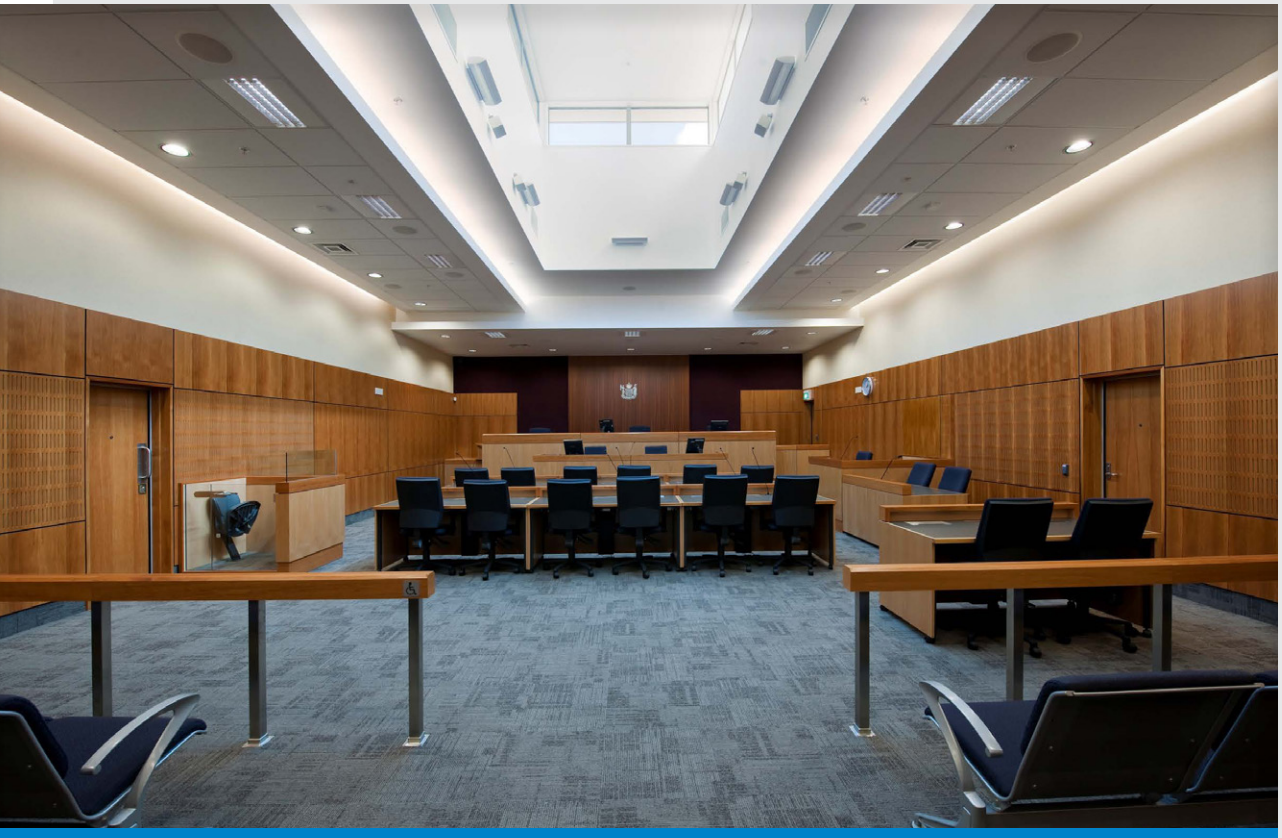
Recommendations recap

A summary of coronial recommendations and comments made between 1 October–31 March 2013



OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Issue 5

Coronial Services of New Zealand
Purongo O te Ao Kakarauri

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- The summaries may be edited to comply with orders made under section 74 of the Act.
- Summaries of self-inflicted deaths may be edited to comply with restrictions on publishing details of such deaths under section 71 of the Act.

Coroners have a duty to identify any lessons learned from the deaths referred to them that might help prevent such deaths occurring in the future. In order to publicise these lessons, the findings and recommendations of most cases are open to the public.

Recommendations recap identifies and summarises all coronial recommendations that have been made over the relevant period. We have also included summaries of any responses to recommendations sent to us from agencies and organisations.

This issue of *Recommendations recap* covers a six-month period and includes 98 coronial cases where recommendations have been made. These findings were released by a coroner between 1 October 2012 and 31 March 2013.

Contents

Adverse effects or reactions to medical/surgical care

Case number

CSU-2011-DUN-000270
2012 NZ CorC 165

CIRCUMSTANCES

The deceased died at Dunedin Hospital of an injury to her brain, which occurred when a naso-gastric tube was incorrectly inserted following a procedure to relieve a build-up of fluid around the brain and spine. Two days after the tube had been inserted the deceased accidentally pulled it out, and, when a nurse tried to replace it, the tube accidentally passed through an area where the bone had been weakened during the procedure. The injury she received was not survivable.

The particular procedure that had been performed on the deceased had become used less often, and staff were no longer fully aware of its complications, such as the weakening of bone. The case notes stated that any replacement of the naso-gastric tube should be done under direct vision, but this was unfortunately overlooked.

Dunedin Hospital reviewed this incident and identified problems with patient handover and intra-hospital communication. The review made several recommendations on how to improve shift-to-shift handover to ensure key points are not overlooked.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to Southern District Health Board (SDHB) that it continue with its development of protocols to avoid the recurrence of the circumstances which led to this death.

The coroner recognised that it is inappropriate to make recommendations too specific in cases such as this and that the main issues that need to be addressed have been identified. In the coroner's view all that could be required of the SDHB is that the lessons to be learned from the tragedy be the subject of critical appraisal and that appropriate enhancement in procedures be later adopted.

The coroner also considered that the issue of critical flags within patient notes being overlooked or buried was so important that the lessons learnt from this death should be appropriately drawn to public attention by the SDHB. The coroner commented that the board should report on the issues identified at a national level.

Case number

CSU-2011-WGN-000329
2012 NZ CorC 114

CIRCUMSTANCES

The deceased, a 2-month-old infant, died at Wellington Public Hospital of septicaemia associated with necrotising enterocolitis, a condition which involves the death of tissue in portions of the bowel. She was a premature baby who developed the bacterial infection after having undergone laser surgery. Though she was given antibiotics, and underwent a second surgery to deal with the infection, it could not be contained.

Necrotising enterocolitis is common in premature babies and can occur without obvious triggers. A small number of infants develop it after having used mydriatic eye drops, but it was not determined whether this was the cause of the deceased's infection. It has been observed that lower concentrations of the eye drops do not seem to correlate as strongly to the onset of infection. Hospitals in New Zealand commonly dilute their eye drops, but lower concentrations could be made commercially available to eliminate the possibility of human error.

After this incident, the Neonatal Intensive Care Unit carried out an audit to identify if infants with necrotising enterocolitis had had an eye test in the preceding 48 hours.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the Director-General of Health that, in accordance with the advice of an ophthalmologist given in evidence, the Ministry of Health consider taking the steps necessary to ensure the availability within New Zealand of the eye drop combination Cyclomydril (Cyclopentolate Hydrochloride 0.2 percent with phenylephrine Hydrochloride 1 percent).

RESPONSE FROM THE MINISTRY OF HEALTH

The Ministry of Health provided the following response to the coroner's findings and recommendations.

In line with your recommendation, Medsafe is exploring the possibility of making a more dilute solution of cyclopentolate with phenylephine available in New Zealand. The Chief Medical Officer plans to meet with the College of Ophthalmologists to discuss ways in

which the systematic absorption of eye drops might be minimised in these frail infants without compromising the examination and treatment of the retinal condition.

Case number

CSU-2008-WGN-000742
2012 NZ CorC 172

CIRCUMSTANCES

The deceased died at Wellington Hospital of encephalitis, an acute inflammation of the brain. Almost two weeks before his death he began experiencing what was described as a bad headache. This progressed to numbness and pins and needles down his right arm. His GP assessed that he had some kind of viral illness, and after a consultation and blood test arranged for him to come for a further review the next day.

Before this review the deceased suffered a seizure and was taken to hospital where he had a CT scan. The scan was returned normal and he was discharged later that same day. He returned to hospital the next day because of further seizures, and the day after an MRI found an extensive infection in the left-side of his brain. Despite procedures to combat the infection and relieve pressure on his brain, it was considered that he was unlikely to ever regain normal function, and life support was withdrawn. The unknown viral infection progressed to encephalitis; if an MRI had been done earlier it might have improved the investigation of the deceased's condition, but it is not likely the outcome could have been changed.

COMMENTS AND RECOMMENDATIONS

The coroner commented that he had this matter extensively reviewed and while he bows to the expert knowledge of the medical personnel, he did agree that it would be appropriate to complete an MRI scan at the earliest opportunity. It was also his view that the deceased should have remained in hospital from the date of his initial admission until all testing had been completed in order to establish a correct and final diagnosis. The coroner did however acknowledge that it appeared that the chances of recovery were, from an early stage, very remote.

Case number

CSU-2010-DUN-000209
2012 NZ CorC 188

CIRCUMSTANCES

The deceased died in Dunedin Hospital of cardiac arrhythmia complicating severe ischemic coronary artery disease and a stent (a device to keep a clogged artery open) becoming re-clogged when a blood clot formed. The deceased had a 'complex coronary anatomy', and had previously suffered a myocardial infarction and undergone a coronary bypass nine years before his death.

He was acutely admitted to Dunedin Hospital four days before his death, but was originally under the care of the emergency department. The transferring doctor put the wrong consultant's name on the admission note, and it was not discovered that he was supposed to be a patient of the acute admitting consultant until mid-morning the next day. Consequently the procedures he needed in order to diagnose and treat his current heart problems took place four days after his admission. It was noted that there was no evidence that this delay played a role in his death. He was stable for several hours after the completion of the procedures, but suffered a coronary arrest in the evening.

An initial higher loading dose of a drug designed to prevent blood clotting was never administered to the deceased, having mistakenly not been charted. However, as he had been given a lower maintenance dose of the drug for four days before his procedure, it was found that, if this omission did contribute to his death, it would have been minor.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the Medical Director of Patient Services and the Clinical Leader of Cardiology at Dunedin Hospital that the Clinical Leader of Cardiology reinforces to relevant personnel the guidelines about consultant responsibility for admission.

He also recommended that the guidelines be adjusted to require that any acute admission/inter-hospital transfers to a consultant, other than to the acute team consultant rostered at the time of the admission, be first discussed with the acute team consultant so rostered.

Case number

CSU-2010-DUN-000318
2012 NZ CorC 200

CIRCUMSTANCES

The deceased died at Dunedin Hospital of pericarditis (an inflammation of the sac around the heart) and severe respiratory disease, secondary to rheumatoid arthritis, with congestive heart failure. She had been admitted to hospital 3 days before her death with shortness of breath and signs of heart failure. It was found that her decreased ventilation had caused a build-up of carbon dioxide in her blood, and fluid had collected around her heart. She had had persistent fluid build-up around her heart for much of her adult life as a result of the rheumatoid arthritis that she'd had since she was 18.

The next day her symptoms persisted and she was transferred to the Coronary Care Unit. The fluid was drained the following morning, but her condition did not improve and she continued to decline.

She had been prescribed Frusemide after her procedure to relieve breathlessness. It was inexplicably not administered until late in the evening, but this is unlikely to have had a material influence on her death.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the Cardiology Department at Dunedin Hospital that it consider the circumstances of the delay of about 11 hours in the administration of Frusemide to relieve the deceased's breathlessness in order to ensure that appropriate procedures representing best practice are in place.

Case number

CSU-2012-DUN-000131
2013 NZ CorC 70

CIRCUMSTANCES

The deceased died at Dunedin Hospital of haemorrhage and shock secondary to severe haemorrhage of the large intestine, ischaemic heart disease and multi-organ failure. He had been admitted to hospital for shortness of breath, and eventually the clinician suspected he may have a blood clot in his lungs. The deceased was given an infusion of Heparin, an anti-coagulant, in order to treat this. The dose given to the deceased was at the level regularly advised despite that fact that the consultant determined that his dose should be slightly lower. Shortly after being given the Heparin the deceased suffered gastrointestinal bleeding and declined severely.

It cannot be determined whether the deceased's sudden deterioration was the result of the slightly higher dose of Heparin. He was a very sick man and the condition of his heart was such that any slight health problem was likely to have catastrophic effects.

COMMENTS AND RECOMMENDATIONS

The coroner endorsed the following recommendations made in the Southern District Health Board's (SDHB) severity assessment code review:

- All attempts should be made to minimise error. The dose of Heparin prescribed was higher than that suggested by the consultant. If given this scenario as a hypothetical example some consultants may have prescribed a lower dose as was the case in this situation. Other consultants may have requested the guideline dose. In either case subsequent adjustments are made based on the first laboratory measurement. It is unlikely that the infusion dose charted here altered the outcome.
- Junior staff must be aware of the need to write thorough notes, including documenting patient assessment and patient plans clearly.
- Communication between staff is a perennial problem yet it remains imperative.

Case number

CSU-2008-WHG-000156
2013 NZ CorC 65

CIRCUMSTANCES

The deceased died at Bay of Islands Hospital of an intra-abdominal haemorrhage that was caused by the rupture of a cyst in her stomach. Her family, noting her worsening symptoms, called an ambulance, but the rural location of her home meant that it took around an hour for her to reach the hospital. On the way to the hospital it was also necessary to pick up another ambulance officer to better provide her with care.

During the journey, based on their initial assessment, the ambulance officers advised the hospital that her condition was 'stable', although she then deteriorated further. On the basis of this assessment there was no one to meet the ambulance when it arrived at the hospital, and the emergency receiving area was

locked. They got the deceased inside the hospital and onto a bed, and the daughter of the deceased got the attention of hospital staff, who immediately started CPR. However, the deceased could not be resuscitated.

The deceased's condition was very serious and would have needed medical attention beyond what Bay of Islands Hospital could have provided. The likelihood that she could have arrived at a more appropriate hospital in time to diagnose and address her condition before she died was very remote.

The status code initially given to the hospital by the ambulance officers was, on review, found to be incorrect. Her vital signs were abnormal enough on initial examination to warrant a status more serious than 'stable'. Furthermore, had hospital staff been advised of the deceased's deterioration, they would have been on hand to help with her arrival. Notwithstanding these issues, it was found that given the seriousness of her condition, the delay in treating the deceased ultimately did not contribute to her death.

COMMENTS AND RECOMMENDATIONS

The coroner recognised and accepted that the running of a St John Ambulance Service in rural areas has its difficulties with staffing levels, distances to services and limited resources. He commented that the trade-off to living in rural areas is that people have to travel long distances in some cases to emergency services, whereas those living in highly populated areas tend to have much quicker access to emergency services. The coroner noted that St John Ambulance provides the most valuable and vital service in the community.

The coroner commented that in this matter there was a genuine difficulty in trying to get the right amount of staffing to help the deceased, and then to determine what her status was before getting her to a hospital. As it was, the Bay of Islands Hospital provides the only accident and emergency service (after hours) for the district. However, the deceased needed far more specialised treatment which would have required her to cover a further distance to at least Whangarei Hospital.

St John Northern Region reviewed the status codes shortly after this unfortunate death. The objective was to ensure that the new status codes reflected the potential for threat to life, rather than purely how abnormal the patient's vital signs and physiology were. Therefore the new approach for ambulance officers when attending an emergency is to make an assessment as usual and then allocate a status code based on the threat to life.

The coroner noted the new status code table was issued to all vehicles and emergency departments replacing the old charts. However even if the new charts had been in operation, the status of the deceased's emergency was beyond what the hospital was able to offer in treatment.

Finally, the coroner commented that communication remains a very important aspect of providing care and attending to medical challenges like this case. He said that in any health system communication always remains a work in progress and has the highest priority as part of the working system. It can be the difference between life and death in some situations. He noted that the Northland District Health Board and St John Northern Region independently acknowledge the miscommunication.

Case number

CSU-2011-WGN-000203
2013 NZ CorC 58

CIRCUMSTANCES

The deceased died at Wellington Hospital as a result of an intracranial haemorrhage, accidently brought on by errors in medication. He had been diagnosed with having had a heart attack on the basis of a high sensitivity troponin T blood test (which tests for proteins released when the heart muscle has been damaged), although there were no other indicators. Originally the doctor had calculated twice the required dose of the prescribed medication and did not realise until after the dose had been administered. In response to this error the drug was withheld the next day. However, the deceased died three days after admission.

It was considered that the decision to diagnose and treat the deceased's condition on the sole basis of the troponin T test, when there were no other indicators, probably contributed to his death. Had this not occurred, the prescribing error would not have occurred, nor would the particular course of drugs have been started.

The treating house officer was not from New Zealand, had not been through the proper orientation process, and was not aware of the correct documentation to be filled out on the death of a patient. Subsequently the documentation following the deceased's death did not meet expected standards. The coroner's office was also not notified of these events until three weeks after the death.

COMMENTS AND RECOMMENDATIONS

The coroner endorsed the following recommendations made by the hospital's serious and sentinel events review team:

- The hospital should review and clarify the guidance available to medical staff across the organisation regarding the diagnosis and treatment of heart attacks of this type, including guidance related to high sensitivity troponin T testing. These guidelines should emphasise the importance of considering the full clinical picture (including the troponin T level) as well as the suitability of the patient for the choice of treatment. These guidelines should be agreed to between the emergency medicine, general medicine and cardiology services in consultation with laboratory services.
- The hospital's Chief Medical Officer should develop and implement a system to ensure a system is in place to check the accuracy and completeness of documentation, and the notification of patients' deaths within the hospital and health services.
- The hospital's human resources Resident Medical Officer Unit should review the orientation process for medical staff who commence at times other than the group intakes, and of medical staff who are new to New Zealand's health service, to ensure that all new medical staff receive a consistent and complete orientation.
- The medical services should review the medical handover process to ensure that the same consistent information is conveyed to both the house surgeons and the registrars.

The coroner commented that it is disappointing that this death was not initially reported to the coroner's office, as it is a well-established protocol that such events were reportable.

Case number

CSU-2009-WGN-00558
2013 NZ CorC 48

CIRCUMSTANCES

The deceased died at Hutt Hospital of congestive cardiac failure. She had a history of heart problems, and a month before her death was admitted to Wellington Hospital for a number of cardiac procedures. She was discharged to the Medical Unit at Hutt Hospital to recuperate.

Approximately two weeks after her discharge, the deceased suffered complications and was admitted to the Intensive Care Unit (ICU) when her heart rate became rapid with hypertension and leukocytosis (a high white blood cell count). Her condition stabilised and she was transferred to the Coronary Care Unit, and then to the Older Persons Rehabilitation Service (OPRS). On the morning of her death the deceased mentioned that she felt unwell and suffered a cardiac arrest. She was again transferred to the ICU, but suffered further cardiac arrests and died later that day.

The family of the deceased raised many issues relating to her initial discharge, the various transfers she underwent, and how their input into her care was received and dealt with. It was found that in all instances there had been appropriate communication between the different hospitals and departments, and that the clinical assessments of the deceased's condition and the appropriate place for her were of an appropriate standard.

Since this death, there has been a greater emphasis on ensuring that a particular case has been discussed with a consultant and clinical nurse manager before transfer between Wellington Hospital and Hutt Hospital. The issue of addressing family concerns about care has also been raised and reiterated at several nurse staff meetings and training sessions in the OPRS. Hutt Hospital has also tried to ensure that communication between the wards and families regarding the transfer of patients has improved so that this transition is smoother for both parties and their families.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this matter required lengthy evidence to be heard from the various health professionals and the family of the deceased. This process would have been avoided in part if, once again, there had been better communication between the family of the deceased and the various medical practitioners. The coroner commented that similar statements have been made in other recent findings. In general, the standard of medical care provided to the deceased was found to be satisfactory. However, the coroner considered it was understandable that the family wanted the issues raised to be the subject of scrutiny and comment.

Case number

CSU-2012-DUN-000090
2013 NZ CorC 77

CIRCUMSTANCES

The deceased died at Dunedin Public Hospital of severe heart failure. He was admitted to hospital three days before his death for a coronary artery bypass graft procedure, which took place the next day. During the procedure a malfunction caused an air bubble in one of the tubes. Though this was dealt with in theatre, after the operation the deceased had a problem coming off bypass and went into heart failure. Air was found in the cardiac chambers and even after its removal the deceased's cardiac function did not improve. His condition continued to deteriorate and he died.

The appearance of air bubbles during this procedure is not unusual and, should it occur, there is not usually a problem. It was found that it cannot be conclusively determined whether the malfunction and the air embolism it caused contributed to this death.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that a copy of this finding be forwarded to Southern District Health Board (SDHB) so that clinicians at SDHB learn from the lessons created by this death, and also that SDHB take a role in disseminating the finding to ensure that the complication identified during the procedure is drawn to the attention of the appropriate clinicians so that the circumstances do not occur again.

Aged and infirm care

Case number

CSU-2009-WGN-000326
2012 NZ CorC 197

CIRCUMSTANCES

The deceased died at her home of constrictive pericarditis (an inflammation of the membrane covering her heart), after not receiving her medication for four days. She suffered from multiple medical problems, and as a result had in-home nursing care provided to her by Capital Nursing and Homecare Limited. The last of her medication was given to her approximately four days before her death, and the nurses who visited her on subsequent days noted her lack of medication, but their service was unable to provide more.

The caregivers' only duty in relation to medication was to help her take it; the understanding was that the deceased's son would be responsible for uplifting it from the pharmacy. The carers had made him aware that the medication had run out; however, it was not the first time he had failed to collect his mother's medication. According to her doctors, failing to take her medication for several days would put the deceased at risk of severe health complications.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this case had taken some time to complete, partially due to the extensive police enquiries that were required in reviewing this matter. He was satisfied that the deceased received very good medical treatment, and he could not fault the care of the caregivers, who clearly formed a close relationship with the deceased.

The area of concern is around where it is known that a patient is at high risk if specific medication is not available for one reason or another. In these circumstances the coroner commented that the dispensing pharmacy should ensure that it has a robust process to record who was uplifting the medication on behalf of a client, and to ensure steps are taken if medication is not uplifted within a day of it being prepared. The coroner stated that it cannot be relied on that the client will have a reserve supply.

Case number

CSU-2010-WGN-000398
2012 NZ CorC 190

CIRCUMSTANCES

The deceased, who was living at Eldersea Lodge in Upper Hutt, died of acute pancreatitis. She became unwell and started vomiting and was at first placed in isolation because it was believed by her carers that she had a case of food poisoning. The vomiting continued the next day and the nurses asked the available doctor at the time to administer some anti-nausea medication while he was at the facility. Although this stopped the vomiting for a short time it resumed again and was specifically noted as green and bile-like. Staff tried to contact a doctor but were unsuccessful. The deceased then collapsed, became unresponsive, and was not able to be revived.

The facility did not keep notes of her condition and treatment on the days leading up to her death. There was also no follow-up assessment of her condition by a doctor after the anti-nausea medication was administered. It was considered that both of these steps would have led to a greater opportunity for her condition to be properly assessed by a doctor.

COMMENTS AND RECOMMENDATIONS

The coroner commented that while it is clear that the deceased had medical matters of some magnitude and that she was a very private person who did not complain, Oceania (the group of which the Eldersea Lodge was a part) has admitted that they failed to keep proper documentation of events that unfolded at the time, and have no doubt taken steps to correct this in the future.

Oceania did not think that there was a link between these failures and the ultimate cause of death; however, it is possible that if clear notes and records had been available to the doctor, given that the deceased had been vomiting over two days and that the vomit was of a green/bile nature, he may have been better informed and might have initiated a physical examination and/or admitted the deceased to hospital.

Case number

CSU-2010-CCH-000768
2013 NZ CorC 8

CIRCUMSTANCES

The deceased was a resident of Redcliffs Rest Home in Christchurch, where she died as a result of choking on a scone.

Two days before her death the deceased had been discharged from Christchurch Hospital. While she was in hospital she had been diagnosed with moderate to severe oesophageal dysphagia (swallowing difficulties), after an episode of aspiration pneumonia two months before her death. The diagnosis concluded that she had a high risk of aspiration of her food. Though she showed improvement, it was recommended that she have a soft diet and be supervised when eating.

When she was discharged to Redcliffs Rest Home there was no note about swallowing on the deceased's discharge summary. The permanent general practitioner locum at the rest home had understood that the aspiration pneumonia in hospital had occurred after vomiting and did not consider dysphagia a particularly high risk. Although there was mention of soft diet requirement on the nursing care assessment made when she arrived back at the rest home, staff were aware that she would eat her own lollies and biscuits.

COMMENTS AND RECOMMENDATIONS

The coroner commented that it is important that residents in rest homes receive the correct recommended diet and while the coroner had no evidence that the scone the deceased choked on was not part of her soft diet, it was clearly harder than she could manage and the consistency of it caused her to choke as she could not chew it. The coroner recommended to Redcliffs Rest Home that it reviews the contents of its soft diet in the light of this death.

The coroner further commented that she was uncertain what the communication difficulties between Christchurch Hospital and the GP were, but recommended that a copy of her findings be sent to Christchurch Hospital so it could consider whether it needs to review its discharge summary policies.

RESPONSE FROM CANTERBURY DISTRICT HEALTH BOARD

The coroner received a report from Canterbury District Health Board (CDHB), dated 5 March 2013 in response to her findings and recommendations. The report detailed the findings of a review done by the General Medical Team at Christchurch Hospital of the discharge summary procedures, as the coroner recommended.

The report noted that in this case an out-of-date *Nursing transfer of care* form had been completed for the deceased's transfer to residential care. Unlike the current form, this form had no box to tick for supervision requirements. There was also no timeframe indicated by the speech language therapist for required supervision during meals. The report received feedback from clinicians on these observations and made the following suggestions for improving discharge documentation:

- Nursing staff should use the latest nursing transfer form.
- The nursing transfer form should be updated to be aligned to the new standardised definitions of terminology for texture modified foods and fluids.
- Speech language therapists should identify the timeframe around supervision requirements.
- It should be recommended to junior doctors that they refer to the nursing hand over information for specific dietary advice in the discharge summary when swallowing has been a problem.

At the time of the CDHB's report, point 1 above had been completed and the remaining points were in the process of being followed up.

Case number

CSU-2012-DUN-000021
2013 NZ CorC 16

CIRCUMSTANCES

At the time of his death the deceased was a patient of Ranui Home and Hospital in Alexandra. He died when he choked on a piece of turkish delight that had been brought to him by his daughter. A carer had given him the sweet and then left the room to tend to another resident. When she returned the deceased was choking. No one on hand knew how to do the Heimlich manoeuvre and the attempts that were made to help him were unsuccessful.

At the time of the incident the registered nurse on call was not carrying her cellphone because it was charging at the nurses' station. There was, in addition, a slight delay in the pager message being transferred to the care wing of the hospital.

