven, South Canterbury on 17 February 2017 of multiple injuries sustained in a motor vehicle collision.

At around 9:40am, Mr Meldrum was driving south on State Highway 1 in his uncle's Mercedes, after dropping his father off at Christchurch Airport. At around the same time, Gary Dick, a Fonterra tanker driver was driving his Volvo work truck and trailer north.

The collision occurred when Mr Meldrum attempted to overtake the Holden in front of him and pulled out into the northbound lane. When he saw the oncoming Volvo, he attempted to immediately return to the southbound lane. However, in performing the manoeuvre Mr Meldrum overcorrected, which caused the Mercedes to fishtail and Mr Meldrum to lose control of the steering.

Mr Meldrum held a restricted driver's licence. The crash analysis report considered that his inexperience as a driver may have contributed to the overcorrection.

The Coroner agreed with the conclusion of the crash analysis report that Mr Dick did not have sufficient time to brake or avoid the collision. However, he was unable to conclude that Mr Meldrum's overcorrection was the result of inexperience, given the circumstances. Mr Meldrum also had very little time to react and attempt to return to the southbound lane.

COMMENTS OF CORONER HESKETH

I. Attending Police staff informed my inquiry that this was not the only fatal collision that occurred on State Highway 1 in the Waimate Police District in 2017. A common theme had been the head on nature of collisions between vehicles involved and two of the three collisions that year involved cars colliding head on with fully laden truck & trailer units. Such head on collisions result in very high impact

38 https://nzta.govt.nz/safety/vehicle-safety/safety-belts-and-restraints

collisions which dramatically reduce the chance of survival for those persons involved, especially the occupants of the cars.

II. The attending Police observed in Mr Meldrum's case he misjudged an overtaking manoeuvre resulting in catastrophic consequences. Furthermore, Police observe ill-judged or risky overtaking manoeuvres were all too commonly reported to them and were often carried out due to frustration and lack of patience with slower moving vehicles in front. Slower moving vehicles were a common occurrence on the 41 km stretch of State Highway 1 between Otaio and Glenavy involved, given the amount of freight and at the time, tourist traffic that existed.

III. I have obtained updated data from Waka Kotahi NZ Transport Agency (Waka Kotahi). During the years 2011-2021 there were 9 fatal crashes on State Highway 1S between Otaio and Glenavy. There were 6 crashes resulting is serious injury and 56 crashes in which minor injuries were recorded. Furthermore there were a reported 138 non-injury crashes reported.

IV. Waka Kotahi confirm that no passing lanes have been constructed since 2017, and none are planned for this section within the next 5 to 10 year programme. They advise passing lanes are not generally aligned with the Government policy statement for Land Transport and the Road to Zero strategy. Road to Zero is focussed on the reduction of death and serious injury on New Zealand roads. Road to Zero funding encompasses infrastructure improvement and speed management, vehicle safety, work related road safety, road user choices, and systems management. The funding allocated to infrastructure improvements is generally based on providing safe system aligned interventions including median barriers, intersection upgrades, raised safety platforms, and grade separation of vulnerable users.

RECOMMENDATIONS OF CORONER HESKETH

I. I recommend Waka Kotahi review its Road to Zero strategy and install passing lanes on State Highway 1S between Otaio and Glenavy as part of its infrastructure improvement to reduce the risk of ill-judged and risky overtaking manoeuvres over this 41 km stretch of road.

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

O'Donnell [2022] NZCorC 2 (19 January 2022)

CIRCUMSTANCES

Ashley Neil O'Donnell, aged 35, died on 28 March 2021 at Christchurch Hospital of hypoxic brain injury resulting from a traumatic cardiac arrest, following injuries sustained in a motor vehicle crash the previous day.

On the evening of 26 March 2021, Mr O'Donnell attended a barbeque with friends. Mr O'Donnell became intoxicated and decided to drive home. His friends persuaded him to sleep in his vehicle as it was apparent he was too intoxicated to drive. Despite this, Mr O'Donnell subsequently left the barbeque in his vehicle.

At around 12:30 – 1:00am on 27 March 2021, two hunters located Mr O'Donnell's crashed vehicle in a gully off Hakatere Potts Road, near Mt Somers Station in the Ashburton Lakes region. Mr O'Donnell was trapped and injured within it. Mr O'Donnell was extracted from his vehicle and flown to Christchurch Hospital. Despite medical intervention, Mr O'Donnell succumbed to his injuries the following day.

Mr O'Donnell's death was investigated by the Serious Crash Unit (SCU). The SCU report noted that the 10° bend where Mr O'Donnell crashed was not signposted, nor did it have a speed advisory warning.

COMMENTS OF CORONER BORROWDALE

I. I make the following comments pursuant to section 57(3) of the Coroners Act 2006. The purpose of these comments is to reduce the chances of further deaths occurring in similar circumstances to those in which Mr O'Donnell died.

Alcohol and driving

II. Coroners repeatedly provide public cautions against the practice of drinking and driving. This crash, like so many others involving excessive alcohol consumption, was avoidable. It points to the very real potential for tragedy and suffering when drivers consume alcohol and do not heed advice to 'sleep it off' or relinquish their keys, instead attempting to drive.

III. It is unsafe to consume alcohol when driving. Even low quantities of alcohol greatly magnify the risk of causing a fatal vehicle accident. A driver of Mr O'Donnell's age with a blood-alcohol level of 100mg/100ml and no passengers is around 35 times more likely to be involved in a fatality than a sober driver. Mr O'Donnell's own blood alcohol level was over twice that level, so his risk was exponentially greater.

IV. I repeat here the advice of coroners over the years: do not drink and drive. Drinkers cannot dependably estimate their own ability to safely drive a vehicle. Even when the drinker seems coherent and functioning, their motor skills and reactions may be dangerously dulled to the point where they risk grave injury to themselves and other road users. I urge the public to follow the alcohol awareness and driving safety advice that is promulgated by the Ministry of Transport, the NZTA, the NZ Drug Foundation and other agencies, and abstain from driving while under the influence of alcohol.

V. Ultimately, however, road safety comes down to individuals making prudent decisions. Mr O'Donnell need not have died, had he exercised greater caution by sleeping the night at Mt Possession or in his ute, as his partner expected him to do. Alternately, Mr O'Donnell could have ensured that he consumed no alcohol, given that he was driving. Either way, this tragedy was avoidable.

Seatbelt use

VI. Mr O'Donnell was not wearing a seatbelt when he drove home on this occasion. His partner says that this was uncharacteristic of his usual practice; perhaps his excessive alcohol consumption explains this decision.

VII. Drivers and passengers should always wear a seatbelt. Seatbelts save lives. Advice on the Waka Kotahi NZ Transport Agency website states that wearing a seatbelt reduces the chance of being killed or seriously injured in a road crash by 40%.[39]

Road signage advising recommended speed

VIII. The SCU identified that this sharp bend in the road does not have any speed advisory signage.

IX. This roadway is subject to a maximum speed limit of 100 km/h. The SCU calculates, however, that the relevant bend in the road is only safely negotiable at a speed of around 52 – 53 km/h. Vehicles travelling at higher speeds would be at risk of losing control, as did Mr O'Donnell.

X. It appears to me that a hazard exists when such a wide disparity exists between the applicable maximum speed limit and the practicable safe speed, and where the driver is not forewarned of the need to decrease speed in the interests of safety.

XI. However, I am advised by the Ashburton District Council that it has approved plans to install roading signage improvements on these bends. I have reviewed the Council's plans, which include multiple speed and curve advisory signs indicating the sharp bends, as well as more prominent centre-line markings.

XII. I am grateful to the Council for identifying the need for these road safety enhancements, which make it unnecessary for me to make any recommendations for action under section 57(3) of the Coroners Act 2006.

O'Sullivan [2022] NZCorC 36 (14 March 2022)

CIRCUMSTANCES

Barry Paul O'Sullivan, aged 64, died on 25 January 2020 at State Highway 1 (SH1), Karapiro, 570m northwest of Hydro Road, of severe chest and head injuries in the context of a motor vehicle accident.

On the morning of 25 January 2020, Mr O'Sullivan was understood to be travelling south from Auckland to Wellington. At around 6:00am witnesses saw Mr O'Sullivan's car drive "oddly". Mr O'Sullivan was then seen to veer out of his lane to pass a truck in front of him, and into the path of an oncoming van. Despite evasive manoeuvres by the van's driver, a collision could not be avoided. Mr O'Sullivan died at the scene. He was not wearing a seatbelt at the time of the crash.

Toxicology analysis following the crash confirmed amphetamine, methamphetamine, cannabis and THC in Mr O'Sullivan's blood. Ephedrine (a stimulant often used in the manufacturing of methamphetamine) and phentermine (a stimulant used to treat obesity) were also detected in the blood.

A full investigation into the collision was completed by the Waikato Serious Crash Unit (SCU). The SCU noted that Mr O'Sullivan was travelling alone during the early morning while under the influence of drugs which may impair ability to perform activities requiring mental alertness, such as driving. While Mr O'Sullivan's sleep patterns prior to the crash were

39 https://nzta.govt.nz/safety/vehicle-safety/safety-belts-and-restraints

unknown, there were several indicators that the collision was fatigue related. The SCU considered that fatigue was a contributory factor for Mr O'Sullivan in the crash.

COMMENTS OF CORONER BATES

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

- Continued education and enforcement in respect to drugged driving.
- A more efficient way to roadside test for drugged driving.
- The addition of a central wire median barrier where the crash occurred.

II. Waka Kotahi NZ Transport Agency ("Waka Kotahi") recently released their National Land Transport Programme for 2021-2024.[40] 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.
- 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, 19kms 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,

40 2021–24 National Land Transport Programme | Waka Kotahi NZ Transport Agency (nzta.govt.nz)

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 SH26 Tatuanui to Waharoa; SH2 Mackaytown to Waikino; and SH29 Matamata–Piako boundary to SH28.

III. I note that subsequent to Constable Chris Johnston's recommendations, The Land Transport (Drug Driving) Amendment Bill 2020 ("LTA (Drug Driving) Bill") has been introduced in Parliament. The LTA (Drug Driving) Bill has passed through the Committee of the whole House and is awaiting its third reading. It seeks to amend the Land Transport Act 1998 to address the risk that drug driving poses, and to help keep roads safe for all users.

IV. The LTA (Drug Driving) Bill establishes a new random roadside fluid testing regime. The LTA (Drug Driving) Bill states that:[41]

> The proposed regime would provide for Police officers to randomly stop drivers of motor vehicles and administer an oral fluid test. The Minister of Police, after meeting requirements specified in the bill, would approve oral fluid devices which would be used for the test. The devices would have detection limits for the drugs tested for, beneath which drug use would not be detected. A driver who failed two consecutive oral fluid tests would be liable for an infringement penalty. If a driver was required to take an evidential blood test, or chose to do so, they could be liable for an infringement penalty or a criminal penalty. The type of penalty would depend on the level of drug(s) detected, and whether multiple drugs, or drugs in combination with alcohol, were detected. Police officers would still have the option in certain situations to conduct a compulsory impairment test, which is the test currently used to determine drug impairment.
>
> The roadside oral fluid testing regime is intended to align in some aspects with the current breath test regime for alcohol detection. As with the alcohol regime, a Police officer would not need good cause to stop a driver to administer the test. The proposed fees for infringement and criminal penalties would be set at the same amount as those for drink driving offences.

V. The Independent Expert Panel on Drug Driving released its final report in April 2021, recommending statutory limits for drug concentrates relating to impaired driving for the purposes of the LTA (Drug Driving) Bill. The Panel noted that:[42]

> It is well recognised that many drugs can adversely impact the ability of people to drive safely. This is based on empirical evidence derived from drivers who are stopped and undergo a Compulsory Impairment Test (CIT), and drivers who are involved in road traffic accidents, and have these drugs in their biological fluids. There is also very limited evidence in which volunteers in scientific trials have taken drugs of interest and then had their ability to drive assessed (e.g., using a simulator) for impairment.

VI. The Panel was tasked with providing objective advice for the Associate Minister of Transport and the Minister of Police and make non-binding recommendations on blood and oral fluid concentration thresholds associated with driving impairment for an array of drugs, with a view to incorporating the values in legislation for a compulsory random roadside oral fluid testing scheme.[43]

41 At Commentary.
42 Independent Expert Panel on Drug Driving Final Report Recommending Statutory Limits For Drug Concentrations Relating to Impaired Driving (April 2021) at 6.
43 At 8 – 10.