COMMENTS AND RECOMMENDATIONS

The coroner did not receive any evidence to the effect that it was unreasonable for the deceased to have been left alone while eating. Nevertheless he drew a number of issues raised by this case to the attention of Presbyterian Support Otago (PSO). In particular this case demonstrates to PSO, and to all other rest home operators and carers, the dangers of leaving a frail elderly patient, with compromised health, eating a food item which has the potential to choke them. The coroner also identified the need for PSO to continue to monitor, and upgrade as necessary, the emergency call systems operating at Ranui. He commented that a protocol must be established by PSO to ensure that patients in distress are attended to by suitably qualified nursing staff more immediately than was the case here.

The coroner recommended that PSO conduct a more intensive training regime for its caregivers. He commented that those looking after vulnerable elderly and frail patients must be instructed on immediate steps to take should such patients need help. Training should be given in techniques to clear the mouth and throat of food obstructions, how to do a Heimlich manoeuvre and how to start CPR resuscitation while waiting for the arrival of other support and more experienced nursing staff.

Case number

CSU-2010-PNO-000375
2012 NZ CorC 139

CIRCUMSTANCES

The deceased died from injuries he sustained when he was struck by a motor vehicle as he walked along State Highway 3 on the northern outskirts of Eltham. He and another resident had absconded from the secure dementia unit of the Mercy Jenkins Rest Home, where they lived. A motorist found the deceased being moved to the side of the road by his companion with obvious injuries, later found to be consistent with having been struck by a motor vehicle, and called an ambulance.

His carers at the time had no knowledge that he had absconded five times previously, or that he remained fixated on leaving the unit to go home. Accordingly there was no specific advice in place regarding the risk of escape that the deceased posed. His absence was also not noticed by staff for over 90 minutes, as the policy at the time was that residents were to be sighted by staff at the start of their shift and at meal times.

COMMENTS AND RECOMMENDATIONS

The coroner commented that she is satisfied that the rest home has taken appropriate steps to reduce the chances of future deaths in similar circumstances. The door to the unit through which the deceased escaped is now more secure than it was at the time. The coroner said that it is difficult to see what further steps can be taken in relation to that matter.

Further, the coroner said that staff in the secure unit are now required to sight residents every 30 minutes, and if this procedure is followed residents will not be able to be gone for 90 minutes before their absence is noticed. If residents do go missing there is still a process staff need to follow to ensure they are in fact missing before police are notified. The coroner commented however that this process involves staff making efforts to find the residents, so it is not as if nothing is being done in response to the absence.

The coroner recommended to Mercy Jenkins Rest Home that they initiate a process where all caregivers in the secure unit are specifically alerted to all instances when residents abscond from the unit so that they are fully aware of the residents' escape risk.

He also recommended that they implement individual care/sighting plans for residents whose security risk is known to be so significant – for example,

due to previous escape or persistent attempts to do so – that 30-minute sightings may not be sufficiently protective.

A further recommendation was made for the rest home to develop special search plans for specific high-risk residents having regard to their past behaviour and likelihood that they may rapidly leave the rest home property if they abscond from the secure unit.

Care facilities (other)

See also *self-inflicted* deaths below.

Child deaths

Case number

CSU-2011-DUN-00347
2012 NZ CorC 189

CIRCUMSTANCES

The deceased, aged just under 2 years old, died of severe head injuries which he sustained when a cow stood on his head on his parents' farm. His parents had put him in the office of their cow shed, with the door unlocked. While they were busy with their tasks, the deceased opened the door himself and found his way into the area where the cows were kept.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that a copy of this finding be forwarded to New Zealand Federated Farmers with his request that the organisation give the finding the appropriate publicity, and emphasise to its members the absolute need to take all appropriate care when supervising children and infants in a farm environment.

Case number

CSU-2012-PNO-000148
2012 NZ CorC 160

CIRCUMSTANCES

The deceased, a 10 month old, died at his home of a traumatic head injury he sustained when he was struck by a trailer being moved forward by a utility vehicle. It is believed that he was in the garage while his mother was elsewhere on the property and his father was out. It appears that he crawled out of the garage and was between the trailer and the vehicle. He was harmed when the trailer was moved forward by someone who was there to help the family move.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the only way striking the deceased with the trailer could have been avoided was if either he was under close supervision of an adult at all times and/or the driver had actually walked around the vehicle and the trailer carefully checking before he drove off. All too frequently this does not happen.

The coroner said that sadly this death serves as a reminder for the need for extreme caution when manoeuvring vehicles in areas where young children are likely to be – or for that matter where they are not likely to be – because young children have a habit of wandering everywhere and anywhere unless they are supervised closely at all times.

Case number

CSU-2010-AUK-000952
2013 NZ CorC 10

CIRCUMSTANCES

The deceased, a 22 month old, died from head injuries she sustained when she was accidentally run over by a motor vehicle that was being reversed by her father down the driveway at her home. When her father reversed the car he had checked his mirrors and his blind spot, and believed his daughter to be inside the house. It is not known whether the deceased was walking, crawling or stationary when she was hit.

COMMENTS AND RECOMMENDATIONS

The coroner commented that New Zealand has one of the highest recorded incidences of child driveway death and injury in the world. Safekids New Zealand and the Child and Youth Mortality Review Committee are two key organisations which are focused on preventing and reducing child death and injury from driveway incidents. The coroner noted that Safekids New Zealand (the injury prevention service of Starship Children's Health) have reported that it is estimated that every two weeks in New Zealand a child is hospitalised with serious injuries from a vehicle driving on a private driveway.

Furthermore, on average five children a year are killed by cars driving on private driveways in New Zealand.

Safekids' 2011 position paper *Child driveway run over injuries* identified three dominating factors associated with child driveway run-overs:

- human factors (including lack of child supervision, and the driver not seeing the child or being alert to the possibility of a child being close to the vehicle)
- vehicle design (including poor rearward visibility)
- property design factors (where there is inadequate separation between driveways and places which children access).

The coroner commented that this death serves as a tragic reminder of the importance of monitoring children around vehicles and checking for children before driving off. The deceased's father didn't check because he did not think that she was anywhere near the car, believing her to be safely inside. Safekids has highlighted the importance of always checking where children are before getting in the car and driving off. It has identified education as an effective way of raising awareness and changing behaviour. To this end it has developed a driveway run-over prevention resource which focuses on the key messages 'Know where your kids are before getting in the car, there's no going back. Check, Supervise. Separate'. In 2011/2012 it spearheaded a Driveway Run Over Campaign in conjunction with other agencies and the media to increase public awareness about driveway injuries. The coroner endorsed the key message from Safekids and the Child and Youth Mortality Review Committee that public education and awareness strategies about driveway safety should be increased and directed both to the public and to decision makers.

The coroner commented that another important aspect of the prevention of driveway deaths and injuries is emphasis on property design factors. This includes both modifications to improve the safety of existing driveway environments and safe driveway design. The 2011 Safekids position paper states that the only built environmental factor that has seen a reduction in the risk of driveway injury is where the pedestrian pathway has been separated from the driveway.

The coroner noted that at the address where the deceased died, a securely fitted gate at the top or bottom of the stairs leading to the front door would have prevented direct access onto the driveway from the front door. Fencing between the grass and the driveway would also ensure a play area for children separated from vehicle movements.

Deaths in custody

Case number

CSU-2011-HAM-000020
2012 NZ CorC 161

CIRCUMSTANCES

The deceased died at Waikeria Prison in Te Awamutu of asphyxia of an undetermined cause, which occurred in combination with being restrained by prison guards who were concerned for his safety. The deceased had an underlying condition of morbid obesity and heart problems, both of which potentially added to his difficulty breathing.

The deceased had been observed via CCTV from the master control room making a noose with a bed sheet and an alarm call was issued requiring incident response officers (IRO) to attend immediately. The officers were instructed not to enter the cell unless it was obvious that the deceased was attempting to self-harm. A senior officer was able to get the deceased to hand the ligature over. At this time a Control and Restraint team was being assembled to relocate the deceased to another cell so the IROs stayed to keep watch on the deceased's cell.

Approximately half an hour later a second alarm call was issued by master control in response to actions observed via the cell camera. The deceased was observed by master control to be slumped onto the floor, but this detail was not communicated to the officers. Due to concerns that he was self-harming the decision was made for IRO officers to enter the cell. The officers immediately attempted to apply control and restraint techniques on the deceased as he lay face down on the cell floor. The deceased violently resisted their attempts to move or restrain him. After five minutes of restraint he stopped struggling, but also had stopped breathing. The attempts to resuscitate him were unsuccessful.

When the deceased was found slumped over he was approached with caution by staff because of his history of threatening and aggressive behaviour. Because of his extended struggles staff were not able to assess his medical condition right away, as would usually occur after a prisoner had been restrained. Though staff took measures to mitigate the risk of asphyxiation involved in restraining a prisoner who is lying face down, at several points it would have been necessary for prison officers to apply some of their body weight to him.

However controlled and momentary such contact was, it cannot be concluded what effect such pressure would have had on the deceased's ability to breathe.

On his arrival at the prison the deceased had originally been assessed as 'at risk' of self–harm. However, that assessment later changed and he was transferred from the Kotuku Unit to the Remand Unit. His mental health record had not been obtained by staff, and so they might have had a reduced ability to understand his mental state when his at-risk status was being reviewed.

A report was issued identifying issues with the involvement of prison health services in the at-risk process, and documentation and communication between prison health services and custodial staff. Recommendations were made in the report of how these issues could be resolved, and these recommendations have been implemented.

COMMENTS AND RECOMMENDATIONS

The coroner considered whether he needed to make a recommendation in relation to the failure by Master Control to inform the team of officers about to enter the deceased's cell of the fact that the deceased had slumped onto the floor. Having considered the evidence provided, the coroner commented that he did not feel the need to make a recommendation. He said that he believed Waikeria Prison management would take on board his comments on this issue and would consider whether this issue needed to be addressed through staff training.

The coroner commented that, with any unnatural death that occurs in an institution, lessons can usually be found by closely examining the circumstances surrounding the death that relate to the systems or procedures of that institution. In this particular case, a comprehensive inspectorate report has been completed, as well as an inquest held with six days of evidence. The coroner said he was confident that if there were any other lessons to be gleaned by the Department of Corrections from this very unfortunate death, then the department will be aware of those lessons and will consider whether systems or procedures can be improved.

Case number

CSU-2011-PNO-000311
2013 NZ CorC 152

CIRCUMSTANCES

The deceased died at Levin Police Station of ischaemic heart disease and coronary artery atherosclerosis. At the time of his death he was in the process of being transferred from Hawkes Bay Remand Prison (HBRP) to the secure psychiatric unit at Purehurehu Prison. He had a history of mental health issues and had originally been remanded in custody at the secure psychiatric care unit at Hawkes Bay Hospital, but he had to be moved to HBRP after he assaulted someone.

Hospital and prison staff had disagreed about the appropriate place to address the needs of the deceased. He was being held at HBRP until his court appearance, and a psychiatric report was prepared during that time. At HBRP his behaviour started to deteriorate further and he was put under a 'no female contact' notice after assaulting a female staff member. As a result of this order he was unable to be examined by the female Prison Medical Officer.

The psychiatrist preparing the report for the court grew increasingly concerned about the deceased's condition and felt that he needed to be transferred to a secure psychiatric unit. The deceased was not eating and had been drinking very little. He was not moving but simply lying on his bed and not communicating. The psychiatrist was also concerned that no physical examination had been done. As Hawkes Bay Hospital was not necessarily willing to accept his admission, it was determined that Purehurehu was the best place for the deceased to go. The deceased would not give consent for a physical examination by the psychiatrist; however, on the day before his transfer the deceased was briefly assessed by a male nurse who did not note any abnormality with his blood pressure or pulse readings.

The deceased was transported to Purehurehu in a prison van. However, in an unscheduled check during the trip a nurse saw that he was unresponsive. He was taken to Levin Police Station for medical attention, where he died. There had been no prior indication that he was at risk of a cardiac episode, fatal or otherwise.

The prison van the deceased was transported in was not ideal transportation, but was the best on offer in the circumstances. Checks were done on him every half hour in the van, but its structure made checks difficult. Since this death prison vehicles have been

updated, and it has been confirmed that it is best practice to transfer a prisoner in a condition like that of the deceased by road ambulance. In this case safety concerns ruled this option out.

COMMENTS AND RECOMMENDATIONS

The coroner commented that had the deceased been transferred in an ambulance transfer vehicle or an ambulance his deteriorating medical condition would probably have been noticed earlier – although this is not certain. If that had happened, the deceased could have been helped more promptly. Time is always of the essence with cardiac emergencies. The deceased may have survived.

He also noted that the ability of the Department of Corrections to transfer the deceased in an appropriate vehicle was severely compromised because none were available. Notwithstanding the evidence before the coroner, he suspected that when a similar situation occurs again, as it is likely to, there will still be problems and issues relating to transfer.

The coroner hoped that the department would look to obtain a small number of much more suitable vehicles for vulnerable inmates. Such vehicles could be centrally located at distribution points on both the North and South Islands so that they could be reasonably available to all prisons, without necessarily having such a vehicle located at every prison. The coroner refrained from making a recommendation about this as he felt he lacked relevant expertise. However, he noted that the department will have access to such expertise, and that the deceased's death presents the department with the opportunity and the challenge to make a significant improvement (both in a social and a physical sense) in respect of transport.

Case number

CSU-2009-AUK-000201
2013 NZ CorC 28

CIRCUMSTANCES

The deceased died at Auckland Regional Prison (ARP) as a result of cerebral hypoxia caused by self-strangulation, using material torn from an anti-suicide gown. He had been transferred to ARP from the Special Needs Unit at Auckland Central Remand Prison two days earlier. At the time of his death he was being held on remand at ARP's at-risk unit and was due for sentencing the following day.

During the day the deceased covered the security camera in his cell with a piece of wet toilet paper. Although staff were aware of this, no action was taken to rectify it. In the evening the officer on duty went to check on the deceased after hearing a thud coming from his cell and found the deceased standing behind the cell door with a cloth cord around his neck. The officer went to his work station to request permission to unlock the door and to have three additional officers help him, as per the usual procedure. The cell was unlocked about 10 minutes later once the last officer had arrived. At this point the deceased was lying on his back on his mattress. The officers removed the cord from his neck, and found that he had no pulse or respiration, and was unresponsive. He was also bleeding from the head and appeared to have struck himself against the wall. CPR was unsuccessful, and he was declared dead by ambulance personnel half an hour later.

The deceased was considered to be a particularly difficult prisoner who was incredibly challenging to manage. His behaviour was at times unpredictable and irrational, which meant he needed to be managed with extreme caution. It was for this reason that his management plan stipulated that his cell door should only be unlocked when four corrections officers were present. The Prison Services Operations Manual provides for an exception to protocol in cases of emergency, which would allow immediate unlocking on advice from the on-call manager. It is, however, unclear whether this provision is subject to a later one, which provides that staff must not intervene where they feel their safety is not assured, and must instead wait for backup. In any case, the officer present at the time was not aware of an exception to the usual procedure of unlocking cells. Had he been aware, it is possible that the cell door might have been opened earlier.

The day before his transfer to ARP the deceased had attempted to strangle himself in a similar manner and as a result was unlawfully placed in a waist restraint. He was transferred to ARP for his own safety and so that a tie-down bed could be used to better restrain him. There had been no consideration that another facility might be more appropriate, nor was his case discussed with the Regional Forensic Psychiatry Services. The fact that the deceased had previously attempted self-strangulation was not known to the on-duty officer at ARP, nor was it a part of the deceased's at-risk management plan. The health issues of the prisoners are, as a matter of policy, not shared with the officers on duty.

The deceased's treating psychiatrist observed him on the day of his death to be exhibiting paranoia and psychotic-like symptoms. The psychiatrist considered that it might be best for the deceased to be transferred to the Mason Clinic, which was responsible for treating prisoners with mental health concerns. He also considered that the deceased should be placed on continuous monitoring until he was no longer at risk of self-harm. Neither of these possibilities was really discussed with prison staff.

It is possible that restraints used by staff at Auckland Central Remand Prison had an adverse effect on the deceased's mental health, but the relationship of this to his decision to harm himself or take his own life can be neither excluded nor confirmed. It is not clear whether the deceased formed an intention to commit suicide, and it is considered possible by his treating psychiatrist that his actions were an attention-seeking gambit or the result of a psychotic episode.

Since these events there is a greater emphasis on active collaboration between the Department of Corrections and the Regional Psychiatry Services, to better manage the placement and treatment of prisoners. There is also a tactical response team available 24/7, allowing for quicker response times of additional staff members. It is now prison policy that a prisoner is monitored continuously if their camera is obstructed, until the obstruction is removed.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the Chief Executive Officer of the Department of Corrections that in addition to the requirements of M.05.03.04 of the *Prison Services Operations Manual*, prisoner risk management plans should accurately record the state of a prisoner's physical and mental health and those behavioural or other issues that may place him or her at risk. The plans should clearly state the nature and degree of the risks posed to the prisoner (or others), the kinds of events or signs that may precede deterioration in health or safety, requiring immediate re-assessment, and any necessary interventions (including monitoring).

He also recommended that the exception provision contained in paragraph 4 of S.06.04 (Prisoner cell and location check) of the *Prison Services Operations Manual* and the provision of IR.01.01 (Initial incident response) of the manual be reviewed with a view to defining the proper relationship between the two provisions and determining whether the former should be subject to the latter and, if so, to what extent.

He also recommended that all prison officers be reminded of the exception provision contained in S.06.04 of the manual (relating to the unlocking of prison cells at night), authorising immediate unlocking in a civil defence emergency or critical incident where a prisoner is in imminent danger or where, during a scheduled prison cell and location check, a prisoner's location or physical wellbeing cannot be ascertained by looking through an observation window.

The coroner authorised publication of particulars of this death as he considered that it is important that the public should have confidence in the New Zealand prison system and the provision of prison and forensic mental health services. Where there may be inadequacies or deficiencies in the delivery of those services, it is desirable that the public should know that the reasons for such inadequacies or deficiencies have been looked into and that steps have been taken to ensure that they do not occur again. Identifying details of one of the frontline officers were prohibited from publication.

RESPONSE FROM THE DEPARTMENT OF CORRECTIONS

The coroner received a report from the Department of Corrections, dated 7 June 2013, in response to the findings and recommendations made in the above case. The report detailed how and to what extent the department was implementing the recommendations the coroner had made, dealing with each recommendation individually. A further update on progress regarding these recommendations was provided to the Office of the Chief Coroner on 23 December 2013.

In relation to the recommendation about prisoner risk management plans, the department reported that several initiatives to reduce the risk of suicide and self harm are being trialled or introduced, including:

- A shared management model for 'At Risk Units' between Health and Custodial Services at Whanganui Prison and Springhill Correctional Facility. The model will take a holistic approach to individuals, their mental health and social issues, and will continue after the prisoner has exited the At Risk Unit. Each prisoner will have a care plan that focuses on their transition from the unit, with a long-term goal of reintegration into the community. These care plans will be discussed daily with various relevant parties, and, if their condition allows, the prisoner themselves.

  Early indications from the trial of this model are that it has made a significant improvement in the

wellbeing of the prisoners, and there will be a review of the results with a view to extending this model to all other sites. This is expected to happen by the end of the year, and until the nation-wide implementation the department will record in the At Risk Management Plan any known behavioural issues, historical facts that have relevance to the management of the prisoner, or events or signs that may indicate that the prisoner is at risk, and the actions staff will need to take in response.

In the update provided in December 2013 the department stated that it is currently reviewing the shared management model for At Risk Units that has been trialled at Whanganui and Spring Hill Corrections Facility to determine the next steps for this model.

The department also said that it has amended the M.05.03.Form.02 of the *Prison services operations manual* to record specific behaviours observed and the activities to be undertaken when assessing the at-risk status of a prisoner. This includes any self-harm behaviours that the prisoner previously demonstrated and what steps were taken to minimise the risk of additional self-harm. Staff have been advised of these changes through *Frontline*, the department's weekly channel for communicating operational updates to Corrections services staff.

- The department has also introduced the Suicide Preventions Framework, the purpose of which is to reduce the rates of suicide and suicidal behaviour by offenders in prison and the community, and minimise its harmful effects on others. Some of the initiatives under this framework are:
  - develop a model of care for vulnerable prisoners in mainstream units to minimise the number of prisoners transferred to At Risk Units
  - develop tools and resources that can be used by staff, prisoners and their families following a suicide or suicidal behaviour
  - review training material available to mainstream and At Risk Unit staff regarding suicide, suicidal behaviour and mental health issues
  - conduct a follow-up evaluation of the risk assessment tool
  - develop better joint working between prisoners and probation to ensure information is more effectively communicated when offenders are transitioned from prison into the community
  - develop community-based resources for probation officers working with people at risk of suicide and suicidal behaviour
  - strengthen relationships with community agencies including aligning the department's approach with the Ministry of Health's suicide prevention strategy
  - establish a Suicide Committee, chaired by the Director of Offender Health.
- A new risk assessment tool, developed by a working group, was implemented in 2011. The process consists of a reception risk assessment and a review assessment tool, both of which involve consultation with health staff. A review assessment occurs when certain events occur, or if staff have concerns.

  Training includes how to complete the tools, how to identify signs of risk, what questions to ask, and there is a refresher course provided every two years. New recruits go through this training as part of their initial training.

  A Mental Health Screening tool was also introduced in 2012, and has been successfully used to identify prisoners with moderate to serious mental health needs. In the first six months 4021 of these screenings were administered and of these, 30% were identified as requiring further assessment.
- The department conducted a review of at-risk clothing and bedding in 2012, and a new range of at-risk clothing and bedding has been implemented nationally. Since this some issues were identified with the mattresses initially supplied and at the time of their response the department was in the process of re-procuring at-risk mattresses.

In relation to the recommendation made about the clarification of paragraph 4 of S.06.04 and IR.01.01, the department clarified the nature of these exemptions. The current exemptions are not true exemptions for prisoner cell and location checks (PCLC), during which if an incident occurs incident response procedures will apply. A critical incident (one of the exceptions to the usual unlock procedure) is not considered to be a prisoner-related incident. When responding to a prisoner-related incident, staff must consider their own safety first. This is unlike a civil defence emergency, when all prisoners are immediately unlocked to preserve life. The department said that a review will be conducted to clarify Incident Response Procedures, what types of incidents are critical incidents, and how they are to be responded to.

In the December 2013 update provided to the Office of the Chief Coroner the department said that the exceptions have now been reviewed. As a result of this review, the IR.01 initial incident response

procedures have been amended to include instructions on emergency unlock (previously contained in S.06 Musters, PCLC and prisoner location checks – PLC). PCLC and PLC are measures to manage the safety and security of prisons covering search processes and checks. These amendments now ensure that when an incident is identified during a PCLC or PLC, the IR.01 initial incident response procedures will apply.

In relation to the recommendation that officers should be made aware of the above mentioned exemptions, the department assured the coroner that once the review has been completed, staff will be made aware through the appropriate channels. The department clarified that circumstances 'where, during a scheduled prison cell and location check, a prisoner's location or physical wellbeing cannot be ascertained by viewing through an observations window' is not an exception provided for in the Prison Services Operations Manual. In such a situation the officer in charge of the site must be contacted to approve the unlocking of the cell. The department stated that this matter would be clarified in the review.

The update provided by the department in December 2013 stated that S.06 Musters, PCLC and PLC have been amended to remove the instructions on emergency unlock, as it is accepted that if the cells are to be unlocked for a civil defence emergency, the direction will come from Master Control. For all other emergency unlocks (for example, incidents), staff are to follow the IR.01 initial incident response processes. As with the other recommendations, staff have been informed of these changes through *Frontline*.

Drugs, alcohol or substance abuse

See also *mental health issues*, *overseas deaths* and *transport-related* deaths below.

Case number

CSU-2011-DUN-000538
2012 NZ CorC 185

CIRCUMSTANCES

The deceased was found dead in his home after having suffered a fatal cardiac arrhythmia. He suffered from serious cardiac problems and although he had sought medical treatment, he often did not attend his specialist appointments and was non-compliant with medical advice. Due to pain in his leg he self-medicated heavily with non-prescription drugs, against the advice of his health care professional. It is unclear what role his self-medication played in his death.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that a copy of this finding be forwarded to the Minister of Health so that the ministry could further publicise both the dangers of taking non-prescription medication in amounts in excess of those which are recommended by the manufacturers, and the dangers of individuals failing to heed medical advice and self-medicating to the exclusion of taking prescribed medication and treatment.

Case number

CSU-2012-DUN-000057
2012 NZ CorC 115

CIRCUMSTANCES

The deceased died in her home of an overdose of the drug Codeine, taken in conjunction with other prescribed drugs, and alcohol. She had been last seen in her lounge the night before, using her computer while drinking a beer, and the next morning she was found lying on the floor in the living room.

The drugs and alcohol she consumed combined to have a depressive effect on her central nervous system which was fatal.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that a copy of this finding be forwarded to the Ministry of Health so they could consider enhancing existing publicity programmes which draw to public attention the dangers of taking prescribed drugs in quantities which exceed those specified in the prescription. The danger of mixing prescribed drugs which have a central nervous system depressant effect and alcohol, which has a similar effect, should also be brought to public attention.

Case number

CSU-2010-CCH-000333
2012 NZ CorC 164

CIRCUMSTANCES

The deceased died in her son's home as a result of anoxia (lack of oxygen), due to alcohol-induced depression of her respiratory system. She had been drinking heavily intermittently throughout the day and a half preceding her death, and ended up collapsing while having a shower.

Her blood alcohol level was approximately 5 times the legal limit for drivers in New Zealand, and when consumed in such large quantities, alcohol can in inhibit the nerves which control breathing. The deceased also suffered from asthma which could have exacerbated the anoxia.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this death was directly attributable to the amount of alcohol consumed by the deceased. It is a constant source of concern to her and other coroners to see the needless waste of life caused by any drug, but in particular alcohol, which is readily available even in supermarkets but carries no labels warning that drinking it in large amounts can kill you.

The coroner observed that there have been recommendations made by other coroners in the recent past for warnings on alcohol containers but, as yet, these recommendations have gone unheeded. Yet, as shown by this death and by many previous ones, alcohol is an inherently dangerous substance as it can kill when consumed in excessive amounts. The coroner stated that it seems to her that the makers of products containing an inherently dangerous substance have an ethical obligation to warn consumers of its dangers.

The coroner recommended to the Health Promotion Agency that the agency advises the Government and the alcohol industry that every container containing alcohol should be labelled with an explicit warning that excessive use of alcohol can kill you.

Case number

CSU-2012-DUN-000010
2012 NZ Corc 191

CIRCUMSTANCES

The deceased died at his friend's home of a drug overdose. While at his friend's house he injected himself with a dose of morphine for recreational purposes, and soon slumped over and fell to the floor. The amount of morphine found in his blood would have been sufficient to prove fatal.

COMMENTS AND RECOMMENDATIONS

The coroner commented that he would like to draw to public attention the dangers faced by people who self-prepare and self-inject illegal drugs. It is impossible for the dose of self-prepared drugs to be calculated exactly and the tolerance between a dose intended to create the perceived recreational effects of the drug, and a fatal dosage, is slight.

He recommended that the public be warned not to take drugs not prescribed for them, and noted that the practice of injecting morphine was, in the circumstances, illegal.

Case number

Coroners Act 1988
2012 NZ CorC 192

CIRCUMSTANCES

The deceased died in hospital of a brain injury caused by oxygen deprivation due to clozapine toxicity. This was likely induced by the ingestion of so-called 'happy pills'.

While socialising at a pub the deceased was given some pills by someone who had bought the pills earlier that evening from another individual at the pub. During the evening the deceased became ill, collapsed and was taken to hospital, as were the two other men that had ingested the pills. Because of the severity of his condition, his family eventually agreed to withdraw life support.

The pills he took were found to be clozapine, an anti-psychotic drug that can have a wide-range of potentially toxic effects, especially in users that have not built up a tolerance to it. Someone who does not take the drug regularly could take what might be considered a 'normal' dose for one who does, and experience serious, even fatal, side effects, as appears to have been the case here.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this death starkly illustrates the dangers of people taking substances offered to them by others, the nature of which cannot be known. The terms 'happy pill' and 'recreational

drug' are misnomers. In many ways, as this case illustrates, taking these kinds of drugs is like playing Russian roulette.

He also noted that the Government is to be complimented for the firmer policy that it is now taking under the leadership of the associate Minister of Health in relation to the manufacture and sales of so-called 'party pills'.

Case number

CSU-2011-ROT-000039
2012 NZ CorC 198

CIRCUMSTANCES

The deceased died of hydrocarbon (butane) inhalation. His father found him deceased in his bed, with an empty aerosol can near him, and a cigarette lighter on his person. One 'huff' from either could have been fatal. This was the first time the deceased had ever been linked to butane inhalation. It is likely he was merely seeking some kind of euphoric effect.

COMMENTS AND RECOMMENDATIONS

The coroner commented that in his view this was an issue of education and responsibility. He recognised that inhalants and propellants are so widely prevalent and available that any ban on sales may be totally impractical. The coroner identified that huffing is a very serious problem and noted that it is not only a problem within New Zealand. He said that he was especially alarmed that young people are unaware of the life-threatening risks they are exposing themselves to from huffing and killing themselves in this way.

The coroner noted that in many instances families are simply not aware that their young loved ones are indulging in this practice of huffing. The dangers of the practice do not appear to be fully appreciated and that is why an educative programme is, in the coroner's view, probably the most instructive way of getting the necessary messages through in an educative way, and in a way which stresses harm prevention.

The coroner noted that he has dealt with other cases of butane toxicity and that New Zealand coroners dealt with 28 deaths due to butane toxicity during the years 2007–2011. Since 2000 there have been over 60 deaths. The NZ Drug Foundation notes that playing around 'huffing' is like playing Russian roulette. This is because butane is so fast acting and unique; you can overdose very quickly. The coroner said that these statistics are frightening and decisive action is needed to help reduce these entirely preventable deaths of New Zealand's young people. There needs to be a carefully coordinated approach to help prevent these deaths and other serious harm that can occur. That education has to encourage young people wanting to not try huffing, but it has to be comprehensive and include the indicators and signs of solvent use.

The coroner recommended that these findings be forwarded to the Ministers of Youth Affairs, Social Development and Health for them to take the appropriate coordinated, cross-agency educative, and possibly regulatory approach.

Case number

CSU-2011-CCH-000967
2013 NZ CorC 21

CIRCUMSTANCES

The deceased died at her home of an acute haemorrhage in a membrane around her brain, which occurred in the context of several alcohol-related falls that had happened in the week leading up to her death. The last fall occurred the evening before her death while she was showering. She declined medical assistance following the fall and was found deceased in her bed the next morning.

The deceased suffered from alcoholism and drank between one and one and a half three litre casks a day. Before her death she had been making attempts, supported by her GP, to wean herself off alcohol and had enrolled in an alcohol detoxification programme.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this death was attributable to the amount of alcohol consumed by the deceased. She commented that it is a constant source of concern for the coroner and her colleagues to see the needless waste of life caused by any drug, but in particular alcohol, which is readily available even in supermarkets but carries no labels warning that drinking it in large amounts can kill you. In this case had the deceased not been intoxicated she would likely not have fallen in the shower, hit her head and died.

The coroner recommended to the Health Promotion Agency (care of its Chief Executive Officer and also its Board) that the agency advise the Government and

the alcohol industry that every container containing alcohol should be labelled with an explicit warning that excessive use of alcohol can kill you.

Case number

CSU-2011-DUN-000502
2013 NZ Corc 5

CIRCUMSTANCES

The deceased died from acute cardio-respiratory failure caused by an accidental overdose. He lived in a boarding house, and was discovered when a neighbour came to see him and found him lying on the floor and unable to be revived.

The deceased had a history of illegal drug use and benzylpiperazine (BZP) was found in his bloodstream at a level well above the fatality level. BZP is a synthetic amphetamine-type drug, compounds of which were the major components of (now banned) 'party pills'.

COMMENTS AND RECOMMENDATIONS

The coroner had no evidence that would persuade him that the deceased self-administered BZP with an intention of ending his own life. He found that it was significantly more likely that the BZP was self-administered for recreational purposes, with the intention that he obtain some benefit.

The coroner noted that there is a significant difficulty with the self-administration of these kinds of drugs (which are now illegal) in that there is little quality or quantity control on their manufacture. Analysis has shown that drugs sold illegally can have significantly varying strength and may also be significantly contaminated with other substances and other drugs. The coroner commented that people who take illegal drugs for recreational purposes must be warned that the consequences of ingestion are difficult to predict.

The coroner recommended that a copy of this finding be forwarded to the Centre for Adverse Reactions Monitoring (CARM) for the information of that organisation.

He also recommended that the media publicise the fact that drugs designed to be used for recreational purposes rather than medical purposes are not manufactured to any legal, or enforceable, quality or quantity standard and that the drugs themselves may be contaminated. The quantity of the active ingredient of the drug may not be able to be predicted from the amount of the drug ingested. The public must be warned to consume only drugs prescribed for them by appropriately qualified medical practitioners and to take these drugs solely as directed in the prescription.

RESPONSE FROM THE CENTRE FOR ADVERSE REACTIONS MONITORING

The Centre for Adverse Reactions Monitoring (CARM) provided the following response to the coroner's findings and recommendations.

Although this report has now been recorded in the CARM database, CARM does not traditionally receive reports for 'party pill-type' products other than occasional/sporadic reports. The work of CARM had focused on products that are used in the therapeutic context. These are either for registered therapeutic products as a consequence of the normal prescribing or errors that have occurred in their prescribing, dispensing or administration/use, or for non-registered products (for example, herbals and alternative medicines) which are used by the public in a therapeutic context.

Case number

CSU-2011-AUK-001728
2013 NZ Corc 19

CIRCUMSTANCES

The deceased died of alcohol toxicity, which occurred when he was visiting a family member's home for a social gathering. During the course of the evening, the deceased was noted to be consuming a significant quantity of alcohol, which included a mixture of beer, wine and spirits. Sometime during that evening he lay down in the rear compartment of his motor vehicle. The next morning his partner came out to find him deceased.

The deceased's blood-alcohol concentration was four times the legal limit for an adult driver at the time. Alcohol is a depressant of the central nervous system and exerts its effects in a manner similar to that of general anaesthetics. At a high concentration alcohol can inhibit the nerves that control breathing. Blood-alcohol concentrations within the range of 300–500 mg per 100 mL are much more common in alcohol-related deaths than concentrations outside this range. The deceased's blood-alcohol level around the time of death fell squarely within that fatal range.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this death was directly attributable to the considerable quantity of alcohol consumed by the deceased. He was probably unaware of the inherent danger of consuming a large quantity of alcohol. The coroner said that it is a constant source of concern to him that a product that can result in the death of the consumer when drunk in excess is able to be sold without any warning to the consumer. The coroner had made a recommendation on this point at least once before to no effect. He felt compelled to reiterate the need for such an inherently dangerous product to contain a warning to consumers.

The coroner recommended to the government agency responsible for governing the sale of alcohol that the appropriate government agency considers making it a legal requirement that every container of alcohol carry a label warning consumers of the risk of death if an excess amount is consumed.

He also recommended to the Alcohol Advisory Council of New Zealand that all agencies concerned with the potential harmful effects of excessive consumption of alcohol institute or support an education campaign alerting the general public to the risk of death associated with excessive consumption of alcohol.

RESPONSE FROM THE HEALTH PROMOTION AGENCY

The coroner received the following report from the Health Promotion Agency (HPA), dated 19 November 2012, in response to his findings and recommendations:

- The Alcohol Advisory Council's (ALAC) functions were taken over by the Health Promotion Agency (HPA) as of July 1 2012. However, ALAC has for a number of years run a social marketing campaign encouraging moderation in alcohol consumption. The 'Ease up the drink' campaign has been off air since February, after running for 2 years and achieving high public awareness. The HPA is currently developing the next phase of the campaign which should on air next year.
- With regard to the recommendation that the appropriate government agency making it a legal requirement that every container of alcohol carry a label warning consumers of the risk of death if any excessive amount is consumed, I note that recommendation is directed at the government agency responsible for controlling the sale of alcohol. While that agency is the Ministry of Justice, the Ministry of Primary Industries is responsible for food labelling, which includes alcohol.
- For your information in 2006 ALAC lodged an application with Food Standards Australia and New Zealand (FSANZ) to require a health advisory label on alcoholic beverage containers advising of the risk of consuming alcohol when planning to become pregnant and during pregnancy.
- The application was overtaken by a comprehensive review of food labelling law and policy by the Australia and New Zealand Food Regulation Ministerial Council (Ministerial Council) over the past couple of years.
- In January 2011 the Review Panel released their report with 61 recommendations to the Ministerial Council. Four of the 61 recommendations have implications for alcohol product labelling. In summary the Review Panel recommended that:
  - Generic alcohol warning messages be placed on alcohol products but only as an element of a comprehensive multifaceted approach.
  - All alcohol products contain a message warning of the risks of consuming alcohol while pregnant.
  - The energy content be displayed on all alcohol products.
- The Ministerial Council released its response to the Food Labelling Law and Policy Review Panel's recommendations at the end of 2011.
- The Ministerial Council said pursuing warnings about the risks of consuming alcohol while pregnant was prudent, but that industry be given a period of two years to adopt voluntary initiatives before regulating for this change. We continue to work with the industry and the Ministry of Primary Industries.

Case number

CSU-2010-AUK-001064
2013 NZ CorC 59

CIRCUMSTANCES

The deceased died in hospital of multi-organ failure, caused by an overdose of prescribed medication. He had been prescribed colchicine to treat gout. Seven days before his death he suffered a particularly bad attack of gout and called his sister to fill his prescription. Two days later his gout had improved, but he was experiencing vomiting and diarrhoea. Six days after having suffered the attack of gout he was found in his home, unable to get up. He was taken to hospital and died the next day.

The deceased had been prescribed colchicine 500 mg tablets three times daily for over six years. His last prescription (for a three-month supply) was provided by his doctor just over a week before his death. Colchicine is a medicine that can be fatal at high doses, and is generally only recommended for intermittent use. The deceased had been prescribed it long-term, and twice his GP had advised him to come off it in favour of another medication. The deceased could not be persuaded, and had taken the appropriate dose reliably for years. His death was, however, consistent with colchicine poisoning.

Vomiting and diarrhoea are warning signs of colchicine toxicity, and patients are advised to stop taking it immediately if these symptoms develop. It seems the deceased was either unaware of this or had forgotten.

COMMENTS AND RECOMMENDATIONS

The coroner commented that colchicine is a 'high-risk' medicine as it can cause significant harm when not used correctly. The deceased's death highlights the risks associated with this drug. Whether it should be able to be readily prescribed for long-term use for gout prophylaxis and whether the number of tablets that are able to be prescribed at one time (or obtained by the patient from the pharmacy) should be limited, are issues which the coroner feels merit consideration.

Case number

CSU-2012-DUN-000335
2013 NZ CorC 68

CIRCUMSTANCES

The deceased died at her home of a medication overdose, and was found deceased in her bed in the morning by her partner. She had been prescribed dihydrocodeine (DHC) to deal with the severe pain she experienced, though in the six months leading up to her death her partner noted that she had been taking more than the prescribed dose. On the night before her death she was described by her partner as appearing 'out of it' and had to be helped to bed.

She was described as having been in a similar state for the three or four previous nights. Her partner had noted that in the days before her death the level of tablets in the shared container was going down by more than eight tablets per day (he and the deceased were each prescribed four tablets per day). Fatal levels of her prescribed medications were found in her bloodstream.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that the media publicise the dangers associated with taking drugs in excess of the prescribed quantities.

He also forwarded a copy of this finding to the Centre for Adverse Reactions Monitoring (CARM) to add to its database.

Electrocution

Case number

CSU-2012-CCH-000077
2013 NZ CorC 22

CIRCUMSTANCES

The deceased was electrocuted when he accidentally made contact with an 11 kV power line that had collapsed and was hanging across a paddock on his farm. His wife and son found him and called emergency services, but all attempt to preserve the life of the deceased failed.

The line that electrocuted the deceased was a high voltage SWER (single wire, earth-return) overhead power line, which is a single 'live' conductor. The SWER line, being only a single conductor, is less visible if it collapses than a two or three line system. MainPower, the body responsible for distributing electricity in New Zealand, found that the line collapsed because of a fire at the top of the wooden pole. The fire occurred when the gap between the line and an uninsulated part of the flammable pole was bridged by a bird. This is not the first pole-top fire that had occurred in this way. Following these events the Department of Labour undertook to prepare an industry alert highlighting the hazards of SWER installations.

COMMENTS AND RECOMMENDATIONS

The coroner noted that MainPower has since redesigned and installed new pole-top insulators on the Inland Kaikoura Road SWER line, so that the clearance between the line and the nearest uninsulated part of the pole is too wide to be bridged by a bird. Surveys of other parts of the MainPower SWER line systems and similar upgrades are also being implemented.

The coroner endorsed these actions by MainPower and the education actions undertaken by both MainPower and the Department of Labour. She considered that they will help reduce the chance of similar deaths.

RESPONSE FROM THE MINISTRY OF BUSINESS, INNOVATION AND EMPLOYMENT

The Ministry of Business, Innovation and Employment provided the following response to the coroner's findings and recommendations.

I note while you have not made any recommendations in your findings, the Ministry continues to consider how the issues raised in this case might be addressed. A new factsheet has been published in regard to SWERs. That fact sheet can be found on the Ministry's website. Your findings have been registered on the Ministry's database.

Fall

See also *product-related* and *recreational/leisure activities* and *work-related (other)* deaths below.

Fire-related

Case number

CSU-2012-HAM-000429
2013 NZ CorC 54

CIRCUMSTANCES

The deceased died at her home of smoke inhalation. She was asleep in the kitchen when a fire broke out in her home. The other occupants of the house were able to get out of the house when alerted to the fire.

The fire was caused by a plug overheating in the lounge of the house. The house was fitted with smoke alarms, and Housing New Zealand records show that these alarms were last checked in March 2012. However, the batteries in the smoke alarms may have since been removed, reducing the deceased's chance of being woken in time to survive the fire.

COMMENTS AND RECOMMENDATIONS

The coroner reiterated the comment made by the National Manager of Fire Investigation and Arson Reduction for the New Zealand Fire Service, that it is of grave concern to the Fire Service that occupants of Housing New Zealand properties tend to disable the smoke alarms by removing the batteries.

The coroner recommended to Housing New Zealand that they ensure that properties owned by them and used for residential purposes be fitted with hardwired interconnected smoke alarms.

Case number

CSU-2012-DUN-000321
2013 NZ CorC 36

CIRCUMSTANCES

The deceased died in hospital of burns and inhalations injuries that occurred when he lit a cigarette while his supplementary oxygen apparatus was active. The machine, which he needed to help him with his breathing, created an oxygen-risk environment which allowed the small flame to become a substantial fire. He was taken to hospital with burns to his head and neck, and he died of his injuries there.

When he was instructed on the home use of supplementary oxygen by a respiratory nurse specialist the deceased said that he smoked about five cigarettes a day. He said he was aware of the safety aspects regarding smoking with supplementary oxygen in the vicinity and that he never smoked with the oxygen turned on. He also had been provided with written safety instructions.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this death has created a lesson. People using domiciliary prescribed supplementary oxygen should learn from this experience and the example, and must exercise even more care to ensure that they do not smoke cigarettes while breathing the oxygen, and take extreme care to ensure that no flammable source is introduced to the area in which the oxygen is flowing to allow a similar event.

The coroner recommended that this finding be forwarded to the New Zealand Fire Service for its information; there is an obvious lesson to be drawn to public attention.

He also recommended that this finding be forwarded to Southern District Health Board (SDHB). He made no criticism of SDHB and merely intended to enlist their support in drawing to the attention of all respiratory physicians and support staff the serious consequences created for patients by their smoking while using the supplemental oxygen.

Homicide or inter-personal violence

Case number

CSU-2009-HAS-000107
2013 NZ CorC 175

CSU-2009-HAS-000111
2013 NZ CorC 176

CIRCUMSTANCES

Two men died of gunshot wounds following a police siege in Napier. One of the deceased was a police officer who, while carrying out a warrant to search for drugs at a residence, was shot by the occupant of that residence. After the subsequent protracted siege and extensive negotiations, the occupant took his own life by way of a single self-inflicted pistol shot the next afternoon.

The police obtained a warrant to search the residence for drugs. The three officers executing the warrant were at first invited into the house by the occupant's partner, who on request showed the officers the cannabis plantation. Partway into the search the occupant arrived home and was immediately very angry. He went and retrieved a rifle, and all three of the officers left the residence after being warned by the partner that he was potentially dangerous. As they were making their way across the driveway, the occupant fired shots at them from his balcony, before making his way out onto the driveway to fire more. All three of the officers were hit by the bullets, with one receiving fatal injuries.

The occupant then returned inside the property and a siege situation developed. During the siege it became apparent to police that the occupant was remorseful and suicidal. Efforts were made in the police negotiations to focus on suicide prevention.

Despite their efforts, the occupant became increasingly distressed and eventually ceased his communications with police.

The occupant had exhibited increasing paranoia in the weeks leading up to the incident, particularly after an earlier visit by police on an unrelated matter. He became increasingly worried about being caught by police, having been a drug-dealer for about 10 years, and was particularly concerned that if convicted he would be stripped of his assets and property, as all his income was drug-related. He was adamant that he would not go to jail.

The type of firearm that the occupant used to fire at Police was a Ruger mini-14 semi-automatic rifle, which he purchased in 1990, before military style semi-automatics (MSSAs) became subject to specific licensing requirements. A few years later a letter would have been forwarded to the occupant as a lifetime licence holder requiring him to surrender that licence and would have had a 10-year licence issued to him. Evidence shows that it is likely that the occupant surrendered his lifetime licence in response to the letter, and he may have surrendered some or all of his firearms at that point. However, if that were the case he likely re-acquired a collection of firearms through illegitimate means, so that police had no warning of the firearms the occupant had in his possession, or the potential danger he posed.

The Department of Labour (DoL) investigated this incident and identified several areas of concern. Firstly, no other officers were available for the search, which compromised the safety of the three officers who did go. Only one of the sergeants who were the supervisors of the three officers knew that the warrant was being carried out. Police communications were also not aware that the search was being carried out as such communication happens over open channels which can be intercepted by civilian radio scanners, creating safety concerns.

Additionally, none of the three officers involved in the execution of the search warrant were wearing stab-resistant body armour (SRBA), which contravened Police General Instructions. It was the responsibility of the deceased officer to ensure that staff were fully equipped in order to minimise foreseeable hazards, and none of the three constables had made notebook entries referring to risk analysis. However, even if they had been wearing SRBA, it would not have protected them from the gunshots.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that a copy of this finding be forwarded to the Commissioner of Police and the Minister of Police. He recommended that they review the Arms Act 1983, as the evidence the coroner received at the inquest hearing identified deficiencies in the legislation and in the enforcement of it. In the coroner's view the policy of tracking MSSAs, and confirming the type of firearm that is an MSSA, must be looked at again.

The coroner also suggested that the report made by Judge Thorpe in 1997 may have to be revisited. He noted that at present the Arms Act is only complied with by honest people. He commented in his findings that if the people supplying firearms to the occupant ascertained, as they were required to do under the Arms Act, that he held an appropriate firearms licence, this would have been conveyed to Police Intelligence and the officers would have been warned of the danger that the occupant presented.

The coroner recommended that the roll-out of police digital radios be expedited as now that appropriate technology exists he felt police ought never to be put in the situation of hesitating to use an unsecure channel.

The coroner also recommended that the programme of review and simplification of Police General Instructions ought to receive prompt attention, as no serving police officer can be expected to have instant recall of each and every General Instruction.

Lastly the coroner recommended that the procedures for the execution of all search warrants by the police be upgraded to ensure that:

- all supervisors are aware of warrants being executed by their staff
- adequate numbers of police officers attend the execution of search warrants
- improved tools and equipment are available to staff and appropriate training in risk assessment and other tasks is given
- staff are continually monitored in their use of personal protection equipment.

The coroner authorised publication of the details of the self-inflicted death in this case because he was satisfied that the making public of particulars of the death was unlikely to be detrimental to public safety.

Mental health issues

See also *self-inflicted* deaths below.

Case number

CSU-2010-WGN-000391
2012 NZ CorC 193

CIRCUMSTANCES

The deceased died at his home of acute drug toxicity. The day before his death he had been referred to Te Haika Mental Health Services (TMHS) of Capital and Coastal District Health Board (DHB) for alcohol detoxification.

The deceased had a known history of alcohol abuse and dependency, as well as experiencing suicidal ideation after bouts of heavy drinking. He was known to several DHB mental health services in relation to his alcohol use and his behavioural issues.

Two days before his death he was taken by ambulance to Hutt Hospital at his request following a fall while intoxicated. At the hospital he expressed suicidal ideation and the emergency department called the Crisis Assessment Treatment (CAT) team. However a decision was made to discharge the deceased before he had seen the CAT team, on the basis that the emergency team believed there was no suicide risk. A follow up with the CAT team was arranged and two attempts were made to contact the deceased, but were unsuccessful. Notwithstanding this, the deceased went to his general practitioner and asked to be referred to the alcohol detoxification unit. His general practitioner was not concerned about any suicidal ideation at that time.

The deceased initially had contact with the CAT team at Hutt Valley DHB about nine months before this death after expressing suicidal ideation while intoxicated. He was given information by the CAT team about how to contact the crisis mental health services and was advised to re-engage with alcohol and drug services. He was instructed to contact them if he felt at risk and two weeks after this initial contact the deceased contacted the CAT team again expressing suicidal ideation. He was uplifted by police and taken to the emergency department who assessed him once sober as having no suicidal risk issues.

COMMENTS AND RECOMMENDATIONS

In the course of this inquiry the issue was raised regarding fragmentation/duplication of certain specialised services within the regional DHBs. It was suggested that it would make more sense that certain specialist services would be best dealt with on a regional basis. The coroner commented that he has for a long time been critical of the myriad of split-off sub-groups within the health services and questioned how economically efficient this is.

The coroner expressed his view that a special standalone regional resource for this type of service, by bringing all professional staff together to provide a strong and coordinated base for the region, would be a far better service.

Case number

CSU-2012-PNO-000151
2013 NZ CorC 1

CIRCUMSTANCES

The deceased died as a result of injuries sustained when he fell while heavily intoxicated. He was discovered at home by his brother after not being seen or heard from for three days. The deceased was affected by both bipolar disorder and alcoholism and had received treatment for both of these conditions in the past.

The deceased had been discharged from mental health treatment about two months before his death because he had missed several appointments and did not respond to attempts to contact by telephone or letter. Normally as a matter of routine a letter would have been sent to a patient's general practitioner confirming the discharge, but there is no evidence that this was done. His family were also not advised as it is the policy of the DHB not to keep the family of a patient informed unless the patient specifically instructs them to.

COMMENTS AND RECOMMENDATIONS

The coroner commented that he has always considered that it would be a positive thing for a patient's immediate family to be advised when a patient is discharged from mental health treatment – or for that matter from substance abuse treatment. He said that families often later state that had they known they would have at least attempted to do something to help the patient themselves. The coroner said he was well aware that measured against this is the patient's right to privacy, and for that reason a DHB is often unable to advise family members.

The coroner recommended to all DHBs that a protocol be developed where, at the start of treatment or the first reasonable opportunity afterwards, a patient's consent is obtained – if at all possible – to the sharing of information with specified family members. Unless later revoked that would enable the DHB to properly inform nominated family members of significant events. He realised that not all patients would give authority – some would be very much opposed to doing so. However, he strongly suspected that consent would be given more often than not. This seemed to the coroner an obvious and very simple process to put into effect that would overcome the 'privacy dilemma' in most cases. The coroner hoped that this DHB and others would seriously consider the recommendation and attempt to implement it.

Case number

CSU-2011-WGN-000351
2013 NZ CorC 169

CIRCUMSTANCES

The deceased died at his home of left lobar pneumonia. He was affected by mental illness and lived in a residence that was owned and managed by Wellink Trust. Over a month earlier he had been admitted to hospital with right lobe pneumonia, and was discharged after four days with antibiotics. At an earlier check-up he appeared fine, but a blood test done four days before his death indicated there might still be an infection. On the morning of his death the deceased complained of feeling unwell, and later that afternoon, while he was sitting in a chair talking to his caregiver, his head rolled back and he became unresponsive. Emergency services could not revive him.

The deceased had to be coaxed into medical care, health and wellbeing by his carers. He was also a heavy smoker, to the point that he preferred cigarettes to food. Additionally, he did not like being cared for in a hospital, and his mental state appeared to be better when he was monitored at home.

COMMENTS AND RECOMMENDATIONS

The coroner was of the view that the deceased has been well looked after in terms of his medical and mental health care and that it was unfortunate that his general health was poor, clearly exacerbated

from cigarette smoking. This poor health made him susceptible to illnesses such as pneumonia. However the coroner asked that the health authorities keep a close watch on patients such as the deceased, particularly when they appear to become unwell.

Natural causes

See also *adverse effects or reactions to medical/surgical care*, *aged and infirm care*, *deaths in custody* and *police pursuits* or *deaths in police custody* deaths.

Case number

CSU-2009-WNG-000456
2012 NZ CorC 174

CIRCUMSTANCES

The deceased died in hospital of a likely cardiac arrhythmia that he suffered while in Wellington Airport. Members of the public, Airport Fire Service, Wellington Free Ambulance, New Zealand Police, and off-duty medical staff made resuscitation attempts for 32 minutes, until he was transported by ambulance to hospital. Ultimately all such attempts were unsuccessful.

Airport staff watched the incident and appeared unknowledgeable of how to perform CPR. The deceased's best chance of survival would have been for an automatic external defibrillator to have been available in the shortest possible timeframe.