VII. The Panel reported that for the five-year period between 2013 and 2018, there were 1,342 identified driver fatalities.[44] The ESR conducted analyses of blood samples received from 1,069 (80%) of this group. Analysis of the blood samples showed that:[45]

- 41% had not used alcohol or other drugs (analytical techniques cannot detect all potentially impairing drugs),
- 27% were positive for alcohol,
- 25% had used cannabis,
- 7% had used both alcohol and cannabis, but not other drugs,
- 8% had used methamphetamine,
- 8% had used opioid type drugs, and
- 7% had used sedative-type drugs.

VIII. These statistics show that that there is a need for continued education, efficient roadside testing and enforcement for drugged driving. I endorse the current legislative work in this area.

IX. Lastly, Waka Kotahi also provides information about safe driving in New Zealand. Its 'Driving in New Zealand' guide,[46] 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.

RECOMMENDATIONS OF CORONER BATES

44 Deceased drivers being drivers who had died as a result of a motor vehicle crash. It is important to recognise that some of these drivers may have suffered a medical event that precipitated the crash and thus drugs might not be involved.
45 Above, n8, at 21.
46 https://www.nzta.govt.nz/assets/resources/driving-in-nz/docs/driving-in-nz.pdf.

I. Waka Kotahi's programme of initiatives are significant, welcome and encouraging. I recommend that Waka Kotahi consider incorporating the recommendation of Constable Chris Johnston of Waikato SCU, in relation to installing wire barriers at the section of road where Mr O'Sullivan lost his life.

II. Legalisation introducing roadside drug testing of New Zealand drivers is currently in progress. As such I make no recommendations in this regard.

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

Reed [2022] NZCorC 19 (8 February 2022)

CIRCUMSTANCES

Beau Ross Reed, aged 25, died on 25 August 2019 at Auckland of blast injuries to his chest.

On 25 August 2019, Mr Reed was at home testing the power output of his motorcycle on a homemade dynamometer when it exploded. As a result, Mr Reed suffered fatal injuries and was not able to be revived.

COMMENTS OF CORONER BELL

I. I have researched safety information regarding homemade dynamometers, however there is no information on that specific topic, further I am not aware of how common it is to make a dynamometer at home.

II. Ride Forever is an ACC initiative and provides some advice on how to modify bikes, with very generic safety warnings (e.g. 'Always be sure parts are properly fitted. You can't beat getting it done professionally').[47]

III. I am not sure if safety information on homemade dynamometers would be suitable for their website, nevertheless I direct that copy of these Findings are sent to them for their consideration of whether any kind of education would be appropriate.

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

Stevenson [2022] NZCorC 6 (22 January 2022)

CIRCUMSTANCES

Kevin John Stevenson, aged 66 years, died on 1 July 2018 on the Winton-Hedgehope Highway as a result of high energy impact injuries sustained during a collision between his car and an oncoming truck, and in the context of Mr Stevenson's significantly raised alcohol levels.

47 https://www.rideforever.co.nz/working-on-your-bike/customising-your-bike/performance-parts/

The collision occurred on the evening of 1 July 2018, after Mr Stevenson left his local tavern where he had consumed alcohol. While he was travelling west on the Winton-Hedgehope Highway near Springhills, Mr Stevenson crossed the fog line before overcorrecting, causing his car to travel into the path of an oncoming truck.

COMMENTS OF CORONER KAY

I. The dangers of driving after having consumed alcohol are well recognised, and have been well publicised for many years. Despite widespread publicity campaigns, extensive coverage in the media of alcohol-related driving deaths, and coroners repeatedly making comments regarding the dangers, New Zealand continues to have an unacceptable number of alcohol-related driving deaths.

II. I reiterate the key message regarding such deaths – do not drink and drive.

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

Self-Inflicted

Choi [2022] NZCorC 16 (4 February 2022)

CIRCUMSTANCES

Sung-Ig Choi (also known as Bryn Choi), aged 19 years, died on 21 November 2017 at Auckland in circumstances amounting to suicide.

In 2015 Sung-Ig began the process of transitioning from male to female using hormone therapy.

In 2017 Sung-Ig came under the care of Waitematā District Health Board (WDHB) mental health services. No specifically targeted transgender health services were available through the WDHB. On 15 November 2017, Sung-Ig disclosed her suicide plan to a community care worker. There was no evidence of a safety plan being introduced.

Following Sung-Ig's death, WDHB completed a significant incident review report, which made the following key recommendations:

a. Where a number of agencies are involved a lead provider must be identified. The lead provider must take responsibility for coordinating liaison between providers and the sharing of information about treatment and treatment plans.

b. Allocation of care coordinators should take into account the complexity of the presentation and aim for uninterrupted relationships where there [are] identified issues for an individual, wherever possible.

c. As per the risk assessment and safety planning policy, republished April 2018, page 2, risk formulation has a foundation of collaboration. More experienced clinicians should be accessible for less experienced clinicians to consult with at all times.

COMMENTS OF CORONER TETITAHA

I. There were key recommendations identified by the WDHB as part of the circumstances leading to Sung-Ig's death. All of the key recommendations could have prevented her death including in particular undertaking an appropriate risk assessment following her disclosure of suicidal intent as per the District Health Board's policies.

II. The WDHB significant incident review report set out a number of actions for the purposes of addressing the above key recommendations. These included:

a. regular liaison meetings between youth services, adult mental health services and Youth Hub.

b. audits recovery team caseload to ensure complex case reviews are scheduled as required by the complex case and team review guidelines.

c. report writer to meet with team manager and clinical coordinators to reinforce prioritisation of therapeutic relationships.

d. team-based risk assessment and safety planning workshop to be completed

III. I sought comment from the WDHB regarding the implementation of the key recommendations as the information on file indicated only one of the recommendations had been actioned. I had intended recommending they complete the recommendations and/or a referral to the Health and Disability Commissioner to monitor completion.

IV. A report has now been received from Dr Patton, Director specialist mental health and addictions services WDHB attaching a revised and updated adverse event report. It notes all of the actions have now been completed, albeit action for (team-based risk assessment and safety planning workshop) was repeatedly deferred due to COVID-19 restrictions through 2021. These have now been completed.

V. The report also notes since this death, the complex case review policy has been recently revised and consultation on a draft revised document undertaken. A copy of the final policy was attached to the report.

VI. I thank the WDHB for their replies and additional information.

RECOMMENDATIONS OF CORONER TETITAHA

I. This is the second death I have received involving suicide by a person transitioning from male to female.[48] The commonalities between the deaths appear to be a lack of support and/or access to gender-affirming healthcare.

II. Ms Choi was identified by her medical practitioner as struggling with her identity. No clear referral pathway was identified that addressed her specific needs.

48 Andrew Peter Ashley otherwise known as Amanda Ashley CSU-2018-AUK-001357.

III. There are guidelines for gender affirming healthcare for gender diverse and transgender children, young people and adults in New Zealand[49] (the guidelines). The guidelines recommend amongst other things training and support services for gender diverse and transgender persons. Those recommendations include that DHB's:

a. provide compulsory training for staff on supporting trans and gender diverse patients;

b. easily accessible information and access to peer support services for trans people of all ages and their whānau;

c. have clear and timely referral pathways for young people and their whānau to access information about gender affirming care.

IV. In 2020 it was understood the northern region DHBs (including WDHB) had a gender affirming healthcare policy. This policy included funding peer support roles for transgender people and their whānau through RainbowYOUTH and OUTline and a transgender health key worker employed by the Auckland DHB specifically to help people navigate access to gender-affirming health services. The information from the WDHB did not address whether these gender-affirming healthcare resources were at the time and remain available for patients such as Ms Choi.

V. The WDHB workshops completed dealt with training in risk assessment but did not reference any training in gender affirming healthcare. This may need further review.

VI. Patients such as Ms Choi require access to gender affirming healthcare resources. Access to gender affirming healthcare has been found to be lower depression and suicidality among transgender and non-binary youth.

VII. Having considered the information received I am making a recommendation that the Waitematā District Health Board draft and/or re-assess its gender affirming healthcare policy and resources including staff training regarding supporting gender diverse and transgender patients.

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.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs taken of Sung-Ig Choi, also known as Bryn Choi, during this inquiry in the interests of decency.

Davidson-Turner [2022] NZCorC 38 (15 March 2022)

CIRCUMSTANCES

Louise Adelle Davidson-Turner, aged 31, died on 17 November 2018 at a walkway between Kereru Close and Helensburgh Road, Dunedin in circumstances amounting to suicide.

49 Professional Association for Transgender Aotearoa "Guidelines for gender affirming healthcare (2018-New Zealand)" online publication https://patha.nz/Guidelines.

COMMENTS OF CORONER KAY

I. I implore individuals to tell someone that they feel suicidal, as soon as they have such thoughts. There are many ways that this can be done:

   a. tell a friend, a family member, or an acquaintance;

   b. make an appointment to see a General Practitioner;

   c. ring a helpline, such as Lifeline Aotearoa's Suicide Crisis Helpline (0508 828 865, free text 4357), Lifeline (0800 543 354), the Samaritans (0800 726 666), the Depression Helpline (0800 111 757, or free text 4202), or Healthline (0800 611 116);

   d. ring the local mental health crisis assessment team, or go to the local Emergency Department; or

   e. if in immediate physical danger, ring 111.

II. The Mental Health Foundation of New Zealand website contains a directory of helplines and local mental health services – many New Zealanders own smart phones, and I urge them to download the directory so that, if required, they can readily access details of services that can help them.[50]

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.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Lou taken by Police in the interests of decency.

Doggrell [2022] NZCorC 40 (17 March 2022)

CIRCUMSTANCES

Ashleigh Anne Doggrell, aged 24, died on 4 February 2018 at Auckland City Hospital in circumstances amounting to suicide.

On 30 January 2018 Ms Doggrell attended a scheduled appointment with her assigned psychologist at Awhinatia, Counties Manukau District Health Board, Community Mental Health Services. Ms Doggrell disclosed to her psychologist that she had constant suicidal ideation which included a plan to end her own life. She did not feel safe to return home.

The psychologist determined that Ms Doggrell was at serious risk of self-harm and recommended respite care, which she agreed to. The psychologist then left the consultation room to make respite arrangements. Whilst out of the consultation room, Ms Doggrell left the premises via a fire exit door at the rear of the building and drove off in her car.

50 https://mentalhealth.org.nz/resources/resource/helplines-and-local-mental-health-services

On finding Ms Doggrell missing from the consultation room, the psychologist attempted to contact her by phone with no response. At 3:03pm, approximately 15 minutes later, the psychologist contacted Ms Doggrell's mother with no reply. Ms Doggrell's mother returned the call at 3:15pm. During the phone conversation the Awhinatia team requested details of Ms Doggrell's home address to conduct a welfare check, as they did not have this information on file. Ms Doggrell's mother was unable to recall Ms Doggrell's address on the phone at that time, but was to call back and let the team know.

Following the phone call Ms Doggrell's mother was notified of a concerning message that Ms Doggrell had posted on her Facebook page. She immediately informed Police of her concerns for Ms Doggrell's welfare.

At 3:30pm the Awhinatia team contacted Ms Doggrell's mother again to follow up on obtaining Ms Doggrell's home address. During the phone call Ms Doggrell's mother informed Awhinatia staff that Police were on their way to Ms Doggrell's home.

When Police arrived at Ms Doggrell's home they found her partially responsive. She was transported to hospital by ambulance, where she later died.

COMMENTS OF CORONER GREIG

I. I recommend that Counties Manukau Health Mental Health Services:

   a. Reviews its processes to ensure that all staff understand that it is a requirement that the address and contact details of its clients are checked at every client contact and updated in the DHB's system if necessary;

   b. Develops a guideline for community mental health staff consistent with the DHB's Health and Safety Orientation Manual for Community Health, Public Health and Community Mental Health & Addictions Services – with the guideline providing direction on the situations in which service users should not be left alone in DHB facilities.[51]

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.

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

Lowery [2022] NZCorC 15 (1 February 2022)

CIRCUMSTANCES

Finn Henry Mrkusic Lowery, died on 24 March 2019 at Northshore Hospital. His death was self-inflicted in circumstances amounting to suicide.

Mr Lowery was under the care of Waitematā District Health Board at the time of his death. However, there was a lack of coordination of mental health services.

51 DHB to refer to report to Coroner from Dr Parasram dated 11 February 2022.

RECOMMENDATIONS OF CORONER MILLS

I. Pursuant s 57A of the Coroners Act 2006 I make the following comments and recommendations.

II. Every suicide is a tragedy. It creates significant and far-reaching impacts on the person's friends, family and whānau, and the wider community.[52] In the year from July 2018- 2019, 685 people are suspected to have died by suicide in New Zealand.[53] The greatest loss of life through suicide occurs among people older than 24, particularly males aged 25–44. Sadly, Finn was one of those 685 people.