COMMENTS AND RECOMMENDATIONS

The coroner addressed his recommendations to the Chief Executive Officers of the following Aerodrome Certification Holders: Auckland International Airport, Chatham Islands/Tuuta Airport, Christchurch International Airport, Dunedin International Airport, Far North Holdings Ltd (Kerikeri/Bay of Islands), Gisborne Airport, Hawke's Bay Airport Limited, Hokitika Airport, Invercargill Airport, Kapiti Coast Airport, Marlborough Airport, Nelson Airport, New Plymouth District Council, Palmerston North Airport, Queenstown Airport, Rotorua Regional Airport, Royal New Zealand Air Force, Southland District Council, Taupo Airport Authority, Tauranga Airport Authority, Timaru District Council, Waikato Regional Airport, Wanganui District Council, Wellington International Airport, Westport Airport Authority, and Whangarei District Airport.

He recommended that, if the Airport Authority has not already done so, it purchase and install in appropriate places within the airport complex sufficient publicly accessible automatic external defibrillator units to enable immediate response to medical emergencies, and that all airport staff should have basic CPR training, including the use of automatic external defibrillator units.

RESPONSE FROM THE NEW ZEALAND AIRPORTS ASSOCIATION

The coroner received a report from the New Zealand Airports Association (NZAA), dated 25 February 2013, in response to his findings and recommendations. The report outlined where things currently stand in regards to the issue of terminal events and defibrillators in airports, from an industry-wide perspective:

- Some members of the NZAA have taken the opportunity to review their equipment levels and staff training to better respond quickly and effectively to cardiac events within airport terminals. The already widespread availability of equipment and trained employees will further improve over coming months, and the NZAA is also investigating the potential advantages of group purchasing of equipment, to make it available at reasonable prices.
- In contrast to the range of activities that take place in and around airport terminals, the roles of airports themselves are relatively narrow. For example, check-in and counter staff, baggage staff and staff at commercial outlets within airport terminals are not employed by the respective airport, and are not under the airport's control. Airports usually take more of a 'landlord' role, with most of the visible activities in terminals carried out by contractors, airlines, food and beverage providers and tenants (and their respective staff) on site at the airport. Within the non-airport employee pool, the proportion of casual and relatively short-term staff is often quite high. The ability of airports themselves to respond to your recommendations is therefore more limited than it might appear.
- Airports are, however, generally responsible for terminal facilities, and those that have not already done so are very willing to consider the provision, or an increase in the availability, and regular checking of defibrillators at appropriate places around terminals. This may not be the case in some smaller centres, however, where the airport may be open only for specific parts of the day when airlines are operating. In those cases airport staff levels are very low, and the numbers of passengers and others in the terminal are also generally low.

- Airports are also responsible for ensuring the provision of emergency response teams, according to the size and volume of air traffic at the location. Some smaller airports do not have fire-rescue teams on site due to the limited number of flight arrivals each day, and the relatively small size of aircraft. Where these teams exist, they are, and will continue to be, an excellent resource for responding to events inside the terminals. We have noted the potential improvements highlighted in your report.

RESPONSE FROM TE ANAU AIRPORT

Te Anau Airport provided the following response to the coroner's findings and recommendations.

[T]hat Te Anau Airport, Manapouri had taken heed of your recommendations, and actions are now in place to ensure that the recommendations are followed through with and completed.

Overseas deaths

Case number

CSU-2011-DUN-000409
2012 NZ CorC 176

CIRCUMSTANCES

The deceased died while he was in Bali from cardio-respiratory failure. He had extensive accumulation of fluid in the air spaces of his lungs and congestion which was caused in part by the inhalation of stomach contents. He was a New Zealander who lived in Perth, Australia.

On the evening of his death he had drunk Arak, a local alcoholic drink. The drink had been contaminated with methanol. This may have been a result of incorrect distillation, or perhaps it had been illegally added to increase the drink's alcohol content. The deceased went back to his hotel, claiming to feel unwell, where he was found an hour later, unresponsive.

Methanol is a poison and ingesting it can be fatal. In this case it likely enhanced the depressant effects of the Arak and led to the deceased's vomiting and inhalation of his stomach contents, and ultimately to his death.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that a copy of this finding be forwarded to the Ministry of Foreign Affairs and Trade so that it can publicise the dangers to which tourists may be exposed when drinking in Bali hotels and bars. The local alcoholic drink Arak has been known to contain, or be contaminated by, methanol, and the effects of drinking methanol can be fatal. He also asked the ministry to forward a copy of the findings to the authorities in Bali.

RESPONSE FROM THE MINISTRY OF FOREIGN AFFAIRS AND TRADE

The Ministry of Foreign Affairs and Trade provided the following response to the coroner's findings and recommendations.

As recommended by the coroner, we have updated our pubic advice on the Ministry's Safetravel website safetravel.govt.nz to publicise the dangers of drinking Arak.

A copy of the coroner's report has been forwarded to the New Zealand Embassy in Jakarta. The embassy will ensure a copy of the finding is passed to the appropriate authorities in Bali.

Police pursuits or deaths in police custody

See also *homicide or inter-personal violence* deaths.

Case number

CSU-2012-HAM-000275
2013 NZ CorC 57

CIRCUMSTANCES

The deceased died of cardiac arrhythmia while she was in a 'booze bus'. She had been stopped at an alcohol check point and was unable to muster enough breath to undergo a breath screening test, despite several attempts. She therefore had to board the booze bus to undergo an evidential breath test. While in the bus she collapsed, and although first aid was administered immediately and emergency services were called, she could not be resuscitated.

The deceased had survived an armed mugging and threats of violence before immigrating to New Zealand and was a timid and anxious person. Her family noted that she would have been terrified at being stopped by the police, at night.

The coroner found that although the deceased was treated with nothing but respect and courtesy by police, the stress of the situation, coupled with her underlying heart disease, led to her fatal cardiac episode. She was not intoxicated and the level of alcohol in her blood was well below the driving limit.

COMMENTS AND RECOMMENDATIONS

Although not at its focus, the issue of whether booze buses should be equipped with defibrillators and CCTV was canvassed at the inquest. The coroner noted that a defibrillator was used by ambulance staff in the attempt to save the deceased's life, but there was no evidence that earlier use would have made any difference in this case. The coroner also stated that the use of CCTV was not a recommendation available in the circumstances of this case, as the use of CCTV would not prevent deaths in similar circumstances in the future. However he did accept that the use of CCTV would help police and the public when cases such as this are under review.

The coroner said that while neither suggestion is appropriate for recommendations in the context of this case, he considered that they were sensible and commended them to the police as worthy of consideration.

Product-related

See also *fire-related* deaths above.

Case number

CSU-2012-DUN-000001
2012 NZ CorC 183

CIRCUMSTANCES

The deceased died in hospital of brain injuries which he sustained when he fell off a ladder while cleaning the windows of his home. It appeared that the deceased was standing on a ladder which was extended to its full 2.5 metres, and which was placed with its base on a landing in the steps to his flat. The fall may have been the result of a stroke, a faint or a slip of the ladder. However as it was not witnessed this could not be determined conclusively.

After the fall the deceased got up and went inside his flat. He was found by his daughter still conscious and responsive; however, he had vomited, was incontinent and disorientated and had a laceration on the back of his head. His daughter called an ambulance but his injuries were so severe that the hospital could only provide palliative care.

COMMENTS AND RECOMMENDATIONS

The coroner commented that in the last calendar year, over 260,000 claims were lodged with ACC in respect of falls in and around the home. ACC identify over 4000 people each year suffering serious injuries after falling from ladders in the home in New Zealand.

Unless placed securely, ladders can easily tip. ACC recommends that ladders always be placed on firm flat ground and that people on ladders do not overreach sideways. The coroner commented that this death demonstrates that people using ladders must exercise an appropriate degree of care. For the deceased to be using the ladder, in the position that he was, proved to be inherently unsafe.

The coroner recommended that the 'ladder safety tips' included in ACC publications be again drawn to public attention:

- Check your ladder before using it.
- Never use a ladder with broken, missing or loose parts.
- When setting up a ladder, make sure it is on a firm, even surface. The best advice is to secure the base of the ladder.
- Always keep 3 points of contact when climbing a ladder (for example, 2 feet and 1 hand) and never overreach sideways.
- Ladders are not designed as working platforms. For big jobs such as painting walls, consider scaffolding or hire a professional.

The coroner also recommended that a copy of this finding be forwarded to ACC and to the Department of Labour.

Case number

CSU-2010-CCH-000951
2012 NZ CorC 167

CIRCUMSTANCES

The deceased died of carbon monoxide poisoning while camping at Lake Alexandrina camping ground. He was asleep with his wife as carbon monoxide, which was likely emitted by a number of appliances, built up in their caravan. They were found by other campers in the morning, at which point the deceased was already dead.

Several appliances in the caravan may have caused or contributed to the build-up of the poisonous gas:

- the refrigerator gave off unusually high levels of carbon monoxide and this could have escaped into the main area if a cupboard door or the door to the refrigerator had been left open
- the cooker had also been operated in 'light back' condition, which would have allowed it to emit carbon monoxide even though it was thought to be turned off
- the deceased and his wife were also using an unflued LPG heater, which should not be used in such a small, unventilated space because they tend to give off excessive levels of carbon monoxide.

COMMENTS AND RECOMMENDATIONS

The coroner commented that there are clearly safety messages arising from this death with respect to caravans and similar units such as campervans and motor homes, particularly relating to:

- the need for proper ventilation
- the importance of regular maintenance of equipment such as refrigerators and cookers
- the desirability of installation of carbon monoxide sensors.

The coroner recommended to Energy Safety that on its website it promotes awareness of the need for regular maintenance of gas applications, safety with LPG equipment in caravans, and the avoidance of carbon monoxide hazards. In light of the circumstances of this death, the coroner made this recommendation with particular reference to the evidence that LPG heating appliances are not designed for, and should not be used in, confined spaces such as caravans and campervans.

RESPONSE FROM THE MINISTRY OF HEALTH

The coroner received a report from the Ministry of Heath, dated 18 March 2013, in response to his findings and recommendations. The report detailed what actions are being taken by health officials as a result of the coroner's advice.

The report stated that without proper ventilation any gas appliance can give off dangerous levels of carbon monoxide, and a faulty appliance may emit carbon monoxide to dangerous levels even in well-ventilated areas. Of the 25 known unintentional deaths from carbon monoxide poisoning from 1975 to the present, 13 have occurred in caravans or campervans. Identifiable faults in refrigerators were implicated in four of these deaths, including the present case.

From 8 November 2011, following amendments to the Gas (Safety and Measurement) Regulations, any gas appliance installed in a caravan must comply with AS/NZS 5601.2 Gas Installations – LP Gas Installations in caravans and boats for non-propulsive purposes. Any imported caravan must comply with the essential safety requirements set out in Section 2 of the standard. The standard prescribes permanent high and low level ventilation openings, which are important to allow the free flow of air through the small space. However, the caravan in this case was at least 25 years old and therefore was not covered by the new requirements. In the case of existing installations there is no prescriptive requirement, only a general requirement relating to the safe maintenance of the installation.

Officials at the Energy Safety Service of the Ministry of Business, Innovation and Employment (MBIE) advise that their focus is on educating consumers about the safe use of gas appliances. They remind consumers not to use portable gas appliances such as unflued gas heaters and lanterns inside caravans, and to have their gas appliances serviced regularly. MBIE regards adherence to installation standards when appliances are installed, maintenance of appliances, and adequate ventilation when appliances are used as the primary methods for managing the risk from carbon monoxide.

Information on gas safety for caravans and motor-homes may be found at med.govt.nz/energysafety/consumer/safe-living-with-gas-lpg/gas-recreational-safety/gas-safety-for-caravans-and-motorhomes

The Ministry of Health is working with the Energy Safety Service to include health messages with the safety messages for gas appliances. These will include advice that people with heart disease may

be susceptible to chest pain or angina if the level of carbon monoxide in a room or enclosed area such as a caravan goes about 'safe levels'. Smokers with heart disease are particularly at risk. Young children, unborn babies and the elderly may also be affected.

Case number

CSU-2011-CCH-000814
2013 NZ CorC 37

CIRCUMSTANCES

The deceased died at his home of carbon monoxide poisoning. The poisoning occurred when the unflued GasCraft Torino LPG heater in his room was left burning overnight in the light-back condition. In this condition heaters of this type emit significant quantities of carbon monoxide and combustion is sustained in this condition until the heater is turned off or the gas cylinder contents are exhausted.

Usually the deceased would turn off the heater before he went to bed, but on this occasion he did not. It was stated at the inquest that the GasCraft Torino heater, and at least five other Chinese models, have the serious design flaw that can lead to occasional light back that would be sustained until the heater is either turned off or the cylinder emptied, and that this highlights a deficiency in the standard BS EN 449.

The tendency of this heater to burn in the light back condition was the result of a design flaw, and the gas build-up was contributed to by the lack of ventilation in the house.

COMMENTS AND RECOMMENDATIONS

The coroner commented that unflued LPG cabinet heaters pose some risk of fire, leakage and carbon monoxide poisoning. As they vent their exhaust gases into the air surrounding them, adequate ventilation is needed in an indoor setting.

He also noted that LPG cabinet heaters should not be used in rooms where people sleep. The deceased used the GasCraft Torino heater in a bedroom, in contravention of the manufacturer's instructions. Further, he did not have adequate ventilation (both the window and door were shut.)

While these recommendations are already in the public domain through education information provided by Energy Safety, the coroner felt that publication of this finding and comments may reinforce the potentially fatal danger in using unflued LPG heaters indoors without adequate ventilation, and the importance of not using heaters in sleeping environments, and not using heaters that may develop light back.

Case number

CSU-2010-DUN-000069
2013 NZ CorC 46

CIRCUMSTANCES

The deceased died at her home of a sudden cardiac arrhythmia. The deceased drank the beverage Coca Cola excessively (between 6 and 10 litres a day), and it is believed the resulting caffeine toxicity substantially contributed to the development of the metabolic imbalances that gave rise to her fatal arrhythmia.

In the six months before her death she had been experiencing health difficulties such as lack of energy, vomiting, blood pressure problems and 'a racing heart'. However she had not sought medical assistance for any of these concerns.

The label on the drink identifies that it contains caffeine, but does not provide a quantity. The family of the deceased did not regard the beverage as potentially harmful, as it did not have a warning label. New Zealand has no current health standard for caffeine exposure.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that the Ministry of Health consider, in consultation with Environmental Science & Research and other appropriate experts, whether, in light of the evidence given to the inquest hearing, the warning labels on carbonated beverages give sufficient protection to consumers. The hazards to the health of the consumers of excessive quantities of sugar and caffeine contained in carbonated beverages could be more clearly emphasised.

The coroner noted that the caffeine content is regulated for 'formulated caffeine beverages', commonly known as energy drinks, defined as those containing 145 mg/L or more (Standard 2.6.4 'Formulated Caffeinated Beverages' of the Australia New Zealand Food Standards Code). He nonetheless felt that consideration could be given to either lowering the caffeine percentage limit or creating a more specific warning such as those printed on cans containing 'formulated caffeine beverages', produced and marketed by the Coca Cola Company (Coca Cola Amital (NZ) Limited,

Coca Cola Oceania Limited). It may also be considered appropriate to review Standard 2.6.4 to reduce the caffeine content threshold to enable more specific advice to consumers to be given.

He also recommended to the Coca Cola Company that they consider including advice about the quantity of caffeine on the labels to its products and adding to the labels appropriate warnings related to the dangers of consuming excessive quantities of the products.

Case number

CSU-2012-HAM-000518
2013 NZ CorC 62

CSU-2012-HAM-000519
2013 NZ CorC 63

CIRCUMSTANCES

Two men died in an abandoned mine shaft in Whitianga of carbon monoxide poisoning. The two men had gone into the tunnel to cook methamphetamine and were using an engine-driven generator in the enclosed and unventilated space. The fumes that were generated caused the poisoning. When the two men were gone for longer than expected, the girlfriend of one of the deceased came to the tunnel in search of them and found them unresponsive. She left and notified the police, who found the two men clearly deceased on their arrival.

COMMENTS AND RECOMMENDATIONS

The coroner commented that these deaths clearly illustrate the danger of operating an engine-driven generator within a confined space. He noted that the men were engaged in an illegal activity at the time, and it goes without saying that, had they not been doing so, then these deaths are unlikely to have occurred.

Putting that matter aside, the coroner said that it is of great concern that these men were not aware of the danger of operating a generator within a confined space. These deaths highlight once again the need for greater public awareness that any fuel-driven machine should not be operated in a confined space without adequate ventilation to prevent a build-up of carbon monoxide.

Recreational or leisure activities

Case number

CSU-2001-CCH-000785
2012 NZ CorC 187

CIRCUMSTANCES

The deceased, a tourist from Australia, died of high-energy impact injuries he sustained when he fell 100–200 metres down a slope into a stream bed while he was snowboarding. He was with a group of his friends at Mt Cheeseman ski area, and though some of the group had decided to refund their day passes because of the icy conditions, the deceased and two others decided to keep going.

Earlier in the day they had received information from the front desk of the Mt Cheeseman Ski Club about an area known as the Tarn Basin, including how to snowboard across it and hike out. They were cautioned that if they did not manage to stay above the tree line the hike out would be much harder. They were also told they should ask ski patrol what the conditions in the area were like. When they made their run across, the firm, icy snow conditions made it difficult to keep a steady and shallow path on a snowboard. They went lower down the slope than they intended, and the terrain became even more difficult for the snowboarders to navigate. The deceased unclipped his snowboard to continue on foot, but slipped and fell into the stream bed.

None of the three men had much experience snowboarding in back country conditions in New Zealand, and though they knew that the Tarn Basin was unpatrolled, it was not apparent to them that this meant it was not officially part of Mt Cheeseman ski area. The lower section of the Tarn Basin is known to be both challenging and difficult to exit.

The deceased was not wearing a helmet at the time of his accident, though given the speed at which he fell, it is not possible to say whether any reduction of the impact that a helmet could have given would have changed the outcome.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that skiers and snowboarders should wear helmets in mountainous terrain, and that every encouragement is given to that use. He did not intend this to be a recommendation as to the mandatory use of helmets. In making this recommendation he referred to an expert report given at the inquests into the deaths of three other people who died at the Mt Hutt ski area in 2010, and evidence given by a representative of the New Zealand Mountain Safety Council at this inquest.

The coroner recommended that the New Zealand Mountain Safety Council and the Mt Cheeseman Ski Club actively encourage ski areas in New Zealand to promote (by such means as websites, signage, and the avoidance of promotional images of skiers and snowboarders who are not using protective helmets) the use of protective helmets by all skiers and snowboarders.

It was also recommended to the New Zealand Mountain Safety Council and the New Zealand Ski Instructors Alliance that they promote awareness of snowboard limitations in back country, and steep terrain with firm snow conditions, as highlighted by this fatality. The coroner noted that central to this recommendation is the need for skiers and snowboarders to be capable of basic self-arrest techniques.

To the New Zealand Mountain Safety Council he further recommended that they promote the importance of a rigorous policy concerning advice about conditions and terrain (if sought from ski area personnel) being given by designated personnel to ski operators. Further, in conjunction with ski area operators, it was recommended that they develop a consistent policy for giving advice to people who wish to leave the ski area boundary.

It was recommended to the Mt Cheeseman Ski Club that it consider extending its ski area boundary in appropriate conditions to include the upper section of Tarn Basin, and that in appropriate conditions, markers should be provided to help skiers and snowboarders exiting Tarn Basin to meet the access road. Information should be included in its promotional material and signage regarding the difficulties of egress from the lower reaches of Tarn Basin, and the hazards highlighted by this inquest. On-field information about the status of Tarn Basin and whether the run is 'open' or 'closed' should be provided, preferably differentiating between the upper basin and the lower basin. He also recommended to it that it continue to update its signage to international signs and symbols.

Lastly he recommended to the New Zealand Ski Instructors Alliance that a requirement for instruction in basic self-arrest techniques be included in ski-school syllabuses.

Case number

CSU-2012-DUN-000083
2012 NZ CorC 196

CIRCUMSTANCES

The deceased, a visitor from Australia, died of multiple traumatic injuries he sustained when he fell while hiking in the Darren Mountains in Fiordland National Park. He and two others had traversed Homer Saddle and were hiking back from Camp Dog a day earlier than planned because of inclement weather. Although the rain stopped during their hike, the terrain was still running with water. The deceased slipped in the mud and fell down a steep slope. He was likely knocked unconscious in his initial fall and died before emergency services could reach him.

The deceased was a very experienced climber, and although it could be speculated that if he had been carrying trekking poles or wearing a helmet he may have been better able to avoid or survive the fall, generally he was well prepared and equipped for the hike.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to Mountain Information Services that they should continue to provide information on the hazardous nature of many of our mountain access routes, particularly in wet conditions.

He also recommend to climbers generally that they, when wearing heavy packs on exposed access routes, pay particular attention to their personal safety and specifically ensure that their chosen footwear is the most appropriate for the terrain. Individuals should also consider their security by always using two- or three-point contact when soloing or scrambling. The use of belay rope should also always be considered when the exposure is great, conditions are adverse and the risk of a fall and death is high.

The coroner noted that climbing or tramping in wet conditions in steep access routes in Fiordland can be particularly hazardous, and that helmets provide limited but useful protection when an inadvertent head bump could cause the loss of hand grip and fall.

Case number

CSU-2010-CCH-000619
2012 NZ CorC 180

CIRCUMSTANCES

The deceased died in hospital as a result of head injuries sustained when she fell while ice-skating. She had received the injuries three days earlier during a school trip where she was a parent helper. She complained of throbbing headaches and feeling sick after the fall, and was referred for hospital admittance by her general practitioner the next day. Despite maintaining a stable condition for a day and CTs showing no significant change, she was found dead in her hospital room a day and a half after her admission. She had not been wearing one of the protective helmets that were provided free of charge, which might have decreased her chance of injury.

The usual symptoms of brain swelling were not present, even through regular monitoring. It is likely that her head injuries caused a sudden seizure, which led to her rapid deterioration.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this case highlights the importance of wearing protective helmets in an ice skating situation, not only for beginner or inexperienced skaters but for all skaters. As highlighted by the Department of Labour, accident data relating to ice skating injuries is not held or reviewed by an independent or central body so the true incidence of accidents may not be recognised within the industry.

The coroner commended the initiative taken by the skating rink operator in providing protective helmets free of charge and commented that such action by other skating rink operators is to be encouraged.

Self-inflicted

See also *deaths in custody* and *homicide or inter-personal violence* above.

Case number

CSU-2011-AUK-001226
2012 NZ CorC 133

CIRCUMSTANCES

The deceased died in his home of self-inflicted injuries. He was found by a friend who was alerted to the deceased's intention to take his life by an email that was sent just before his death. By the time the friend and emergency services got to the house it was too late.

The deceased had bipolar disorder and depression, and had attempted to take his life in the past. In his email he gave two specific reasons for his decision – the breakdown of his marriage and the subsequent Family Court proceedings over relationship property. In particular he referenced the failure of the court to acknowledge his predisposition to depression, and the protracted nature of the proceedings.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the New Zealand Law Society and the Ministry of Justice that they consider implementing a system of providing mental health support to people engaged in Family Court proceedings, similar to the pilot programme operated by the Family Court of Australia.

The coroner also recommended that they review current measures in place within the Family Court to ensure that there are no unnecessary delays in relationship property proceedings, for the purpose of strengthening those measures. Further, the coroner recommended that consideration be given to enable people suffering mental health issues who are parties to Family Court proceedings to fast-track those proceedings in order to minimise the detrimental effect of the litigation on their mental health.

The coroner considered that the making public of further particulars of this death would be unlikely to be detrimental to public safety. On the contrary, the coroner considered that making some of the particulars public may prevent similar deaths. Accordingly, the

coroner authorised the making public of any particulars of this death apart from the cause of death and means used by the deceased to take his own life.

Case number

CSU-2010-CCH-000609
2012 NZ CorC 144

CIRCUMSTANCES

The deceased died at his home of self-inflicted injuries.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the Ministry of Health that it provide strong advice to the public about what to do if a person says they are intending to commit suicide, or says they have engaged in suicidal behaviour, or that they want to or feel like killing themselves. She also recommended that this advice include launching an advertising campaign through news media that shows people ways to respond to someone who says they are thinking of committing suicide or want to kill themselves.

The coroner prohibited publication of all particulars and evidence of this death, but specifically allowed publication of her recommendation.

RESPONSE FROM THE MINISTRY OF HEALTH

The coroner received a response from the Director of Mental Health, dated 11 December 2012. The response outlined the initiatives the Ministry of Health (MoH) has taken in respect of suicide prevention and support to at-risk individuals.

The Director of Mental Health acknowledged that suicide is a complex issue that requires strong community involvement. The causes of suicide are complex and multi-level, and usually caused by an accumulation of risk factors, the most common of which is a mental disorder. Other risk factors are broad ranging and include traumatic childhood events, life stresses, social isolation, family issues, genetic characteristics, cultural factors and socioeconomic issues. The Government recognises the role that communities and families play in suicide prevention. Some of the most effective prevention methods are strong friendships, healthy, supportive family relationships, and an individual's belief in a positive future.

The MoH funds a number of initiatives to support members of community to respond to individuals who are at risk of suicide. One of these is the funding of the *Suicide Prevention Information New Zealand (SPINZ)*, which provides information and resources to people and organisations about responding to suicide, including interactive web seminars that aim to help people talk about suicide.

The MoH also funds skills-based workshops across New Zealand focusing on increasing awareness of the signs of suicidal ideation and behaviours. Applied Suicide Intervention Skills Training (ASIST) explores common myths and beliefs about suicide and teaches people how to respond to someone thinking about committing suicide. It targets people who, in their day-to-day routine, come into contact with vulnerable populations and are in a position to respond (for example, nurses, social workers, youth workers, teachers and others in a position of trust).

A number of initiatives were also announced in April 2012 as part of the Prime Minister's Youth Mental Health Project. These include mental wellbeing programs in schools, online and in the health system, as well as support for families and communities dealing with suicide and mental illness. This includes the Whānau Ora providers working with 40 Māori and Pacific 12–19 year olds and their whānau/aiga over two years, to help support families protect and improve the mental health of their young people.

The Director of Mental Health commented that in terms of possible further investment in this area in the future, evidence supports the provision of information to community members through skills-based workshops such as ASIST, rather than through advertising campaigns through news media. At the time of its response the Ministry was considering these issues through the development of its new Suicide Prevention Action Plan for 2013–2016.

Case number

CSU-2010-CCH-000697
2012 NZ CorC 159

CIRCUMSTANCES

The deceased died at his home of self-inflicted injuries.

COMMENTS AND RECOMMENDATIONS

The coroner again recommended to the Ministry of Health that it provide strong advice to the public about what to do if a person says they are intending to commit suicide, or says they have engaged in suicidal behaviour, or that they want to or feel like

killing themselves. As above, she also recommended that this advice include launching an advertising campaign through news media that shows people ways to respond to someone who says they are thinking of committing suicide or want to kill themselves.

The coroner prohibited publication of all particulars and evidence of this death, but specifically allowed publication of her recommendation.

RESPONSE FROM THE MINISTRY OF HEALTH

The Director-General of Health responded to the coroner's findings and recommendations on 8 January 2013.

The Director-General noted that these recommendations mirror those in the case cited above as 2012 NZ CorC 144. He supported the response provided by the Director of Mental Health to those recommendations.