III. As acknowledged by the Adverse Event Investigation Report and the He Puna Waiora Review report, the mental health services provided to Finn on his return to New Zealand were far from optimal and fell far short of what New Zealanders expect from a competent health service.

IV. Unfortunately, the poor experiences of mental health services experienced by Finn and his family are not unique to them. In its report, He Ara Oranga, released in December 2018, the Government Inquiry into Mental Health and Addiction (the Inquiry) noted that a significant number of submissions it received from families told of having difficulty in accessing services, long waits, over worked staff, and over medicalised care.[54] Consistent themes in submissions received by the Inquiry included having to fight for access to mental health care due to high thresholds of acuity, limited and non-existent services, or complex care requirements beyond current service provision.[55]

V. The Inquiry heard from many whānau and families about the lack of available services, especially talk therapies, and the over medicalisation and reliance on the biomedical approach to mental health care. Gaps in services, difficulty navigating the system and poor co-ordination were further common issues.[56]

VI. These issues heard by the Inquiry are consistent with those raised by the Lowery family and acknowledged in the Waitematā Adverse Event Investigation Report and He Puna Waiora Review Report.

VII. Finn's family should be commended for their proactive and collaborative way they have engaged with the DHB and advocated for better services. Finn's family acknowledge that many services users do not have the resources and capacity to engage in this manner and they have acted not only for Finn but on behalf of others who have lost whānau members, and especially for services users at risk in the future.

VIII. Given the significant amount of effort by Finn's family to engage with the DHB, the external reviews that have taken place and the commitments made by the Waitematā to improve their services it is difficult to make further purposeful recommendations.

52 The Government Inquiry into Mental Health and Addiction review exec summary https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/executive-summary/
53 https://mentalhealth.org.nz/suicide-prevention/suicide-statistics
54 He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction, November 2018, - available at https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/
55 https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/chapter-2-what-we-heard-the-voices-of-the-people/2-10-access-wait-times-and-quality/
56 Ibid.

IX. However, in addition to endorsing all the recommendations made by both He Puna Waiora Review Report and The Adverse Event investigation, I made the following recommendations and comments and, pursuant to s 57B of the Coroners Act 2006, sought comment from the relevant parties.

Waitematā DHB

X. These recommendations and comments were directed at Waitematā DHB:

a. While I acknowledge the changes the Waitematā DHB advise they have implemented, it is important that these changes are sustained and are more than just a policy change on the paper. Sustained and effective change to entrenched patterns of staff behaviour, models of care and patterns of communication requires on-going training, monitoring, and review. While I note there is committee established to oversee the implementation of the recommendations from He Puna Waiora report, I encourage the DHB to consider establishing a process to review the effectiveness of the changes implemented and to ensure staff receive the on-going training and support required to ensure sustained and effective change. Such a review process should always ensure that the voices of Tangata whai ora/health care consumers and their whānau are heard and are fully integrated in the process.

b. That the DHB continue to improve the involvement of family and whānau in care planning and ongoing service delivery.

c. While I recognise the DHB may be constrained by resource limitations, there remains a number of recommendations that have not been addressed or which require on-going monitoring. I encourage the DHB to continue to address the issues raised, in particular improving the accessibility and safety of the sensory room, and the outside courtyard.

d. I have been advised that a business case for the enhancement to ED acute services had been submitted which aimed to improve the availability of community mental health acute teams to, and within, ED. I am unsure if this has been progressed, but in the event it has not, I encourage the DHB to strongly consider enhancing the quality of the ED acute service in this way.

e. Throughout Finn's interaction with the Waitematā DHB there were inadequate psychological services available. I therefore recommend that the Waitematā DHB take steps to ensure that there are adequate psychological services available to both inpatient and community-based patients, so that the lack of psychological input and the wait times experienced by Finn are not experienced by others.

XI. As required under s 57B of the Coroners Act, I provided a draft copy of my Findings and recommendations to the Waitematā DHB for their comment. In response they advised that they accepted the recommendations and provided an update on the progress made. Attached as appendix "D" is the full response. In summary the Waitematā DHB confirmed they have:

a. established a committee to implement the He Puna Waiora report recommendations. The Committee reports to the Board on a regular basis. I note that CEO is member of that group

and I would encourage the committee to continue to report to the Board on at least a quarterly basis;

b. A working group (which includes whānau with lived experience) has been established to develop specific milestones in the care journey where family and whānau involvement is required as a minimum;

c. Progress has been made to address outstanding recommendations however, the DHB noted that Covid 19 and the need to prepare the Ward has impacted on some of the proposed work; and

d. Recruitment is underway for additional staffing for Liaison psychiatry in the emergency department and for additional phycological positions both inpatient and in the community. The DHB acknowledged however that staff recruitment continues to be an issue;

XII. I commend the DHB for their on-going commitment to improving their services. I reiterate the importance of on-going review and monitoring of service provision in an endeavour to achieve excellence and to provide mental health service user and their whānau with services that consistently reflect best practice.

Health Workforce Advisory Board and Health Workforce Directorate (Ministry of Health)

XIII. Talk therapies and psychology input were recognised as being essential for Finn's recovery however, due to staff shortages he was placed on a wait list for these therapies. Staff shortages, long wait lists to receive psychological services and lack of sufficient allied health practitioners were identified as issues by the He Puna Waiora review and Finn's family. These comments were therefore directed at the Ministry of Health and the Health Workforce Advisory Board and Health Workforce Directorate.

XIV. There is a well-publicised and unfortunately long-standing shortage of skilled workforce in the mental health area. The shortage is across the work force – allied health professionals, nursing and medical staff. Building a mental health workforce across the country was a key challenge identified in He Ara Oranga report. I also note there is references to continued staff shortages in the Waitematā DHB's most recent response indicating this is an ongoing issue.

XV. I therefore recommend that the Health Workforce Advisory Board and the Health Workforce Directorate at the Ministry of Health act with urgency and specifically consider how to address New Zealand's chronic mental health workforce shortage and take steps to increase the capacity and competency of our Mental Health and Addiction Workforce.

XVI. As required under s 57B of the Coroners Act 2006, I provided a draft copy of these Findings and recommendations to the Health Workforce Advisory Board and the Health Workforce Directorate at the Ministry of Health for comment. I received a response from the Acting Deputy Director-General of Mental Health and Addictions who advised that the Mental Health and Addiction Directorate now has responsibility for growing the mental health workforce force. A copy of the full response is attached as appendix "E".

XVII. The Acting Deputy Director-General of Mental Health and Addictions advised that Kia Manawanui is the government's high-level plan for the long-term transformation of mental health services, and this has a clear goal for the workforce needed to support mental well-being. The response referred to the 2019 mental wellbeing budget announcement and details what has been set aside to tackle the shortage of mental health and addiction workforce. It advised of a range of initiatives that have already been introduced including:

a. More than 100 additional New Entry to Specialist Practice places in 2021 for nurses, social workers and occupational therapists to practice in mental health and addiction;

b. more than 100 additional places for mental health practitioners to up skill with postgraduate training in cognitive behaviour therapy, infant, child and youth, coexisting mental health and substance use and specialty forensic training;

c. 200 new places in 2021 for primary care nurses to achieve credentialing and mental health and addiction;

d. increasing the number of funded of clinical psychology internships (8 in 2017, to 20 in 2021 and 28 in 2022);

e. the development of new health improvement practitioner and health coach roles as part of the national rollout of the new primary mental health and addiction services; and

f. new bursaries for Māori students and scholarships for Pacifica students pursuing a career mental health and addiction.

XVIII. The Acting Deputy Director of Mental Health also advised they were committed to exploring additional ways of growing the workforce and expanding the work program this year 2022. He also advised that mental health workforce force is an international issue and while they can also look to explore international campaigns there is a global shortage of skilled mental health workers.

XIX. I acknowledge the initial steps taken by the Mental Health and Addiction Directorate to increase both capacity and competency of the mental health workforce. I recognise that increasing work force capacity is a long-term process. I also note that mental health and addiction workforce is an international problem. However, given the urgent need for increased skilled mental health workforce, I reinforce my recommendation that they act with urgency to address this shortage.

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 Finn Lowery taken during this inquiry in the interests of decency.

Nath [2022] NZCorC 5 (20 January 2022)

CIRCUMSTANCES

Riki Rikash Verma Nand Nath, aged 34, died at his home in Sunnyside Crescent, Papatoetoe, Auckland between 29 December and 30 December 2019 in circumstances amounting to suicide.

Riki was born in Fiji and was of Indian descent. He had been married to his wife, Sherine Nath, for about 14 years, and together they had a young son. The evidence suggested that Riki had inflicted significant and serious physical and emotional abuse on Sherine from the start of their marriage.

In March 2019, Sherine left the family home with their son after reporting a recent serious assault to Police. Sherine disclosed that Riki had stated he would harm both her and their son and had threatened to harm himself if she left him. Riki was subsequently arrested and admitted to charges of assault with intent to injure and threatening to injure for the purpose of intimidation. He remained on bail for these charges at the time of death, with non-contact provisions in relation to Sherine. A final protection order was also issued in October 2019 favour of Sherine.

Despite this, Sherine was placed under considerable pressure by both Riki and members of his family to return to live with him. She eventually moved back into their home with their son on 23 December 2019. However, later text messages to her sister confirmed that Sherine was unhappy and struggling to cope with Riki's anger, possessiveness and controlling behaviour.

The couple were last seen alive on the evening of 29 December 2019 by Riki's cousin and his wife, who lived at the property with them. The following morning, Riki's cousin found Riki dead in the garage. Sherine was found deceased on her bed with signs of strangulation and of trauma to the rear of her head. Their son was also found lying on the bed badly injured.

Facebook posts set to be published after Riki's death on 30 December 2019 and 31 December 2019 confirmed that Riki had been monitoring Sherine and tracking her movements. He made allegations against her and apologised for what he was about to do.

COMMENTS AND RECOMMENDATIONS OF CORONER MILLS

I. The circumstances of this tragedy caused enormous grief and loss to all the families and friends who knew Riki as well as Sherine and [their son]. However, as tragic as Riki's death was, Sherine was not to blame in any way for his actions: she was a victim in this relationship.

II. I consider there are comments and recommendations that I can usefully make pursuant to section 57A of the Coroners Act 2006. These comments are made to raise greater awareness of the need for more culturally appropriate stopping violence services for migrant men and to raise awareness of the signs that indicate a woman may be in serious danger from their partner. It is hoped that these recommendations and comments may help others respond to and help those who are in abusive relationships.

Stopping violence services

III. Domestic violence is predominantly perpetrated by men. There are many complex reasons why women living in abusive relationships stay or return to their abuser. For migrant ethnic women this is exacerbated by a range of complex cultural factors.[57] These may encompass individual, (language barriers, isolation), household (migration factors, employment conditions), community (gender norms, patriarchal values), and systemic (racism, colonisation, capitalist structures) factors.[58]

IV. Sadly, Sherine is not the only migrant woman to have experienced domestic violence. 14% of the men who used violence in intimate partner violence deaths between 2009 and 2018 in New Zealand were of South Asian origin.[59]

V. The Family Violence Death Review Committee 2020 report (the FVDRC report) also noted that within South Asian ethnic groups, men often continue to hold tightly to the view that they had a right to control the movements of the female family members and that any potential disruption to the family unit brought shame on the wider family.[60] Riki's behaviour and the control he exerted over Sherine suggests he may have held these views.

VI. The FVDRC report looked at structural changes needed to prevent family violence. It discussed the cultural and structural dynamics at play particularly amongst the South Asian migrant community that contribute to domestic violence.[61] The Report reinforced the need for agencies and programmes to understand cultural norms for effective engagement as well the structural factors that make violence more likely to occur.[62]

VII. Riki attended a court ordered stopping violence programme, however sadly this did not appear to address his core belief system or stop his controlling and violent behaviour. While it is impossible to speculate, had the programme addressed some of the cultural and structural factors as suggested in the FDVRC report, things may have been different.

VIII. Currently there are very limited ethnic specific responses to men who use violence. Ghandi Nivas based in Auckland is one such organisation however there are few others, if any, available outside of the main urban areas. There is therefore a need for more culturally appropriate programmes for men who use violence.