He commented that the Ministry of Health is committed to addressing the critical issue of suicide in our communities. The recently released Mental Health and Addiction Service Development Plan 2012–2017 'Rising to the Challenge' has specific actions in relation to working to prevent suicide among people known to mental health and addiction services and to developing an all-age, cross-agency suicide prevention action plan that outlines an integrated approach to suicide prevention. Other actions in that Plan will also address some of the drivers of suicide (for instance the National Depression Initiative).

At the time of this response the Ministry of Health was finalising the development of the new Suicide Prevention Action Plan for 2013–2016. This was due to be released in the first part of 2013. The Ministry envisaged that the plan will provide opportunities for improved information for families and communities about responding to individuals at risk of suicide.

Case number

CSU-2012-PNO-000310
2012 NZ CorC 116

CIRCUMSTANCES

The deceased died of self-inflicted injuries.

Approximately two months before his death he began making references to suicidal ideation in a series of text messages, some of which were quite explicit. He had another similar exchange with his girlfriend on the night of his death, but these resulted in him telling her he would not harm himself. Sadly, he was found dead early the next morning.

It appeared to those closest to the deceased that despite some setbacks, he was thinking positively about life and about his future. Apart from the texts, he did not give any signals or indications of what he planned to do.

COMMENTS AND RECOMMENDATIONS

The coroner commented that he does not think anyone acted inappropriately in respect of the circumstances leading to the deceased's death.

However the coroner said that this death does serve as yet another example of the tragedy that can occur for apparently relatively insignificant reasons and with probably inadequate warning. This is an opportunity to draw attention to the circumstances of this death so that should anyone else be placed in a similar position – and sadly almost inevitably they will be – they may recognise risk factors that were not recognised here.

The coroner considered that there may be some benefit in making public the circumstances of this death in the hope that it may at least reduce the chances of similar deaths. However, some identifying details and other particulars of this death were prohibited from publication.

Case number

CSU-2008-WGN-000754
2013 NZ CorC 15

CIRCUMSTANCES

The deceased was found dead from self-inflicted injuries in the respite care facility where she was staying.

The day before her death the deceased had gone with her mother to the police station. Her mother was concerned about the deceased as she was displaying psychotic tendencies. She was afraid to return home as she believed that an American musician she thought she had been having contact with had bugged her apartment and that there were hidden cameras. The constable at the station spoke to the Crisis Assessment Treatment (CAT) team present at the police station to assess the deceased, but the CAT team members were

due to finish work and could not help. It was agreed that the deceased's mother would take her to the emergency department at Wellington Hospital.

At Wellington Hospital on the evening before her death the deceased was assessed by Mental Health staff (two CAT nurses and a doctor). A decision was made to admit her into the respite facility and to await further assessments. On her admittance no documentation from the doctor who assessed her was available, although copies of the CAT assessment and risk management plan were provided to the support worker at the home. No statement was given to the respite care personnel about the deceased's risk from self-harm or suicidal ideation.

In the two years before her death the deceased had attended a number of general practitioners at a medical practice for various medical matters, which included depression and anxiety. She had admitted experiencing thoughts of self-harm and had been prescribed anti-depressants. The deceased was referred to a clinical psychologist and had attended six therapy sessions. At these sessions she had raised concerns regarding chronic pain, stress and anxiety, particularly around some relationships within her family. Towards the end of these sessions she had demonstrated increased levels of anxiety and depression. In her final session she was particularly upset and said she felt unsafe, but would not say why. The deceased would not allow the psychologist to contact the CAT team. The deceased had denied that she planned to self-harm or commit suicide and had not discussed the breakdown of the relationship with her boyfriend during any of the sessions.

The deceased's mother expressed concerns that information about her daughter was not shared with her by the psychologist. The psychologist would not speak to the deceased's mother as she considered that she was bound by patient confidentiality. The deceased had instructed her psychologist not to talk to her mother. Rule 11(2) of the Health Information Privacy Code 1994 (HIPC) provides for an exception to the rules prohibiting the disclosure of information, where there is an imminent threat to the health or life of an individual. This exception sets a high bar for disclosure and should be not used lightly. The psychologist was asked by counsel for the family what training she had received regarding interpreting the interventions under the privacy rules and she could not recall any such training in recent times.

COMMENTS AND RECOMMENDATIONS

Counsel acting on behalf of the family made a number of submissions on issues that the coroner was asked to consider when making recommendations:

- That general practitioners in group practices should maintain very full notes so as to ensure continuity for patients when being seen by various doctors within the practice group.
- Awareness of health professionals, and in this case psychologists, as to their obligation to notify appropriate persons where there is a real risk of self harm, as provided for under the Psychologists Code of Ethics, and HIPC Rule 11(2)(f). The Psychologists Society and Psychologists Board should be asked to ensure registered psychologists fully understand the privacy rules and in particular the need to take advice from senior colleagues.
- Health professionals who undertake counselling, particularly those who do so on referral from a medical practitioner, should do so on the basis they will provide feedback on the patient to the referring practitioner. This is permissible on the basis, as provided for under the HIPC, that report back is one of the purposes for which the personal information is obtained.
- Health practitioners should not alter their notes and that a copy of this court's decision should be referred to the relevant Primary Health Organisation for it to consider whether its contracts need to be enhanced having regard to the issues arising from this case so as to provide feedback to the referring doctors regarding privacy and proper note-taking.
- Mental health professionals, when in attendance at institutions such as police premises, should be prepared and willing to be proactive; and if their shift is about to finish, obtain back-up.
- The proper completion of documentation relating to assessments of risk, including risk management plan, respite checklists (as per Goal 3 of Suicide Prevention Strategy) at Capital and Coast DHB.
- The proper updating of a patient's risk assessment and risk management plan.
- The proper review of diagnosis and treatment of patients at multi-disciplinary meetings.
- Contractual requirements for review of [the risk of carrying out forms of self harm] within respite facility environments.
- As regards respite facilities, a comprehensive self harming hazard identification surgery, to mitigate any [unusual hazards].

- A review of the adequacy of respite checklists, to ensure that all necessary information is handed over by a DHB to a respite service.
- In specific training as to responses to [self-harm] to be offered to support workers, as part of first aid training during staff induction and as a part of introduction of support workers to respite facilities.
- Urgent consideration to establishing a mortality review committee to focus on suicide prevention (under section 17 of New Zealand Public Health and Disability Act 2000).

In general, the issues identified by counsel for the family were endorsed by the court. The coroner commented that there were several matters referred to in counsel's submissions which he would expect there to be no need for debate, and which should simply be implemented as best practice. However he considered that some of the issues mentioned required comment.

The coroner considered the necessity of the establishment of a mortality review committee to focus on suicide prevention. There is currently a Ministerial Committee on Suicide Prevention that is chaired by the current Associate Minister of Health. This committee has the responsibility for research and other initiatives designed to look at suicide. The coroner did not think there was a need to establish a mortality review committee into suicide given the existence of the ministerial committee.

The coroner also noted that the Law Commission completed a review of the Privacy Act 1993 in June of this year. He commented that there is a thrust to provide a clearer interpretation of the HIPC rule 11, and particularly the ability to share information with concerned family members who are often in a better position to help both the family member concerned with mental health issues, and the mental health professionals involved. The coroner hoped that the Law Commission's recommendations are adopted by Parliament as soon as possible.

The coroner did not propose to make any specific recommendations in this instance, having endorsed those made by counsel. Health professionals concerned had already taken steps to adopt some of these recommendations, such as respite facilities carrying out comprehensive self-harm hazard identification, and CAT services ensuring, when attending at police stations, that they provide required services until other personnel arrive, even if a shift is ending.

The coroner referred to the Health Practitioners Competence Assurance Act 2003, the principal purpose being to protect the health and safety of members of the public by providing mechanisms to ensure the health practitioners are competent. This Act includes psychologists as health practitioners. Given the answers that the clinical psychologist provided to the court as evidence at the inquest in this matter, particularly around the issue of rule 11(2)(d) of the HIPC, the coroner suggested that the psychologist concerned should further her education about this important aspect.

The coroner authorised publication of particulars of this death as he considered that it raised significant matters regarding mental health care. He considered there where there have been inadequacies or deficiencies in the delivery of such services, it is desirable that the public should know of these issues with a view that they should not occur in the future. Identifying details of the names of the deceased's family, and the method that she used to take her life were prohibited from publication.

Case number

CSU-2010-WGN-000187
2013 NZ CorC 73

CIRCUMSTANCES

The deceased died at her home of self-inflicted injuries. She was found deceased by her brother after having missed an appointment with the Upper Hutt Community Mental Health Office of the Hutt Valley District Health Board (DHB). They day before her death she had seemingly drove her car into the path of an oncoming vehicle. At the time of her death she was the subject of a community treatment order, under section 29 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

The deceased had a long history of contact with psychiatric services extending back into her teenage years. She had a history of self-harm and had been diagnosed with bipolar disorder, as well as experiencing severe bouts of depression and anxiety. She had previously made a number of attempts to take her own life. The year before her death she was admitted to Te Whare Ahuru (TWA), the psychiatric unit at Hutt Hospital and became the subject of a compulsory treatment order. From that point she was in-and-out of TWA as her self-harming behaviour continued to escalate, including on occasions that she was in TWA.

Approximately three months before her death the deceased's treating clinicians began a plan for her gradual transition from TWA. Although she had

episodes of leave, she would continue to return to TWA following further self-harming behaviour. The deceased was discharged a final time less than a week before her death, and only two days following her most recent readmission to TWA, following another self-harm attempt. The discharge notes recorded that the deceased denied suicidal thoughts and that discharge was sought by both the deceased and her mother.

Post-discharge arrangements were made for her to be seen by her psychiatrist and the community psychiatric nurse. The deceased was also required to attend the Acute Day Service (ADS) and Hutt Hospital on a daily basis. However, it appears that she attended only once on the day following her discharge. During this visit to ADS the deceased saw her psychiatrist informally and a follow-up appointment had been scheduled for the day she died. The deceased was also supposed to be visited by her nurse three days after discharge; however, the nurse was unable to attend on this occasion due to illness. No replacement nurse was organised to visit the deceased.

Though the hospital noted that the family had been informed of her early warning signs of a relapse, the deceased's mother claims she was not told what to look for. The family were also concerned that they were not given a management plan, nor were they told of the high risk of self-harm the deceased posed to herself. Although TWA is now considered to be fully staffed, an inquiry into the service (dealt with in the *Report of the findings of an inquiry into the board's mental services*) found the ward to be under exceptional staffing pressures during the period from late 2009 to early 2010. In the report TWA was described as facing 'a sense of crisis'.

Although this death was self-inflicted, the coroner was unable to determine that the deceased would have been able to form the intention to commit suicide due to her psychiatric condition which raised questions of volition.

COMMENTS AND RECOMMENDATIONS

The coroner found that while it was open in all the circumstances to the doctor to discharge the deceased from TWA, the process of discharge was poorly executed and follow-up was inadequate. She remained at continuing risk of serious self-harm. The view of a consultant psychiatrist provided to the inquest was that there had been no mental health state assessment showing an improvement in her mood disorder which would alleviate her risk of self-harm.

The coroner stated that it follows that at the time the deceased was discharged on the final occasion she remained at risk of further serious self-harming behaviour. This was important information that should have been passed onto her family as it needed to be factored into her care. The coroner stated that constant vigilance was required on the part of her minders in the circumstances. The deceased should not have been left alone at any time. It was further found that no risk management plan was drawn and no written plan was handed to the deceased's family. The coroner stated that there should have been such a plan and the fact that there was none constituted a failure of process. The coroner observed that while the deceased's mother knew her daughter was very ill, she had not been given a proper understanding of the seriousness of the risk that she might attempt to take her life. Had her mother been given a full understanding of the nature and extent of such risk she said she would never have left her daughter alone.

The coroner further commented that the deceased should have been followed up daily by the board's mental health services following discharge, as stated by an expert clinician who provided evidence to this inquest. The coroner again found that there was a failure of process.

The coroner commented that it is unknown whether the deceased attended ADS after her discharge as the ADS notes are missing for those days. The coroner said that this is unsatisfactory. While the evidence suggests the deceased did attend ADS on one occasion (the day following her discharge), there is no written confirmation of that attendance as there ought to have been if that were the case. The coroner also found it to be unsatisfactory and a further failure of proper process that no one else checked on the deceased after her nurse could not attend her appointment due to illness. The coroner stated that as result of the failures on the part of Mental Health Services staff to follow up the deceased after discharge there was a loss of opportunity to re-assess her mental health state and to check on her medication compliance.

In the *Report of the inquiry into the board's mental health services,* the inquiry panel concluded that the deceased's was a 'challenging presentation for the treating team and her family to manage. With the benefit of hindsight, the pattern of repeated leaves and self harm/suicide attempts was striking for the review team'. The panel also acknowledged the staffing shortages at TWA. The panel stated that 'in retrospect, it seems that inappropriate reliance was put on the close support and presence of family members

when the deceased was an inpatient'. Submissions were made also by counsel for Hutt Valley DHB. The board acknowledged that it is disappointing and regrettable that the deceased was able to self-harm while a patient in its mental health unit.

The coroner made a recommendation to the Chief Executive Officer of the Hutt Valley DHB. He recommended that on the discharge of a patient from Te Whare Ahuru, especially patients who remain the subject of a community treatment order, the terms and conditions of such discharge, the nature and extent of any risks to which the patient remains subject, the early warning signs and all necessary interventions (including monitoring) should be documented in the multi-disciplinary team Plan. The coroner further recommended that a copy of such plan should be given to the family members/whānau/caregivers or friends into whose care the patient is discharged.

The coroner authorised publication of particulars of this death as he considered that it is important that the public should have confidence in the New Zealand public hospital system and the provision of mental health services. Where there may be inadequacies or deficiencies in the delivery of those services, the coroner's view is that it is desirable that the public should know that the reasons for such inadequacies or deficiencies have been inquired into, and that steps have been taken to ensure that they do not occur again. Details of the method that the deceased used to take her life were prohibited from publication.

Sudden unexpected death in infancy (SUDI) and other infant deaths

Case number

CSU-2011-AUK-000157
2012 NZ CorC 131

CIRCUMSTANCES

The deceased, a 2-day-old infant, died at Birthcare maternity hospital of accidental asphyxia, occurring in the context of the unsafe sleeping environment of bed sharing with her mother. Following her birth at Auckland City Hospital, she moved with her mother to Birthcare for post-natal care. While there she was given to her mother to feed in bed in what was considered a safe position. However, while feeding, her mother fell asleep. Her mother later noticed that the deceased had patches of dark skin on her neck and called for help. All attempts at resuscitation failed.

Forensic evidence indicated that the deceased probably died while in bed with her mother. There is an increased risk of Sudden unexpected death in infancy (SUDI) when a mother who is awake has her baby in bed with her, as mothers who do not intend to sleep with their baby can inadvertently fall asleep while feeding.

Although Birthcare does not condone bed sharing, their breastfeeding policy does provide that mothers can breastfeed while sitting upright or lying in bed. The nurse assigned to care for the deceased and her mother was following Birthcare's policy. The coroner nevertheless has concluded that she did not properly understand the risk that a tired mother could fall asleep with her baby in the bed, and that that could lead to smothering.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this death highlights the necessity for safe sleeping policies to be developed and implemented. As was stated by an expert witness at the inquest, health care professionals in hospitals should be modelling safe sleeping practices from the time of a baby's birth and reinforcing safe sleeping messages and strategies with parents. An appropriate safe infant sleeping policy is an important starting point to guide such practice.

The coroner said that this case also highlights the important issue that the risks of bed sharing or co-sleeping are poorly understood by many health professionals in New Zealand, who are exposed to conflicting and confusing messages about this matter. As a consequence, many parents/caregivers are not being given clear messages about the risks.

In the coroner's view, the development of clear evidence-based guidelines would be a major achievement that would help all involved to ensure a consistent message and to make principled, informed decisions on how to ensure that every sleep for infants is a safe sleep and that infants are not exposed to the risk of preventable death from suffocation.

The coroner recommended to the Director-General of Health that the Ministry of Health should highlight to the public and to health care and social service providers the risks of a mother or other adult sharing a sleeping surface with a baby when the adult is asleep.

They should advocate for a focus on the prevention of suffocation deaths by all health and social service providers, and lead an initiative to develop, by consensus of all stakeholders, National Guidelines for Safe Sleeping. The ministry should also ensure that all birthing centres and private maternity hospitals that receive public funding for maternity services have safe sleep policies for infants that include all matters identified by the Health Quality and Safety Commission.

The coroner further recommended to all district health boards (DHBs) that, as recommended by the Health Quality and Safety Commission in June 2012, all DHBs develop and implement as a matter of priority a safe sleeping policy for infants. This policy should aims to ensure:

- staff who support families caring for infants receive mandatory training and updates about prevention of SUDI and ways of communicating risks to families
- safe sleeping practices are modelled for all infants in DHB facilities
- safe sleeping arrangements are available for all infants after they are discharged home
- families are provided with education and support tailored to their level of need about hazards that arise in some sleeping situations
- advice on safe strategies for night feeds and settling infants is provided to parents
- all services and staff encourage safe sleeping practices in ways that include Māori and Pacific cultures and values.

The coroner stated that those DHBs that currently have safe sleeping policies should review the adequacy of those policies and where necessary amend their policies to include the matters identified by the Health Quality and Safety Commission. All DHBs should monitor the impact of their safe sleeping policies to ensure desired outcomes are being achieved.

The coroner recommended to Birthcare Auckland Limited that Birthcare should review the safe sleeping policy introduced in October 2011 to ensure the policy includes all the matters identified by the Health Quality and Safety Commission. It should ensure that its current mandatory staff training on SUDI includes specific training on risks of SUDI arising from bed sharing/co-sleeping and assess whether midwifery and nursing staff are adequately trained to be able to effectively communicate the risk of SUDI and the situations in which this can occur to parents, with further training available if required. The impact of its amended safe sleeping policy should also be monitored to ensure the desired outcomes are being achieved.

RESPONSE FROM THE NEW ZEALAND COLLEGE OF MIDWIVES

The coroner received a response to her findings and recommendations from the New Zealand College of Midwives, dated 22 February 2013. The College said that it shared the coroner's findings with its members and will discuss them with the National Committee at its March meeting. The response provided the following further information.

The College has also been involved in the development of the Ministry of Health Consensus statement to guide practice – Observation of mother and baby in the immediate postnatal period (2012). We also maintain a close watch on all work in this area including the international commentary about the complexities in this area for both families as well as health professionals.

Assisting parents to understand the principles of safe sleeping practices means parents themselves are better placed to ensure that every sleep is a safe one. The unequivocal evidence based messages for all those involved in reducing SIDS/SUDI that the College continues to reinforce are that every sleep their baby should be:

- face up
- face clear
- smokefree.

As the main health professionals involved in maternity, midwives have a key role in providing information to support parents in their early parenting practices. We are working to ensure that we provide clear, concise and consistent information to parents to ensure that they are aware of what contributes to safe sleeping practices for all babies. When parents have a full understanding of what contributes to hazardous sleeping practices, they are better prepared and able to ensure that they follow safe sleeping practices consistently, in whatever environment they are in.

RESPONSE FROM WHANGANUI DISTRICT HEALTH BOARD

A short response was received from the Chief Executive of the Whanganui District Health Board on 6 March 2013. The response acknowledged receipt of the findings and stated that 'as a result of receiving these findings our policies and procedures have been reviewed and I am pleased to advise that we are compliant with the coroner's recommendations'.

RESPONSE FROM THE MINISTRY OF HEALTH

The coroner received a response from the Ministry of Health (MoH), dated 10 January 2013, in response to her findings and recommendations. The report detailed the MoH's current activities to strengthen SUDI prevention advice and support, and its other actions under consideration

The response discussed the development of a Child and Youth Mortality Committee statement on Prevention of Suffocation or Strangulation in Place of Sleep for Infants in New Zealand, with contributions from national experts in SUDI prevention (including ministry officials). The statement, which was due to be released in March 2013, will formally define a safe sleep space, recommend a safe sleep assessment for every infant and provide guidance on best practice approaches to sleep environment support. The ministry acknowledged that differences of expert opinion on safe sleep messages have previously posed a significant barrier and that the statement will set a foundation for strengthening and broadening safe sleep messages by promoting consistent advice.

The ministry is also currently revising the Safe Sleep Essentials pamphlet to improve messages in a way that is relevant to high-risk families and whānau. The revised pamphlet, which is to be used in the health sector, strengthens the co-sleeping message and was to be available in early April.

The response discussed the ministry's three SUDI prevention services which are also reviewing their health promotion messages for consistency with the statement. The Whakawhetu and Taha services (which are targeted specifically at Māori and Pacific peoples) have completed national e-learning toolkits for health professionals who work with families. The toolkit incorporates the advice of the statement and includes Māori and Pacific values and cultural competence training to support the provision of relevant advice in meaningful ways to high risk families and whānau.

The ministry stated that it is preparing to contract for baseline monitoring of SUDI awareness and safe sleep behaviours among priority populations in 2013. This will provide measurable outcomes of family and health professional awareness and SUDI prevention practice over time.

Change for Our Children has developed the pēpi-pod to reduce the risk of co-sleeping associated with SUDI. It is a general purpose storage box converted to a baby-sized bassinet for use in, or on, an adult bed, on a couch, in a makeshift setting, or away from home. In response to the Christchurch earthquakes the MoH funded the purchase of 642 pēpi-pods for distribution in early 2011 as an emergency response to an increase in co-sleeping. There are now DHB-funded pēpi-pod services in Hawke's Bay and Waikati, pēpi-pod research planned in Counties Manukau, and pēpi-pod discussions occurring in Northland, Rotorua, Whanganui, Wellington and Nelson-Marlborough. Wahakura research is also underway in Hawke's Bay.

The response said that all DHBs without a safe sleep policy have been encouraged by the Health Quality and Safety Commission and the Child and Youth Mortality Review Committee to develop and implement one as a matter of urgency. Promotion of safe sleep practices in ways that include Māori and Pacific values were also encouraged. The MoH said that for over a decade it has consistently promoted the message that the safest place for a baby to sleep is in a cot by the parental bed, and had more recently broadened its message to encompass the popular Wahakura and include other pēpi-pod initiatives which are designed to provide a safe sleeping space for babies on the parent's bed.

The MoH said that it is considering other actions and has begun conversations with Te Puni Kokiri and the Health Promotion Agency to explore potential for improving safe sleeping messages to families and whānau. Potential actions include ensuring resources are appropriate for Māori; providing Whānau Ora workers with SUDI prevention training; and exploring future potential for a national health promotion campaign on SUDI prevention.

Case number

CSU-2010-AUK-000087
2012 NZ CorC 162

CIRCUMSTANCES

The deceased, an 8-week-old infant, died in the Neonatal Intensive Care Unit at Auckland City Hospital of accidental asphyxia, which occurred in an unsafe sleeping environment; namely co-sleeping with his mother. He had been cared for in the parent-infant nursery (PIN) section of the unit, where family are fully involved in caring for the baby in order to prepare them for discharge. In the PIN, families are not directly supervised. His mother fell asleep while breastfeeding him in her bed and woke up later to find him unresponsive. Although hospital staff were able to restore his heartbeat, ultimately he died.

Sharing a bed with an adult is a particular risk factor for sudden unexpected death in infancy (SUDI). Though bed sharing is not supported in the neonatal unit, there was no written policy on the subject at the time, nor was it included in the publication given to parents detailing what was expected of them while using the PIN room. It was, however, included in some pamphlets and verbal instructions.

There was no assessment of the readiness of the deceased's parents to take over his care before they were transferred to the PIN, nor did they recall being warned about feeding their baby while in bed.

The publication for parents using the PIN room now warns against co-sleeping, and there are notices in the PIN room that advise babies should be put back in their cots after feeding. The new screening process parents must go through before they can use these facilities includes a SUDI component.

COMMENTS AND RECOMMENDATIONS

The coroner commented that bed sharing/co-sleeping is inherently dangerous. Studies have shown that sharing a sleeping surface with a baby increases the risk of SUDI. She commented that this death highlights the importance of clear, practical, appropriate messages about the risks of bed sharing/co-sleeping, how such risks can arise, and how they can be communicated to parents/caregivers.

In the coroner's view the development of national guidelines for safe sleeping by consensus of all stakeholders would be a major achievement. She considered that such guidelines would provide a consistent message for health care providers and families, and help all involved make principled, informed decisions on how to ensure that every sleep for infants is a safe sleep. The coroner noted that the neonatal unit did not have an explicit safe sleeping policy and relied on an understanding amongst staff that bed sharing/co-sleeping in the neonatal unit was simply not done. The evidence noted that an appropriate safe sleeping policy is important to guide practice.

The Health Quality and Safety Commission's outline of what a safe sleep policy should include covers a range of matters applicable to neonatal units, as well as maternity services. Health care professionals in hospitals (including in neonatal units) should be modelling safe sleeping practices from the time of a baby's birth and reinforcing safe sleeping messages and strategies with parents. An appropriate safe infant sleeping policy is an important starting point.

The coroner recommended to the Director-General of Health that the Ministry of Health highlight to the public and to health care and social service providers the risks of a mother or other adult sharing a sleeping surface with a baby when the adult is asleep. It was further recommended that the ministry advocates for a focus on prevention of suffocation deaths by all health and social service providers and leads an initiative to develop, by consensus of all stakeholders, National Guidelines for Safe Sleeping.

The coroner also recommended to the Chief Executive Officer and Chair of the Auckland District Health Board (ADHB) that ADHB ensures it has an explicit safe sleeping policy for infants in the Neonatal Intensive Care Unit that includes all the matters highlighted by the Health Quality and Safety Commission, and that the ADHB's Neonatal Intensive Care Unit audits the adequacy and effectiveness of its safe sleeping messages to families.

To the chief executive officers and chairs of all district health boards (DHBs) the coroner recommended that, as already recommended by the Health Quality and Safety Commission in June 2012, all DHBs develop and implement as a matter of priority a safe sleeping policy for infants. This policy should aim to ensure that:

- staff who support families caring for infants receive mandatory training and updates about prevention of SUDI and ways of communicating risks to families
- safe sleeping practices are modelled for all infants within DHB facilities
- safe sleeping arrangements are available for all infants after they are discharged home
- families are provided with education and support tailored to their level of need about the hazards that arise in some sleeping situations
- advice on safe strategies for night feeds and settling infants is provided to parents
- all services and staff encourage safe sleep practices in ways that include Māori and Pacific cultures and values.

The coroner recommended that those DHBs that currently have safe sleeping policies should review the adequacy of those policies and where necessary amend their policies to include the issues identified by the Health Quality and Safety Commission. All DHBs with neonatal units ensure that such units have appropriate safe infant sleeping policies.

RESPONSE FROM AUCKLAND DISTRICT HEALTH BOARD

The ADHB provided the following response to the coroner's findings and recommendations.

Following the death of [the deceased] and receipt of the inquest findings ADHB had undertaken significant work and is in the process of implementing the recommendations made. Further advice as to the steps taken is expected to be available in the next few weeks and will be provided for your information once it is to hand.