IX. I therefore recommend that the Ministry of Justice and the Ministry of Social Development, who fund stopping domestic violence programmes, review the range of programmes they provide and ensure

57 See: Briefing paper for Judge Fraser Family Violence Court: Auckland and Manukau towards raising an awareness of the complex cultural factors that exacerbate domestic/family violence within Asian, African and Middle Eastern immigrant communities in New Zealand presented by Shila Nair, For Shakti May 5, 2017; and https://nzfvc.org.nz/sites/default/files/NZFVC-issues-paper-14-ethnic-perspectives.pdf
58 Simon-Kumar, R. (2019). *Ethnic perspectives on family violence in Aotearoa New Zealand.* Issues Paper 14. Auckland, New Zealand: New Zealand Family Violence Clearinghouse, University of Auckland.
59 Family Violence Death Review Committee. 2020. Sixth report Te Pūronga tuaono: men who use violence/Nga Taāne ka whakamahi i te whakarekereke Wellington: Health Quality and Safety Commission. April 2020 pg 50. The report notes that men of Indo Fijian ethnicity have been grouped with South-Asian men due to their ties to Indian rituals and faith.
60 Ibid.
61 Ibid pg 50.
62 Ibid pg 52.

that there are sufficient programmes throughout Aotearoa/New Zealand that address the specific cultural issues identified in the FVDRC report.

X. As required under s 57B of the Coroners Act 2006, I provided a copy of my draft findings to the Ministry of Justice and the Ministry of Social Development. The Ministry of Social Development has not responded to this recommendation. The Ministry of Justice did not respond directly to the recommendation, however noted that, once the Protection Order was made permanent in October, Mrs Nath would have received, by post, the offer of a free safety programme which would have resulted in a further referral to Shakti if she had wished to take this up. The Ministry of Justice also advised that their records indicate Riki may not have attended the mandated stopping violence course, however I note the Court record I have reviewed indicates he did.

XI. Having considered this response, I reiterate my recommendation that the Ministry of Justice and the Ministry of Social Development review the range of programmes they provide and ensure that there are sufficient programmes throughout Aotearoa/New Zealand that address the specific cultural issues identified in the FVDRC report.

Help available

XII. In addition, I draw attention to the programmes that are currently available for men who perpetuate family violence and wish to seek help:

a. Ghandi Nivas – (Home of Peace) is an early intervention, family harm prevention residential service for men who are involved in family harm incidents. https://www.gandhinivas.nz/

b. 0800 Hey Bro, a 24/7 help line for men who feel they are going to harm a loved one, run by He Waka Tapu.

c. No Excuses – a free, positive change programme for people who perpetuated family violence – see https://www.2shine.org.nz/how-shine-helps/no-excuses/

d. Te Ara Taumata Ora https://www.manalive.nz/living-without-violence/

Serious risk factors

XIII. Riki's death was intimately connected with Sherine's death. While not intended as a criticism, it is possible that if those around him had recognised and better understood the danger signs associated with a violent relationship, and had intervened, this tragedy may have been prevented.

XIV. Increasing the public's knowledge and understanding of domestic violence and the behaviours that are associated with greater risks may help women who are in danger from their partner. It may also help others identify potentially dangerous relationships. The website www.areyouok.org.nz identifies a

number of behaviours that indicate that a person maybe in serious danger from their partner.[63] The NZ Police also identify the following as signs that someone is being harmed by a family member:[64]

a. Controlling behaviour

b. Intimidation

c. Threats to kill

d. Strangulation and choking

e. Physical or sexual violence

f. Jealousy or possessiveness

g. Stalking.

XV. These danger signs should be taken seriously. Riki exhibited many of these behaviours. In addition to physical violence, he had previously threatened to harm himself, and harm Sherine and [their son] if she left him. He was controlling, and jealous, and tracked Sherine's movements.

XVI. It is important that those in danger know help is available. For those who are experiencing an abusive relationship:

a. If you are in immediate danger, please call 111;

or seek support and help from:

b. Shakti 24-hour crisis line with multilingual staff: 0800 SHAKTI/0800 742 584

c. Women's Refuge National Helpline – Crisis line: 0800 REFUGE/0800 733 843

d. shine* Domestic Abuse Helpline: 0508 744 633

e. Worried about a child? Call: 0508 FAMILY or 0508 326 459 (Oranga Tamariki—Ministry for Children)

f. Rape Crisis: National call line: 0800 88 33 00

g. Safe to talk – Kōrero mai, ka ora 24/7 sexual harm helpline: 0800 044 334 or text 4334.

XVII. I also direct that a copy of these Findings be sent to the office of the Minister for the Prevention of Family and Sexual Violence who leads the whole of government response on family and sexual violence.

63 https://www.areyouok.org.nz/home/understanding-unsafe-relationships/is-your-partner-making-you-feel-unsafe/ This website contains valuable information, resources and help for those affected by domestic violence. It is managed by the Social Campaigns Team within the Ministry of Social Development.
64 https://www.police.govt.nz/advice/family-violence/help

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of Riki's death, or any detail that suggests the method of death.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Riki Nath, Sherine Nath, and their son entered into evidence during this inquiry, on the grounds of personal privacy and decency; the name of Sherine and Riki Nath's son on the grounds of personal privacy and interests of justice; and the Facebook live post and photos made by Riki Nath on 29 December2019 and published publicly on his Facebook page at about 4:00pm 30 December 2019 and 1:30pm 31 December 2019, on the grounds of interests of justice, personal privacy and decency.

Nilsson [2022] NZCorC 33 (10 March 2022)

CIRCUMSTANCES

Cian Marcus Toa Nilsson, aged 20, died on 7 July 2020 at Honeymoon Valley, in the Far North in circumstances amounting to suicide.

In the 12 months prior to his death, Cian experienced mental health issues. As part of the Coroner's inquiry, she received reports from Cian's treating psychiatrist, his alcohol and drug practitioner and the community mental health nurse involved in his care. The Coroner also received the serious event analysis from the Northland District Health Board mental health services. A further report was received from Ngāti Kahu Social and Health services ("NKSHS") who provided non-clinical support to Cian

The Northland District Health Board's serious event analysis found a number of concerns with the services provided to Cian, and noted that contact from DHB staff was intermittent, care was not coordinated and there was no identified plan of engagement or assessment of risk for Cian.

COMMENTS AND RECOMMENDATIONS OF CORONER MILLS

I. Having given due consideration to all of the circumstances of this death, I make the following comments. These comments are directed at the Northland District Health Board and made in the hope that, if acted on, they may reduce the chances of further deaths occurring in similar circumstances.

II. I do not consider the services provided to Cian by the Northland District Health Board were adequate or of an appropriate standard. As noted in the Serious Event Analysis there was no plan of engagement, no medical reviews were initiated and, significantly, no risk assessments undertaken. Contact from staff was intermittent and his care was not coordinated.

III. The lack of consistent follow-up of Cian following his February 2020 psychiatric review is very concerning. While Covid 19 may have contributed to the lack of face to face contact, there is no evidence of any risk assessments being undertaken, drug testing, or care plans being prepared. There was no coordinated engagement and no proactive steps by DHB staff appear to have been taken.

IV. The lack of coordination between services is particularly apparent by a comment from the chief executive of NKSHS who questioned whether there was an agency or service assisting Cian with his ongoing cannabis and alcohol use. The lack of shared information and care planning is disappointing.

V. While Cian did live in a remote location and was at times reluctant to engage with services, these factors are not unique to him. In fact, these characteristics are very common, particularly in the Far North and with young people/rangatahi. These factors make the need for a coordinated care plan and robust risk assessments even more important.

VI. In my opinion, given the views of the psychiatrist expressed in his medical notes, an urgent medical review should have been sought when it became apparent Cian was reducing his medication. He had not been reviewed by his psychiatrist since February 2020 despite the plan being for a review in four weeks. His family should also have been made aware of the risks associated with any reduction in medication and the need for a review.

VII. In addition, the notification of concern on 3 July 2020 from NKSHS to the mental health service should have triggered an urgent risk assessment and face to face review particularly in light of the lack of recent contact, the known risks for Cian associated with cannabis use particularly when not taking his medication, his history of suicide attempts and his disclosure of suicidal thoughts.

VIII. The lack of support and engagement with Cian's family, and in particular the failure to share critical information during the phone call just days prior to his death is of concern. The recent He Ara Oranga report emphasises the need to support families and whānau to be active participants in the care and treatment of family members and to ensure there are clear guidelines on sharing information while maintaining confidentially.[65]

IX. The Northland DHB was given an opportunity to comment on my adverse comments above and advised that they accepted that the services they provided to Cian were below the standard expected.

X. I made a number of recommendations directed at the Northland DHB, whose response to these are recorded below:

a. Review the mental health services provided to the Far North to ensure there is improved care co-ordination and communication within the multi-disciplinary team including regular meetings and reviews with all involved in the provision of services;

i. The Northland DHB have implemented changes to their system that they believe will improve coordination, timely and appropriate assessments and access to medical reviews.

ii. The prioritisation tool is an electronic form that the key worker will complete. The information helps sort clients in order of priority, provides sufficient information to support those making contact with the client if it is not the

65 He Ara Oranga: report of the Government Inquiry into Mental Health And Addiction. November 2018 https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/chapter-8-people-at-the-centre/8-2-partner-with-families-and-whanau/

usual keyworker, and identifies and tracks clients who have not had recent contact. This was a new tool introduced at the beginning of the first Covid lockdown in April 2020 and has since been significantly improved and is now widely used.

b. Ensure there is clear pathway to access psychiatric and medication reviews across the services in the Far North and a process for ensuring reviews occur on a regular basis;

    i. The Northland DHB advised there is now an urgent pathway for access to a psychiatrist, so that despite ongoing difficulties recruiting psychiatrist to Northland, clients who need a medical review have priority access

    ii. the involvement of early intervention psychosis team in the general adult community mental health team in the Far North is now formalised with a clear pathway and better integration.

c. Review their policy and practice on information sharing and partnering with families and whānau caring for rangatahi with mental illness to ensure it reflects the benefits of including whānau and family in their care as identified in He Ara Oranga report;

d. Ensure staff receive on-going training in risk assessment and identification of suicidality.

    i. The Northland DHB advised that refresher training in risk assessment and suicide prevention has already commenced and will continue.

XI. I thank the Northland DHB for their positive engagement with this inquiry, their acknowledgement that their services failed to meet Cian's needs and the steps they have taken to improve their services. I encourage them to continue to review and assess the quality of the services being provided to ensure ongoing improvement.

XII. In particular I reinforce my recommendation (d) above that they work to review and improve their policy and practice on information sharing and partnering with families caring for rangatahi with mental illness to ensure it reflects the benefits of including whānau and family in their care as identified in He Ara Oranga report. The need for this is particularly pertinent in light of Cian's father's comment that more information, advice and contact from Cian's treating team would have helped him understand Cian's patterns of behaviour and risk factors.

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.

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

Saunders [2022] NZCorC 29 (4 March 2022)

CIRCUMSTANCES

Amber Rose Saunders, aged 26 years, died on 26 January 2019 at Fairview Heights, Auckland in circumstances amounting to suicide.

Amber had a mental health history dating back to 2016, which included multiple presentations to hospitals and mental health services with symptoms of mood instability, self-harm and suicidality.

RECOMMENDATIONS OF CORONER HO

I. I have considered whether I should make any formal recommendations in relation to Amber's death.

Amber's care

II. Amber's mother expressed concerns to this inquiry about the long waitlist times to see a therapist. She said that she had been trying for over a year to get help for Amber but for various reasons had been unsuccessful.

III. From the evidence provided to me by the DHBs I have not identified any shortcomings in the primary care which Amber received. Amber was promptly assessed by mental health services when circumstances, including suicide attempts, warranted. In respect of the two specific concerns raised by Amber's mother:

a. After she moved to Hamilton Amber sought a psychiatric referral. Her GP at the time explained that it was difficult to get a psychiatric review but she would try to re-refer Amber. The Waikato mental health services record shows that the referral was closed and not progressed because Amber did not respond to phone calls or letters.

b. I agree that constraints on therapy availability are frustrating for families of those seeking help. However, resourcing of such programmes is an operational and governance decision to be determined by the appropriate DHB, working within their funding and capacity constraints. It would obviously be desirable for more funding to be allocated to this area but this is an allocation issue which is the responsibility of central government.

Online suicide forums

IV. Amber's flatmate gave evidence that in the period leading up to her death Amber would normally spend part of her day on suicide forums.

V. While I acknowledge that information can always be found by those determined to seek it, including through other less legitimate sources such as the dark web; and that there are technical and legal constraints on the ability to restrict internet pages, including the fact that suicide is not illegal in New Zealand, it is nevertheless concerning that such possibly fatal information can be so readily available to a person with a troubled mental state such as Amber. If there is an aim in New Zealand to reduce suicide, then issues such as the ability to easily access pro-suicide information must be debated and

proportionate restrictions considered. I direct that a copy of these findings be provided to the Suicide Prevention Office for its consideration.

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.

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

Sewell [2022] NZCorC 1 (31 January 2022)

CIRCUMSTANCES

Peter Taylor Sewell, aged 15, died on 16 January 2019 at the Albert Town Camping Ground, Wanaka in circumstances amounting to suicide.

Peter performed well at school both academically and with sports. He was well liked by his peers.

The night before his death Peter had been moody and withdrawn. However, there were no indicators that he was suffering from any mental health issues or had any intentions to end his own life.

COMMENTS OF DEPUTY CHIEF CORONER TUTTON

I. Peter was 15 when he died, just weeks away from his 16th birthday. It is clear from the evidence before me that his family and his friends were shocked by his death. There is no evidence before me that anyone who knew him suspected that Peter was about to take his life.

II. There is no evidence before me that there were any indications to Peter's friends or family that he was at imminent risk of self-harm.

III. Several family members and friends said that, in hindsight, they wished they had taken certain steps while Peter was alive.

IV. It is important that Peter's family and friends know that none of them are responsible for the decision he made – they are not to blame for his death.

V. People who take their own lives usually do so as a result of a complex range of factors.[66] 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".*[67]

VI. 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 feeling that way.

66 Ministry of Health, New Zealand Suicide Prevention Action Plan 2013-2016 (May 2013).
67 Ministry of Health, A strategy to Prevent Suicide in New Zealand 2017: A draft for public consultation (April 2017).

VII. Information about the ways you can support someone who is thinking about harming themselves is available at:

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

VIII. 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:

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

IX. Some options and the contact details of some agencies that can help are listed below:

Services that offer more information and support

Below is a list of some of the telephone helplines or services available which offer support, information and help. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated.

For counselling and services:

- **Need to talk**? Free call or text 1737 any time
- **Lifeline** – 0800 543 354
- **Samaritans** – 0800 726 666

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; 1:00pm to 11:00pm)
- **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

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any other detail that suggests the method of death.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of that show the deceased in the interests of decency and personal privacy; and the names of four witnesses or any particulars likely to lead to their identification in the interests of personal privacy.

Singh [2022] NZCorC 52 (30 March 2022)

CIRCUMSTANCES

Tina Singh, also known as Tina Sharma, aged 28, died on 11 September 2017 at 586 Selwyn Street, Christchurch in circumstances amounting to suicide.

Tina was born in Punjab, India. In January 2017 she married Narinder Singh, a Punjabi man who had moved to New Zealand some years previously. The marriage was arranged by Tina and Narinder's families. In June 2017, Tina moved to Christchurch. Her intention was to obtain approval to work as a pharmacist in New Zealand, after which she and Narinder would start a family.

Tina did not happily adjust to her new life. She spent her time at home, studying or doing housework, while Narinder worked. She had some concerns about Narinder's lifestyle, and was worried about his financial position. She did not have any friends in New Zealand and had limited contact with her brother, who had moved to Christchurch a few years earlier. Her marriage did not appear to be a happy one.

On the night of 10 September 2017, Narinder came home from work and started drinking beer. Between 12:45-1:15am neighbours heard loud banging and arguing from Narinder and Tina's unit. Coroner Cunninghame noted that it was plausible that the banging and thudding sounds heard by the neighbours were the result of Narinder being violent towards Tina. Narinder said that Tina fell asleep and that he could not wake her when he had a meal at 3:00am.

Narinder was still unable to rouse Tina when he woke in the morning, and subsequently realised that she was unconscious. He called 111 at 9:04am on 11 September 2017. When emergency services arrived, Narinder was drunk and shouting about being "sorry". He gave inconsistent accounts of what had happened to Tina, which raised suspicions.

An inquest was held to investigate the circumstances of Tina's death. Having considered all the available evidence, Coroner Cunninghame was satisfied that after Narinder had arrived home, something occurred between the couple which upset Tina so much that she decided to take her own life. The catalyst was most likely the argument heard by the neighbours between 12:45-1:15am. At some time after this, Tina took actions intending to end her life, which the Coroner was satisfied that Narinder was unaware of at the time.

COMMENTS OF CORONER CUNNINGHAME

I. Having made the above findings, I am required to consider whether I might make comments or recommendations that, if brought to public attention, would prevent the chance of further deaths occurring in similar circumstances.

II. This is a situation where bringing the circumstances of Tina's death to public attention may have a positive outcome. The media can play a useful role in educating the public about where and how people who experience domestic violence can get help and support.

III. Having considered the factors that led to Tina's suicide, I have determined that the following comments are appropriate:

a. Tina arrived in New Zealand from India in June 2017. She was recently married by way of an arranged marriage. She was experiencing violence in her relationship. She was socially isolated and was worried about her future.

b. An argument arose between Tina and her husband Narinder on the night of September 10 2017. This argument included violence. Tina, who may have felt that she had no way out of her situation, took steps which resulted in her dying in the early hours of the morning of September 11 2017.

c. Narinder did not appreciate what Tina had done until it was too late. By the time he called 111, Tina was dead.

d. Tina's best friend and her mother believed that Tina would not have known that she could have sought help from organisations which exist to support women who are experiencing domestic violence.

e. There are organisations in New Zealand which can provide free advice and support to women who find themselves in unhappy or violent relationships. Women's Refuge is the one with which people are most familiar. Aviva is a Canterbury-based organisation that provides a similar service.

f. There are also organisations which focus on assisting migrant women. The best known of these is Shakti Community Council (Shakti), a non-profit organisation serving migrant and refugee women of Asian, African and Middle Eastern origin. In Christchurch, Shakti offers a safe refuge and a drop-in centre, and provides domestic violence intervention support, crisis response, community-based support, English language classes, road safety programmes and other life skills programmes for ethnic women and their children.

g. While I accept that Tina may not have approached one of these organisations even if she had been aware of them, I have determined that the tragic story of her short time in New Zealand should be shared with the public with the message that these organisations are available to help women, and that there is no shame in contacting them. It is particularly appropriate that this information is disseminated among the Indian migrant community.

h. I hope that encouraging conversations about these difficult topics can go some way towards further educating and empowering our community so that other families can avoid such tragic events.

IV. In accordance with the requirements of s 57B of the Act, I sought feedback from Women's Refuge and Shakti. I advised that I proposed to direct that my findings be forwarded to the media so that the above comments could be published, so that women, and in particular migrant women, can be remined about the existence of support networks and organisations. I advised that I was seeking the organisations' feedback in order to ensure that my comments are culturally appropriate and would not put vulnerable women at any further risk.

V. Dr Ang Jury, Chief Executive of Women's Refuge advised that the organisation "thoroughly endorses" my proposed approach. Dr Jury noted that:

> This is a community that we, and even agencies such as Shakti, struggle to connect with, so any wider publication/promotion of available services is very welcome.

VI. Shakti advised that the organisation supported my approach and was happy that such issues are being voiced. Their response also included observations about how migrant women are affected by domestic violence.

VII. Shakti noted that a lack of cultural competency within the system can cause issues for migrant and ethnic women, who experience different power dynamics in their relationships. This can deter women from reporting violence. Furthermore, trust issues, or perceived lack of Police response, which may deter women of all backgrounds from reporting violence, may have an even greater impact on migrant and ethnic women. Shakti advised:

> Starting a discussion on how reporting can be improved may greatly help not only immigrant women but all women facing domestic violence.

VIII. Finally, Shakti noted that underfunding affects the organisation's ability to advocate for migrant and ethnic women as efficiently as it would like.

RECOMMENDATIONS OF CORONER CUNNINGHAME

I. I am grateful to Women's Refuge, and to Shakti, for their responses to my inquiry. Speaking generally, I endorse the observations made by Shakti regarding the need to provide culturally responsive services, and to consider the reasons why some women may prefer to report violence through agencies other than Police. However, any recommendations or comments must be connected to the causes and circumstances of Tina's death. I am not able to find that the reasons set out by Shakti deterred Tina from seeking help. In fact, it appears that she simply did not know that organisations such as Shakti or Women's Refuge even existed.

II. Accordingly, I direct that Ministry of Justice staff forward a copy of these findings to the media, for publication of the above comments at [168] so that women, and in particular, migrant women, can be reminded of the existence of support networks and organisations. I direct that the Indian Weekender, a

New Zealand based publication which is specifically targeted at Indian readers, be included in this approach.[68]

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.

Note: An order under s 74 of the Coroners Act 2006 prohibits the publication of photographs of Tina entered into evidence in this inquiry, in the interests of decency and personal privacy. In addition, during the inquest, orders pursuant to s 74(b) were made permanently prohibiting the publication of the names of three witnesses who lived in neighbouring flats to Narinder and Tina.

Smith [2022] NZCorC 42 (18 March 2022)

CIRCUMSTANCES

Sam Jeremy Smith, aged 31, died between 27 April 2019 and 28 April 2019 at 77 John Street, Pukekohe. His death occurred in circumstances amounting to suicide against a background of repeated concussions, including a very recent concussion.

Mr Smith's repeated concussions were a result of accidents while motorsport racing, which he had been involved in from a young age. In January 2019, Mr Smith suffered a serious crash whilst speedway racing, followed shortly afterwards by a fall from his dirt bike. Family members noticed a significant change in Mr Smith's personality around this time, noting that he was often tearful and emotional. Mr Smith presented to his GP with depression and began taking an antidepressant in February 2019.

Mr Smith again rolled a car while speedway racing in late February 2019. A week after this crash, he collapsed at home and hit his head on a tiled floor. He was considered to be suffering from post-concussion syndrome and was referred to the ACC Concussion Service for further review.

Over the period leading up to his death, Mr Smith continued to struggle with the effects of concussion, including vertigo, difficulties judging speed and distance, poor memory and slowness of thought, poor appetite and trouble sleeping. He was also experiencing ongoing marital conflict and separated from his wife. On 1 April 2019, he attempted to end his life but was interrupted by his father.

On 27 April 2019, Mr Smith became upset after items connected with his young child were removed from his home. His mother also described him as devastated when the term "brain damage" was used during his appointment with a neurologist that afternoon. Mr Smith was found deceased at his home by his aunt the following morning, after family and friends became concerned that he could not be contacted.

The Coroner concluded that the effects of traumatic brain injury may well have played a role in Mr Smith's death, based on expert medical advice that the risk of death by suicide in those who sustain a traumatic brain injury compared with the general population is increased and that co-morbid depression is a significant risk factor.

68 The Indian Weekender published articles about Tina's death in 2017.

COMMENTS OF CORONER GREIG

I. From the time Sam Smith was a young boy, he was racing vehicles of all sorts and he achieved highly in motorcycle racing. Over the years he had a number of crashes, some of which were heavy impact, and he received a number of injuries to his head. It appears from his parents' evidence, that as well as 'spectacular' crashes in competitions he also had regular hard falls and crashes when training and out enjoying motorcycling or mountain biking. It also appears that for the most part Mr Smith 'dusted himself off' and picked up competing again after crashes – even though at times he exhibited symptoms that with hindsight suggest concussion. Many of these incidents occurred at a time when the effects of concussion were less well researched and widely appreciated than today.

II. Mr Smith snr (Bernard) said that since his son's death "his mum and I have learnt a lot about the brain and know that with this knowledge we know now we would have approached things differently." Mr Smith's mother Jo Steele said that the family firmly believe Mr Smith to be a casualty of head injury. She too highlighted the increase in awareness about the harmful effects of concussion stating, "we now live in a time when New Zealand rugby players are benefiting from a global awareness around concussion in sport". She said that since Mr Smith's death his family has raised awareness and funding for head injury assessment within motorcycle racing in New Zealand.

III. There is growing awareness about the risks of concussion and its harmful effects – including in motorcycle racing and motorsports. See for example *Consensus statement on concussion in sport: the 5th International Conference on Concussion in Sport held in Berlin, October 2016*[69] and Naomi Deakin and others "Concussion in motor sport: A medical literature review and engineering perspective".[70] Speedway New Zealand has an explicit concussion process and information about concussion on its website[71] as does Motorcycling New Zealand.[72] Awareness is also being promulgated by organisations such as ACC which commenced a Traumatic Brain Injury Strategy and Action Plan in 2017.[73] Part of the focus of the ACC strategy is on prevention, effective diagnosis, treatment and rehabilitation.

IV. A copy of these findings will be sent to ACC to highlight the issue of traumatic brain injury and concussion in motorsports.