A copy of the findings has been provided to the Chief Executive Officer and the Chair of the ADHB.

RESPONSE FROM THE NEW ZEALAND COLLEGE OF MIDWIVES

The coroner received a response to her findings and recommendations from the New Zealand College of Midwives, dated 22 February 2013. The college said that it shared the coroner's findings with its members and will discuss them with the National Committee at its March meeting. The response provided the following further information.

The college has also been involved in the development of the Ministry of Health consensus statement to guide practice – *Observation of mother and baby in the immediate postnatal period* (2012). We also maintain a close watch on all work in this area including the international commentary about the complexities in this area for both families as well as health professionals.

Assisting parents to understand the principles of safe sleeping practices means parents themselves are better placed to ensure that every sleep is a safe one. The unequivocal evidence based messages for all those involved in reducing SIDS/SUDI that the college continues to reinforce are that every sleep their baby should be:

- face up
- face clear
- smokefree.

As the main health professionals involved in maternity, midwives have a key role in providing information to support parents in their early parenting practices. We are working to ensure that we provide clear, concise and consistent information to parents to ensure that they are aware of what contributes to safe sleeping practices for all babies. When parents have a full understanding of what contributes to hazardous sleeping practices, they are better prepared and able to ensure that they follow safe sleeping practices consistently, in whatever environment they are in.

RESPONSE FROM THE MINISTRY OF HEALTH

The coroner received a response from the Ministry of Health (MoH), dated 10 January 2013, in response to her findings and recommendations. The report detailed the MoH's current activities to strengthen SUDI prevention advice and support, and its other actions under consideration.

The response discussed the development of a Child and Youth Mortality Committee statement on Prevention of Suffocation or Strangulation in Place of Sleep for Infants in New Zealand, with contributions from national experts in SUDI prevention (including ministry officials). The statement, which was due to be released in March 2013, will formally define a safe sleep space, recommend a safe sleep assessment for every infant and provide guidance on best practice approaches to sleep environment support. The ministry acknowledged that differences of expert opinion on safe sleep messages have previously posed a significant barrier and that the statement will set a foundation for strengthening and broadening safe sleep messages by promoting consistence of advice.

The ministry is also currently revising the Safe Sleep Essentials pamphlet to improve messages in a way that is relevant to high-risk families and whānau. The revised pamphlet, which is to be used in the health sector, strengthens the co-sleeping message and was to be available in early April.

The response discussed the ministry's three SUDI prevention services which are also reviewing their health promotion messages for consistency with the statement. The Whakawhetu and Taha services (which are targeted specifically at Māori and Pacific peoples) have completed national e-learning toolkits for health professionals who work with families. The toolkit incorporates the advice of the statement and includes Māori and Pacific values and cultural competence training to support the provision of relevant advice in meaningful ways to high-risk families and whānau.

The ministry stated that it is preparing to contract for baseline monitoring of SUDI awareness and safe sleep behaviours among priority populations in 2013. This will provide measurable outcomes of family and health professional awareness and SUDI prevention practice over time.

Change for Our Children has developed the pēpi-pod to reduce the risk of co-sleeping associated with SUDI. It is a general purpose storage box converted to a baby-sized bassinet for use in, or on, an adult bed, on a couch, in a makeshift setting, or away from home. In response to the Christchurch earthquakes the MoH funded the purchase of 642 pēpi-pods for distribution in early 2011 as an emergency response to an increase in co-sleeping. There are now DHB funded pēpi-pod services in Hawke's Bay and Waikati, pēpi-pod research planned in Counties Manukau, and pēpi-pod discussions occurring in Northland, Rotorua, Whanganui, Wellington and Nelson-Marlborough. Wahakura research is also underway in Hawke's Bay.

The response said that all DHBs without a safe sleep policy have been encouraged by the Health Quality and Safety Commission and the Child and Youth Mortality Review Committee to develop and implement one as a matter of urgency. Promotion of safe sleep practices in ways that include Māori and Pacific values were also encouraged. The MoH said that, for over a decade, it has consistently promoted the message that the safest place for a baby to sleep is in a cot by the parental bed, and had more recently broadened its message to encompass the popular Wahakura and include other pēpi-pod initiatives which are designed to provide a safe sleeping space for babies on the parent's bed.

The MoH said that it is considering other actions and has begun conversations with Te Puni Kokiri and the Health Promotion Agency to explore potential for improving safe sleeping messages to families and whānau. Potential actions include ensuring resources are appropriate for Māori, providing Whānau Ora workers with SUDI prevention training and exploring future potential for a national health promotion campaign on SUDI prevention.

RESPONSE FROM WHANGANUI DISTRICT HEALTH BOARD

A short response was received from the Chief Executive of the Whanganui DHB on 6 March 2013. The response acknowledged receipt of the findings and stated that 'as a result of receiving these findings our policies and procedures have been reviewed and I am pleased to advise that we are compliant with the coroner's recommendations'.

Case number

CSU-2011-DUN-000314
2012 NZ CorC 157

CIRCUMSTANCES

The deceased, an infant who was almost 5 months old, died at his home of sudden unexpected death in infancy (SUDI) in a background of unsafe sleeping arrangements. He had been breastfed in his parents' bed and left there while they slept. When his parents woke up the deceased was not breathing.

He had been exposed to maternal smoking during pregnancy, which is a key identified risk factor for SUDI, as is sharing a bed with an adult.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the Director-General of Health and the Ministry of Health that they continue with public health advice in relation to safe infant care practices and safe sleeping environments.

He also recommended to the Ministry of Health that they should continue to strengthen and broaden advice previously given to make it clear that:

- bed sharing by adults and siblings with infants under the age of 6 months exposes such infants to a substantially increased risk of death
- the safest place for babies to sleep during the first 6 months of their lives is in a cot beside the parental bed.

He recommended that the ministry should take steps to ensure that the advice on safe sleeping is given by all public health educators and health professionals in all public health sectors over which the Ministry of Health has influence.

He further recommended that the ministry encourage the Moe Ora scheme to provide newborn infants with a self-contained sleeping cradle (wahakura) (which researchers advise goes some way to ensuring the safety of an infant in a co-sleeping environment). He suggested that the Ministry of Health should consider providing such a cradle to every new mother if she can't afford to buy one.

RESPONSE FROM THE MINISTRY OF HEALTH

The coroner received a response from the Ministry of Health (MoH), dated 10 January 2013, in response to his findings and recommendations. The report detailed the MoH's current activities to strengthen SUDI prevention advice and support, and its other actions under consideration

The response discussed the development of a Child and Youth Mortality Committee statement on Prevention of Suffocation or Strangulation in Place of Sleep for Infants in New Zealand, with contributions from national experts in SUDI prevention (including ministry officials). The statement, which was due to be released in March 2013, will formally define a safe sleep space, recommend a safe sleep assessment for every infant and provide guidance on best practice approaches to sleep environment support. The ministry acknowledged that differences of expert opinion on safe sleep messages have previously posed a significant barrier and that the statement will set a foundation for strengthening and broadening safe sleep messages by promoting consistence of advice.

The ministry is also currently revising the Safe Sleep Essentials pamphlet to improve messages in a way that is relevant to high-risk families and whānau. The revised pamphlet, which is to be used in the health sector, strengthens the co-sleeping message and was to be available in early April.

The response discussed the ministry's three SUDI prevention services which are also reviewing their health promotion messages for consistency with the statement. The Whakawhetu and Taha services (which are targeted specifically at Māori and Pacific peoples) have completed national e-learning toolkits for health professionals who work with families. The toolkit incorporates the advice of the statement and includes Māori and Pacific values and cultural competence training to support the provision of relevant advice in meaningful ways to high-risk families and whānau.

The ministry stated that it is preparing to contract for baseline monitoring of SUDI awareness and safe sleep behaviours among priority populations in 2013. This will provide measurable outcomes of family and health professional awareness and SUDI prevention practice over time.

Change for Our Children has developed the pēpi-pod to reduce the risk of co-sleeping associated with SUDI. It is a general purpose storage box converted to a baby-sized bassinet for use in, or on, an adult bed, on a couch, in a makeshift setting, or away from home. In response to the Christchurch earthquakes the MoH funded the purchase of 642 pēpi-pods for distribution in early 2011 as an emergency response to an increase in co-sleeping. There are now DHB funded pēpi-pod services in Hawke's Bay and Waikati, pēpi-pod research planned in Counties Manukau, and pēpi-pod discussions occurring in Northland, Rotorua, Whanganui, Wellington and Nelson-Marlborough. Wahakura research is also underway in Hawke's Bay.

The response said that all DHBs without a safe sleep policy have been encouraged by the Health Quality and Safety Commission and the Child and Youth Mortality Review Committee to develop and implement one as a matter of urgency. Promotion of safe sleep practices in ways that include Māori and Pacific values were also encouraged. The MoH said that, for over a decade, it has consistently promoted the message that the safest place for a baby to sleep is in a cot by the parental bed, and had more recently broadened its message to encompass the popular Wahakura and include other pēpi-pod initiatives which are designed to provide a safe sleeping space for babies on the parent's bed.

The MoH said that it is considering other actions and has begun conversations with Te Puni Kokiri and the Health Promotion Agency to explore potential for improving safe sleeping messages to families and whānau. Potential actions include ensuring resources are appropriate for Māori; providing Whānau Ora workers with SUDI prevention training; and exploring future potential for a national health promotion campaign on SUDI prevention.

The ministry acknowledged that there is not universal agreement among health professionals and parents about the degree of risk posed by co-sleeping. While epidemiologic studies consistently find an increased risk to infants from co-sleeping, a more detailed examination of cases reveals that in almost every case the infants affected are more vulnerable to asphyxia or SUDI, in particular they are more likely to be premature or low-birthweight, or were exposed in-utero and/or postnatally to tobacco toxins. They were also more likely to be sleeping in particularly adverse situations such as on a couch, or a mattress on the floor, leading to entrapment and suffocation; or with a parent (usually the mother) impaired by drugs, alcohol, extreme tiredness or post-operative sedation. Maternal obesity is also a risk factor. Some of these factors were present in this case.

The response also noted, with reference to the coroner's recommendation, that Work and Income also provides support to ensure that infants are

able to sleep in a cot or bassinet, whether their parents are beneficiaries or not. The ministry said that its messaging to health professionals will be to encourage support for Work and Income applications in such circumstances.

Case number

CSU-2012-HAM-000325
2012 NZ CorC 205

CIRCUMSTANCES

The deceased, a 7-month-old infant, died at a marae of bronchopneumonia. He slept the night on the marae while he was there for a tangi. He was swaddled, and placed next to his mother to sleep on a foam mattress on the floor. His mother awoke the next morning to find him unresponsive.

The cause of the death was found to be bronchopneumonia, resulting from an influenza infection. However the pathologist suggested that the baby's sleeping conditions may have contributed to the death.

COMMENTS AND RECOMMENDATIONS

The coroner acknowledged that there was no clear evidence that the sleeping environment contributed to the baby's death. However, he commented that this is an issue which should be highlighted to marae across the country so that the danger of co-sleeping with very young babies is highlighted. The coroner said that coronial data has shown that, in recent years, the number of deaths where co-sleeping may be a contributing factor has been reduced overall but the number of deaths where co-sleeping may be a contributing factor is still too high in Māori families. The coroner commented that research has shown that babies who share beds with adults face an increased risk of sudden and unexpected death. Whereas in this case a cause can be identified (bronchopneumonia) the risk posed by co-sleeping is still very real.

The coroner recommended that all marae committees should encourage their whānau to use safe sleeping practices when attending hui or tangihanga by promoting the use of wahakure (a woven bassinet) or a pēpi-pod or other similar devices, which provide a safer sleeping environment for babies in circumstances of a shared sleeping environment such as on a marae.

He also recommended that a copy of the findings be sent to the Minister of Māori Affairs and Minister of Whānau Ora so that they can disseminate a copy of the anonymised version and its recommendations to all marae throughout the country.

Case number

CSU-2011-ROT-000008
2013 NZ CorC 4

CIRCUMSTANCES

The deceased, a 2-month-old infant, died of accidental asphyxia caused by an unsafe sleeping environment. After a night of socialising and drinking, the baby's mother left her home to go to another address. Later that evening, after an argument with her partner, she ended up going to another but was unable to get inside. She slept in the back seat of a car parked outside with the deceased cradled in her arm. When she woke up the next morning, the baby had died.

Four years earlier, the mother had another two-month-old son who also died of sudden unexpected death in infancy (SUDI). When she became pregnant with the deceased her midwife provided information to her on SUDIs prevention. After the deceased was born the midwife advised police that bed sharing was occurring, although she had been told by the mother that a cot was coming. The mother also had a history of drinking during her pregnancies. As a result of this incident the deceased's mother was charged and convicted of manslaughter.

COMMENTS AND RECOMMENDATIONS

The coroner commented that he sadly had to repeat the chilling message that keeps coming out from these inquests. These babies are being unwittingly killed. He said that all of these deaths are entirely preventable. He referred to findings he had made in April 2011 into a death involving the practice of bed sharing and unsafe sleeping practices, and commented that the findings from that case should be read contemporaneously with these findings. He referred to the following excerpt from those previous findings.

In my view the message is simply not getting out there to the level and extent it should. Babies in this country are dying unnecessarily. Latest figures suggest it could be as many as 55 to 60 babies dying each year from unsafe sleeping arrangements who might otherwise be alive. The vast majority are Māori and Pacific Island babies. This is an indictment on our society and needs to be corrected urgently. It can be corrected very simply by education and on the ground assistance to

families with new babies. Whilst tragically it seems there will always be SUDI deaths with young babies it is clear that if unsafe sleeping arrangements were eliminated then a very significant number of babies and young New Zealanders would survive.

The coroner repeated recommendations made by another coroner in similar findings:

- That the public health advice in relation to safe infant care practices and safe sleeping environments be strengthened and broadened to as to make clear that:
  - Bed-sharing by adults and siblings with infants under six months exposes the infant to the risk of death and should be avoided.
  - The safest place for babies to sleep for the first six months of life is in a cot beside the parental bed.
- That steps be taken by the Ministry to ensure that the same advice is given by public health professionals in those public health sectors over which the ministry has influence.

The coroner also recommended that these findings be forwarded to the Minister of Social Development to form part of the overall information available in respect of the investigation they are conducting. He urged the Minister to read these findings and the others referred to and to adopt practices recommended so that these entirely preventable deaths are in fact prevented.

The coroner commented that he and other coroners had had the sad experience of presiding over a number of high-profile cases involving child abuse. The coroner said that he could not help but draw the analogy that when society talks about child abuse resulting in death there is enormous publicity, and a number of inquiries and commissions have resulted. He drew attention to the fact that there is, on a continuing basis, a huge number of annual preventable deaths of young babies in New Zealand and society seems to have almost become immune to it. He commented that it is a tragedy that these deaths occur and that it is even more of a tragedy that the necessary resources do not appear to be being put in place so that these preventable deaths are in fact prevented.

Transport-related

See also *aged and infirm care* and *child deaths* above and *work-related (agriculture)* and *work-related (other)* below.

Case number

CSU-2010-CCH-000784
NZ CorC 97

CIRCUMSTANCES

The deceased died on State Highway 1 of injuries she sustained when the vehicle she was driving collided with an oncoming truck. She veered into the oncoming lane while negotiating a bend, and collided almost head-on with the truck.

She had earlier been observed to be driving erratically and was described as appearing 'vacant and motionless' behind the wheel by another motorist. She was an insulin-dependent diabetic, and the evidence suggests that she was hypoglycaemic at the time of the crash, and therefore unable to recognise that her driving was dangerous.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the facts of this case, and expert opinion given, highlight that hypoglycaemia may not only impair driving safety but also judgement about whether to continue to drive or self-treat.

He noted that the deceased was, in the words of her general practitioner, 'highly motivated to care for herself'. However because of hypoglycaemia that occurred in the course of her journey of less than 30 minutes, she failed to recognise her condition and that to continue to drive in the circumstances was hazardous.

Case number

CSU-2012-DUN-000102
2012 NZ CorC 168

CIRCUMSTANCES

The deceased died in hospital as a result of traumatic brain injuries he received in a motor vehicle crash. He lost control while driving down his rural driveway and

went off the road and through a fence, striking his head in the collision. He underwent surgery for his injuries but died the next day.

It is likely that the deceased was not wearing a safety belt, as the airbags on the vehicle he was driving will only be deployed if a safety belt is fastened, and they did not deploy. He had seemed unwell in recent days and was advised by his doctor to rest, but on the day of his death he had gone to work against this advice. It is most likely that he suffered some kind of medical event while driving which caused him to lose consciousness.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to Federated Farmers and the NZ Transport Agency that, even in an 'on farm' situation where the wearing of safety belts may not be legally compulsory, the use of a seat belts is still recommended and can save a driver or passenger from serious injury, or death, in certain circumstances. The coroner commented that it needs to be drawn to public attention that, in some vehicles at least, air bags fitted to the vehicle will only deploy if a safety belt is fastened.

He further recommended to Federated Farmers that it circulate the advice to its members.

Case number

CSU-2011-WNG-000117
2012 NZ CorC 123

CIRCUMSTANCES

The deceased died in hospital from injuries she received when her car was struck by another vehicle being driven at speed in the opposite direction, partly on the wrong side of the road.

The driver of the other vehicle had served jail time about a year before this death for driving offences, at which time he had been disqualified from driving. Approximately two months after leaving prison (and several months before the crash that killed the deceased) he was caught committing another driving offence. His disqualification period had ended and he was once again disqualified from driving. When he was stopped again a week later with excess breath alcohol he used a different name given to him by the witness protection programme. As a result he was dealt with in court as a first-time offender. The crash that killed the deceased occurred less than two months later.

Had the period of his disqualification from driving started when he was freed from prison, rather than running concurrently with his time there, he would still have been disqualified from driving when he was caught two months after leaving prison.

Had this been the case the sentencing judge might have jailed him rather than only suspending his licence again.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the Minister of Transport that consideration be given to amending the law, as presently stated in section 85(1) of the Land Transport Act 1998.

He recommended that an amendment be made to provide that an order made by a court disqualifying an offender from holding a driver licence, imposed concurrently with a sentence of imprisonment, will have practical effect and not be subsumed in that sentence of imprisonment. That is, a period of disqualification from holding a driver licence shall take effect (unless for good reason the court thinks otherwise) only after the offender is released from prison.

Case number

CSU-2012-HAM-000367
2012 NZ CorC 169

CIRCUMSTANCES

The deceased died as a result of severe injuries he sustained when he was struck by a train. He had been spending time with two friends in the trees by the railway line when he left, while texting, to buy some food. As he exited the tree line and stepped out onto the track he was struck by an oncoming train.

The train driver had no opportunity to avoid hitting the deceased, as neither could have seen the other any earlier due to the trees lining the railway. Likewise, the deceased was less likely to hear the train as it had yet to pick up any carriages. The deceased had also been smoking cannabis with his friends earlier, which may have contributed to his distraction, as would have the fact that he was texting at the time.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the evidence indicated that the death occurred in an inherently dangerous situation where train tracks in an urban setting were bordered by trees and shrubs.

Although pedestrians are not permitted to cross railway tracks at an uncontrolled point, where you have a park on one side of the tracks and a main road on the other side, it is inevitable that pedestrians are going to cross the track. This is especially so when the area is frequented by children or youths in whom the sense of social responsibility and personal safety is not usually keenly felt. It is therefore appropriate for safeguards to be put in place to protect such vulnerable people.

The coroner recommended to KiwiRail that they consider measures that can be practically implemented to make this area of the rail system safer for pedestrians. This could be done either by fencing off this section of the track or by reducing or removing the trees bordering the track to improve visibility for both train drivers and pedestrians. In addition, the company may wish to review the applicable speed limit for trains travelling on a particular section of track.

Case number

CSU-2011-HAM-000525
2012 NZ CorC 147

CIRCUMSTANCES

The deceased died of injuries he sustained in a motor vehicle crash which occurred when he lost control of his car on State Highway 3 and slid over the centreline and into the path of an oncoming vehicle.

Although the surface adhesion of the stretch of road where the crash occurred was within the acceptable range, it was at the lower end of that spectrum. In addition, the road at the time was wet, which may also have contributed to the deceased's loss of control and the subsequent crash. It was considered that the surface adhesion of the road could be improved by re-sealing or water blasting.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the NZ Transport Agency that this finding and the Serious Crash Unit report be sent to the State Highway Manager at the Agency to investigate the issue of surface adhesion on the stretch of road where this crash occurred, and determine whether improvements are needed.

Case number

CSU-2009-CCH-000883
2012 NZ CorC 206

CIRCUMSTANCES

The deceased died on State Highway 6 of injuries he sustained in an un-witnessed motor vehicle crash, which occurred while the deceased was attempting to turn a corner on his motorcycle. The crash occurred in the early hours of the morning and he was found shortly after by passersby, but died at the scene.

The deceased had a significantly high blood-alcohol concentration – almost 3 times the legal limit for a driver at the time. He was also riding a motorcycle without a current warrant of fitness and which was defective to the point that it could have contributed to the crash. Additionally, the speed at which he was travelling was above that recommended by the speed advisory signage for the corner.

There was an area of sump in the seal of the road shortly before the corner where the crash occurred. Though it was on the opposite side of the road to where the deceased was travelling and therefore could not have caused the crash, it remained an area of concern in general.

COMMENTS AND RECOMMENDATIONS

The coroner endorsed the recommendation made in the Serious Crash Unit report that the seal damage be brought to the road controlling authority's attention for further maintenance. However, this was not as a consideration that the seal damage caused the crash. The coroner addressed this recommendation to the New Zealand Transport Agency (NZTA).

RESPONSE FROM NEW ZEALAND TRANSPORT AGENCY

The NZTA provided the following response to the coroner's recommendations.

In the Certificate of Findings it was noted that while it was not a direct cause of the crash, the seal damage identified and raised by the Serious Crash Unit should be brought to the attention of the road controlling authority for future maintenance.

The NZTA is grateful for the indication of seal damage in the proximity of the site, and indeed recognition that this did not contribute to this accident. We do get relatively frequent rock falls through this section of road, which occasionally leave damage to the road

seal. Typically the NZTA carry out repairs as soon as practicable, but this will be dependent on the nature and severity of the damage done.

The NZTA stated that this would be followed up to make sure this site has been attended to, although the Agency expressed every confidence it already has.

Case number

CSU-2012-HAM-000319
2013 NZ CorC 7

CSU-2012-HAM-000321
2013 NZ CorC 11

CSU-2012-HAM-000320
2013 NZ CorC 13

CIRCUMSTANCES

Three young people died in Hamilton from injuries sustained in a motor vehicle crash. The crash occurred when one of the deceased, the driver of the vehicle, fell asleep at the wheel and lost control of the vehicle, which collided with a tree.

Earlier in the evening the young people had been drinking and socialising. The driver had a blood-alcohol level that exceeded the limit for a driver over 20 and as he was aged only 18, legally he should not have had any alcohol in his bloodstream.

The tree the car struck was situated so close to the road as to be considered a hazard and a factor in the crash.

COMMENTS AND RECOMMENDATIONS

The coroner commented that these deaths occurred as a result of the combination of intoxication and fatigue in the driver. The coroner said that the driver's decision to drive after drinking and while deprived of sleep suggests a willingness to flout the law, and a disregard of the consequences that can ensue. The location of the gum tree has also been identified as a factor which contributed to the death of these three young men. The coroner therefore considered it appropriate to make recommendations.

The coroner recommended that all relevant agencies continue their efforts to educate young people of the dangers of driving while under the influence of alcohol and while sleep deprived, and to impress on them the tragic consequences that can flow from breaking the law.

He also recommended to the Waikato District Council that the council, or the road controlling authority responsible for the site where the crash occurred, remove the mature gum tree that the vehicle crashed into as soon as possible. Alternatively, he recommended that the council erect a barrier around the tree that would deflect a vehicle which struck it rather than allow a front-on impact.

RESPONSE FROM WAIKATO DISTRICT COUNCIL

The Waikato District Council responded to the coroner's findings and recommendations that it intends to have the mature gum tree removed by the end of September 2013.

Case number

CSU-2011-ROT-000419
2013 NZ CorC 12

CIRCUMSTANCES

The deceased died on State Highway 1 of injuries which she sustained in a motor vehicle crash. The crash occurred while the deceased was driving around a sweeping left-hand bend. She crossed the centre line and collided with a vehicle coming in the opposite direction. She died at the scene and the driver and two passengers from the other vehicle were transported to Waikato Hospital with serious injuries.

Evidence from the crash scene indicated that the deceased had been preoccupied texting on her cellphone at the time of the crash.

COMMENTS AND RECOMMENDATIONS

The coroner commented that there had recently been considerable media coverage concerning texting and driving. New Zealand Police had run a campaign in recent months. He noted that press reports show that in the first 21 months of the ban on the use of cellphones while driving that more than 14,000 tickets were issued. New Zealand Police figures show that 28 people have died on New Zealand roads in crashes caused by people using cellphones since 2007. Press reports also state that figures released under the Official Information Act 1982 in the year ended 31 March 2012 show that 149 crashes were thought to have been at least partly caused by cellphone use. The coroner stated that there is no doubt from studies conducted and basic commonsense that texting while driving impairs the driver's ability.

The coroner recommended that these findings be forwarded to the Minister of Transport for consideration to support and increase a public education campaign about the dangers of driving while distracted which includes the use of cellphones, texting and general tiredness.

Case number

CSU-2008-WGN-000310
2013 NZ CorC 6

CIRCUMSTANCES

The deceased died of injuries he sustained when he was hit by the trailer of a truck when cycling home. The truck and trailer was travelling in the same direction as the deceased, on his right-hand side, near the intersection of Hutt Road and the Petone Esplanade.

At the time of the incident traffic volumes were high and the light was fading. As the truck turned to approach the roundabout that controlled the intersection, the wheels of the trailer tracked inside the circular path of the front wheels, a phenomenon known as 'vehicle off-tracking', and into the deceased. He was thrown from his bicycle and died at the scene.

The part of the road that the deceased and other cyclists were travelling on was not a dedicated cycle lane. Moreover, at a critical point of this part of the road there was an area of sump in the seal by a drain. It seemed likely that the deceased was cycling as close as possible to the kerb, but swung out to avoid the sump and the truck and tracked too far to the left. These two factors combined to cause the collision.

The deceased was wearing reflective strips on his clothing and backpack, and had the front and rear lights of his bicycle on.

COMMENTS AND RECOMMENDATIONS

The coroner identified several issues that this tragic death raised:

- the issue of whether it should be compulsory for cyclists to wear high-visibility clothing in the same manner that it is compulsory to wear a cycling helmet
- the issue of the competing use of roadways by cyclists and other powered vehicles
- the design and complexity of the particular roundabout where the crash occurred.

The coroner commented that it should be compulsory for cyclists to wear hi-vis clothing at all times when riding on public roads (with the exception of a controlled cycle race or similar). All road contractors' workforces must wear such clothing as it clearly stands out. While the wearing of such clothing will not stop a specific incident happening it simply must be commonsense in the interests of safety to wear such clothing.

As to the issue of the particular crash site in question, the coroner acknowledged that there has been considerable effort and funds spent by the authorities to attempt to improve the plight of cyclists since this death. However, unfortunately in his view the efforts still fall short of making the road safe for cyclists. Evidence from the Cycling Advocates Network was that cyclists want to use a direct route between where they are coming from and where they are going to.

In the coroner's view, the alternative cycle route that incorporates the underpass degenerates in terms of its quality and connectedness and is therefore unattractive for cyclists to use. As a senior traffic engineer stated in his evidence, improvements of incorporating the electronic cycling activated warning signs have been installed and they are clearly an added safety feature, but the coroner also had concerns about the road markings. The fog lines were refreshed after the deceased's death, but a more current observation again showed that they were worn. A recent site inspection showed that a high percentage of the motorised vehicles tracked across those lines in the vicinity of this crash, and particularly the large trucks. It also was acknowledged that the roadside draining sump has now been replaced but it still protrudes into the roadway, particularly at the pinch point. Despite the traffic engineering improvements undertaken, the intersection was in the coroner's view a most dangerous area for cyclists to use, no matter how experienced the riders are. He commented that cyclists who use this cycle/traffic lane area are literally taking their lives in their hands, and a complete rethink and redesign of this area was required.

Turning to the area of the traffic regulations in respect of the conflict between motor vehicles and cyclists, the coroner commented that it appeared under the current legislation that cycles are also considered as a vehicle, and just as entitled to use a road as a motor vehicle.

The Traffic Regulations 1956 stated at regulation 76(4) that 'When a reasonably adequate bicycle track is available, every rider of a bicycle shall keep to that track as far as possible'. This was replaced in the

Traffic Regulations 1976 with regulation 41(1), which changed some of the wording slightly to read, 'When a reasonably adequate cycle track is available, every rider of a cycle or power cycle shall keep to the track as far as practicable'.

Regulation 41 was subsequently revoked and it is now part of the Land Transport (Road User) Rule 2004 and the Land Transport Rule: Traffic Control Devices 2004 that dealt with cycle lanes. The Land Transport (Road User) Rule 2004 in respect of cycle lanes deals with the road markings and traffic signs. In the road user rule, cyclists are defined as a form of driver and the cycle lanes are regarded as simply another species of special vehicle lane.

The approach to the rules is to empower road controlling authorities to create special vehicle lanes and to specify the class of vehicles that may use them. The road user rules also ban use by vehicles not authorised to use those lanes. The previous requirements as seen at regulation 41(1) are, however, not repeated in the road user rules and do not appear in any legislation. The official New Zealand code for cyclists (latest version published March 2012 by the NZTA) states under the heading 'Using cycle lanes and cycling in bus lanes':

> Where there are cycle lanes you should use them. However, at times you may need to move further out into the road (if the lane is too close to the sides of parked cars or because of rubbish or uneven road surfaces). You should also leave the cycle lane well before an intersection to join a different lane to turn right or left...
>
> Vehicles turning left may need to cross a bus or cycle lane. The law states that they must give way to all vehicles using the lanes.

This means effectively therefore cyclists should use the cycle lane if available, but there appears to be no legal obligation to do so.

The coroner noted that New Zealand is a signatory to the Geneva Convention on road traffic. This states at article 16(2)(a) that cyclists shall use cycle tracks where there is an obligation to do so indicated by an appropriate sign or where such obligations are imposed by domestic regulations. Therefore the coroner took from this that there is a great deal of confusion for road users to determine what the correct rules are, and that this is not helped by the extreme complexity at deciphering the land transport laws applicable. The legislation is complex and is a behemoth and in the coroner's view needs a more simplistic revamp.

The coroner made the following recommendations to the Minister of Transport:

- Just in the same manner that it is compulsory for a cyclist to wear a safety helmet when cycling on public roads, all cyclists (with the exception of those partaking in a controlled event, such as a road race) should wear high-vis clothing.
- The road user rules (road code) include that where a motor vehicle is passing a cyclist that a 1 metre gap be provided between the cyclist and the vehicle.
- An enhanced cyclist education (primary schools) and driver licence education with respect to cyclists be incorporated to a high degree.
- The rules as they apply with respect to cycle lanes be clarified, making it compulsory for cyclists to utilise those lanes where they are in existence and to clearly determine where cyclists can intermingle with motorised vehicles.

The coroner recommended to the Chief Executive of the Hutt City Council that a complete review of the cycle/traffic lanes be undertaken at the Petone interchange to provide an adequate separation between cyclists and other forms of traffic using that area. He said it was clear that while attempts have been made to provide a separate cycleway, the quality and limited connectedness fails to meet a level that cyclists are likely to use.

RESPONSE FROM HUTT CITY COUNCIL

The coroner received a response from the Chief Executive of the Hutt City Council, dated 25 February 2013, to his findings and recommendations.

I would like to advise that Hutt City will undertake a review and complete works on the site, with a view to achieving a minimum separation of 1metre between a cyclist and the likely 'swept turning path' of a heavy truck and trailer negotiating the roundabout. This year's budget for minor improvements (safety) works has already been committed, so the work at the Petone Interchange will be programmed for early in the 2013/2014 financial year.

We are hopeful the current NZTA investigation into the proposed Petone to Grenada link road, that includes provision for a new State Highway 2/ Esplanade Interchange, will provide the justification for NZTA to construct this route as programmed in the 2020–2024 period.

Consequently, in anticipation of this major re-build, I need to stress our current review will be limited to the cycle/traffic lanes on the existing roundabout and not 'a complete rethink and redesign of this area' as noted in [the coroner's findings].

I acknowledge however, that while it will continue to be its strategy to provide off-road cycle ways wherever feasible, there are certain locations including the Petone Interchange, where experienced, confident cyclists will take the most direct route regardless, and we do need to made safe provision for them on the road.

Case number

CSU-2012-HAS-000058
2013 NZ CorC 61

CIRCUMSTANCES

The deceased died of multiple injuries which she sustained in a motor vehicle crash. The crash occurred when she turned left into the path of an oncoming truck. The truck driver did not realise, the truck's left-hand indicator remained on after it had turned onto the road. It is likely that the deceased saw the indicator and believed the truck was about to turn left, making it safe for her to turn.

COMMENTS AND RECOMMENDATIONS

The coroner commented that road users rely on indicators at their peril. Road users must ensure that they can proceed safely, even if other vehicles do not do as they are indicating.

Case number

CSU-2012-HAM-000343
2013 NZ CorC 75

CIRCUMSTANCES

The deceased died in hospital of acute chronic renal failure, after he sustained severe injuries in a motor vehicle crash. While travelling at night down a rural section of road with no street lights, the deceased's vehicle struck a cow that was standing in the traffic lane. The black cow was difficult to see from a distance in the dark, lessening the reaction time available to the driver of the car.

The fence that was supposed to keep the cow on its owner's property was 12 years old, and it was possible for the cow to have pushed itself out between the wires.

The NZ Transport Agency (NZTA) has agreements with some district councils to monitor the state of fencing along state highways. There is no such agreement with the relevant district council (Matamata-Piako District Council) in this case.

COMMENTS AND RECOMMENDATIONS

The Serious Crash Unit report into this incident concluded that a contributing factor to the crash was the escape of the cow from a farm at night through a fence that was probably inadequate. The coroner commented that this highlights the need for all landowners with property adjoining roads to ensure that their boundary fences comply with the requirements of the Fencing Act 1978.

The coroner recommended to the chief executive officers of the NZTA and the Matamata-Piako District Council (MPDC)that Federated Farmers, and all other organisations involved in promoting good farming practices or road safety, continue to remind landowners whose properties border state highways that they must construct and maintain adequate boundary fences along those highways.

He also recommended that the NZTA consider entering into an agreement with MPDC in relation to the monitoring of fencing along the major highways running through the district, as provided for under NZTA *State highway control manual SM012*.

RESPONSE FROM THE NEW ZEALAND TRANSPORT AGENCY

The NZTA provided the following response to the coroner's findings and recommendations.

The NZTA has delegated matters regarding wandering stock on state highways within the Matamata-Piako District to the MPDC that has been in effect since 2003.

The extent of the delegation includes:

- responding to emergency situations
- acting in terms of s353(c) of the Local Government Act 1974 and carrying out any enforcement.

Section 353(c) of the Local Government Act states 'whenever the public safety or convenience renders it expedient, require the owner or occupier of any land not separated from the road by a sufficient fence to enclose the same by a fence to the satisfaction of the council'.

RESPONSE FROM FEDERATED FARMERS

Federated Farmers provided the following response to the coroner's findings and recommendations.

Federated Farmers has carried out the coroner's recommendation and reminded its members to maintain roadside fences. We have issued a member advisory and put a brief in the Federation's weekly newsletter, the Friday Flash, which will be sent to all our members tomorrow.

Case number

CSU-2012-HAM-000460
2013 NZ CorC 69

CIRCUMSTANCES

The deceased died of severe injuries sustained in a motor vehicle crash. His car lost control on an uneven road surface and collided with a large timber culvert on the opposite side of the road. He was thrown from his vehicle and died of his injuries in hospital several days later.

Although the undulations in the road were only minor, the deceased was driving at a speed that was excessive. He had also modified the suspension of the car, so that it fell outside the warrant of fitness standards. These factors caused the car to become unsettled.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the crash highlights the danger to motorists who drive modified vehicles. Whether a person modifies a vehicle themselves or purchases a modified vehicle, it is crucial that they satisfy themselves that the modifications are legal and do not compromise the stability of the vehicle. He commented that this death also highlights once again the dangers of driving at excessive speeds.

Case number

CSU-2012-HAM-000472
2013 NZ CorC 47

CIRCUMSTANCES

The deceased died of injuries he sustained when his motorcycle became unsteady while he was negotiating a corner, causing him to fall off and into the path of an oncoming vehicle.

When the deceased had left work earlier that day it was pointed out to him that one of the tyres on his motorcycle was flat. He decided to ride his motorcycle anyway, and it is most likely that, as a result of the flat tyre, he was not able to keep his motorcycle properly balanced in an upright position. Blood tests indicated that he had likely smoked one cannabis cigarette approximately one hour before his death.

COMMENTS AND RECOMMENDATIONS

The coroner commented that there is some uncertainty about precisely when the deceased last smoked a cannabis cigarette. Notwithstanding this, it was clear that the deceased had smoked cannabis at some time before he decided to ride his motorcycle with a flat tyre. The coroner's view was that the cannabis probably reduced the deceased's sense of personal responsibility to the point where he chose to ride his motorcycle in a dangerous condition.

The coroner commented that this death serves as a warning to any person smoking cannabis that their choice to do so may have fatal consequences. He noted that cannabis remains an illicit drug for good reasons, and that two of those reasons applied in this case – it is known to affect a person's ability to perceive danger, and it impairs a person's ability to control a motor vehicle.

Case number

CSU-2009-WGN-000626
2013 NZ CorC 25

CIRCUMSTANCES

The deceased died of injuries she sustained when she was hit by a bus while out jogging. She had stepped out onto the road to avoid a person waiting for the bus without checking to see if there was any approaching traffic. As she did this she was struck by the bus.

The footpath in the area was quite narrow at this particular point and did not allow easy passing for both pedestrians and runners. Also, the exterior fixed mirrors on the bus gave an extremely limited view along both sides to the rear of the bus, which was compounded once the bus filled with passengers.

COMMENTS AND RECOMMENDATIONS

The coroner identified several factors which played a part in this death. These were the roadside/bus stop configuration, the bus driver's restricted vision and more importantly the actions of the deceased by wearing headphones and dark glasses and stepping onto the roadway into the path of the bus. The coroner said this highlighted the danger of wearing equipment

that would likely inhibit hearing and vision. The coroner was however pleased that the council has since taken positive steps to improve the safety of the bus stop and the footpath area.

The coroner noted that the bus company had said that its newer buses had been fitted with larger rear vision side mirrors that provided a clearer rear view, but pointed out that they stick out further than the smaller mirrors on the other buses and this may be a factor to the safety of pedestrians or others. The company commented that they would like a recommendation or comment from the coroner on this matter.

The coroner observed both types of mirrors and concluded that the larger mirrors should be fitted to all the buses as it will provide a better rear vision for the drivers. He did not consider that it would cause a problem for other road users or pedestrians.

Case number

CSU-2012-DUN-000014
2013 NZ CorC 51

CIRCUMSTANCES

The deceased died on State Highway 8 following injuries she sustained in a motor vehicle crash. The crash occurred when she crossed the centre line while negotiating a moderate right-hand bend, and collided with a car coming from the opposite direction.

It is most likely that at some point in the bend the deceased considered she was going too fast for the corner and attempted to correct her speed, and the resulting under or over steer caused her to travel across the centre line.

It was raining on the day of the crash and the road was very wet. It was also worn down below standards set by the NZ Transport Agency, and as a result had a 'slippery when wet' sign posted. The condition of the road likely contributed to the crash.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that further publicity be given to the phenomenon of roads becoming more slippery when a long dry period is followed by rain. The moisture draws accumulated road pollutants to the surface, making it more slippery, particularly when in conjunction with a worn road surface.

Case number

CSU-2010-WGN-000581
2013 NZ CorC 67

CIRCUMSTANCES

The deceased died of severe injuries sustained when he was struck by a motor vehicle. While walking home late at night after having attended a party, the deceased started jumping out in front of cars to get them to stop to give him a lift home. He had appeared suddenly in front of the driver of a van, and followed its movements when it tried to take evasive action, resulting in him being hit.

Motorists had notified police of his dangerous behaviour, and the deceased himself had called police three times. He knew he was drunk and as it was dark and his vision was limited, he was worried for his own safety. After the second call from the deceased police dispatched a vehicle to look for him, but before he could be found he was struck by a van. The police officer who was dispatched initially picked up a backpacker, believing him to be the deceased, but returned to State Highway 1 to keep looking once he realised his mistake.

COMMENTS AND RECOMMENDATIONS

The coroner commented that there is no doubt that the deceased was the author of his own misfortune. However, the coroner believed there to be an issue with the response of the police communications personnel that took the deceased's telephone call in the early hours of the morning. When the transcript is considered, it is clear that the deceased had no suicidal ideation and that while he was clearly under the influence of alcohol, he generally had contact with the police because he was disoriented and walking along a state highway in the middle of the night. No doubt his vision would have been severely impacted by the glare of oncoming vehicles.

The general public had also become very concerned at the deceased's behaviour and had contacted police. In the coroner's view, he would have expected, given the telephone transcript, a quicker and firmer police response. The coroner did not consider the actions of the police officer who had been dispatched to be subject to any criticism; he attempted to perform his duties to the best he could, given the information he had to work with.

The coroner recommended to the Minister of Communication and Information Technology that consideration be given, either by legislation or

voluntary agreement made by Telecommunication Companies operating within New Zealand, to make GPS locations from clients' cellphones immediately available to emergency services (police, fire and ambulance) on request.

RESPONSE FROM THE MINISTER OF COMMUNICATIONS AND INFORMATION TECHNOLOGY

The coroner received a response to his findings and recommendations from the Minister of Communications and Information technology, dated 26 June 2013.

The Minister said that the ability of emergency service providers to obtain sufficiently accurate and reliable caller location information in order to respond promptly is one of the policy objectives announced by the Government earlier in the year.

A review was conducted by the Ministry of Business, Innovation and Employment (MBIE) into the 111 calling service in late 2012. The review identified the lack of accurate and prompt caller location for mobiles as an issue needing attention. Cabinet subsequently directed MBIE to look into caller location issues, and to identify potential options to address these.

The Minister said that MBIE is currently carrying out this work in consultation with emergency service providers, the Telecommunications Forum and telecommunications operators, and a shortlist of the most promising options is being finalised. The Minister said that GPS technologies feature in the shortlist and the coroner's recommendations will be taken into account.

The Minister noted that enabling automatic notification of accurate caller location information for mobile 111 calls will take time to implement and may require significant investment. The Minister said it was therefore important that any chosen solution is the most appropriate with regard to:

- the accuracy of location data
- alignment to future technology trends
- costs to industry and government; reliability
- data security.

It was also acknowledged that there were privacy considerations, and appropriate protections will need to be put in place. The Office of the Privacy Commissioner had been and will continue to be involved in the process.

Case number

CSU-2012-DUN-00094
2013 NZ CorC 168

CIRCUMSTANCES

The deceased died of severe injuries that he sustained when he was hit by a car while cycling. He had been cycling ahead of a car when he abruptly crossed over the lane and moved in towards the centre. The driver of the car was unprepared for him to take such an action, and although he attempted to avoid the deceased he could not help but collide with him.

It seems that the deceased did not look to see if there was any traffic behind him before he moved. It is not certain why the deceased moved so suddenly. He was wearing an appropriate cycle helmet and a high-visibility vest. The deceased was noted to generally keep close to the edge of the road so as not to present a hazard to himself or motorists. He normally wore hearing aids but did not do so while cycling for fear that perspiration may upset their normal function.

COMMENTS AND RECOMMENDATIONS

The coroner commented that, unfortunately, cyclists are vulnerable to other vehicles on the road. The only protection they have is a crash helmet, which is insufficient protection in the majority of cases when a cyclist is struck by a vehicle. He commented that riders of bicycles, particularly on main roads, owe a duty and a responsibility to other road users.

The coroner felt that the fact that the deceased needed hearing aids required comment. The deceased did not see the approaching vehicle because he did not look. The coroner said it can only be speculation, but if the deceased had been wearing his hearing aids, he may have heard the car approaching and he may have paid more particular attention to staying on the left-hand side of the road to enable the car to pass safely.

The coroner recommended that a copy of the finding be forwarded to the NZ Transport Agency. Although the wearing of a hi-vis vest by the deceased did not result in the collision being avoided, in the coroner's view it is always appropriate for people riding cycles on roads carrying other vehicular traffic to do all that they can to ensure they made themselves visible to other road users.

RESPONSE FROM NZTA

The coroner received a response from the NZ Transport Agency, dated 26 March 2013.

We agree that cyclist visibility is an important component to cycling in our urban and rural environments and we have provided guidance in *The official New Zealand code for cyclists* and our Bike Wise resources. We are also currently updating the Cyclist Code to better emphasise this aspect.

Pertinent to this particular case we also provide guidance in the cyclist code and the cyclist skills training guidelines on cycling in different situations and the importance of communication with other road users: 'Where possible, communicate with drivers – make eye contact and signal intentions clearly'.

We look forward to our guidance and other education and promotional initiatives having a positive impact and reducing the number of similar reports in the months to come.

Case number

CSU-2012-HAS-000217
2013 NZ CorC 170

CIRCUMSTANCES

The deceased died of severe injuries which he sustained when he lost control of his vehicle shortly before a corner and went off the road, ending up upside-down in a paddock. Although another motorist witnessed the crash and called emergency services, the deceased's injuries were too serious and he died in hospital.

Before driving, the deceased had consumed alcohol at a social gathering, and it is considered more than likely that the alcohol he had consumed affected his ability to safely navigate the corner. From the evidence it is also unlikely that he was wearing a safety belt at the time of the crash.

COMMENTS AND RECOMMENDATIONS

The coroner endorsed the recommendation made in the Serious Crash Unit report that reflective roadside marker posts be installed on the outside of the relevant bend. The coroner commented that such markers would indicate the bend for drivers approaching State Highway 2 at night along Whatatutu Road, and may reduce the chances of similar deaths.

The coroner noted that the fact the deceased was not wearing a safety belt may or may not have contributed to his death (as the vehicle was damaged on the driver's side door, likely upon collision with the concrete power pole). However, he acknowledged that the wisdom of wearing safety belts in moving vehicles is well known.

Case number

CSU-2012-DUN-000026
2013 NZ CorC 171

CSU-2012-DUN-000027
2013 NZ CorC 172

CIRCUMSTANCES

Two individuals died of injuries that they sustained in a motor vehicle crash at the intersection of State Highway 8B and State Highway 6. One of the deceased died of her injuries the day after the crash in hospital. The driver of the vehicle, who died at the scene, failed to give way while turning, as he was directed to by the signage. As a result the car collided with another vehicle. Two other passengers who were in the vehicle survived.

The two deceased were fruit-pickers, working in New Zealand on working visas. At the time of the crash the driver may have been tired from the long day's work he had just completed. This may explain why he neither heeded the direction to give way, nor saw the approaching vehicle. He also may have been unfamiliar with the road and traffic conditions.

COMMENTS AND RECOMMENDATIONS

The coroner noted that, at the time of the crash, the area of the intersection of State Highway 8B and State Highway 6 was the subject of a 100 kilometres per hour speed limit. Since the crash, a temporary speed limit of 80 kilometres per hour was instituted.

He also noted and commended the fact the New Zealand Transport Agency (NZTA) has, since the crash, also created safety enhancements for the site. An upgrade has occurred, including the acquisition by the NZTA of land from adjoining owners to open up visibility.

The coroner observed that the intersection is in an area of Central Otago which is frequently travelled by visitors to New Zealand who may not always be alert to the hazards created by others who may approach

intersections at high speeds. Such drivers may not always be familiar with the signage provided at intersections in New Zealand.

The coroner recommended that a copy of the finding be forwarded to the NZTA, and that they again review the speed limit to ensure that appropriate safe speed limits for the intersection are continued. The coroner also requested that the NZTA continue monitoring the crash site to ensure that the safety enhancements remain appropriate.

Water-related (general)

See also *water-related (recreational fishing and boating)* and *work-related (other)* below.

Case number

CSU- 2012-DUN-000003
2012 NZ CorC 170

CIRCUMSTANCES

The deceased died in hospital of immersion hypothermia. While he was exploring Motatapu Gorge, the current pushed him off a rock at the top of a waterfall and in between two large rocks. His leg became caught above him, and the force of the water kept him pinned in place. Others at the scene helped him until search and rescue could arrive, but he lost consciousness soon after he was freed. He was airlifted to Dunedin Hospital, but died soon after.

Motatapu Gorge is filled with very smooth and steep rocks, and the current is very strong. At the time there were signs warning of the potential dangers involved in swimming in the river, but these have since been changed to include stronger language.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that a copy of this finding be forwarded to the Department of Conservation with a request that the department review the signage at Motatapu Gorge and give thought to emphasising the extreme hazard presented by the steep and slippery rocks and by the swift, cold water. The department should consider erecting a sign of appropriate design and colour at the point in the gorge where the swimming area ends and the waterfalls begin.

The coroner also recommended that a copy of this finding be forwarded to the Minister of Police to ensure that the courage of police personnel involved in the rescue be recognised. Similarly, he recommended that a copy of this finding be sent to the Royal Humane Society so that it can arrange for recognition of the courage of rescuers in recovering the deceased from a most difficult and dangerous predicament.

Case number

CSU-2010-CCH-000118
2012 NZ CorC 184

CIRCUMSTANCES

The deceased drowned at Waimakariri River in Canterbury when he got caught in a current while on a family outing. He was not a strong swimmer and was pulled under the water. His body was found the next day.

A coastguard sign was installed on one of the bridge piles that said 'Beware: strong currents, Think water safety if swimming' and showed a large picture of a swimmer and an arrow pointing to the water. The deceased's father and step-mother both saw this sign, but thought it meant that the river was a swimming river, as is showed a person swimming. That sign has now been replaced with a series of other signs that show much more clearly that swimming can be unsafe, due to strong currents, sudden changes in depth and effluent outflow.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this death, like those of two others at the same location less than two years before, is an example of how recreation in water can quickly turn from pleasure to tragedy. She noted that the new signs put up by Environment Canterbury (ECan) after this death will go a long way to prevent further deaths by drowning in this part of the Waimakariri River, but that people need to take notice of those signs.

The coroner recommended to ECan, the Waimakariri District Council and the Christchurch City Council that they continue educating the public about the dangers of swimming, specifically in this part of the Waimakariri River, and the importance of taking notice of the advisory signs.

She also noted that as the hot weather approaches and people want to swim outdoors, the Waimakariri River can look flat and calm and very inviting, when in fact it is very dangerous. Accordingly the coroner recommended to the news media that it be publicised that the Waimakariri is not a safe swimming river, especially by its bridges, and that people should not ignore the signs advising not to swim there.

Case number

CSU-2012-WGN-000048
2012 NZ CorC 118

CIRCUMSTANCES

The deceased drowned when he was carried out to sea by a rip while swimming in the sea at Titahi Bay Beach, Porirua. He had gone swimming with his brother, his girlfriend and her sister. At the time of the incident the beach was at high tide with strong wave surges and it was extremely rough. The deceased could not swim and panicked when he could no longer feel the sea floor beneath his feet; he then began struggling in the water. Both the deceased and his girlfriend were pulled out by a rip. A local surfer was able to rescue the girlfriend but the deceased was already unconscious, and was pushed out of the surfer's arms by a large wave.

The group were not swimming between the flags erected by the Titahi Bay Surf Life Saving Club as they should have been; this is the area that the Surf Life Savers give priority to in their monitoring.

Surf Life Saving New Zealand (SLSNZ) submitted a paper to the Porirua City Council in connection with the council's Ten Year Plan discussions, seeking to establish a funding agreement for summer holiday periods. The paper says there is a high level of risk of drowning and injury at Titahi Bay, and that additional measures are needed to mitigate the risk further.

COMMENTS AND RECOMMENDATIONS

The coroner endorsed the recommendations made in the paper SLSNZ submitted to the Porirua City Council. The paper recommended that water safety signage, which meets the requirements of the combined Australia/New Zealand Standard (AS/NZ 24165:210), should be installed at all coastal access locations at Titahi Bay. It also recommended that the provision of lifeguard services should be extended beyond their current capacity at Titahi Bay, as detailed in the paper.

In particular, the coroner endorsed the recommendation that a sign should be erected as soon as possible at the northern and southern ends of Titahi Bay beach warning the public of the presence and dangers of the rips.

Case number

CSU-2010-CCH-000076
2013 NZ CorC 9

CIRCUMSTANCES

The deceased, an exchange student who had only been in New Zealand for four days, drowned at Sumner Beach. He had been taken to the beach by his host family, and had informed them that although he had not swum in the sea before he considered himself a strong swimmer, having had lessons. His host mother told him the sea in New Zealand has currents and rips and is more difficult than a pool. He went swimming with her grandsons, but they returned without him. The ensuing search found his body that evening.

Although he had expressed an intention not to go into the water over his waist, it was revealed that he hadn't been swimming since he was young and was in fact not a strong swimmer. The area in which he was swimming had very strong currents and there were warning signs on the beach to that effect.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the hazard signs on the beach had been erected in the hope they would be taken notice of. Clearly it is not possible to make people look at them.

The coroner drew attention to a website launched in October 2012 by SLSNZ – findabeach.co.nz The website contains helpful information about New Zealand beaches including Sumner Beach. It sets out the times of the patrol and also water safety messages including:

- Have an adult watch over you.
- Learn to recognise rip currents.
- Swim between patrol flags.

The coroner commended this website and the information it contains. She recommended to SLSNZ that, if it can, it advertises this site for maximum publicity, so that more people become aware they can access it and see the safety messages before going to the beach.