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.

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

69 https://bjsm.bmj.com/content/51/11/838
70 2017 1 Journal of Concussion 1-11.
71 https://www.speedway.co.nz/COMPETITORS-1/CONCUSSIONS-MEDICALS
72 https://mnz.co.nz/manuals-policies/health-safety/
73 https://www.acc.co.nz/assets/provider/1bf15d391c/tbi-strategy-action-plan.pdf

Stewart [2022] NZCorC 22 (15 February 2022)

CIRCUMSTANCES

Connor Stewart, aged 27, died on 21 March 2020 at 24 Minifie Avenue, Melville, Hamilton in circumstances amounting to suicide.

COMMENTS OF CORONER BATES

I. I do not make, nor intend to imply, any criticism of anyone Mr Stewart had contact with and to whom he had made comments about suicide. On 21 March 2020 these were comments made in the context of pain and discomfort due to physical illness, likely while under the influence of cannabis and/or methamphetamine, and not considered genuine threats or expressions of an intent because he had previously made comments about suicide without acting on them. However, Mr Stewart's death is a reminder of the need to take any threats of suicide or self-harm seriously. The Ministry of Health offers the following guidance, which I endorse:

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

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

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death.

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

Sudden Unexpected Death in Infancy (SUDI)

Sudden Unexpected death in Infancy (SUDI) is an ongoing issue in New Zealand and Coroners continue to endorse the advice of the Ministry of Health. SUDI findings are also referred to the agencies responsible for SUDI prevention strategies.

Edwards-Te Rangi [2022] NZCorC 41 (17 March 2022)

CIRCUMSTANCES

Eli Edwards-Te Rangi, aged 4 weeks, died on 16 June 2021 at 60 Hamilton Drive, Waiuku. The cause of death was unascertained in the context of Sudden Unexplained Death in Infancy (SUDI).

Eli had a normal birth. When his mother, Kuini, was discharged from the birthing unit, she was offered a Pēpi-pod and wahakura but declined, saying that she already had a bassinet at home. In the weeks following his birth, Eli was put to sleep in his bassinet.

On 14 June 2021, Kuini reported to her midwife that Eli had been unsettled and as a result she had been co-sleeping with him. Kuini was reminded of safe sleeping practices and was offered a Pēpi-pod referral, which she accepted. Kuini also mentioned that Eli was making a small rattling noise in his throat. The midwife advised her to keep breastfeeding Eli but to call her or take him to the doctor if it got any worse. The midwife collected a Pēpi-pod with the intention of taking it out to Kuini on the morning of 16 June 2021.

On the evening of 15 June 2021, Eli was placed on one side of a queen-sized bed, on his back, with his head resting on a long “log” breastfeeding pillow on which Kuini also slept. The mattress was fitted with thermal mattress sheets and had multiple blankets on it. Kuini woke up at around 1:50am to feed Eli. After she finished, she wrapped him in his baby sized fleece blanket and again put him next to her in the bed, on his back with his head on the pillow and a gap between them.

Kuini woke up at around 6:00am and found Eli lying face down next to her in the foetal position. He was no longer wrapped in the blanket. Sadly, attempts to resuscitate Eli were unsuccessful and he was pronounced dead at the scene.

In accordance with the family’s wishes, a lesser post-mortem examination was conducted by a forensic pathologist. External examination showed possible petechiae on the right side of Eli’s face, which could be explained by him being found in a face down position. The radiologist’s report noted that there were no suspicious findings, but the distribution of lung abnormality made them wonder whether there had been an aspiration event in the prone position. The forensic pathologist concluded that the cause of death could not be determined due to inadequate post-mortem examination.

Coroner Ho identified several risk factors present which were circumstantial of a SUDI death. Specifically, Eli was using a pillow, Eli was co-sleeping with his mother and Eli was exposed to second=hand smoke during and after the pregnancy.

COMMENTS AND RECOMMENDATIONS OF CORONER HO

I. I have found that SUDI was a possible cause of Eli’s death. Considerable effort has been made in New Zealand to promote the message that every sleep for a baby should be a safe sleep. That is for every sleep, babies up to one year of age should be put to sleep on their backs, in their own sleeping space – being a firm, flat surface with no pillow – and with their face clear.

II. Motherhood is exhausting. I appreciate the circumstances in which a sleep-deprived mother, frequently woken during the night to breastfeed, might choose to have a baby in bed with her instead of placing him back in the bassinet. This is especially the case where the baby might settle easier in bed than in his own separate sleeping surface and where the mother has suffered days or weeks of interrupted and inadequate sleep. While safe sleep messages advising that best practice is to put babies in their

own sleep surface, such messages also need to take into account the demands of new parenthood and the reality of compliance.

III. Kuini was offered a Pēpi-pod when she left the birthing unit but she understandably declined because she already had a bassinet. It appears she changed her mind and realised the benefits of such a device on 14 June when she accepted her midwife's offer for one. Unfortunately, despite her midwife's commendable efforts in going out of her way to deliver the Pēpi-pod on 16 June, it was too late for baby Eli.

IV. To the extent that baby Eli's death resulted from co-sleeping with his mother, and therefore could have been prevented by the use of a Pēpi-pod or wahakura, I do not regard it as sufficient that new parents are simply "offered" such a device at birth. Many new mothers are tired and overwhelmed after giving birth. They do not want to make another decision. If there is to be a serious public health desire to reduce deaths of babies from SUDI caused by co-sleeping, there must be commensurately serious attempts at ensuring that simple steps which can prevent such deaths are routinely taken before they are needed. One possible course of action is to automatically give each new mother a Pēpi-pod after birth rather than ask if they would like one. My research shows that the cost of a basic Pēpi-pod, albeit in 2016, was $100 each[74] and in the year to September 2021 there were 59,382 live births registered in New Zealand.[75] An annual cost of $6 million appears to be a small price to pay to ensure that babies do not unnecessarily die from co-sleeping.

V. I recommend that the Ministry of Health consider automatically issuing all new babies with a Pēpi-pod or wahakura at birth. I direct a copy of these findings be sent to the Ministry of Health, the Child Youth Mortality Review Committee, and Change for our Children, all of which are actively involved in working to strengthen and promote consistent safe sleep messages.

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

Elers [2022] NZCorC 26 (25 February 2022)

CIRCUMSTANCES

Jodarce Leo Elers, aged two months, died on 19 December 2020 at Tamatea Street, Hastings of an unascertained cause or Sudden Unexpected Death in Infancy.

Jodarce's birth was normal with no complications. Post-natal care was provided by a midwife and Jodarce was referred to Te Taiwhenua o Heretaunga ("TToH") for Well Child services.

74 https://www.stuff.co.nz/national/health/82801474/government-uturn-on-funding-pepipods-could-save-dozens-of-babies-lives#:~:text=Mitchell%20told%20the%20New%20Zealand,would%20be%20about%20%24100%20each.
75 https://www.stats.govt.nz/information-releases/births-and-deaths-year-ended-september-2021

On 19 December 2020, Jodarce was sleeping on a single mattress with his mother, Courtney Elers and step-father, Joshua Clarke. When Mr Clarke woke at about 11:00am, he found Jodarce in his arms, unresponsive. Resuscitation attempts were unsuccessful. Sadly, Jodarce had died.

COMMENTS OF CORONER DUGGAL

I. On the evidence before me, Jodarce appeared to be growing and gaining weight well. Ms Elers co-slept with Jodarce both on her own and with Mr Clarke. This was an unsafe sleeping environment and a known significant risk factor for Sudden Unexpected Death in Infancy ("SUDI"). Jodarce was also exposed to the effects of cigarette smoking both in utero and after his birth. This is also a known risk factor for SUDI.

II. Both the midwife and TToH provided Ms Elers with advice about the risks of SUDI from co-sleeping. Jodarce's death is a tragedy for his whānau. His risk of SUDI was increased due to the co-sleeping arrangement. I am satisfied that information about safe sleep had been given to Jodarce's mother but this advice was not followed.

III. There has been increasing focus in New Zealand on promoting key, research based, safe sleep messages. Specifically, that for every sleep babies up to one year of age should be put to sleep on their backs, in their own sleeping space (such as a cot, bassinette or Pēpi-pod) with no pillow and their faces clear. The challenge for those working with parents and caregivers is how to ensure that the importance of the safe sleep message is appreciated by parents and caregivers so that they take the steps necessary to ensure that every sleep is a safe sleep.

IV. There have been a number of recommendations and comments made by coroners focussed on the issue of safe sleep. Given this, I do not consider further recommendations are necessary.

Ranapia [2022] NZCorC 39 (16 March 2022)

CIRCUMSTANCES

Halo-Seianna Leeshave Ranapia, aged six weeks, died on 8 May 2019 at Manurewa, Auckland of sudden unexpected death in infancy.

Baby Ranapia was born on 1 April 2019 and lived with her mother, siblings and grandmother in Manurewa, Auckland. At around 10:50pm on 7 May 2019, baby Ranapia was put to sleep in her own cot. The following morning baby Ranapia's mother woke up and saw that baby Ranapia was blue. Despite medical assistance, baby Ranapia was sadly declared deceased.

Reports compiled following baby Ranapia's death noted that her mother was alleged to have been intoxicated on 18 April 2019, and that a report of concern was made to Oranga Tamariki. In addition, services involved with baby Ranapia's care noted that her mother was a smoker and that a referral to smoking cessation had been made.

COMMENTS OF CORONER TETITAHA

I. I have determined to make comments in respect of this death pursuant to section 57A of the Coroners Act 2006.

II. This is the third SUDI decision I have issued where there have been social factors of poverty, overcrowding and damp housing in the circumstances preceding death.[76] Given the number of agencies involved with baby Ranapia and her whānau, it is surprising these issues are raised for the first time by the SUDI liaison report writer. No other agency involved with baby Ranapia's whānau identifies these as issues of concern.

III. Academic researchers have confirmed that these social factors can result in the marginalisation of Māori including disengagement with mainstream health services:[77]

> Data analyses found that a doctor's perceived emphasis on risky and unhealthy behaviours deterred patients from seeking medical care – because the doctor's emphasis on patient's "unhealthy" behaviours caused patients to self-blame for their own ill health. Self-blame and fear of blame and judgement on the part of healthcare workers were most common among respondents who lived in lower socioeconomic areas. Respondents from poorer neighbourhoods also reported believing that because they were responsible for their ill health, health professionals would be able to do little to help them. Those from more affluent areas were less likely to self-blame for their poor health and more comfortable seeking health care.
>
> Taking into account these data, we believe Māori pay a high cost for being labelled "high risk". Negative health stereotypes attached to Māori, coupled with a focus on unhealthy lifestyle choices (i.e., risky health behaviours), may deter Māori from seeking health care in the first place. In addition, the labelling of Māori as being "high risk" for poor health may encourage health providers to develop a fatalistic attitude toward Māori, thinking that nothing they do will change the behaviour of their Māori clients.
>
> …
>
> Māori women who experience SUDI are more likely to live under conditions of serious deprivation and to experience alienation, marginalisation and exclusion in New Zealand society. Continuing to treat these distal risk factors as non-modifiable tracks away from focusing on preventable approaches to Māori health that aim to improve the conditions in which Māori mothers live and raise their babies.
>
> …

76 Similar previous death of Vahnah-Faith Abigail Salt CSU-2018-AUK-000728 and Elizabeth Dianna Isabella Hepoto-Vailahi Vuna CSU-2018-AUK-001356.
77 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 Maori communities" New Zealand College of Midwives Journal Issue 52 2016.

> A holistic approach is required; one which considers the social milieu of the smoking mother and the social determinants of health that predispose younger Māori women to start smoking in the first place. In addition, much more work needs to be done to explore and develop interventions which normalised smoking in the environments of Māori women. Glover (2000) suggests that Māori themselves need to control the allocation of resources and the content and focus of education and public health prevention activities for Māori as Māori are acutely aware of how to deliver and design healthcare services in interventions that are culturally specific and thus more likely to be effective.

IV. I am concerned that these facts are present here. These factors indicate the potential marginalisation of baby Ranapia's whānau by mainstream health and social welfare agencies. The investigation into the mother's alleged behaviour on 18 April 2019 had the hallmarks of actively discouraging engagement of this mother with mainstream health and social welfare agencies. These facts also indicate the smoking cessation program was unsuccessful given the mother continued smoking up to 5 cigarettes per day.

V. The reporting of baby Ranapia being underweight due to being solely breast fed and the mother's financial circumstances highlights the inability to afford additional food including the high cost of baby formula. None of the agencies involved seemed motivated to assist baby Ranapia's family in addressing these issues which may indicate a larger health and welfare malaise.