Case number

CSU-2010-AUK-001538
2013 NZ CorC 29

CIRCUMSTANCES

The deceased drowned at Quarry Lake, Takapuna when he jumped from the cliff at the southern side of the lake, and after re-emerging started to panic and sink. The attempts of others with him to help him were unsuccessful, and his body was later recovered by the dive squad.

He was at the lake for a class excursion with the School of Business (Mt Eden); their scheduled field trip was cancelled so instead they went on an unauthorised trip to the lake. Had it been submitted for authorisation, either it would not have gone ahead or there would have been opportunity for better safety protocols to be put in place.

Though the deceased is said to have been able to swim, he was described as not a particularly strong swimmer, and may have been unused to swimming in fresh water, or may have been winded by the fall. Cannabis was also found in his system, but it is unclear whether this impacted his ability to swim.

COMMENTS AND RECOMMENDATIONS

The coroner endorsed the recommendations made by the Auckland Council's feasibility study regarding how the safety features of Quarry Lake could be improved. The report made 12 recommendations. It recommends (among other things) placing new signage warning of the dangers, a permanent pool fence along the 6-metre cliff on Shea Terrace, and further planting to limit the visibility of, and access to, the 12-metre cliff by the squash club as well as the 6-metre cliff along Shea Terrace. It also recommended improving entry and exit points to the lake.

The coroner commented that there is inherent risk associated with the diving points – not only for the person jumping or diving, but for anyone who attempts to aid someone in trouble as a consequence of the jump/dive. To exit the lake from these points requires at least a 15-metre swim. The coroner said that in the context of the council undertaking this work she did not intend to make any further comments or recommendations regarding the lake, although she encouraged the council to audit its implementation of the recommendations.

The coroner also recommended to the school that it consider undertaking regular audits of staff compliance with their policies/protocols – particularly those policies/protocols relevant to the safety of its students.

Water-related (recreational fishing or boating)

Case number

CSU-2011-DUN-000497
2012 NZ CorC 193

CIRCUMSTANCES

The deceased died in Lake Wanaka of drowning after he fell from the yacht he was sailing. A significant wind shift tipped the boat, causing him to fall. Once in the water his personal flotation device (PFD) did not inflate. His crew mates were not able to get him back onto the boat and he eventually grew tired and sank. His body was recovered by searchers some time later.

The PFD he was wearing was not in a safe condition; the replacement carbon dioxide (CO^2) canister had not been screwed in after a previous inflation, and was held in place merely by the fabric of the PFD. He was also wearing it inside out, which apparently prevented him from pulling the ripcord or inflating the device manually.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to Maritime New Zealand that they continue with their efforts to make it compulsory that all people involved in activities on the water wear appropriate PFDs.

He also recommended that a copy of his finding be forwarded to Survitec, the New Zealand importers of these PFDs and that they send it to the manufacturers (RFD). The coroner encouraged them to cooperate with an education programme, both nationally and internationally, to draw to public attention the dangers this inquiry discovered regarding the failure in the CO^2 cylinder.

Case number

CSU-2011-DUN-000375
2012 NZ CorC 195

CIRCUMSTANCES

The deceased, a German tourist, drowned in Lake Hawea while he was kayaking. He had borrowed a kayak from his flatmate and journeyed to the lake. Although the kayak was located, the body of the deceased was never found. It is considered likely that the kayak capsized.

A person who had observed him on the lake noted that he appeared to be struggling at the time. The kayak that he was using was not one that was designed for open water paddling, and paddling and keeping the kayak upright required more energy than in other kayaks. The deceased's ability to survive in the cold water of the lake would have been significantly decreased by the fact that he was wearing neither a wetsuit nor any kind of flotation device.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that a copy of this finding be forwarded to Maritime New Zealand. He requested that the organisation take further action to ensure that the need for persons in small boats to wear life jackets at all times receives further publicity.

He also recommended that a copy of this finding be forwarded to the Minister of Transport. He said that the Government should take action to ensure that the wearing of life jackets by all people using small boats in New Zealand be made compulsory and that there ought to be compulsory policing and enforcement of the necessary legislation.

Case number

CSU-2012-DUN-000007
2012 NZ CorC 135

CSU-2012-DUN-000009
2012 NZ CorC 136

CIRCUMSTANCES

Two men died of hypothermia from cold water immersion on Foveaux Strait when the fishing boat they were on was struck by a rogue wave and overturned. Both of the deceased and the other passengers ended up in the water. Although they were wearing life jackets, neither of the deceased were wearing sufficient warm clothing to survive the swim to safety. The remaining passengers survived.

The passengers were not able to call for help immediately because the bulky emergency position indicating radio beacon became trapped when the boat rolled over, and was therefore not available after it had sunk.

Both of the deceased were found to have smoked cannabis earlier in the evening, though what effect this may have had on their ability to survive in the cold water is indeterminable.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that a copy of this finding be forwarded to Maritime New Zealand (MNZ). He noted that the three surviving passengers are still alive because one of the deceased insisted that life jackets be worn. The coroner commented that all too often a coroner will draw to the attention of MNZ the need for the wearing of life jackets to be made compulsory. The coroner considered that the fact that the use of life jackets saved lives in this case adds weight to the call for MNZ to continue to press for the wearing of life jackets on small boats to be made mandatory.

MNZ has education programmes stating 'water and alcohol don't mix'. The coroner recommended that a programme warning those in boats not to smoke cannabis should be added to this. The effects of cannabis can decrease survivability in cold water. He also commended MNZ for its education programmes relating to communication and recommended that these continue.

Case number

CSU-2012-CCH-000011
2013 NZ CorC 3

CIRCUMSTANCES

The deceased drowned in Lake Opuha after jumping from the boat he was on into the water. He had taken off his life jacket and got into difficulty when he was about 10 metres away from the boat. Though his companions tried to rescue him, the boat drifted away from him before he could be pulled in and he sank below the water.

Earlier that day he had consumed some alcohol before going to the lake. However, it is unclear what effect, if any, this had on him later in the day.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the case illustrates how a drowning situation can rapidly evolve in apparently benign circumstances. It also illustrates the dangers of

swimming after consuming alcohol, even if the amount is modest (as in this case.)

He made no formal recommendations, noting that Water Safety New Zealand had endorsed the message from this case as highlighting the quick and very deadly nature of water 'which in itself is an important issue for all New Zealanders to be mindful of'.

Case number

CSU-2012-ROT-000003
2013 NZ CorC 24

CIRCUMSTANCES

The deceased died at Lake Ohakuri, Rotorua of multiple injuries he sustained in a collision between an inflatable biscuit and a speed boat. He and another were riding the inflatable biscuit being towed by a boat down a narrow stretch of water that extends from the main body of the lake.

The deceased was in a relay with another boat and biscuit. On one of the runs the two boats towing the biscuits went around the turn at the end of the course in opposite directions. Although both boats came to a stop in time to avoid a collision, the momentum was such that the biscuit the deceased was on continued forward in an arc, colliding with the other stationary boat. The other rider was knocked unconscious and pulled from the water, but the deceased's injuries were more severe.

The boats were travelling in excess of a 5-knot speed restriction in place in the area surrounding the buoy around which they were turning. There was adequate signage explaining the restrictions. The boat the deceased was being towed behind did not have a spotter as per the local bylaws.

COMMENTS AND RECOMMENDATIONS

The coroner commented that in his view it is simply incredible that there is no licensing of boats or operators. It is clear to him that if there was more responsibility taken for the operation of boats, and more serious charges available, more seriousness may be given to maritime safety law.

The coroner recommended that previous coroners' recommendations from inquests involving similar maritime circumstances be adopted and that there be a complete review of maritime law. The recommendations were:

- All powered recreational vessels or maritime products be registered and issued with an identification number. It must be highly visible.
- All operators of powered recreational vessels or maritime products be required to hold a licence before operating the vessel or maritime product.
- All candidates for licences be required to know the basic safe boating rules and their legal responsibilities.
- The laws relating to maritime activity be reformed to incorporate the above recommendations, and in addition provide for a graduated form of penalty similar to the land transport legislation.
- Consideration be given to the introduction of an 0800 number like 0800 Crime Stoppers to make it easier for people to report hoonish and other behaviour on the water.
- Consideration be given to requiring all operators and passengers on jet skis to be required to wear life jackets and helmets at all times.

The coroner also recommended that the laws relating to maritime activity be reformed to incorporate an appropriate level of charges, similar to land transport legislation. It was further recommended that more education be given to boaties and the public in general concerning maritime safety, and where and how it applies.

Case number

CSU-2011-WHG-000036
2013 NZ CorC 32

CIRCUMSTANCES

The deceased drowned at Martin's Bay in Warkworth when the small dinghy he was in overturned. He was not wearing a life jacket and he was not able to swim. Though the skipper of a passing boat pulled him out of the water, attempts to resuscitate him were unsuccessful.

The deceased was an inexperienced boatie. The water was calm and there was no other evidence to suggest that the boat capsized for any reason other than the actions of the deceased.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to Maritime New Zealand that it should be compulsory for all occupants of small boats to wear life jackets at all times while they are on the water. The coroner left what constitutes a 'small boat' for marine experts to consider.

Work-related (agriculture)

See also *electrocution* deaths above.

Case number

CSU-2011-DUN-000432
2012 NZ CorC 186

CIRCUMSTANCES

The deceased died at the farm where he worked when he lost control of the fertiliser spreader he was operating and it overturned. The fertiliser spreader had hit a rock, causing it to lose traction and slip down a slope. It ended up rolling downhill, ejecting the deceased from the vehicle in the process.

The wearing of a safety belt in such a vehicle is not mandatory, although it is encouraged by the company policy of the deceased's employer, and the industry Code of Practice.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that a copy of this finding be forwarded to the Department of Labour and the New Zealand Ground-Spread Fertiliser Association (NZGFA), for them to promote ongoing cooperation in the creation of further safety enhancements. The coroner asked that they work together to clarify the benefits of operators using safety belts and investigating methods to ensure that restraints are more 'user friendly' for operator/drivers in difficult situations. They should consider establishing a protocol between customers, contractors and employees, ensuring that employees are not pressured to complete spreading tasks beyond safe parameters.

The coroner further recommended to the NZGFA that it should investigate the provision of an emergency call and tracking system in the vehicles of its members, which does not depend on cellphone or radio coverage, or the continuing consciousness of an operator/driver who may have been disabled in a rollover.

Case number

CSU-2012-HAM-000180
2012 NZ CorC 132

CIRCUMSTANCES

The deceased died at a farm of acute cardio-respiratory failure, with a background of other heart conditions and likely positional asphyxiation causing compromised breathing. An excavator had toppled onto him after a section of earth around the pit he was excavating gave way. As the excavator toppled he fell out of it, landing with it on top of him.

The soil in that area was very soft, with a potential for collapse, and this hazard had not been identified before he started his work.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the deceased does not appear to have been wearing a safety belt while operating the excavator. The coroner had no evidence before him to indicate whether wearing a safety belt would have made any difference, but given that the deceased was ejected from the seat when the excavator toppled into the pit, it is reasonable to suggest that a safety belt would have held him in the seat.

In the absence of any evidence on this matter, and on whether wearing safety belts in the cab of an excavator poses any risks to the operator, the coroner was reluctant to make a recommendation relating to the use of safety belts in such excavators. He therefore simply made these comments in the hope that industry operators will consider this issue and take any appropriate action.

He directed these comments to all manufactures and operators of such excavators, and all industry parties promoting the safety of operators of such machinery.

Work-related (other)

Case number

CSU-2011-DUN-000356
2012 NZ CorC 171

CIRCUMSTANCES

The deceased died at Overton Forest in Southland of injuries he sustained when he was struck by a tree that was blown on top of him while he was working as a tree-feller. He had been in the process of de-limbing his second to last tree of the day. As he was working with a chainsaw, he was wearing ear muffs and could not hear the warnings of others who saw the tree fall.

The roots of the tree that fell over were small for a tree of its size, and it had been raining recently, making the ground softer. Both of these factors combined to make it easier for the tree to be blown over by the wind.

The workers noted that the wind was strong on this particular day, but determined that they were sufficiently sheltered by moving to a lower area to fell trees less affected by the wind. As the deceased worked the wind increased in strength, and though he was an experienced bushman, he either did not notice the increase in wind strength or took an intentional risk in finishing the block where he was working.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that a copy of this finding be forwarded to the Department of Labour (Ministry of Business, Innovation and Employment – MBIE) and to the Forestry Industry Association in order that the lessons learned from this tragic death not be lost.

RESPONSE FROM THE MINISTRY OF BUSINESS, INNOVATION AND EMPLOYMENT

The MBIE provided the following response to the coroner's findings and recommendations.

It is difficult for the MBIE to respond specifically to such a general recommendation. Your findings have been registered on the MBIE's database and distributed to various areas of Health and Safety Groups including the General Manager of Health and Safety Operations, the Sector of Engagement and Technical Services teams and the Health and Safety Policy team. The findings are also available to staff. In this way they are available to be used in a variety of aspects of the MBIE's work relating to health and safety in the workplace.

Case number

CSU-2012-HAS-000144
2012 NZ CorC 134

CIRCUMSTANCES

The deceased died at Whareongaonga Forest in Gisborne from injuries he received when he was hit by logs that slipped free from the pile they were in. He had been working in a crew of four men removing logs from the bottom of the pile, which caused the pile to destabilise. He was not able to get out of the way of the logs as they slid.

A Department of Labour investigation emphasised that as mechanical grapple technology becomes more widespread, there will be fewer and fewer people placed in these types of hazardous employment situations.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to harvesting contractors, forestry owners, principals and cable harvesting employers that cable harvesting contractors use mechanical grapples as the preferred method of log extraction.

The coroner also recommended to the Forestry Industry Training and Education Council (FITEC) and the Ministry of Business, Innovation and Employment (MBIE) that they immediately consider including a recommendation that mechanical grapples are used in both the *Best practice guidelines* and the *Approved code of practice (ACoP) for safety and health in forest operations*. It was further recommended that immediate consideration be given to including recommendations for extraction, location and height restrictions of bunched logs in both of these documents.

RESPONSE FROM THE MINISTRY OF BUSINESS, INNOVATION AND EMPLOYMENT

The Ministry of Business, Innovation and Employment provided the following response to the coroner's findings and recommendations.

The Health and Safety Group has reviewed your recommendations from [this inquest].

It is not practical for the group to republish the *Best practice guidelines* and the *ACoP for safety and health in forest operations* to include your recommendation that mechanical grapples are used. The group notes that mechanical grapples are an emerging technology with considerable evident benefits, and has already publicly stated its view that their use could contribute to reducing serious harm in the forestry sector. The ministry will continue to make that

point publicly and when it is appropriate to republish the guidelines and the ACoP, publish its position in those documents.

FITEC is currently producing a best practice guidelines on breaking out and your recommendation that this document should include recommendations for extraction, location and height restrictions of bunched logs is being addressed in that. The Ministry raised with FITEC (now Competenz) the recommendations and anticipate that the intent of the recommendations will be reflected in the best practice guidelines.

Case number

CSU-2012-DUN-000197
2013 NZ CorC 2

CIRCUMSTANCES

The deceased died of injuries he sustained in a vehicle crash in the course of his employment as a courier driver. He failed to negotiate a left-hand bend and struck a power pole with his vehicle. It is not clear exactly how the circumstances of the crash came about.

The time he started work on the day of his death was too early to comply with his rest-period obligations, having finished work at 6pm the day before. The Commercial Vehicle Investigation Unit (CVIU) found that there were deficiencies with the 'work time' rule across courier service operations in New Zealand. It considered that New Zealand Couriers Limited failed to adhere to their own internal controls and failed to monitor the operations of their contractor, the deceased. CVIU accordingly issued an improvement notice.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the deceased was known as a professional driver who was careful and always conscious of his obligations and therefore he found it unlikely that the deceased would have been distracted while driving. He considered that the more likely possibility was that due to the early hour of the morning the deceased merely lapsed into a micro-sleep. The coroner said that there was no significant evidence on which he based any such hypothesis, apart from expressing his preference as to a cause.

The coroner noted that the issue of micro-sleep does have relevance when considering the obligations of a driver and of an employer contractor under the Health and Safety in Employment (HSE) Act 1992. Safety legislation is imposed for the purpose of keeping those in the workforce safe. The coroner was surprised that the HSE Act and driving hours legislation do not require courier drivers (because of the size of the vehicles they drive) to complete logbooks.

The coroner recommended that a copy of this finding be forwarded to the NZ Transport Agency and to the NZ Police in order that the issues identified relating to driving hours be re-appraised.

RESPONSE FROM NZ POLICE

The coroner received a response to his findings and recommendations from the NZ Police, dated 11 July 2013.

Not all persons subject to work time limits are also required to complete driver logbooks, as the [coroner's findings] note, but [the deceased] was required to comply with work time requirements as his vehicle was carrying goods for hire or reward.

The [findings note] that NZ Police conducted a review of the courier service operation of the company [the deceased] was contracted to and found deficiencies with its compliance with the 'work time' rule. NZ Police visited a similar sized courier company and found evidence that the 'work time' rule was also being breached. It would seem that courier operators have difficulty in complying with the 'work time' rule; however it is noted that this crash is one which occurred very early in the shift after a period of time off. What is difficult to establish is what activities a driver does while on days off.

The completion of paper logbooks would be an onerous task for courier drivers however technology has developed significantly over the years, especially around electronic recording of work time. Police believe it is an opportune time for the matter to be reconsidered with Ministry of Transport and NZTA officials to reappraise the situation around courier drivers being required to use logbooks.

This response was copied to the NZTA and the Ministry of Transport, so that they may be made aware of the discussion, and the CVIU was asked to initiate the conversation.

Case number

CSU-2010-CCH-000578
2013 NZ CorC 79

CSU-2010-CCH-000579
2013 NZ CorC 80

CSU-2010-CCH-000580
2013 NZ CorC 81

CIRCUMSTANCES

Three men, all from Indonesia, drowned around 400 nautical miles east of the South Island of New Zealand when the O Yang 70, the Korean-registered commercial fishing vessel they were working on, sank near the Bounty Islands. The ship had left port with stability problems. These problems were further exacerbated by the high volumes of water kept on the factory level of the vessel, among other issues. When attempts were made to bring an unusually large load of fish on board the ship began to lean to the left side and take on water in volumes too great to be pumped out. The water entered through waste chutes on the left side of the factory deck, and travelled through open access hatches to the lower deck and the engine room. Workers eventually left their stations of their own initiative, donned life jackets and moved to life boats. At some point the captain issued a distress call, which was heard by nearby fishing vessels that came to the aid of the survivors. In total 6 people drowned in this incident, but only three bodies were brought to shore in New Zealand.

The O Yang 70 was fishing for a New Zealand company under a Time Charter Agreement and its sinking occurred outside New Zealand Territorial Waters, but within New Zealand's exclusive economic zone (EEZ). As such, the ship came under New Zealand's regulatory control, although this function notably did not include matters such as employment conditions due to the fact that the ship was not a registered New Zealand vessel.

A Maritime New Zealand (MNZ) inspection had held that the vessel was sea-worthy, after a problem with the life rafts was fixed. The vessel was considered sufficiently watertight and the waste chutes were noted as having operational closing mechanisms. Another inspection had found the vessel to be satisfactory and in compliance with the New Zealand Maritime Rules for entry into safe ship management (SSM). However, the SSM was flawed as New Zealand only has limited jurisdiction over foreign charter vessels (FCVs), and many operational matters are outside the knowledge or control of the system.

In particular there were many unsafe employment practices aboard the ship that were unable to be assessed and contributed to the sinking of the ship. There were no excavation drills, and there was no training in either emergency protocols or safety protocols. As a result watertight hatches and doors were not shut when not in use and very few of the crew were wearing immersion suits when the vessel sank. The crew appears to not have known how to operate the radio equipment; therefore when the ultimately effective distress call did go out, it was only short-range. The captain of the ship did not have sufficient knowledge of how to maintain stability, nor did he ensure that the stability of the ship was monitored. As a result the ship was completely destabilised by a load it should have been able to handle.

Since this sinking, among other measures taken to improve New Zealand's ability to regulate the safety of vessels in its waters, MNZ has also pursued diplomatic avenues of addressing non-compliant Korean FCVs.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this case illustrates the difficulties for agencies to enforce laws and regulations that were referred to by the Ministerial Inquiry into Foreign Charter Vessels. The fact that the flag state (in this case Korea) has primary jurisdiction for employment and vessel safety means the coastal state (in this case New Zealand) has difficulty enforcing internationally accepted standards.

The coroner noted that a proposed new regulatory framework, known as the maritime operator safety system (MOSS), will require FCVs to enter the MOSS before operating in New Zealand, without the two-year window that was available under the SSM system. The MOSS is expected to deliver a simplified system and strengthen MNZ's regulatory control over FCVs operating in New Zealand.

The coroner commented that a Cabinet decision that was announced on 22 May 2012, if enacted, appears to substantially adopt and exceed the recommendations of the Ministerial Inquiry and will fundamentally change the operation of foreign fishing vessels in New Zealand's EEZ. It will require reflagging of FCVs operating in New Zealand's EEZ. Only New Zealand registered vessels will be licensed to fish in New Zealand's EEZ. The Fisheries (Foreign Charter Vessels and Other Matters) Amendment Bill currently before Parliament would ensure improved management of vessel safety, employment and fisheries management matters for FCVs operating in New Zealand waters.

The two international instruments specific to fishing are each yet to come into force. They are the 1977 International Convention for the Safety of Fishing Vessels (the 'Torremolinos Convention', superseded by the 1993 Torremolinos Protocol) and the 1995 International Convention of Standards of Training, Certification and Watchkeeping for Fishing Vessel Personnel (STCW-F). The coroner noted that New Zealand is not a signatory to either convention, and that expert witnesses urged that New Zealand becomes signatories to these conventions. Recommendation 11 of the ministerial inquiry is to a similar effect. The coroner recommended to the

Minister for Primary Industries that as a matter of priority the government proceeds in accordance with recommendation 11 of the ministerial inquiry relating to the international conventions referred to above and the International Labour Organisation Convention C188 – Work in Fishing.

The coroner made further recommendations to the Minister of Transport regarding the MOSS, the proposed new regulatory framework. He recommended that the MOSS:

- requires instructional videos in appropriate languages for crew induction on all safety matters
- addresses access to, and requirements in certain circumstances to wear, immersion suits
- addresses the issue of Maritime Safety Inspectors engaging directly with the master and command crew of a vessel on safety matters rather than with, or in addition to, a New Zealand on-shore agent as occurred in this case
- develops a communication strategy to demonstrate expected standards to the industry in matters such as fire drill, evacuation, man overboard, knowledge of mandatory policies, contact man ashore and roles and responsibilities of individuals.

Case number

CSU-2010-DUN-000447
2013 NZ CorC 177

CIRCUMSTANCES

The deceased died of injuries he sustained when the power pole he was working on fell 20 metres down a bank, with him attached to it in a safety harness. The deceased worked for Delta Utility Services Limited (Delta), the company that manages distribution lines for the distribution network Aurora Energy Limited (Aurora). He was tasked with carrying out some work on a particular pole which was necessary for a regular safety assessment. The pole in question fell from its position because it had been erected with insecure footing. As the deceased fell, he also received severe burns from the power lines which livened as the pole fell. These burns may or may not have been debilitating or fatal.

The coroner determined that the 'hazard identification' procedure adopted in this case by Delta and its employees proved unsuitable. There was sufficient information available, at all times, to show that the relevant pole was unsafe in its placement.

Delta was convicted of offences under the Health and Safety in Employment Act 1992, because the company did not take all practicable steps to ensure that the deceased was not exposed to the hazard of an unstable power pole in his place of work.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to Delta that the company specifically make reference to the future practice of 'sign-off' for a project identified in a work instruction sheet (for example, 'project has been completed, checked for defects and been left a safe condition').

He recommended that the company's 'working alone' policy applying at the time of the death of the deceased continue to be addressed. The policy must go beyond merely having two workers on site, with one to give aid or to call for help for another in the event of a mishap. As two minds are better than one, another worker may have identified the hazard the pole presented when such hazards were not noticed by the deceased.

He also recommended that Delta adopt 'red tag' identification for all suspect poles, and a system whereby 'job sheets' are not created without the instruction of specifically identifying hazards which may exist and of which the employee uplifting the 'job sheet' may be unaware.

The coroner recommended that a copy of the finding be forwarded to the Electrical Engineers Association for wider distribution through the electrical supply industry. He asked that all those engineers who have assisted with the enquiry, as part of their role within the Association, draw the attention of their colleagues to the circumstances of the death of the deceased and to the enhancements identified which could, if acted on, reduce the chances of similar deaths.

Acronym glossary

Below is an list of acronyms used in this issue of *Recommendations recap*.

ACC	Accident Compensation Corporation
ACoP	Approved code of practice
ALAC	Alcohol Advisory Council
ARP	Auckland Regional Prison
ASIST	Applied Suicide Intervention Skills Training
BZP	benzylpiperazine
CARM	Centre for Adverse Reactions Monitoring
CCTV	close-circuit television
CPR	cardiopulmonary resuscitation
CT scan	(x-ray) computed tomography scan
CVIU	Commercial Vehicle Investigation Unit
DHB	district health board
ADHB	Auckland District Health Board
CDHB	Canterbury District Health Board
SDHB	Southern District Health Board
EEZ	exclusive economic zone
DHC	dihydrocodeine
DoL	Department of Labour
ECan	Environment Canterbury
FCV	foreign charter vessels
FITEC	Forest Industry Training and Education Council (now Competenz)
FSANZ	Food Standards Australia and New Zealand
GP	general practitioner
GPS	global positioning system
HBRP	Hawkes Bay Remand Prison
HIPC	Health Information Privacy Code 1994
HPA	Health Promotion Agency
HSE	Health and Safety in Employment (Act 1992)
ICU	Intensive Care Unit
IRO	Incident response officers
LPG	liquefied petroleum gas
MBIE	Ministry of Business, Innovation and Employment
MoH	Ministry of Health
MOSS	maritime operator safety system
MNZ	Maritime New Zealand
MPDC	Matamata-Piako District Council
MRI	magnetic resonance imaging
MSSA	military style semi-automatics
NZAA	New Zealand Airports Association
NZGFA	New Zealand Ground-Spread Fertiliser Association
NZTA	New Zealand Transport Authority
OPRS	Older Persons Rehabilitation Service
PCLC	prisoner cell and location checks
PFD	personal flotation device
PIN	parent-infant nursery
PLC	prisoner location checks
PSO	Presbyterian Support Otago
SIDS	Sudden infant death syndrome
STCW-F	Certification and Watchkeeping for Fishing Vessel Personnel
SLSNZ	Surf Life Saving New Zealand
SPINZ	Suicide Prevention Information New Zealand
SUDI	Sudden unexpected death in infancy
SRBA	stab-resistant body armour
SSM	safe ship management
SWER	single wire, earth-return
TMHS	Te Haika Mental Health Services
TWA	Te Whare Ahuru

Index

Below is an index of recommendations (by broad topic area) in *Recommendations recap* issues.
As cases may involve multiple topic areas or themes, they may be included in the list below more than once.

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