VI. The lead agency tasked with investigating these concerns was Oranga Tamariki. The response by Oranga Tamariki was directed at the mother's alleged bad behaviour. There was no assistance provided to address the social issues that were underlying these records of concern. This could have included assistance with access to respite care for the mother of 6 children, finding suitable rental accommodation and financial assistance for baby formula.

VII. These types of responses require interagency action. Oranga Tamariki has an existing relationship through the Ministry of Social Development with Work and Income New Zealand (WINZ) to provide access to financial assistance for families such as baby Ranapia's. Oranga Tamariki could establish relationships with Kāinga Ora/Housing New Zealand to ensure families such as baby Ranapia's obtains suitable housing as well as other public and private organisations that could meet their needs. Addressing the underlying social issues could have prevented this death.

VIII. There may also be a need for funding of Tikanga Māori smoking cessation programs such as Heru & Hapū Māmā program piloted in the Waikato. This program has a reported 92% success rate and is currently seeking funding from the Ministry of Health. They do not appear to have had the same engagement issues with Māori mothers. Assistance and funding of culturally appropriate programs for Māori mothers may also prevent similar deaths to baby Ranapia in the future.

RECOMMENDATIONS OF CORONER TETITAHA

I. The following recommendations are made pursuant to section 57A of the Coroners Act 2006, for the purposes set out in section 4:

a. That Oranga Tamariki establish relationships with other agencies and focus on addressing the underlying social issues underpinning records of concern about infants such as baby Ranapia;

b. That the Ministry of Health consider funding culturally appropriate programmes such as the smoking cessation program Heru & Hapū Māmā program piloted in the Waikato.

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

Te Ua [2022] NZCorC 53 (30 March 2022)

CIRCUMSTANCES

Rohana Marlien Te Ua, aged three and a half months, died on 19 June 2021 at Auckland of sudden infant death associated with unsafe sleep with a contributing condition of respiratory infection.

On 18 June 2021, Rohana was sitting in her mother's bed with her mother, Sandy. At around 8:00pm, Sandy placed Rohana on top of her lying face up with the intention of transferring Rohana into her cot, but this did not eventuate as Sandy fell asleep before doing so. The following morning, Rohana was found unresponsive and was declared deceased.

COMMENTS OF CORONER HO

I. All unexplained infant deaths are tragic losses both for the infant's family and for the wider community. This death is particularly unfortunate because Rohana was usually placed in her own cot at night and her mother had every intention of transferring her back to her cot after she had been winded. It was only because Rohana's mother succumbed to exhaustion and fell asleep that this did not occur.

Safe sleep practices

II. Considerable effort has been made in New Zealand to promote the message that every sleep for a baby should be a safe sleep. That is for every sleep, babies up to one year of age should be put to sleep on their backs, in their own sleeping space (being a firm, flat surface with no pillow) and with their face clear. That message is usually discussed with expectant parents by their lead maternity carer and after birth. It is important that it occurs in the case of every baby born in New Zealand. However, as I understand that this is already the general practice followed by lead maternity carers and birthing units, I do not consider it necessary to formalise this as a recommendation.

Availability of support

III. Rohana's mother may blame herself for falling asleep. She should not. New parenthood is tiring. Babies demand frequent attention and parents' sleep patterns and circadian rhythms are disrupted. Compounding the situation in this case was that Rohana's mother was not only dealing with one newborn, but three other young children under the age of five with little family or social service support.

IV. In the course of this inquiry I received a report from Sandy's lead maternity carer (LMC). The LMC stated that Sandy had very little support unless she went to the home of her ex-partner's family in Onehunga. The LMC said that it was difficult to make postnatal visits because the Kāinga Ora housing block had no working intercom and the front door was always locked for security reasons, meaning it was impossible to walk up to Sandy's apartment and knock on the door. The LMC also said that while Sandy had funded daycare for the other young children it was difficult for her to drop the children off as the youngest would become distressed at being left, and it was also difficult for her to get three children under five and a baby in arms safely down three flights of stairs from her apartment. The LMC made referrals to the Anglican Trust for Women and Children and via Noho Ahuru and ADHB for housing and social support but it does not appear anything resulted from these referrals. The LMC concluded that Sandy was a good mother and that following Rohana's birth she had deeply inadequate accommodation and support either formally from social services or informally from family.

V. It is impossible to say whether, with better support, Sandy's tiredness might have been ameliorated to the extent that she would not have fallen asleep with Rohana on top of her. All I am prepared to find is that the lack of support likely did contribute to her state of tiredness. It follows that any step that can be taken to reduce or relieve the burden on new parents is one that can reduce the incidence of future deaths in similar circumstances and can appropriately be the subject of coronial comment.

Kāinga Ora

VI. I considered that my findings should be sent to Kāinga Ora and the Ministry of Social Development (MSD), which often make decisions relating to social and financial support for those looking after newborns. It is important that these agencies are reminded of the impact that their decisions may have on new parents and consequently on their infant children. A proactive, not reactive, stance is required. For example, while I acknowledge that issues around resourcing and availability of social housing are complex, I found it difficult to comprehend how a third floor walk-up apartment with a broken intercom could ever have been deemed to be suitable accommodation for a solo mother of a newborn baby and three children under the age of five. I considered it incumbent on these agencies to reflect on and incorporate the learnings from Rohana's death into their workflow and delivery with the aim of reducing, as much as possible, any unnecessary burden their decisions might impose on new parents.

VII. Pursuant to sections 57B and 58 of the Coroners Act 2006 I notified Kāinga Ora and MSD of my intention to make the above comments and provided both agencies with a copy of my provisional findings. Kāinga Ora responded on 16 March 2022. It advised me that when Sandy was placed in her third floor walk-up apartment in 2017 there were three people on the tenancy: a pregnant Sandy, her partner and their six month old baby. Kāinga Ora stated that there was nothing to suggest the placement was unsuitable.

VIII. In May 2019 Sandy requested a transfer to a different property on the basis that she, her partner and her (by that time) three children – aged 2, 1 and a three month old baby – were living in a two bedroom apartment and she was finding it difficult to enter and exit the apartment building with all her young children given its location on the third floor. Kāinga Ora advised that under the policies that were in place at the time, its staff would determine whether it met the criteria for a Business Initiated Transfer.

Such criteria included matters such as “severe overcrowding”, which was characterised as requiring two extra bedrooms or more. Kāinga Ora did not assess Sandy’s household as meeting the definition of “severe overcrowding” because her household required only one extra bedroom and therefore her request for a transfer did not meet the criteria for a Business Initiated Transfer. Kāinga Ora referred Sandy to MSD to apply for a transfer, and MSD was then responsible for determining her eligibility for a transfer within social housing.

IX. It seems to me Kāinga Ora’s policy in 2019 misses the point. While Sandy’s family’s desire for an extra bedroom might have been part of the reason for requesting a transfer, Kāinga Ora’s response itself notes that the family’s difficulties with leaving and accessing their walk-up apartment was a key factor in the request. It is disappointing that accessibility appears not to have been a policy criterion which was assessed when determining whether the housing placement remained a suitable one for that family.

X. Kāinga Ora has advised me that since 2019 it has launched a “Customer Programme” which includes as one of its four key service outcomes a “suitable house match”. Kāinga Ora also advised me that it has reduced the portfolio responsibilities of its Housing Support Managers meaning that they can increase the amount of time they can spend with their customers, and which will likely result in Kāinga Ora staff being more proactive in assessing the ongoing suitability of its customers’ housing circumstances as need and circumstances change. In light of this apparent shift in policy, and a more focused attention under the new “Customer Programme” on ongoing suitability of housing match, I do not make any comments on recommendations under s 57A of the Act.

XI. It is also appropriate to record two further specifics of Kāinga Ora’s response:

a. Kāinga Ora acknowledged the comments in my provisional finding recorded at [22] above. It advised me that it and MSD meet regularly at local, regional and national levels to ensure connection between agencies when working to support mutual customers and that work is under way to improve the sharing of information between agencies.

b. Kāinga Ora acknowledged that there were maintenance issues with Sandy’s apartment complex that “could have, and should have, been addressed earlier”. Kāinga Ora accepted that the failure to include intercom checks as part of the routine maintenance undertaken on the complex was an oversight on its part. Kāinga Ora advised that intercom checks are now included as part of the routine maintenance for that complex and it was in the process of replacing all the individual intercom units in the complex. Kāinga Ora stated it would endeavour to be more proactive in addressing maintenance issues like this in the future.

XII. I thank Kāinga Ora for its considered response to my provisional findings and its candid acknowledgement of areas in which it could have done better.

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

Ward [2022] NZCorC 48 (23 March 2022)

CIRCUMSTANCES

Lee Barry Ward, 27 days old, died on 19 July 2020 at Oraiwa of sudden unexpected death in infancy in the context of unsafe sleeping.

Lee was born on 23 June 2020 with no complications during his birth. Lee and his family frequently visited their relatives' farm in Oraiwa for overnight stays. When at home Lee slept in a bassinette but at the farm Lee slept on a pull-out mattress with his mother.

On 18 July 2020, Lee and his family travelled to the farm for an overnight stay. At approximately 10:00pm, Lee was put to bed on the pull-out mattress. He was placed on the mattress in a diagonal position as the mattress sagged in the middle. The mattress had a mink blanket on top. Lee was loosely wrapped in a mink baby blanket, and another full-sized mink blanket was laid over him.

Lee was noted to be his usual self when he was fed at 2:00am. When Lee's mother awoke at approximately 6:00am to feed Lee, she noted that he was lying parallel to her, in the sagging area of the mattress. He was face down, and the full-sized mink blanket was on top of him. Despite efforts to revive him, Lee sadly passed away.

The Coroner received a report from Elaine McLardy, a Sudden Unexpected Death in Infancy (SUDI) liaison officer to assist in understanding the circumstances of Lee's short life and his death.

RECOMMENDATIONS OF CORONER CUNNINGHAME

I. Having made the above findings, I have considered whether any recommendations or comments under s57A of the Coroners Act are necessary, for the purposes of reducing the chance of other deaths occurring in similar circumstances. I have consulted with the New Zealand College of Midwives (NZCOM) and with Plunket, and have considered responses received from both organisations.

II. The safe sleep messages that are given by MOH, Plunket, midwives, and other providers, are frequently endorsed by my colleagues in this Court. As I said above, I am confident that Lee's parents were aware of the messages, and that they had followed the advice to ensure that Lee was safe when he slept at home.

III. The use of the mink blankets on the bed Lee slept in is a factor which I consider warrants making specific recommendations. Using heavy synthetic blankets increases risk to babies, and this risk outweighs the benefits of keeping warm, particularly on cold nights.

IV. Synthetic blankets are marketed to parents as being ideal for keeping babies and children warm and cosy. Parents and caregivers should be made aware that using these types of blanket poses risks to young babies, and that, where possible, natural fibres should be preferred. Ms McLardy suggested that fabric swatches of natural and synthetic blankets could be included in education resources as part of a campaign to encourage knowledge about natural fibre blankets.

V. Having said this, I acknowledge that the cost of wool or other natural fibre blankets makes them an unrealistic choice for many whānau in New Zealand, even if they are educated about their benefits. As Jacqui Anderson, NZCOM Midwifery Advisor put it:

> Midwives recognise that parents and caregivers want information on the best way to support their babies but [recommending against synthetic blankets] may be difficult for those families without the resources to achieve this. Midwives will continue to support parents and caregivers to access the support they need in these situations.

VI. In its response to my proposed recommendations, NZCOM suggested that in addition to recommending against the use of synthetic baby blankets, I should recommend against the use of adult-sized blankets of any material, synthetic or not. NZCOM advises that adult-sized blankets are not recommended for babies because of their weight and size, and the potential for babies to be covered by them, or to become entangled in them.

VII. Both Plunket and NZCOM have advised my inquiry that they will audit and update information in line with recommendations regarding this issue, in order to promote the safe sleep message.

VIII. I recommend that the NZCOM and Plunket continue to update their safe sleep information to inform parents and caregivers of the risk posed by using synthetic baby blankets, and to advise them that adult-sized blankets should never be used in babies' beds or sleep spaces. Consideration should be given to Ms McLardy's suggestion that fabric swatches demonstrating the difference between synthetic and natural blankets be included in education resources.

IX. I direct that a copy of these findings be sent to Hāpai Te Hauora which oversees SUDI prevention education under contract to the Ministry of Health, for further consideration, and to the Well Child Tamariki Ora team at the MOH which also provides guidance regarding safe sleep and SUDI. Both Plunket and NZCOM referred to these groups which play a key role in educating providers and the community about how to keep babies safe.

X. Finally, I observe that the MOH and other organisations which make decisions about funding assistance may wish to consider whether additional support should be made available so that safe blankets are accessible to all babies in New Zealand.

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

Workplace

Hore [2022] NZCorC 45 (22 March 2022)

CIRCUMSTANCES

Suzanne Joan Hore, aged 67, died on 3 November 2019 at Paerau of a fracture of the second cervical vertebra with significant displacement after falling from a farm vehicle. Her death was an accident.

On 3 November 2019 Mrs Hore was helping her husband move a ewe across their farm. The ewe was in the cargo try of a side-by-side vehicle, and Mrs Hore was holding it. While the vehicle was stopped so her husband could open a gate, the ewe kicked and Mrs Hore fell off the cargo tray, landing face down on the ground. She died from injuries received in the fall.

WorkSafe investigated the farm's safe systems of work. The farm had implemented a procedure for safely moving sheep and lambs, which required workers to transport them in either a caged trailer, or in cages on the back of a ute. The side-by-side vehicle was not intended for use transporting sheep.

The farm did not allow workers to ride unsecured in the rear trays of vehicles or on trailers. A sticker on the cargo tray of the side-by-side vehicle reminded users not to carry passengers in the cargo tray, and this message was also reinforced in the owner's manual kept in the glove box.

WorkSafe concluded there was no public interest in conducting a prosecution.

RECOMMENDATIONS OF CORONER CUNNINGHAME

I. Having considered s57A of the Coroners Act, I have concluded that it is appropriate to make recommendations which may, if drawn to public attention, reduce the chance of further deaths occurring in similar circumstances.

II. WorkSafe's guidelines do not identify the risk that can arise when sheep are transported across farms unsecured, or when they are held down. I recommend that WorkSafe updates the Safe Sheep Handling Guidelines to include advice that sheep should only be transported across farms by a vehicle if they are secured in a caged trailer, and that they should never be held down by a person while they are transported in a vehicle.

III. I wrote to WorkSafe advising of my proposed recommendation. In reply I have been advised that WorkSafe has nothing to add to the wording of the recommendation, and that it may be taken into account when the two guideline documents come up for their scheduled review.

IV. I thank WorkSafe for its considered response.

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

King [2022] NZCorC 47 (23 March 2022)

CIRCUMSTANCES

Michael Kauahi King, aged 49, died on 29 December 2019 at Waikato Hospital of a head injury sustained as a result of being struck by a horse upon which he had recently been mounted and was in the process of breaking in.

On 28 December 2019, Mr King was at the cattle yards at Taharoa ("the Yards") breaking in a horse. He was not wearing a helmet when riding the horse without a saddle. The horse's owner, Shawn Tuapaki, noted that, in Taharoa, locals do not wear a helmet when breaking in their horses. After dismounting the horse, it became spooked and stomped down on Mr King with its front hooves. Mr King sustained an injury to the head and was transported to Waikato Hospital. He was declared deceased the following day.

Toxicological testing of ante-mortem blood samples taken from Mr King detected the presence of alcohol at a concentration of 136 milligrams per 100 millilitres of blood. For comparison purposes, the legal blood alcohol limit for a New Zealand driver 20 years old or over is 50 milligrams per 100 millilitres. Testing also detected cannabis. The Forensic Toxicologist reported that the combined use of cannabis and alcohol tends to accentuate the effects of alcohol.

WorkSafe carried out an investigation into Mr King's death and provided a report to the Coroner.

The Coroner considered what role, if any, Mr King's intoxication at the time of the horse attack played in his death. She was satisfied that Mr King must have been affected by alcohol (and potentially cannabis) at the time of his death due to the high level detected in his ante-mortem sample taken more than three hours after the incident.

The Good Practice Guidelines Riding horses on farms ("the Guidelines"), produced by WorkSafe New Zealand, identify drugs or alcohol as one of the "personal factors" that can impair riders and "…cause poor judgement, reduced balance, co-ordination and reaction times, which increase the risk of serious injury or death." The Guidelines recommended: "Never ride a horse while under the influence of drugs or alcohol."

The Coroner accepted that Mr King's intoxication could have affected his judgement in managing the risks associated with handling a horse he was breaking in and his co-ordination in responding to any dangerous behaviour by the horse. However, the Coroner was not satisfied there was any evidence that Mr King's handling of the horse was in fact impaired or that his co-ordination was adversely affected.

Mr King dismounted the horse when visitors arrived at the Yards in their vehicles. He took steps to converse with the visitors outside the Yards. The Coroner considered this behaviour showed sensitivity to manage potential stressors for the horse.

The WorkSafe Report asserted that:

> The arrival of vehicles and visitors to the scene should have been identified as a change in the environment.

However, the WorkSafe Inspector recognised that:

> [Mr King] may have assessed this risk as he had articulated his intention to remove himself from the yards to continue his discussion with his friends. Unfortunately before he could complete his manoeuvre the horse had already lashed out.

The Coroner agreed with the WorkSafe Inspector's assessment.

The Coroner concluded that Mr King's level of intoxication cannot have significantly affected his motor skills and response time given that he was able to ride the horse bare back. She considered that the way in which the 16-hand horse lashed out at Mr King, who was 1.66 metres tall, was so violent that his level of intoxication was unlikely to have made any difference to his ability to protect himself.

While Mr King's use of alcohol and cannabis before engaging in the dangerous tasks of breaking in a horse is highly inadvisable, the Coroner was not satisfied on the balance of probabilities that it contributed to his death.

Dr Grant Christey, one of the surgeons who attended to Mr King at Waikato Hospital, advised that helmets reduce the risk of brain injuries caused by high energy forces, and that it is possible that the force from the horse's kick would have been reduced had Mr King been wearing a helmet.

RECOMMENDATIONS OF CORONER WRIGLEY

I. Mr King's death illustrates the risk of fatal (head) injury associated with handling horses, particularly those being broken in. His death demonstrates that this risk exists whether the handler is mounted or unmounted and regardless of experience. Dr Christey's position is:

> New Zealand has relatively high rates of traumatic brain injury (TBI) related to horse riding and handling activities, particularly affecting males and it is reasonable to adopt routine helmet-wearing and other risk-avoidance strategies during high risk activities.

II. For the reasons given by Dr Christey and because of the circumstances in which I have found that Mr King's death may have been prevented had he been wearing a helmet, I recommend that all those handling a horse being broken in wear a helmet whether they are mounted or unmounted.

III. I consider the circumstances of Mr King's death also call for a revision of the Guidelines for the purpose of either expanding or supplementing them to better address the hazards Mr King confronted at the time of the attack.

IV. In research conducted by Dr Christey and others in 2018, it was found that "working males" are a group particularly at risk of sustaining equine-related injuries. This group is more frequently kicked than injured by other mechanisms such as falling from a horse. Dr Christey and his co-authors suggest that, if working males are at greater risk of equine injury, prevention strategies should include workplace health and safety frameworks.[78]

V. The Guidelines do provide "general horse-handling tips" together with guidance on approaching a horse, leading a horse, lunging (described as a "useful horse training tool") and managing difficult horses. However, the Guidelines contain no specific advice or commentary on the work of breaking in a horse. The Guidelines do advise that a helmet should always be worn "when riding a horse" but advice to wear a helmet "when around horses whether they are riding or not" is confined to children.

VI. The advice in the Guidelines to wear a helmet when riding a horse did not apply to Mr King when he was struck by the horse; he was on the ground. The process of breaking in a horse will not always involve riding a horse. The Guidelines do not recommend the use of a helmet in those circumstances. I consider this is an omission.

78 Amy R Jones, Alastair Smith and Grant Christey "Equine-related injuries requiring hospitalisation in the Midland Region of New Zealand: a continuous five year review" (2018) 131 NZMJ No 1483 at 50; and Meredith Chapman and Kirrilly Thompson "Preventing and Investigating Horse-Related Human Injury and Fatality in Work and Non-Work Equestrian Environments: A Consideration of the Workplace Health and Safety Framework" [2016] Animals May 6 6(5):33.

VII. I consider the Guidelines ought to be reviewed to ensure they adequately address safety considerations and measures when handling (as opposed to just riding) a horse, especially when working on breaking in a horse. Such a review is further warranted given the age of the Guidelines (June 2014) which WorkSafe has identified as requiring an "update to reflect the latest legislative changes".

VIII. Accordingly, and in summary, I recommend that:

a. those breaking in horses wear a helmet when handling them whether they are mounted or unmounted;

b. that WorkSafe review and supplement the Guidelines to ensure they adequately address the risks identified in the circumstances in which Mr King was handling a horse he was breaking in when he was fatally struck. Such a review of, and any additions to, the Guidelines ought to be completed within a year from the date of these findings.

IX. I consider a review by WorkSafe of the Guidelines and provision of supplementary advice regarding the risks of breaking in a horse may reduce the chances of further deaths like Mr King's by setting appropriate safety standards in the horse pre-training industry and providing education about safe practice. The need for such standard setting is confirmed by Shawn Tuapaki's evidence that, in Taharoa, locals do not wear a helmet when breaking in their horses. This evidence also supports my recommendation regarding the use of helmets when breaking in horses, a recommendation which if drawn to public attention may result in the increased use of helmets thereby reducing the chances of further deaths like Mr King's.

X. I consulted with WorkSafe, Accident Compensation Corporation ("ACC"), Harness Racing New Zealand ("HRNZ"), NZ Rodeo Cowboys Association, and New Zealand Thoroughbred Racing ("NZTR") on the recommendations.

XI. WorkSafe did not specifically respond to recommendation (a) except to indicate that it supported consultation with the other consultees. All other consultees indicated support for that recommendation.

XII. The response of Lyal Cocks, President of NZ Rodeo Cowboys Association, included an observation that:

> … [Mr King] was significantly under the influence of alcohol and for the same reason it was illegal for him to drive, he should not have been working with the horse. Yes, [Mr King] was able to ride [the horse] bareback in this state of impairment but alcohol affects the decision-making and can make people feel somewhat invincible. It appears [Mr King] let his guard down due to his impairment. In view of this, should there also be a guideline saying don't break in horses while under the influence of alcohol?

I have addressed the issue of intoxication above and consider those findings do not permit me to make the recommendation proposed by Mr Cocks. However, his proposal warrants repetition of the advice at [3.11] of the Guidelines: "Never ride a horse while under the influence of drugs or alcohol."

XIII. The response of James Dunne, GM Legal, Regulatory and Compliance, on behalf of NZTR commented upon the potential challenges of "implementation" of recommendation (a) in the thoroughbred racing industry given

> … an unresolved question [is] whether NZTR's rule-making powers under the Racing Industry Act 2020 enable NZTR to mandate the wearing of helmets when an unlicensed person breaks in an unregistered thoroughbred.

I consider that the scope of NZTR's rule-making powers falls outside the proper scope of my inquiry into Mr King's death, which involved an appaloosa horse. However, Mr Dunn advises that NZTR "… can ensure that [my recommendations] are sent to all industry participants", a step which will assist in making recommendation (a) effective.

XIV. ACC, HRNZ and NZTR all supported provisional recommendation (b). The NZ Rodeo Cowboys Association did not specifically address this recommendation.

XV. WorkSafe's response to provisional recommendation (b) is as follows:

> Our Guidance Products team have … confirmed that the "Riding Horses on Farms – Good Practice Guidelines (the GPG)" are currently on our work programme to be updated as part of our work programme on the upcoming Plant and Structures Regulations. The entire suite of guidance relating to agriculture/animals on farms (including the GPG and the supplementary fact sheet "Riding horses on farms") is to be reviewed and will be updated as part of this work programme.
>
> The GPG has been assessed as requiring a major review/revision and although the phasing for individual pieces of guidance has yet to be confirmed, a 1-year timeframe for completion is not currently viable. The development of new or review and re-development of existing Good Practice Guidelines (GPGs) can take up to 2 years to complete once started. However, we could potentially produce short-form guidance (a fact sheet or quick guide) on hazards in breaking-in horses to supplement the GPG within the 1-year timeframe.
>
> We note however that WorkSafe don't have any general horse riding or racing industry guidance currently and if we were to look at horse riding (to include other wider industry specific issues, should they be raised by other parties consulted on by the Coroner) outside of our existing review programme it would likely extend the timeline further out.

This response indicates that recommendation (b) is both warranted and feasible. I consider the "short-form guidance" on hazards in breaking and horses, which WorkSafe indicates could be prepared within the one year time frame specified, is capable of satisfying recommendation (b).

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

OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND