

# Recommendations recap

A summary of coronial recommendations and comments  
made between 1 April–30 June 2013



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OF NEW ZEALAND

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Coroners Act 2006

- 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 similar deaths. 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 made over the relevant period. Summaries of any responses to recommendations from agencies and organisations are also included.

*Recommendations recap – Issue 6* features 31 recent coronial cases where recommendations have been made. These final findings were released by a coroner between 1 April and 30 June 2013.

This *Recommendations recap* features a case study report on drowning deaths related to recreational boating activities, including powered and non-powered boats, kayaks, canoes and rafts. The report contains the key statistics relating to these deaths, an outline of the issues involved and the legal framework surrounding these types of incidents. It also provides a summary of recommendations made by coroners following these deaths.

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# Case study

## Drowning deaths during recreational boating

This case study is about deaths resulting from drowning during recreational boating activities, including powered and non-powered boats, kayaks, canoes, dinghies and rafts. It focuses on the use of lifejackets during these activities.

*Please note that this case study does not include drowning deaths in relation to commercial operations (including tourist activities), natural causes or workplace deaths. Workplace and commercial operations have codes and practices in place under health and safety legislation, and therefore are not considered recreational.*

### DROWNING DEATHS AT A GLANCE AS AT 31/12/2013

There have been a total of 113 drowning deaths between 1 July 2007 and December 2013.

Of those deaths:

- 109 were male
- 15 are missing, presumed deceased
- 28 remain open coronial cases
- 46 had access to flotation devices but did not wear them
- 26 did not have access to flotation devices
- 24 involved vessels under 4 metres in length, and 35 cases involved vessels over 4 metres
- 4 were under the age of 14 years.

Deaths	Year of death
6	2007*
18	2008
24	2009
14	2010
19	2011
19	2012
13	2013

*\*Data collection began on 1/7/2007. Therefore 2007 data is incomplete.*

Coroners have made comments and recommendations in 20 of these cases. An outline of these cases and the comments and recommendations, and any responses received, can be found in the following section.

Water Safety New Zealand kindly provided statistical data to help us compile this case study. (Drownbase is the official drowning database of Water Safety New Zealand.) This data has been used alongside data we hold in Coronial Services.

## Background

New Zealand is surrounded by extensive coastlines, and many residents live in coastal areas. Inevitably this leads to more access to water-related activities, with the climate encouraging people to enjoy the water environment. While this is of course a positive aspect of living in our country, the negative is the potential for near-drownings and deaths from drowning to occur.

People can drown in a broad range of water activities. This case study looks at deaths during recreational boating activities, including powered and non-powered boats, kayaks, canoes, dinghies and rafts.<sup>1</sup> Males are vastly over-represented in drownings during recreational boating activities.

The Office of the Chief Coroner has released this case study to present the facts and background to this area of preventable death, and collate recommendations made by coroners in these cases. Where appropriate, this case study includes stakeholders' responses to the coroners' comments and recommendations.

## Lifejacket safety and recent proposals

Maritime New Zealand has run a number of safety campaigns about the importance of wearing lifejackets. Lifejackets not only provide flotation but allow people to keep still in the water and conserve energy, which can delay the onset of hypothermia. Some lifejackets can also protect the wearer from the cold or prevent injury in collisions. While these safety campaigns continue to promote the use of lifejackets, it is also important to ensure the correct type is available for the conditions.

In New Zealand, a pleasure boat must have a correctly sized and serviceable lifejacket for each person on board.<sup>2</sup> This applies to all boats, of all sizes, including

<sup>1</sup> ACC (2005) *The drowning prevention strategy: Towards a water safe New Zealand 2005–2015*, Wellington, p32.

<sup>2</sup> Maritime New Zealand (2011), *Maritime Rules*, Part 91 – Navigational safety rules, part 91.4 (6), Wellington, p4.

tenders (charter vessels) and larger crafts. Lifejackets are also known as personal flotation devices or PFDs. Some regional councils have made the wearing of lifejackets mandatory. The Waikato Regional Council has made it mandatory to wear lifejackets on vessels under 6 metres when underway<sup>3</sup> and the Northland Regional Council<sup>4</sup> has made lifejackets mandatory on vessels under 6 metres when underway and propelled solely by oars or paddles.<sup>5</sup>

There are many types of lifejackets and the right type needs to be available for the likely conditions. Maritime New Zealand's website contains information about the types of lifejackets available and their use ([maritimenz.govt.nz/recreational-boating/lifejackets/types-of-lifejacket-and-pfd.asp](http://maritimenz.govt.nz/recreational-boating/lifejackets/types-of-lifejacket-and-pfd.asp)). They must meet New Zealand Standard (NZS) 5823: 1999, NZ S5823: 2001 or NZS 5823:2005 or other national standards that comply with the New Zealand Standards, such as US, Australian, European and ISO standards.

Recently there has been a lot of debate on the issue of the compulsory wearing of lifejackets for children (under the age of 15), specifically on boats of a certain length. A private member's Bill has been introduced to Parliament to make lifejackets compulsory nationally for all children under 15 years of age.<sup>6</sup> This is a contentious issue and there are vocal supporters both for maintaining the status quo and for legislative reform. The National Pleasure Boat Safety Forum supports reform and has made a general recommendation for more stringent rules on the wearing of lifejackets on recreational vessels 6 metres and under. Failure to wear lifejackets in small vessels that are prone to capsize are the main cause of death in boating incidents.<sup>7</sup>

The current overarching legislation, the Maritime Transport Act 1994, provides local authorities with the power to make bylaws 'specifying requirements for the carriage and use of personal flotation devices and buoyancy aids on pleasure craft'.<sup>8</sup> In 2014 Auckland

Council is proposing to include a new rule in its navigation safety bylaw that would make it mandatory for all people to wear a lifejacket when on a vessel under 6 metres.<sup>9</sup> The current bylaws require compulsory carriage of a sufficient number of lifejackets for those on board, and they are to be worn if instructed by the skipper. Auckland Council says this proposal aims to 'reduce risk of drowning and to enhance public health and safety, by providing regulation for the wearing of personal flotation devices'.<sup>10</sup>

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## The legislative and regulatory framework

### THE CORONERS ACT 2006 – DECISION WHETHER TO OPEN AND CONDUCT AN INQUIRY

In deciding whether or not to open and conduct an inquiry, a coroner must think about if the death appears to have been natural, whether it is a result of the actions or inactions of any other person, the existence of any allegations, rumours, suspicions or public concern and if publicity about the circumstances of the death may help prevent other deaths in similar circumstances.<sup>11,12</sup>

Therefore, a coroner is likely to open and conduct an inquiry following drowning deaths, and may make recommendations targeted at preventing deaths in similar circumstances.

### MARITIME TRANSPORT ACT 1994

The Minister of Transport may from time to time make maritime rules that support the implementation of the Maritime Transport Act 1994 (MTA). Rules in relation to Personal Flotation Devices (PFDs) or as they are commonly known, lifejackets, are found under Part 91.4 (1) of the Navigational Safety Rules.<sup>13</sup> A person in charge of a recreational craft is legally required to have on board sufficient, correctly sized PFDs for everyone on board their vessel -while in use.

These rules make it the skipper's legal responsibility to ensure that lifejackets are worn in situations of

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<sup>3</sup> Waikato Regional Council (2013), *Navigation safety bylaw*, 2.7.1, Hamilton, p11.

<sup>4</sup> Northland Regional Council (2012), *Navigation safety bylaw 2012*, 2.1.3, Whangārei, p10.

<sup>5</sup> Subject to exceptions – unless the person in charge of the vessel who is over the age of 15 years has expressly given permission for PFDs not to be worn and considers that conditions pose no significant increase in the risk to safety to any person through not wearing a PFD.

<sup>6</sup> New Zealand National Party (2013), *MP launches Bill to make lifejackets compulsory for kids*, (press release, 3 September).

<sup>7</sup> Maritime New Zealand (2008) *Boating safety strategy: 2007 Review of the New Zealand pleasure boat safety strategy*, Wellington, p72.

<sup>8</sup> Maritime Transport Act 1994, s33M (1) (i), [legislation.govt.nz/act/public/1994/0104/latest/DLM334660.html](http://legislation.govt.nz/act/public/1994/0104/latest/DLM334660.html)

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<sup>9</sup> Subject to a limited number of exemptions – Auckland Council (2013), *Statement of proposal, Navigation safety bylaw 2014*, Auckland, p16.

<sup>10</sup> Auckland Council, *Statement of proposal, Navigation safety bylaw 2014*, Auckland, p5.

<sup>11</sup> The coroner also listens to members of the deceased's immediate family and anything else the coroner thinks fit.

<sup>12</sup> Coroners Act 2006, s4 (2) (b), [legislation.govt.nz/act/public/2006/0038/latest/DLM377057.html](http://legislation.govt.nz/act/public/2006/0038/latest/DLM377057.html)

<sup>13</sup> Maritime Transport Act 1994, s36 (t) and (tb), [legislation.govt.nz/act/public/1994/0104/latest/DLM334660.html](http://legislation.govt.nz/act/public/1994/0104/latest/DLM334660.html)

heightened risk – such as when crossing a bar, in rough water and during an emergency.<sup>14</sup> It is recommended that children, and adults who cannot swim, wear lifejackets at all times in boats under 6 metres.

#### LOCAL BYLAWS

As stated above, the Maritime Transport Act 1994 gives local authorities the power to make bylaws about the use of lifejackets on boats.<sup>15</sup>

Recreational boaties in charge of a vessel should ensure they are familiar with specific maritime rules and local bylaws. Local bylaws aim to ensure the safety of water users and reduce conflicts between different water-based activities. Instant fines may be given for some offences while more serious offences may result in prosecution.

#### DROWNING PREVENTION STRATEGY: TOWARDS A WATER SAFE NEW ZEALAND 2005–2015

The Drowning Prevention Strategy: Towards a Water Safe New Zealand 2005–2015 (the strategy) was released in August 2005 by the Minister for ACC.<sup>16</sup>

The strategy is a plan to enhance water safety in New Zealand and prevent death and injury due to drowning and other water-related causes. It emphasises that it is not about reducing people's use and enjoyment of water environments, but ensuring people are safe when they do.

The water safety sector comprises a number of organisations and the strategy provides a framework to guide drowning prevention and water safety education generally. It links people and organisations and clearly states goals and how they will be achieved.

## Other key organisations

#### MARITIME NEW ZEALAND

The role of Maritime New Zealand (MNZ) is to maximise compliance with the regulatory framework that applies to the maritime environment. MNZ is included in the Coroners Act 2006 as an 'other investigating authority'<sup>17</sup>. This means that the coroner can refer a death to Maritime New Zealand for investigation if the coroner believes this would serve the public interest.

MNZ is a Crown entity established to promote a safe and clean marine environment at reasonable cost. In furthering its principal objectives, MNZ investigates accidents, incidents and mishaps relating to maritime transport. MNZ investigations aim to:

- determine the cause of an accident, incident or mishap, so that remedial measures can be put in place to prevent recurrences
- establish whether the Maritime Transport Act 1994 or other legislation have been breached and whether prosecutions need to be taken.

#### WATER SAFETY NEW ZEALAND

Water Safety New Zealand (WSNZ) was formed in 1949 and is the national organisation responsible for water safety education in New Zealand. It is a membership-based collective of 36 organisations. The vision for WSNZ is that everyone in New Zealand will have the water skills and behaviours necessary to use and enjoy the water safely. WSNZ maintains Drownbase, the official drowning database that has been used to monitor drowning since 1980.

#### NATIONAL PLEASURE BOAT SAFETY FORUM

The National Pleasure Boat Safety Forum (forum) is a formal network that promotes recreational boating safety in New Zealand. The network is made up of national and regional government agencies, local body groups, organisations and the marine industry. It develops and implements a common safety recreational boating strategy to support agreed boating safety policy, communications, education, compliance and regulation.

*Boating safety strategy: 2007 Review of the New Zealand pleasure boat safety strategy* focuses on skipper responsibility and four key risk factors in fatal and non-fatal accidents, including the failure to wear lifejackets in small craft (those under 6 metres), which are over-represented in fatalities.

<sup>14</sup> Maritime New Zealand (2011), *Maritime Rules*, Part 91 – Navigational Safety Rules, part 91.4 (6), Wellington, p4.

<sup>15</sup> Maritime Transport Act 1994, s33M (1) (i), [legislation.govt.nz/act/public/1994/0104/latest/DLM334660.html](http://legislation.govt.nz/act/public/1994/0104/latest/DLM334660.html)

<sup>16</sup> ACC (2005), *The Drowning Prevention Strategy: Towards a Water Safe New Zealand 2005–2015*, Wellington.

<sup>17</sup> Coroners Act 2006, s9, [legislation.govt.nz/act/public/2006/0038/latest/DLM377057.html](http://legislation.govt.nz/act/public/2006/0038/latest/DLM377057.html)



# Summary of coronial recommendations and comments on drowning deaths during recreational boating

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## Case number

CSU-2008-AUK-000672

DATE OF FINDING: 8 August 2008

## CIRCUMSTANCES

The deceased accidentally drowned when he was thrown from his boat during a hard right-hand turn. He grabbed hold of a rope attached to the boat and was dragged through the water for a period of time. He was not wearing a lifejacket and had on heavy wet-weather gear and gumboots. His failure to wear a lifejacket or other flotation device significantly contributed to his death. Alcohol was detected in his blood after his death.

## COMMENTS AND RECOMMENDATIONS

The coroner recommended that all people travelling in small boats wear lifejackets or other flotation devices regardless of their boating experience, their swimming ability or the weather conditions. The coroner endorsed the comments and recommendations in the 2007 Review of the New Zealand Pleasure Boat Strategy, which recommended that people wear lifejackets at all times on the water and a limit be imposed on the amount of blood-alcohol concentration allowed for a person operating a pleasure boat.

## Case number

CSU-2008-CCH-000292

DATE OF FINDING: 12 December 2008

## CIRCUMSTANCES

The deceased drowned in Lake Poerua in Grey District after a Canadian canoe he and a companion were using without lifejackets capsized in water. The water temperature was 10° celsius and he was unable to reach the shore.

## COMMENTS AND RECOMMENDATIONS

The coroner recommended to Maritime New Zealand that they make public recommendations in their *Lookout!* magazine to highlight the need to carry lifejackets and ensure that suitable means of communication are always available in an emergency. Furthermore, they are to continue promoting safe practices to recreational boaters through established forums including their online periodical publications, representation at boat shows, and the work of their safe boating advisors. The coroner endorsed these types of recommendations.

## Case number

CSU-2008-ROT-000216

CSU-2008-ROT-000263

DATE OF FINDING: 3 February 2009

## CIRCUMSTANCES

The deceased and his son drowned in Lake Taupo, contributed to by hypothermia. The deceased left with his two sons from the Tokaanu ramp in a 3 metre long aluminium dinghy in calm conditions. They went to the Tongariro River delta where they fly fished from the shore. At about midnight they returned to the ramp in rough conditions, and the dinghy took on too much water and sank. The three ended up in the water, clutching a buoyant chilly bin. One of the sons decided to swim to shore to get help as he was the better swimmer. The following morning he was spotted by other boaties, who picked him up from the lakeshore. The bodies of the other two men were discovered under the water near the Tokaanu boat ramp.

The deceased and his son were wearing neoprene waders, which added to their buoyancy and slowed the onset of hypothermia. However, hypothermia eventually set in and reduced their ability to remain buoyant, as well as functionally impairing their ability to cope. Both men also had traces of methamphetamine and cannabis in their system. It is not possible to say to what extent they were affected by either of these substances, but their judgement and ability to handle the situation was probably impaired.

The men were not wearing lifejackets, and there were none in the boat. They had a cellphone for communication, but it was wet and stopped working. They had no radios, flares or any other way to get the attention of others.



## COMMENTS AND RECOMMENDATIONS

The coroner recommended to Fish and Game New Zealand, and any other bodies with responsibility for recreational fishing that they take steps to publicise and draw to the public's attention the benefit of neoprene waders. These waders can help a person float and keep them warm, and this should be drawn to the attention of all anglers.

The coroner recommended to the Government and the Ministry of Transport that the following safety measures be made compulsory for all boaties and in particular for boaties of small craft under the 6 metre limit, and that these recommendations are properly publicised and drawn to the attention of all boaties:

- A lifejacket or buoyancy aid that meets New Zealand standards must be carried on all boats and must be the right size and type for every person on the boat.
- At night, all people on board must wear a lifejacket.
- All boats must carry marine communications equipment or a waterproof cellphone.
- All boats must carry a second means of communicating distress, such as hand-held flares.
- All boats operated between sunset and sunrise must be fitted with proper navigation lights.

It must be drawn to boaties' attention that the use of recreational drugs (either while travelling in a boat or when they are likely to be travelling in a boat within a reasonable period of time) will significantly reduce their ability to think and make decisions, and greatly affect their chances of surviving an emergency.

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## Case number

CSU-2008-PNO-000219

DATE OF FINDING: 22 April 2009

## CIRCUMSTANCES

The deceased was a passenger on a vessel undertaking a fishing trip. The boat was hit by two 'freak' waves in otherwise calm conditions, took on too much water and sank rapidly. As a result the deceased spent several hours adrift in the ocean, wearing only a t-shirt, shorts and a lifejacket. He and the other two men adrift had no way of contacting rescuers other than a mobile phone, which failed. The men decided to swim to where they might be seen, and to try to make their way to shore.

The wife of the boat owner phoned the coastguard when her husband didn't call at the pre-arranged time. As the trip had been logged with the coastguard and had not yet been closed, the coastguard was already checking whether or not the boat had returned.

The three men were found the next day by an air search, but the deceased had succumbed to hypothermia and drowned. His clothes didn't protect him from the cold, and by swimming he lost energy that could have been used to delay the onset of hypothermia. Swimming can also increase water aspiration due to the splashing. The lifejackets the men were wearing were of differing categories, but none were suitable for use in open water for an extended period of time.

The owner of the boat thought that if they failed to close their trip with the coastguard by the time indicated a search would quickly be initiated. Therefore he did not think he needed to get any flares from the boat when it sank. However, the coastguard spent some time finding out whether or not the boat had returned, and did not start searching until after speaking with family. Though the actions taken were reasonable, in the fading light the search needed to start as soon as possible. None of the men had an emergency position indicating radio beacon (EPIRB) or a personal locator beacon (PLB) to help rescuers find them.

The search for the three men did not follow best practice, as it did not allow for the revaluation of strategies or assumptions, such as the decision not to engage in an air search at the late hour. Though it is inconclusive whether such a search would have changed the outcome, the people involved in the search lacked experience and training, and there was no clear procedure.

The boat was never recovered, so we don't know why it sank so quickly. It may have been as a result of a fault in the 27-year-old boat, or of deficiencies in its water-tightness possibly resulting from at-home repairs.

## COMMENTS AND RECOMMENDATIONS

The coroner endorsed the recommendations of New Zealand Police and Maritime New Zealand as outlined in the following.

## **RECOMMENDATIONS OF THE POLICE REVIEW INTO THE MARINE SEARCH & RESCUE OPERATION AT WANGANUI**

### *Principal recommendation*

To mitigate the principal risks attached to a lack of skill currency Central District should appoint a full time search & rescue coordinator who in addition to responsibilities outlined in existing job descriptions will be responsible for the following:

- ensuring all police search & rescue squads in the district plan execute regular multi-agency training exercises
- ensure that all district police search & rescue squad incident controllers are trained to the appropriate skill level and that they maintain skill currency
- ensure that all district search & rescue plans are maintained having regard to local resources and or local environment
- participate nationally to ensure that search & rescue agency interaction is based on best practice
- To provide an advice safety net for district search & rescue controllers during search & rescue operations.

### *Recommendation 2*

The Wanganui Police Search & Rescue plan should have the following prompts added to priority 2, 'With the confirmation of duty police search & rescue incident controller (IC) advise key incident management personnel to respond to a common location to set up an ICP (incident control point).'

The plan must list the minimum people to be contacted:

- marine search & rescue advisor
- coastguard representative
- marine radio operator
- police support for logistics and enquiry
- (consider and/or consult with) air liaison officer (contact phone numbers to be included):
  - helicopter operators
  - military
  - local or other fixed wing operators.

### *Recommendation 3*

A working group comprising of Police, Royal New Zealand Coastguard and the Rescue Coordination Centre New Zealand (RCCNZ) continue the work started to provide a common system of search & rescue participant certification.

Search & rescue controller skill currency to be addressed and information relating to skill sets and currency should be contained in a database accessible at all times.

### *Recommendation 4*

Wanganui Police to plan and conduct a minimum of 2 marine desktop exercises per year.

Wanganui Police to plan and conduct at least one physical marine search & rescue exercise per year using resources that can reasonably be expected to be available for search & rescue operation use.

### *Recommendation 5*

Wanganui Police to activate an ICP with an incident management team (IMT) for all marine search & rescue operation. IMT to include:

- marine search & rescue advisor
- coastguard representative
- marine radio operator
- police support for logistics and enquiry
- police incident controller.

### *Recommendation 6*

Search and rescue communications should, when local conditions allow, occur on the international marine distress and calling frequency VHF channel 16.

### *Recommendation 7*

Police and the RCCNZ jointly identify a independent air resource specialist advisor to advise on the capability and suitability of any air asset military or civilian during the planning and execution stages of search & rescue operations.

## **RECOMMENDATIONS OF THE MARITIME NEW ZEALAND ACCIDENT REPORT**

It is recommended that Maritime New Zealand (MNZ):

- undertake research to review the seaworthiness of all remaining boats of this model to ensure there are no inherent design failures, which could place other people at risk, and
- take steps to review the longevity of the fibreglass commonly used in recreational boats to determine the effects of age and exposure to the weather.
- review its advisory circulars and other educational material relating to the use of lifejackets/PFDs to ensure they are up to date.

It is recommended that MNZ take steps to ensure that the recreational boating community is better informed about the following safety measures:

- The safe use of lifejackets/PFDs. The information should highlight the importance of using the correct lifejacket/PFDs for the area of use. In addition the information should clearly state the categories of lifejackets/PFDs and their intended use as per the Advisory Circular, Maritime Rule Part 91, Navigational Safety.

- The best methods available for indicating a distress situation, noting that relying on one form of communication in a distress situation may not work.
- The correct methods of in-water survival techniques.
- The effects of hypothermia and the steps that can be taken to reduce the onset of hypothermia.
- The need to be prepared for any emergency situation, and the value of assessing the associated risks and implementing contingency plans to mitigate such risks.
- The proper method for pressure testing vessels of this type to check for possible leakages.

It is recommended that the New Zealand Coastguard Education Service bring this report to the attention of all attendees of future courses especially the marine VHF and day skipper courses.

It is recommended that this report be forwarded to the National Pleasure Boat Safety Forum (NPBSF).

#### RECOMMENDATIONS OF THE CORONER

That it be made compulsory for recreational boat owners/operators to carry either a 406 MHz EPIRB or a 406 MHz PLB whenever they are on the water.

That information highlighting the importance of using the correct lifejacket/personal flotation device for the area of use, and descriptions of areas of use in product labels, be reviewed to ensure they are meaningful to and easily understood by the intended users.

##### *To the Wanganui Coastguard*

That their operating procedure in respect of overdue boats is amended to include a prompt to remind personnel that if a trip report is not closed within two hours of dusk, time is of the essence, and they need to establish as quickly as possible whether it is in fact overdue.

##### *To Maritime New Zealand and the New Zealand Coast Guard Education Service*

That they take steps to ensure that the recreational boating community understands what happens if a Trip Report is not closed, and that practices can vary from region to region.

##### *To the Central District Police*

That the present arrangement that does not require police officers who are search and rescue volunteers to be available while off duty with a view to establishing a process by which an Incident Controller can be assured of assembling an incident management team that includes at least two SAR trained police officers, in addition to him or herself.

## Case number

CSU-2008-AUK-001188

DATE OF FINDING: 8 May 2009

#### CIRCUMSTANCES

The deceased was using a jet ski at Muriwai Beach in conditions described as moderate for the West Coast. He was an inexperienced jet ski user, and when he fell off into the surf he was not able to pull himself back onto the jet ski. A friend went out on his surfboard and brought the deceased back to the shore. A post-mortem examination found a significant level of alcohol in the deceased's blood. For comparison, it was one and a half times the legal limit for an adult driver in New Zealand.

#### COMMENTS AND RECOMMENDATIONS

The coroner commented that this was another in a continuing series of drownings at West Coast beaches. The dangers of any activity in such waters means that people need to avoid alcohol, be experienced in the activity and be aware of the state of the sea.

## Case number

CSU-2009-PNO-000128

DATE OF FINDING: 12 October 2009

#### CIRCUMSTANCES

The deceased was fishing in his small 8-foot dinghy in the Port Taranaki Harbour, New Plymouth. He fell from his boat and drowned. Although he was carrying a lifejacket on his boat as required by law, he had not been wearing it. Even though the deceased could not swim, he only wore the lifejacket in rough weather. The weather conditions in the harbour that day had been described as perfect.

#### COMMENTS AND RECOMMENDATIONS

The coroner commented that all people on board vessels 12 feet long or less should have to wear lifejackets or personal flotation devices that will support the head of an unconscious victim in the water and help keep their airway open. People using such vessels need to be skilful, as they can be unstable, which could cause a person to fall from or capsize the vessel (such as when moving around or standing to cast a fishing line or tie the vessel up).

## Case number

CSU-2008-CCH-000834

DATE OF FINDING: 22 March 2010

## CIRCUMSTANCES

The deceased drowned in the Grey River after the Canadian canoe he was in with his friend and three children capsized in rapids. He was not wearing a lifejacket.

## COMMENTS AND RECOMMENDATIONS

The coroner commented that recreational activities on and around New Zealand waters, particularly in this West Coast region, call for the highest standards of self-protection by having suitable equipment.

The use of Canadian canoes has its own dangers. The design of the canoe means that it will more readily capsize, and once capsized is difficult to control, to bale and to regain access to. An expert opinion has shown that this type of craft is largely unsuitable for general use in New Zealand conditions. It is primarily designed for flat water and may be safely used in certain circumstances in flat water. The coroner recommended that Water Safety New Zealand give publicity to the unsuitability of Canadian canoes for general use in New Zealand conditions.

Each of these fatalities has involved the person who has died not wearing a lifejacket. It is mandatory to carry lifejackets for each person on small watercraft of this type. It is open to the local authority (Grey District Council) to adopt boating and/or water safety bylaws including policy for wearing of lifejackets. The coroner recommended that the Grey District Council urgently consider the adoption of boating and/or water safety bylaws to include the compulsory wearing of a properly secured lifejacket by every person on board a recreational craft that is less than 6 metres in length.

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## Case number

CSU-2009-PNO-000182

CSU-2009-PNO-000183

DATE OF FINDING: 21 May 2010

## CIRCUMSTANCES

The two deceased were on board a fishing vessel off the coast of Waitarere. The boat was equipped with lifejackets, VHS radio, CB radio, flares and a hand-held GPS. The vessel had not returned by 6pm and family were concerned. At 9.35pm the on-call officer in charge of search and rescue in Levin was notified that the men were overdue and a search was started. The vessel was

located the next day, partially submerged. The two deceased were located a short time later. Both had drowned, with hypothermia being a contributing factor.

The vessel had been modified and repaired, and it had deteriorated due to age. This made it unseaworthy. Leaks probably caused the vessel to founder and then sink. If a proper maintenance check had been done, the points of water entry could have been identified and fixed. Furthermore, the vessel was not properly equipped for this kind of an emergency and did not carry any hand-held radios or a personal locator beacon. The lifejackets the two men were wearing were Type 402, which are meant for sheltered waters where an early rescue may be expected. The more appropriate lifejacket for this type of emergency is a Type 401 open water lifejacket, which provides more buoyancy and can slow down hypothermia and allow the wearer to survive for longer.

## COMMENTS AND RECOMMENDATIONS

The coroner endorsed the recommendations made by Maritime New Zealand (MNZ) in their investigation report. They are outlined as follows:

- MNZ will continue to promote to the recreational boating community the importance of proper vessel maintenance, in particular:
  - the danger of do-it-yourself type repairs or modifications
  - the necessity to regularly check the structural integrity of older aluminium vessels
  - that consistent water ingress is indicative of a leak which should be repaired by a professional before the vessel is used again.
- MNZ will continue to promote, in line with the National Recreational Boating Safety Strategy, the carriage of effective emergency equipment through:
  - a national safety campaign
  - the introduction of legislation making the carriage of communications equipment in recreational crafts compulsory.
- MNZ will continue to promote throughout the recreational boating community:
  - the safe use of lifejackets/PFDs
  - the correct method of in-water survival techniques
  - the effects of hypothermia and the steps that can be taken to reduce its onset
  - the need for trip reporting
  - the need to be prepared for any emergency situation, and the value for assessing risks and implementing contingency plans to mitigate such risks.

The coroner further commented that instructions about when to wear the various types of lifejackets/PFDs might be improved with better descriptions of terms such as 'sheltered waters' and 'early rescue'.

The coroner recommended that information about the use of lifejackets should make it clear that inflatable lifejackets are Type 401 lifejackets.

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## Case number

CSU-2009-HAM-000862

DATE OF FINDING: 26 August 2010

## CIRCUMSTANCES

The deceased died in the sea near Whangamata. The cause of death was drowning with traumatic injuries due to shark bites. The deceased and another man were on a fishing trip on a kayak when it overturned. The coroner was unable to say with certainty whether the deceased drowned before or after being attacked by a shark and made an open finding in relation to this death.

## COMMENTS AND RECOMMENDATIONS

The coroner commented that this death may have been prevented if the two men had taken greater safety precautions before setting out on a fishing trip on a kayak. Whether or not the deceased would have survived that swim if he been wearing a lifejacket is unknown, as he may still have been attacked by a shark. Nevertheless, wearing a lifejacket while on the ocean in a kayak has to be a very basic safety requirement.

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## Case number

CSU-2009-DUN-000453

DATE OF FINDING: 4 October 2010

## CIRCUMSTANCES

The deceased had been drinking in the evening with friends. He decided to sleep on his yacht for the night, which was moored in the bay. He fell into the water while going from his dinghy onto the yacht. He wasn't wearing a lifejacket. Later in the morning a friend saw the dinghy semi-submerged some distance away from the yacht. The deceased was found lying face-down in the water.

A post-mortem examination revealed not only a significant blood-alcohol level, but also traces consistent with the smoking of one cannabis cigarette. The deceased would have been weighed down by

his clothes, and his movements restricted. The cold temperature of the water and his intoxication would also have affected his ability to save himself.

## COMMENTS AND RECOMMENDATIONS

The coroner commented that the deceased had not taken the safety precaution of wearing a lifejacket. Had the deceased replaced the heavy coat he was wearing with a lifejacket, he could have more easily gotten to a safe place after falling in the water. The coroner sent a copy of the findings to Water Safety New Zealand for their information as a further example of the fatal consequences of over-indulging in alcohol (and cannabis) when boating.

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## Case number

CSU-2010-HAS-000014

DATE OF FINDING: 12 October 2010

## CIRCUMSTANCES

The deceased was rafting on the Mohaka River with family. Her husband was an experienced rafter, both in the USA and New Zealand; he had rafted this particular route twice before. All members of the group were wearing lifejackets, appropriate clothing and helmets. As the raft approached a drop, the boat was flipped by a wave. The other occupants found their way to the shore of the river, but the deceased was pulled under the surface and trapped there by the force of the water. Family members saw her lifejacket under the water, and she was eventually pulled out with the help of police. Though her husband had negotiated this route before, he had not done it with four people in the raft. On this day he had estimated the rapids to be grade 3.5, but with the volume of water present it would have been grade 4.

Rule 80B.28 of the Maritime Rules under the Maritime Transport Act 1994 requires commercial rafting operations in New Zealand to use lifejackets with 100 newtons of buoyancy. Recreational users are not required to use such a lifejacket. The lifejacket the deceased was wearing was tested independently and revealed to have 53 newtons of buoyancy, making it the equivalent of a lifejacket appropriate for aquatic sports such as dinghy sailing.

## COMMENTS AND RECOMMENDATIONS

The coroner commented that recreational users on moving water must be aware of their capabilities, the capabilities of their equipment and the dangers presented by moving water. Despite all reasonable precautions being taken, tragedies can and do occur.

## Case number

CSU-2010-DUN-000168

DATE OF FINDING: 13 June 2011

## CIRCUMSTANCES

The deceased was the skipper of a boat that was struck by a rogue wave, throwing both him and his boating companion into the water. While swimming towards the coastline, the deceased succumbed to the cold water and died.

## COMMENTS AND RECOMMENDATIONS

The coroner endorsed the comment of a local launch master, in relation to signage at Bluff Harbour regarding the dangers of The Spit area. He understood that signage has been installed and would send a copy of the finding to the regional council so that the dangers of the area continue to be identified. The coroner further commended Maritime New Zealand for promoting boating safety and providing boaties with a free information pack.

The coroner made the following recommendations:

- That a copy of the finding be sent to Maritime New Zealand to express support for their continuing education programme.
- That a copy of this finding be forwarded to the Otago Regional Council, who is the appropriate agency to supervise safety findings in the area.

## Case number

CSU-2009-DUN-000008

CSU-2009-DUN-000009

DATE OF FINDING: 11 August 2011

## CIRCUMSTANCES

The two deceased died in the Kawarau River, Queenstown. One of the deceased was driving a jet boat and the other was a passenger. The jet boat collided with a jet ski. Both received injuries in the collision that likely rendered them unconscious and they were thrown into the Kawarau River. Both died of drowning. While appropriate PFDs were carried on the jet boat, they were not being worn.

## COMMENTS AND RECOMMENDATIONS

The coroner made the following recommendations.

*To Maritime New Zealand*

That the issues identified in relation to the wearing of personal flotation devices/lifejackets results in a mandatory requirement for all those in small boats. It

was noted with approval that the Regulation to this effect by Queenstown Lakes District Council and that the compulsory wearing of lifejackets should be a national initiative. Maritime New Zealand should also give consideration to the type of personal flotation device/lifejacket used. The minimum Standard (adopted from New Zealand Standards) should be considered as should colouration.

That Maritime New Zealand commission further research into the use of helmets by both drivers and passengers on personal watercraft and on jet boats. The users must of course be consulted.

*To Queenstown Lakes District Council*

A request that the submission by counsel for the family in relation to the speed limit on rivers or sections of rivers in region be further considered.

## Case number

CSU-2009-CCH-001127

CSU-2009-CCH-001128

CSU-2009-CCH-001016

DATE OF FINDING: 9 September 2011

## CIRCUMSTANCES

The three deceased died at Lake Tekapo on 21 October 2009. They were on aboard a recreational fishing vessel that was fishing for trout in the lake. When the vessel did not return as scheduled, police were alerted and a search and rescue operation started. The vessel was located semi-submerged on a shingle bar. One of the deceased was located at the scene. The other two deceased were not located and are presumed deceased. Investigations by Maritime New Zealand determined that the vessel had collided with a solid object while underway.

## COMMENTS AND RECOMMENDATIONS

The coroner directed recommendations to Maritime New Zealand through the National Pleasure Boat Safety Forum (NPBSF):

- That a list of matters to be promoted through the recreational boating community include the importance of using the clip and lanyard system associated with the emergency stop switch.
- That the NPBSF's proposal that the carriage of appropriate communications equipment be mandatory on recreational craft, and that lifejacket wearing be made mandatory for recreational craft less than 6 metres unless the skipper authorises them to be taken off at times of very low risk.



## Case number

CSU-2010-DUN-000440

CSU-2010-DUN-000441

DATE OF FINDING: 12 October 2011

## CIRCUMSTANCES

The two deceased (both French) had planned to kayak across Lake Wakatipu, hike up Cecil Peak and kayak back across the lake. They were using an older 'open cockpit' kayak, with one paddle that they swapped between them. An onlooker considered them to be inexperienced and poorly equipped. He warned them about oncoming bad weather and offered them a ride back to Queenstown. Despite language difficulties, he believed that they had understood him and the two men said they wanted to have a walk. He gave them his phone number in case they needed to contact someone. That night he heard the two kayakers were in trouble. He set out in his boat with two others and made for Hidden Island and then to the area of the lake where he had seen them. They were joined in their search by the coastguard. The bodies of the two men were recovered shortly after midnight. The cause of death was drowning.

The type of kayak they had used was considered not appropriate for open water; furthermore, having only one paddle would have made it very difficult to manoeuvre, especially in difficult weather conditions. Both kayakers were wearing lifejackets, but one was designed only for use by children up to 40 kilograms. Because it was too small for him he wore it inside out, which affected its visibility. Their clothing was inappropriate for the journey they had planned.

## COMMENTS AND RECOMMENDATIONS

The coroner recommended that the Queenstown Lakes District Council and Queenstown Coast Guard continue to create and distribute the cards (produced at the inquest hearing) designed to educate water users on safe practice. A copy of the findings was sent to Maritime New Zealand and the National Pleasure Boat Safety Forum with the following recommendations.

- That the wearing of appropriate lifejackets by small boat users be made compulsory nationally.
- That they consider the evidence given to the inquest hearing in respect of the visibility of lifejackets. It is clear that searches with night vision goggles are able to locate fluorescent strips on lifejackets from a considerable distance. The manufacture of lifejackets incorporating reflectorised material would have obvious benefits. Consideration ought to also be given to the alteration of the New Zealand Standard to ensure all lifejackets or PFDs are manufactured in high visibility colours.

## Case number

CSU-2011-DUN-000497

DATE OF FINDING: 4 October 2012

## CIRCUMSTANCES

The deceased fell from his yacht on Roy's Bay, Lake Wanaka, when a significant wind shift tipped the boat. His personal floatation device (PFD) did not deploy, and efforts by his crewmate to rescue him failed. A search was launched and his body was recovered from the lake floor sometime later. The deceased was a competent and experienced sailor. Earlier that day he had been observed to tire easily. Though he was wearing a PFD, he had it on inside out. There were indicators that the PFD had been inflated previously, but the replacement CO<sub>2</sub> canister had not been screwed in properly. The lifejacket was not in safe condition to be worn. There was no evidence that he had pulled the ripcord to inflate the device, or tried to inflate it manually.

## COMMENTS AND RECOMMENDATIONS

The coroner recommended that Maritime New Zealand continue with their efforts to ensure that the wearing of appropriate PFDs by everyone involved in activities on the water is made compulsory. He directed a copy of his findings be forwarded to Survitec and recommended that they send it to RFD, the manufacturers. They are encouraged to cooperate with an education programme, both nationally and internationally, to draw public attention to the dangers of CO<sub>2</sub> cylinders failing.

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## Case number

CSU-2011-DUN-000375

DATE OF FINDING: 9 November 2012

## CIRCUMSTANCES

The deceased was a tourist in New Zealand. He had borrowed a kayak from his flatmate, and left home to kayak on Lake Hawea. He was seen being hit by ripples while kayaking and he appeared inexperienced. The weather was beginning to change, with the water becoming rougher and the wind stronger. He did not return from the lake and after two days was reported missing. Although police located the kayak, a comprehensive search did not locate the deceased. It is considered likely that the kayak capsized and he was overcome by the cold water and subsequently drowned. The kayak that he was using was not designed for open water paddling. He was not wearing a personal floatation device or a wetsuit, which would have decreased his ability to survive in the cold water.



## COMMENTS AND RECOMMENDATIONS

The coroner made the following recommendations.

### *To Maritime New Zealand*

That the organisation takes further action to publicise the need for people in small boats to wear lifejackets at all times.

### *To the Minister for Transport*

That the Government should take action to ensure that the wearing of lifejackets 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.

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## Case number

CSU-2011-WHG-000036

DATE OF FINDING: 15 March 2013

## CIRCUMSTANCES

The deceased died as a result of drowning. He was fishing in Martins Bay and was approximately 20 metres out from the beach in his dingy. He was not wearing a lifejacket. A short time later one of his companions noticed that his boat had overturned and he was in the water struggling to stay afloat. The deceased did not know how to swim, and was an inexperienced boatie.

## COMMENTS AND RECOMMENDATIONS

The coroner recommended to Maritime New Zealand that it should be compulsory for all occupants of small boats to wear lifejackets at all times while they are on the water.

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## Case number

CSU-2012-WGN-000676

DATE OF FINDING: 20 August 2013

## CIRCUMSTANCES

The deceased was rafting on the Waiohine River with two other people. They were on an inflatable pontoon raft. While negotiating a left-hand bend, the raft struck a submerged log and overturned. While the other two people were able to get to shore, the deceased was swept out of sight by the current. Rescuers found his body later that afternoon. A police officer, with experience in rescue operations, suggested early in the search that aviation assets be deployed to help. This was not done for a further 20 minutes.

## COMMENTS AND RECOMMENDATIONS

The coroner discussed the emergency response by police and recognised the bravery of a bystander who had helped when the raft overturned. Specific recommendations were directed:

### *To the Secretary, Department of Prime Minister and Cabinet*

That consideration is given to officially recognising the bravery of a bystander who helped in the rescue attempt.

### *To the District Commander, Wellington Central Police Station*

That the emergency management and response mechanisms of Police Communications be reviewed to ensure that the reasonable recommendations of experienced frontline police officers are acted on immediately, time being of the essence in rescues.

## RESPONSE FROM NZ POLICE

The Acting District Commander, Wellington Police thanked the coroner for the opportunity to respond to the recommendations and made the following comments.

A review of Police District Mobilisation Plans (DMPs) used by Central Communications when responding to Marine and Land SAR was conducted after this incident.

The review covered all Police Districts in the Lower North and South Islands and recommended that all DMPs covering Marine and Land Search and Rescue (SAR) involving rivers, lakes and estuaries were updated to make it clear that where life is at risk appropriate rescue craft can be deployed by the communications centres without prior authorisation.

The following text was approved for inclusion (with minor amendments as appropriate) in every Police District's Marine and Land SAR DMPs:

- In a life threatening situation – in or on water [lakes, rivers, estuaries or sea] the communications centre dispatcher or the communications centre incident controller has authority to commit resources for all category 1 SAR call outs.
- Dispatcher, immediately, on receipt of viable information that a person or persons life is at risk in or on water:
  - immediately contact Rescue Helicopter making sure you specify that water rescue capability is required. If injury is possible, ensure that medical support is available.
  - contact the on-call SAR incident controller and brief on the incident and action taken to date and confirm that points 4–6 below are required.

- activate [or place on standby] closest marine search unit [Coastguard or other local asset]
- depending on information provided and/or instruction from the District Incident Controller.

This recommendation has now been implemented and it is reflected in the Wellington Police District Marine and Land SAR DMPs.

The same or similar text has also been approved for implementation in all other Police District DMPs.

The feedback provided to Police by the other witnesses involved in this fatal tragedy is that they were grateful for the speed and efficiency of the response provided by Police and Ambulance to them. They also noted that the ‘speed that everyone took control of the rescue was fantastic’.

Finally, I note your recommendation to the Department of Prime Minister and Cabinet that consideration be given to recognise the bravery of a bystander that day who assisted after the raft overturned.

Police are supportive of this move and we are more than willing to support this recommendation.’

face and the coroner hoped that people would be more sympathetic when making such comments to family or media who have lost a loved one at sea.

Having said that, lifejackets need to be worn on the sea, particularly Wellington Harbour, particularly when you are using a light canoe or a dinghy.

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## Case number

CSU-2011-WGN-000490

DATE OF FINDING: 22 October 2013

## CIRCUMSTANCES

The deceased was canoeing with a friend in Wellington Harbour. Both were paddling to Ward Island and back. On the return trip, conditions became rougher, and they both got into difficulty and fell out of their canoes. Unlike his companion, the deceased let go of his canoe and it drifted away before he could get back into it. His companion tried to reach him, but eventually lost sight of him, and had to paddle back to shore for her own safety. The deceased was never located and he was presumed drowned.

Although there were lifejackets in both canoes, they were not being worn at the time. The canoe the deceased was in was designed in a way that would make it float away from the user quickly without a leg-rope attachment.

## COMMENTS AND RECOMMENDATIONS

The family commented on the issue of not wearing lifejackets. They said that there were 3 reasons why people should wear them: ‘One was for your own safety, two was to find you, and the third was to keep the media and others off your back for not wearing one.’ Clearly this has been difficult for the family to

# Summaries of general coronial recommendations and comments

## Adverse effects or reactions to medical or surgical care

See also *drug, alcohol or substance abuse* below.

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### Case number

CSU-2010-WGN-000582  
2013 NZ CorC 33

### CIRCUMSTANCES

The deceased died at Hutt Hospital as a result of haemolysis following surgery. She was discharged 2 days after the procedure and her discharge papers noted that she should contact the hospital if her temperature rose. A week later the deceased's daughter noticed she was hot and feverish. Her daughter called the hospital but the person she spoke to said they could not help and she should take her mother to an after-hours doctor. The deceased did not want to do this. She was found the next day semi-conscious, having collapsed in her home. Although she was taken to hospital she could not be resuscitated.

The hospital acknowledged that a phone call was received but no notes were made of the conversation and the staff, when questioned, could not recall any details of the call. As a result of this incident, the hospital has implemented a process where calls of this nature are recorded.

On the day the deceased was admitted to hospital for the surgery, her daughter discussed the details of her mother's past renal failure with hospital staff. The hospital acknowledged their staff knew that the deceased had a history of haemolytic anaemia and had been under the care of a haematologist, but they were unable to clarify when they became aware of this information.

### COMMENTS AND RECOMMENDATIONS

The coroner commented that concerns raised by the family had not fully been answered by the Hutt Valley District Health Board.

The first issue was the phone call made by the deceased's family in response to the directions on the discharge notice. The hospital indicated they were taking this matter seriously. The hospital discussed recording phone calls. However, more important to the coroner was that, when the family notified the hospital of the increase in temperature and fever, hospital staff should have advised the deceased to return to the hospital immediately. The coroner regarded this as standard practice.

The second issue was about previous hospitalisation at Wellington Hospital. The deceased and her daughter had outlined her history of haemolytic anaemia. The coroner expected the hospital to follow this up immediately, in case there were medical ramifications.

The coroner noted that the hospital was to arrange a discussion with the deceased's daughter to address these issues.

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### Case number

CSU-2012-WGN-000274  
2013 NZ CorC 31

### CIRCUMSTANCES

The deceased died at Wellington Hospital of pneumonitis, an inflammation of his lung tissue. He got this when he aspirated some of his stomach contents during an operation. The following day he developed respiratory failure and his condition continued to deteriorate despite treatment. Before the surgery he had been offered a nasogastric tube to clear fluid from his stomach, but he declined.

At the time of his death the deceased was the subject of an indefinite compulsory treatment order under the Mental Health (Compulsory Treatment and Assessment) Act 1992 (the Act). He had been diagnosed with a condition that did not allow him insight into his condition or potentially to medical matters. Under the order, compulsory treatment was restricted to matters relating to his mental disorder, not other medical care, so he was able to refuse the nasogastric tube.

### COMMENTS AND RECOMMENDATIONS

While the coroner accepted the medical limitations that may apply following the Act, he was concerned that the nasogastric tube was not automatically inserted,

as the deceased was the subject of a compulsory treatment order. His mental condition meant that he had a reduced understanding of reality and the coroner believed that the deceased was not able to fully grasp the consequences of refusing the nasogastric tube. The coroner commented that if the deceased had the nasogastric insertion it is more likely that he would have recovered from the operation.

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## Case number

CSU-2010-WGN-000016

2013 NZ CorC 35

## CIRCUMSTANCES

The deceased died at home of unknown natural causes. She had been treated at Wellington Hospital 7 months before her death for problems with her eyesight. When she was discharged, arrangements were made for an MRI and a subsequent review. At that time, the waiting list for an MRI was over a year. Four months later the doctor in charge of her case noted that she had not yet had an MRI and decided to bring her into the clinic to conduct the review anyway. After the review he noted that he needed to 'chase up' the MRI. The hospital had no record of any action or request about providing an MRI to the deceased. At the end of that year her MRI request was reviewed and sent to the booking clerk for an appointment to be made. Before a booking could be made or forwarded, she was found dead at home by a neighbour. The hospital was not notified of her death until 2 months later.

In the event that a patient failed to turn up to an appointment it was the general practice of the radiology department of the Capital and Coast District Health Board to contact the patient and re-book the appointment. If a patient could not be contacted the referring clinician or the patient's general practitioner would be contacted instead.

## COMMENTS AND RECOMMENDATIONS

The coroner commented that the Capital and Coast District Health Board needs to review its process to ensure that a patient is able to be contacted when they fail to make and keep an appointment. Although this places a further requirement on hospital staff, it may isolate a patient's medical issues. The coroner made no formal recommendation to the hospital but said they need to ensure they have robust processes for patient contact.

## Case number

CSU-2009-AUK-001307

2013 NZ CorC 39

## CIRCUMSTANCES

The deceased died at North Shore Hospital of septicaemia arising from pneumonia. Earlier that month she had fallen and injured her knee and was taken to the orthopaedic unit at North Shore Hospital. She was in a stable condition and showed no other symptoms. She was scheduled for discharge 6 days after her admission. However, on the day of discharge she developed vomiting and diarrhoea and due to a diagnosis of 'likely gastroenteritis' her discharge was delayed. She continued to experience this over the next day and became short of breath with some central chest pain. At this stage a pulmonary embolism was considered to be a possible diagnosis. Her condition deteriorated enough to trigger an alert, and on review her chest pain was found to have become acute. While she was being clinically reviewed an hour later, she went into cardiac arrest. She was transferred to the intensive care unit, but died the next day.

Following her death, the deceased's family raised concerns about the care provided by North Shore Hospital. Some of those concerns fell outside the jurisdiction of the coroner and were addressed by the Health and Disability Commissioner. The overriding issue for the family were whether or not the deceased's death could have been prevented if hospital staff had recognised her pneumonia earlier.

Though the deceased's vomiting would have placed her at increased risk of hospital acquired pneumonia (HAP), the usual markers of the infection were uncharacteristically silent, and there was no indication to start antibiotics until her sudden deterioration the night before her death. Pneumonia was never considered as a possible diagnosis.

Up until her breathlessness and chest pain, gastroenteritis was a reasonable diagnosis to make, as was the later diagnosis of a pulmonary embolism. The coroner suggested that clinicians should have considered possible infection and taken steps to rule it out. The deceased experienced shortness of breath the day before her death as well as acute chest pain. However, insufficient note-keeping means it is not clear when each of these symptoms started and so at exactly what point there might have been sufficient indication to staff that a cardiovascular examination should be performed. At that point such an examination may have shown signs of pneumonia.

The hospital's early warning system for the deterioration of acutely ill adults (NEWS) monitored her heart and respiration rate, oxygen saturation levels, temperature and blood pressure. The value attributed by this system is based on readings of the patient's oxygen saturation levels when a patient is breathing normal air. However, when the deceased's NEWS score was being calculated on the evening before her death she was on nasal prong oxygen. Initially that evening she had a reading of 0 and it was not until later on, when her condition had deteriorated further, that it increased to 7, activating an alert. The coroner suggested that as the deceased was on oxygen and not normal air her rating should have been higher.

The Waitemata District Health Board (WDBH) has since made changes to address concerns about note keeping and documentation. At the time the coroner's final findings were released, the WDBH was undertaking a medical documentation quality improvement project which established an audit programme of doctors' documentation in parallel with the audit of nursing documentation. Further quality improvement activities were to be undertaken according to the results of the audit.

## COMMENTS AND RECOMMENDATIONS

The coroner considered whether recommendations were needed about the sub-standard (doctor's) clinical documentation in this case. The coroner decided that the quality improvement project was enough.

The coroner noted the clinical evidence is that HAP can present atypically and the classical symptoms and signs of pneumonia may not be evident. It is associated with a high mortality rate. Given the potentially devastating consequences of HAP, the coroner recommended to the WDBH that the specific circumstances of the deceased's illness and deterioration, together with her findings regarding the deceased's care and the expert opinions, be used as an educational tool to heighten awareness of atypical features of the illness to clinical staff.

The coroner also recommended that the WDBH consider whether measuring a person's oxygen saturations while on oxygen, rather than on natural air, accurately reflects that person's condition, and whether changes in the measurement of that physiological parameter should be made.

## Case number

CSU-2011-AUK-000291  
2013 NZ CorC 74

## CIRCUMSTANCES

The deceased, aged 5 years, died at Starship Children's Hospital in Auckland after she contracted chickenpox that progressed to viral encephalitis. After continued drowsiness and diarrhoea associated with her chickenpox, the deceased's general practitioner referred her to Middlemore Hospital. On admission she was sleepy but responsive. Her doctor thought she was merely dehydrated, and she was initially given fluids. However, after further testing and observation, hospital staff suspected she had an infection of the central nervous system, such as encephalitis. A lumbar puncture was performed that afternoon to rule out meningitis and she had difficulty regaining consciousness for a time after the procedure, for which she had been anaesthetised. That evening she stabilised, but was later transferred to the intensive care unit, where her condition deteriorated rapidly. On the morning of her death she was transferred to the paediatric intensive care unit at Starship, where staff considered that her condition was very grave. She died later that morning.

Chickenpox leads to encephalitis in approximately 2% of cases. The swelling of the deceased's brain caused by the encephalitis compressed her brainstem (cerebral herniation), which led to her death. Cerebral herniation is also a very rare complication of a lumbar puncture. In the case of the deceased, it cannot be concluded that the cerebral herniation was caused by the lumbar puncture, and the notes do not show that any contraindications for the procedure, although they do show it is considered inadvisable to perform a lumbar puncture on a child who has been experiencing fluctuations in consciousness.

Other issues were identified with the deceased's treatment. For instance, an expert was considered that she was given too much intravenous fluids and the sodium content of the fluid was too low. The fact that she was sedated even though she was experiencing fluctuations in consciousness was also noted, as procedural sedation should be used cautiously with a child who already has an altered conscious state. However neither of these factors contributed to the her decline and death.

## COMMENTS AND RECOMMENDATIONS

The coroner endorsed the following comments made by a consultant paediatrician who gave expert evidence in the inquiry, regarding lessons that could be learned from this case:

- If encephalitis (or meningitis) is suspected, pay careful attention to fluid and electrolyte status.
- If intravenous fluids are required, 0.9% saline (with glucose) is the ideal fluid to administer. Consider restricting the rate of administration, especially if the serum sodium is low.
- Administer boluses of intravenous fluid with caution and reserve it for children with signs of shock.
- Do not perform a lumbar puncture in a child with a fluctuating conscious state.
- A normal CT brain scan does not exclude raised intracranial pressure.
- Use procedural sedation with caution in a child who already has an altered conscious state.

The coroner commented that the appropriateness of performing a lumbar puncture and its role in contributing to the deceased's death was directly called into question in the inquiry. The evidence makes it clear that the decision of whether or not to perform a lumbar puncture on a child presenting as the deceased did should be treated with real caution. Likewise fluid and electrolyte management of a child with a reduced conscious state needs to be carefully controlled.

Based on the expert advice the coroner received, adverse findings were not made in relation to the decision to perform a lumbar puncture on the deceased or its role in her deterioration. The coroner also did not make adverse findings on the deceased's intravenous fluid management and its possible role in the amount of cerebral oedema the deceased developed.

The coroner recommended that Middlemore Hospital use the deceased's case as a learning tool for medical and nursing staff, and that it review whether its policies on administering intravenous fluid to children with suspected encephalitis or meningitis need to be amended in view of the issues raised in the expert evidence.

## Case number

CSU-2010-AUK-001025  
2013 NZ CorC 78

## CIRCUMSTANCES

The deceased died at North Shore Hospital of ischaemic heart disease. He had seen a doctor who was not his usual general practitioner (GP) 19 days before his death for abdominal cramps and a slight fever. He did not show any signs of appendicitis and tested positive for a bacterial infection. He was later prescribed antibiotics over the phone from his regular GP surgery (the practice). The antibiotics improved his pain for a couple of days, but it later returned. As instructed, he called the practice and new antibiotics were prescribed over the phone. He was referred to hospital 5 days before his death, when his abdominal pain became severe. At hospital he was diagnosed with a ruptured appendix and a pelvic abscess and was operated on that night. He initially recovered well from his operation, but on the day of his death complained of pain in his arms and, later, chest pain. An emergency resuscitation call went out once it was clear he was in cardiac distress. Although staff responded promptly he could not be revived.

His surgery was performed satisfactorily, but the presence of acute appendicitis may have contributed to his heart failure. The appendicitis arose secondary to his initial bacterial infection and an earlier diagnosis may have lessened the strain on his heart.

Because the nurse from the practice who spoke to the deceased on the second phone call did not record the details of the call, it is unclear whether appendicitis had developed at that point. Other evidence suggests it arose later, closer to his admission to hospital.

The deceased did not show signs of heart disease, and it was not routine to do any cardiac examinations on a man of the deceased's age who presented with acute stomach pain. His cardiac symptoms arose very rapidly before his death.

The ECG machine (a diagnostic tool) on the deceased's ward was not working but his death occurred too soon after any possible cardiac distress became clear for an ECG assessment to have changed the outcome. Expert evidence suggested that a cardiac monitor would have identified any concerning cardiac arrhythmias until an ECG could be done.



## COMMENTS AND RECOMMENDATIONS

The coroner asked North Shore Hospital to consider whether cardiac monitors should be available as a diagnostic tool, where the need for such monitoring is indicated, until an ECG can be done. The coroner also noted that keeping accurate clinical records is a basic competency and necessary component of medical practice. The Medical Council of New Zealand's standard *The maintenance and retention of patient records* (August 2008) states that clear and accurate clinical records should be kept. They are an integral tool to ensure that a patient receives good, ongoing care. The coroner commented that an accurate clinical record also helps inquiries when questions are raised about a patient's care and management.

The coroner accepted that the practice knew it should keep accurate and complete notes, and that the improvements to their documentation standards are satisfactory. Accordingly she felt that a formal recommendation was not called for. The coroner encouraged the practice to continue reviewing and monitoring its compliance with documentation standards.

## Aged and infirm care

### Case number

CSU-2012-DUN-000199  
2013 NZ CorC 41

### CIRCUMSTANCES

The deceased died at Dunedin Public Hospital of an obstructive lung disease. While being treated at the hospital for a fractured hip, staff discovered she was experiencing further health problems, including an infection that dilated or blocked the bronchi. She chose conservative treatment and palliative care and was discharged to Montecillo Veterans' Hospital. Two days before her death she tried to adjust the lounge chair she had been placed in with its motorised mechanism. However, she was unable to adequately operate the controller and accidentally raised it too high, causing her to fall out. She was found by staff and transported back to Dunedin Public Hospital where her injuries were treated. Her condition continued to decline and, under the conservative treatment she had requested, she died 2 days later.

Following this incident the controls of all such chairs at Montecillo Veterans' Hospital are now placed out of the reach of residents for their safety.

## COMMENTS AND RECOMMENDATIONS

The coroner recommended that the hazard created by the use of electrically operated lazy-boy chairs by patients who aren't trained in their use and whose ability to operate the controls may be compromised by physical or mental health should be drawn to the attention of the following organisations: Ministry of Business Innovation and Employment, the rest home industry (through its national association) and the Southern District Health Board, so that the hazard is more widely recognised and to mitigate the hazard.

### Case number

CSU-2010-WGN-000102  
2013 NZ CorC 38

### CIRCUMSTANCES

The deceased died at the Rita Angus Retirement Village (the Village) of a myocardial infarction. He had a history of ischemic cardiomyopathy and a pacemaker was inserted some years before his death. He was found deceased in his unit 10 days after one of his neighbours had last seen him.

The deceased lived in an independent unit that was managed without any reference to Village staff. He was reasonably self-sufficient and had a separate general practitioner. Due to this, staff at the Village were not kept informed of his health. Though the Village did offer checking or care services to their independent residents, the deceased had never asked for them. Village staff would not ordinarily check on the deceased or inquire into his affairs.

## COMMENTS AND RECOMMENDATIONS

The coroner commented that it is unacceptable for a person to lie deceased in their home for weeks, and any aspects that can prevent this occurring must be explored. It had to be established who would take responsibility for monitoring such individuals, such as family, neighbours or some other organisation.

He noted that during the course of this investigation, the public offered various solutions that retirement complexes should consider, including:



- Village management includes a regular weekly check on each resident's wellbeing as part of the initial service. Residents and intending residents could 'opt out' of this service, rather than having to 'opt in', which is the current system.
- Village management notifies next of kin in writing of the resident's initial choice and any changes.
- Village management meets with each resident every 2 years to review their circumstances. When residents reach 80 years of age, the review occurs every year. Village management record details of that review and of each resident's decision.
- Village management notifies next of kin in writing that a review has occurred and the decisions that were made. Village management advises next of kin in writing of the manner and nature of any checks they undertake with the resident.

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## Case number

CSU-2011-WGN-000293  
2013 NZ CorC 211

## CIRCUMSTANCES

The deceased died at the complex known as Village at the Park Rest Home (the Village) after food got stuck in his throat and blocked his airway. Staff noticed his distress and slow breathing, and rubbed his back and kept him under supervision. However, he eventually collapsed and could not be revived when emergency services attended.

Approximately a month before his death the deceased was found on the floor after he fell. He was admitted to Wellington Hospital for 2 weeks and then discharged to the hospital unit at the Village. A week later staff noted that he was coughing when he consumed food and fluids. Two days before his death he saw a speech therapist who started him on a diet of mildly thickened fluids and soft foods.

When the deceased first started coughing, Village staff thought he could be choking, but no airway clearing procedures were performed. The Heimlich manoeuvre is not necessarily recommended, especially on old or frail people, but the rest home lacked robust first aid training for other methods of dealing with choking and with clearing airways.

The Village now has clearer notes about dietary needs, and has presented on the Heimlich manoeuvre to staff and demonstrated the procedure.

## COMMENTS AND RECOMMENDATIONS

The coroner noted that Village management has made improvements but in his view further training is needed about the deceased's care. Once it was obvious that he was having difficulty breathing, staff should have immediately checked for airway blockages. The coroner regarded the establishment of these procedures as absolutely vital, and he was not convinced that the staff dealt with this appropriately at the time. The further coughing collapse when the deceased returned to his room should have prompted emergency procedures. The coroner hoped that medical staff were updated with the best training to ensure that patients have always got clear airways.

# Aviation-related

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## Case number

CSU-2011-CCH-000451  
2013 NZ CorC 102

## CIRCUMSTANCES

The deceased died at Mistake Creek in Canterbury of injuries sustained when the helicopter he was piloting crashed. He had landed his Robinson R22 helicopter on uneven ground near the head waters of Mistake Creek. When he tried to reposition his helicopter, one of the snow shoes welded to the landing gear caught on a vertical bank by the landing site. This caused the helicopter to undergo dynamic rollover and tip to the side, crashing down the steep terrain into the creek.

The landing site was considered suitable by the Civil Aviation Authority (CAA) for the deceased to land his helicopter although the uneven surface and narrow area would have required precision flying. The deceased had to carefully select a suitable place to land in order to maintain the stability of the helicopter during landing. The characteristics of the area, including a steep drop-off by a cliff, meant that visual clues didn't give enough close-in detail for a precision repositioning manoeuvre.

The type of helicopter flown by the deceased is particularly susceptible to dynamic rollover. In order to avoid the onset of rollover, manufacturers advise pilots not to land near objects that a skid could catch on.

## COMMENTS AND RECOMMENDATIONS

The coroner commented that this inquiry may help people carrying out similar activities. The CAA's *Aircraft accident report* into this crash is available on their website (caa.govt.nz). The deceased was an experienced helicopter pilot who was flying at the limits of the aircraft's capabilities in the terrain.

### Case number

CSU-2010-CCH-000621 2013 NZ CorC 194	CSU-2010-CCH-000626 2013 NZ CorC 199
CSU-2010-CCH-000622 2013 NZ CorC 195	CSU-2010-CCH-000627 2013 NZ CorC 200
CSU-2010-CCH-000623 2013 NZ CorC 196	CSU-2010-CCH-000628 2013 NZ CorC 201
CSU-2010-CCH-000624 2013 NZ CorC 197	CSU-2010-CCH-000629 2013 NZ CorC 202
CSU-2010-CCH-000625 2013 NZ CorC 198	

## CIRCUMSTANCES

Nine people – 4 tourists, 4 skydiving instructors and 1 pilot – all died at Fox Glacier Airstrip in South Westland of injuries they sustained when the aircraft they were in crashed in a field shortly after take-off. The initial ascent of the Walter Fletcher FU24 aircraft was very steep and described by onlookers as 'near vertical'. The aircraft then did a 'stall turn' to the left and went into a short vertical drop.

The Transport Accident Investigation Commission (TAIC) investigated the crash. Their report indicated that the aircraft may have been carrying more weight at take-off than it was designed to carry. The aircraft however had the capacity to carry the amount of weight it was laden with on that day and this in itself should not have proved fatal. This does not excuse the breach of the weight requirements of the aircraft, but indicates that the excess weight alone is unlikely to have caused the crash.

TAIC considered the dangerously 'nose high' altitude of the aircraft at take-off to be a significant factor in the crash, although its cause is not completely clear. An incorrectly set pitch trim was considered, but while this would have explained the steep ascent of the aircraft, the evidence suggests that it was likely in the correct position at take-off. Other possible explanations of the angle of ascent include a partial control column failure or rare events such as engine mount failure

or cable failure. Pilot error during take-off cannot be excluded, despite the pilot's good reputation.

Given the steep climb of the aircraft there was probably a load shift around the point of take-off. This shift was likely rearward and could have been the result of unrestrained passengers. Passengers in aircraft on parachuting operations were not at the time required to be restrained because of the possibility of individuals snagging on something as they slide along the floor to exit the aircraft, which could cause a catastrophe. The current operator at Fox Glacier airstrip uses restraints that attach to the tandem harness worn by pairs of parachutists and connect them to the aircraft. The restraints are stowed away once the aircraft reaches 450 metres to prevent snagging, but can be re-attached if the pilot asks.

Skydive NZ, the owner and operator of the aircraft, did not carry out weight and balance tests before every flight nor was it industry practice to do so. The weight and balance calculations would have been done using standard figures, although Skydive NZ didn't know that modifications to the plane had put its centre of gravity further back than on other aircraft of the same type. The aircraft had also been cleared to fly with 8 passengers, even though that number of passengers put it over the acceptable weight limit. At the time of this crash, tandem parachute flying operations were not subject to continual audit by the Civil Aviation Authority, and so were exempt from Civil Aviation Rule Part 119. Had there been an audit, the weight and balance problems caused by carrying 8 unrestrained passengers in a Walter Fletcher aircraft might have been identified and acted on.

## COMMENTS AND RECOMMENDATIONS

The coroner commented that evidence highlighted that passengers need to be restrained to prevent inadvertent load shift during 'the critical take-off and climb-out phase of flight'. Passenger restraints would also ensure the pilot's calculations included passenger weights at known positions (stations) in the cabin. He noted that passengers carried in an aircraft on parachute operations were exempt from the requirements of Civil Aviation Rule 91.207.

The Emergency Airworthiness Directive (AD) to all operators of Fletcher series aircraft conducting parachute operations that came into effect on 11 September 2010 contemplated passenger restraint but did not mandate it in all circumstances. This directive restricted the number of passengers to 6 people.

The AD which replaced it on 28 August 2012 does not require passenger restraints and removed the limitation of 6 people. Weight and balance calculations for each parachuting flight using actual weights continue to apply. There is a requirement for fuselage station markings in the cabin to help pilots determine weight and balance positions in accordance with acceptable technical data.

The current tandem parachute operator at Fox Glacier airstrip appeared to the coroner to have a safe and reliable means of passenger restraint, and had been operating this system since early 2012.

The coroner commented that deficiencies in the regulatory regime relating to commercial tandem parachuting operations and in particular the carriage of passengers to altitude appear to have been met by the introduction of Rule Part 115 of the Civil Aviation Rules applying to Adventure Aviation. These provisions came into effect on 1 May 2012 and require commercial tandem parachuting operations to be certificated and subject to audit by the Civil Aviation Authority.

The coroner recommended the Minister of Transport urgently consider implementing passenger restraints across the industry for tandem parachuting operations in New Zealand during aircraft take-off and ascent to a given altitude, along the lines of those presently installed and operated by the current tandem parachute operator at Fox Glacier airstrip.

He also recommended that all Fletcher series aircraft (or equivalent) used for parachute operations in New Zealand have a maximum of 6 passengers.

## Child deaths

See also *adverse effects or reactions to medical or surgical care* and *self-inflicted*.

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### Case number

CSU-2011-AUK-001348  
2013 NZ CorC 60

### CIRCUMSTANCES

The deceased, aged 4, died from drowning. He was staying at his grandparents' home with his mother and sister. In the afternoon he left the lounge where he had been playing with his sister. A few minutes later, his mother went to look for him and discovered him

at the bottom of the swimming pool. She immediately pulled him from the pool, and started CPR. Emergency services were called, but he could not be revived.

The fencing of the pool did not comply with the Fencing of Swimming Pools Act 1987 (the Act) in many ways, but most importantly the pool can be reached through a back door that was not self-closing, did not open inwards, and had a latch that was less than 1.5 metres from the floor. Had the back door complied with the Act, the deceased would probably not have been able to open it on his own. The Waitakere City Council (now Auckland Council) did not know about the pool and had not inspected it. The deceased's grandparents believed the council did know and that an inspection would have been done before they bought the property. They had not checked that the pool complied with the Act.

The pool has since been back-filled with topsoil and no longer needs to comply with the Act. Auckland Council has taken steps to identify unknown, non-compliant pools, and educate the public on pool safety.

### COMMENTS AND RECOMMENDATIONS

The coroner recommended that Auckland Council and Water Safe Auckland pool safety pamphlets be distributed more widely to places such as supermarkets and other retail outlets where swimming pools and pool products are sold to maximise availability of the pool safe message.

## Deaths in custody

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### Case number

CSU-2012-HAM-000576  
2013 NZ CorC 42

### CIRCUMSTANCES

The deceased, aged 41 years, died at Waikeria Prison in Te Awamutu of cardiac arrhythmia that occurred after he played a game of hockey in the prison gymnasium. Immediately after he finished the game he appeared to be in some distress, but he declined the medical help offered to him. When he collapsed prison staff immediately called for medical help and started CPR. They managed to resuscitate and stabilise him but he had another cardiac arrest while the ambulance was travelling to Waikato Hospital and could not be resuscitated.

Waikeria Prison was found to have given the deceased an appropriate standard of care. On his original assessment the deceased did not have any immediate health needs to be monitored and it was not, at the time, protocol to offer cardiovascular assessment to men of his age. Though the prison staff were initially able to resuscitate him, had they been qualified to insert intravenous lines, they might have given the deceased a greater chance of surviving his second cardiac event. Despite this, the emergency medical treatment provided remained of a high standard.

Since this death, the range of people offered a cardiovascular assessment has been broadened and, with his family history, the deceased would have come under the new criteria.

## COMMENTS AND RECOMMENDATIONS

The coroner recommended that the Department of Corrections seriously consider amending its policy and practice so that medical centre staff are trained and qualified to insert intravenous lines during the course of their normal prison duties.

## RESPONSE FROM DEPARTMENT OF CORRECTIONS

*The coroner received a response from the Department of Corrections dated 7 May 2013 in response to his findings and recommendation.*

[The deceased's] initial assessment

[The deceased] had 2 health assessments completed while at Waikeria Prison – on 22 August 2012 and 1 November 2012. At these assessments no immediate health needs were identified and you [the Coroner] conclude[d] he received a standard of health care that was equivalent to that expected to be provided to any person in the community. However, in line with the Primary Care Handbook which was in operation at the time, [the deceased] did not have a cardiovascular risk assessment completed as this was not indicated for men of his age. The Primary Care Handbook has since been updated to broaden the range of people to be offered cardiovascular risk assessments.

## THE RESPONSE OF HEALTH CENTRE STAFF TO [THE DECEASED'S] COLLAPSE

You [the Coroner] conclude[d] that the medical response by both custodial and health staff to [the deceased's] sudden collapse was to a very high standard. However, you [the Coroner] do recommend that 'The Department of Corrections gives serious consideration to amending its policy and practice so

that medical centre staff are trained and qualified to insert intravenous lines during the course of their normal prison duties'.

The Department of Corrections provides a primary health care service, which is similar to general practice in the community. Our health team would not use intravenous lines as part of their normal day to day duties in primary health care.

In terms of emergency management and in particular the management of a cardiac event, our expert advice for pre-hospital management is:

- quality CPR
- early defibrillation
- a strategic approach to the management of the event.

As the Department of Corrections does not require the use of intravenous access for the day to day care of prisoners, there is limited or no opportunities for any nurse to maintain their competency regarding cannulation.

However, if in the future secondary level care interventions (ie hospital care) are being delivered in primary health settings, there will be a need to reconsider the requirement for cannulation.

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## Case number

CSU-2010-WGN-000496  
2013 NZ CorC 27

## CIRCUMSTANCES

The deceased died as a result of hypertensive heart disease while he was at his mother's home. Shortly before his death the deceased had been at Rimutaka Prison after violating his home detention. While in prison he was treated for his cardiomyopathy and mental health issues by Prison Services. On release back to home detention, the Capital and Coast District Health Board was responsible for his psychiatric care, and it was intended that his general practitioner (GP) should be in charge of his other health issues. Generally, the Department of Corrections will ensure a person on home detention can access their GP, if they need to. It was not confirmed whether or not the deceased had a GP and there is no evidence of correspondence between Prison Services and any GP.

In the past, Mental Health Services had also prescribed his cardiac medication. His psychiatrist considered his circumstances of being in and out of prison and

on home detention exceptional. The day after release his mother picked up a prescription for his psychiatric medication only, as his psychiatrist only sent the pharmacy a script for his psychiatric medication. Two days later when the deceased asked for a prescription for his cardiac medication, she agreed to provide him with one. However, the day before the medication was dispensed, the deceased's mother found him dead, having suffered a cardiac episode.

The deceased's probation officer was aware he had health difficulties but did not know he did not have medication available to him. There is no definite evidence that he would not have died if he had been taking his cardiac medication.

## COMMENTS AND RECOMMENDATIONS

The coroner recommended to the Honourable Minister of Corrections that, when a prison inmate is transferred to home detention under the control of Probation Services, Prison Services must ensure that all medical matters, including general medical and specialist medical/mental health care, are well documented and passed on to the Probation Service.

## RESPONSE FROM DEPARTMENT OF CORRECTIONS

*The coroner received a response from the Department of Corrections dated 13 May 2013 in response to his findings and recommendation.*

[The coroner] recommended that 'in situations where there is to be a transfer of a prison inmate to home detention under the control of Probation Services, then it is recommended that the Prison Service ensure that with the transfer that all medical matters, including general medical and specialist medical/mental health care are well documented and implemented and passed on to the Probation Service'.

The Department has a responsibility to provide primary health care services to prisoners. While in prison, [the deceased] received full medical services, with specialist secondary mental health care provided by the appropriate District Health Board (DHB) services.

On release from prison that responsibility for provision of health care services passes to the DHB or providers contracted to the DHB.

The Department acknowledges that it has a clear role in ensuring continuity of health care where possible for prisoners released into the community. Before release, every reasonable effort is made to ensure that the prisoner has a GP and in these cases all medical information is transferred to that GP.

Currently it is not always possible to identify a GP for people being released from prison. In these cases, the patient will be provided with a reasonable supply of their prescribed medication (we have amended our policy in that previously only 1 week's supply of medication was available) and a discharge summary for them to provide to a GP once they make contact with one in the community.

The Ministry of Health is currently working with Primary Health Organisations to strengthen primary health care in the community, including the formation of partnership arrangements. The Department has met with the Ministry of Health and we have agreed that we will work together to improve access to GP services for prisoners at the time they are released.

The Department has no statutory responsibilities in relation to the provision of medical services to offenders based in the community, including those on Home Detention. However, we have decided that Probation Officers will be asked to facilitate contact between the offender and a primary health care provider in the community when we have information that indicates that this is a need of the offender. The Probation Officer will approve attendance at medical appointments when these are needed.

[The Department] believe(s) that these changes should avoid a situation similar to what happened with [the deceased].

## Drug, alcohol or substance abuse

See also *transport-related* below.

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### Case number

CSU-2011-DUN-000009  
2013 NZ CorC 72

### CIRCUMSTANCES

The deceased died at Dunedin Public Hospital of multi-organ failure and lactic acidosis in association with an overdose of hypoglycaemic drugs, aged myocardial infarcts and alcoholic cardiomyopathy. He was on a range of medications that were dispensed to him in 'blister packs'. His pharmacist mistakenly supplied him with a blister pack of medication from

another person's prescription, which was picked up from the pharmacy by a friend of the deceased. The deceased took the medication in the prescribed manner. He did note that this was different from previous instructions but complied nonetheless. In the following days he became unwell and eventually collapsed. He was taken to Dunedin Public Hospital, where he was diagnosed as having had an acute cardiac event.

Two of the drugs wrongly taken by the deceased were designed to treat type 2 diabetes. These 2 drugs can have lactic acidosis as a serious side-effect. This contributed to the deceased's death, although it is not possible to determine the extent. The deceased had severe alcoholic cardiomyopathy that had progressed rapidly over the 3 months before his death. Though the wrongly dispensed medication was a factor in his death, his general health was already severely compromised.

The medication was a 'repeat'. Repeats are automatically prepared by the pharmacy when it notes that the previous prescription has run out, or when the patient's general practitioner (GP) asks or provides a new prescription. It is not clear which way the deceased's repeat was generated. On this occasion the medication for the other person, along with their medication list, were put in the plastic container with the deceased's name on it. The person who put the blister pack together for the deceased uncharacteristically failed to check that the name on the medication list was the same as on the plastic container.

## COMMENTS AND RECOMMENDATIONS

The coroner expressed concern at the way the pharmacist and GP arranged for repeats of prescribed medication, but said this was not the cause of the identified problem. The coroner was satisfied with the training, experience and professionalism of the doctors and pharmacists but the death of the deceased has identified shortcomings in their systems. In the coroner's view, repeats of prescription medication should be triple checked.

A patient must also take responsibility for their health and should diary and track to ensure that the prescriptions are up to date. This may be more difficult for a patient who is provided with medication in blister packs rather than a patient who merely sees the number of tablets in a bottle reduce over time, but patients ought to protect their own health and recognise their own needs.

The coroner also commented that the GP practice should diary and monitor patient prescriptions. A review system requiring a patient to return to the practice would be easily instituted. The GP, practice nurse or practice manager should therefore ensure that a formal request in a written prescription is forwarded to the dispensing pharmacy so that the continuity of medication is not broken.

The coroner further commented that the pharmacy should have a system for medication delivered in blister packs, where a 'bring-up' system is activated as a prescription is running out; this would create a prompt for a further prescription to be generated.

The coroner accepted that in cases of urgency a phone call between trusted professionals, who are known to one another, may be enough but such shortcuts should always to be followed as soon as possible by appropriate documentation. The prescribing GP must note on the patient file what was prescribed and when, and similarly the pharmacy must create a written record of what was prescribed, for whom the medication was prescribed, and when it was prescribed. The pharmacy has the continuing obligation of recording the dispensing of the medication.

The coroner recommended that a copy of the finding be forwarded to the Pharmacy Council of New Zealand, Medsafe and PHARMAC so the lessons learned from this death may result in more appropriate protocols being set up for the prescribing of medication and the dispensing of prescribed medication, and the adoption of more suitable aids to the dispensing.

## RESPONSE FROM PHARMAC

*The coroner received a response from PHARMAC dated 22 July 2013 in response to his findings and recommendation.*

PHARMAC has referred this matter to its clinical governance group which has now reviewed the Finding, giving particular consideration to those aspects that were identified by [the coroner] as being required to be circulated to PHARMAC. This includes the following specific references:

- At paragraph 42 of the Finding, [the coroner] identified concerns in relation to the Nomad dispensing system, noting that there are more recent innovations which seem, on the evidence heard, to be preferable. [The coroner] thereafter stated his intention to circulate [the] Finding to the Pharmacy Council of New Zealand, to Medsafe and to PHARMAC to raise [the coroner's] concerns and ask that these concerns be addressed.



- At paragraph 46 of the Finding, [the coroner] further reiterated that a copy of the Finding be forwarded to the Pharmacy Council of New Zealand, to Medsafe and to PHARMAC in order that the lessons learned from the death of [the deceased] may result in the establishment of more appropriate protocols for the prescribing of medication, for the dispensing of prescribed medication and for the adoption of more suitable aids to the dispensing of medicines.

PHARMAC's role is prescribed by the New Zealand Public Health and Disability Act 2000 (NZPHDA), which sets out its objectives, functions and other requirements for its activity. Section 47 of the NZPDHA states the objective of PHARMAC is to secure for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical management and maintenance of the Pharmaceutical Schedule which sets out subsidies payable for pharmaceuticals.

While [PHARMAC] share the coroner's concerns about the tragic circumstances of [the deceased's] death, we consider that [the coroner's] areas of concern, particularly those identified in paragraph 42 and 46 of the Finding, including the need for more appropriate protocols for the prescribing and dispensing of prescribed medication and the adoption of more suitable aids to dispensing, are areas that fall outside PHARMAC's role. Rather, the organisations that do have a role in relation to dispensing packs, aids to dispensing and dispensing processes, and which are more appropriately placed to respond to [the coroner's] concerns, are Medicines Control (Medsafe), the Pharmacy Council of New Zealand, Pharmacy Defence Association and the Pharmaceutical Society.

We note further, that the Pharmacy Guild and District Health Boards have a contractual relationship that covers dispensing processes, so they may also have a role in managing prescribed medication dispensing issues and ensuring appropriate protocols are established.

## Fire-related

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### Case number

CSU-2011-WGN-000168  
2013 NZ CorC 66

### CIRCUMSTANCES

The deceased died at her home as a result of a house fire. The cause of the fire was undetermined, but believed to be electrical and originated in the lounge area of the house in the early morning. Other occupants of the house were able to get out but the deceased was later found by Fire Service officers on the floor of her room.

### COMMENTS AND RECOMMENDATIONS

The coroner commented that this is another tragic loss of life from a household fire. It highlights the importance of ensuring that households have very good smoke alarm systems. In this instance, the facts confirmed that the deceased had disconnected one of the alarms on the day of the fire because of the noise coming from it earlier in the day. The coroner said that alarms do make a noise when the battery needs replacing but it is imperative to replace the batteries to ensure that they continually work.

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### Case number

CSU-2012-AUK-001299  
2013 NZ CorC 209

### CIRCUMSTANCES

The deceased died at his home of carbon monoxide poisoning. A Fire Service report concluded that the fire had been confined to the mattress in his bedroom. It appears that the fire had been smouldering for approximately 24 hours and may have been caused by the deceased falling asleep on his bed smoking a cigarette.

### COMMENTS AND RECOMMENDATIONS

The coroner commented that this death highlights the danger of people smoking while in bed. The danger comes from the very real risk of a person falling asleep and the lighted cigarette dropping onto the bedding and causing a fire.



A significant factor in the deceased's death was that the unit had no operational smoke alarms. Even if the deceased had been unconscious due to a cardiac event, a smoke alarm may have been heard by a neighbour in time for the deceased to be rescued. Therefore, this death also highlights the absolute necessity for residential properties to have fully operational smoke alarms.

The coroner commended the New Zealand Fire Service and any other agency involved in promoting the installation and proper operation of smoke alarms in residences for their efforts to educate the public on how these devices save lives.

The coroner recommended to the Chief Executive Officer of the New Zealand Fire Service that such agencies continue their efforts, and use actual case studies such as this particular case to highlight the dangers of not properly maintaining smoke alarms.

## Mental health issues

*See also self-inflicted below.*

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### Case number

CSU-2012-WGN-000142

2013 NZ CorC 212

### CIRCUMSTANCES

The deceased died at his home of self-inflicted injuries. Six weeks before his death he separated from his wife due to excessive consumption of alcohol. About 2 weeks later he was caught driving with excess blood-alcohol and resigned from his job. Three days later his general practitioner (GP) prescribed him anti-depressants and medication to help him sleep and control his alcohol withdrawal. He applied for a sickness benefit to help him financially and was encouraged to undergo counselling. At the end of this consultation, the deceased's GP did not regard him as being at high risk of suicide.

Two days before his death the deceased sent text messages to his wife asking her to come to his flat. When she declined he inferred to her that he planned to commit suicide. He then rang her and told her that he had taken a large amount of his medication. She drove to his house and rang an ambulance and he was taken to the Wellington Hospital emergency

department. He was discharged in the early hours of the next day having told Mental Health Services that he planned to seek counselling with the Salvation Army. It was intended that he would follow up by phone with the Crisis Assessment and Treatment Team (CATT) who had seen him in the emergency department, but their subsequent attempts to contact him here unsuccessful. On the evening of his death he texted his wife again with explicit references to how he was going to take his life, sending her photos as well. She went to his house with his father to stop him and called emergency services. He was found dead.

The Capital and Coast District Health Board (CCDHB) conducted a serious adverse event review and identified several issues. Clinicians had come up with a treatment plan when he was admitted to the emergency department and shared it with the deceased, but they did not provide him with a copy in accordance with the CCDHB guidelines for mental health assessments in the emergency department. Nor was a copy of the plan given to his GP, who was not aware that the deceased had been to hospital. The on-duty registrar was alerted before the deceased's discharge, but did not see him. Though the deceased's case was discussed in multi-disciplinary team meetings on the 2 mornings after his hospital admission, no notes were taken of these discussions and no changes were made to his plan in light of the fact that he hadn't been able to be contacted. Furthermore, nurses who had attended him were off-duty at these times and unable to attend.

At the time of his hospital assessment the deceased was intoxicated and staff seem to have under-appreciated the effects of the deceased's medication. Although he met the hospital's criteria to be assessed, the criteria themselves do not include any real or accepted measure of the level of a patient's intoxication or suitability for assessment. The timeframe the emergency department clinicians had to examine the deceased was affected by pressure to stick to the '6-hour rule', where patients are seen and discharged within 6 hours of their arrival.

### COMMENTS AND RECOMMENDATIONS

The coroner endorsed the recommendations, both organisation wide and specifically to the directorate, that the CCDHB made in the end of their serious adverse event review.

Organisation wide:

- That the *Guidelines for mental health assessments in the emergency department* are reviewed in regard to assessment of client intoxication and updated to align with clinically applicable validated guidelines.
- That the use of the short stay unit or medical admission should be considered for patients presenting as intoxicated when 6 hours is unlikely to provide a sufficient period of time in which to allow for an accurate assessment.

Directorate specific:

- That given that Benzodiazepines and z class equivalents are commonly taken in overdose it is recommended that their effects on assessments are recognised in CATT training.
- That this report and review findings are communicated to the CATT for their consideration and registrar group with regard to their development and support of their clinical practice.
- That the findings of this report be communicated to the wider CCDHB mental health consultant and registrar group with regard to their development and support of their clinical practice.
- That formal communication with CATT staff be completed to include:
  - the need to review the clinical presentation and development of a crisis assessment plan for suicidal patients presenting to the emergency department with a mental health directorate medical clinician prior to discharge
  - the need to communicate information to the client's GP following assessments as stated in CATT guidelines.
- That printable format or alternative means than the current electronic health record crisis assessment plan for providing a written assessment and crisis plan should be considered for patients discharged after a crisis contact.
- That the mental health directorate after-hours registrar hand-over process be reviewed to ensure night-time cover is in place at the start of a shift.

## Natural causes

See also *adverse effects or reactions medical or surgical care, deaths in custody, aged and infirm care, transport-related*.

## Product-related

See also *aged and infirm care, child deaths, SUDI and other infant deaths*.

## Recreational or leisure activities

See also *aviation-related* above.

## Self-inflicted

See also *mental health issues* above.

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### Case number

CSU-2008-AUK-000695  
2013 NZ CorC 121

### CIRCUMSTANCES

The deceased, a 12-year old girl, died of self-inflicted injuries.

At the time of her death she was in the custody of Child Youth and Family (CYF) along with her sister, living with a Barnardos caregiver in Auckland. Previously she and 7 of her siblings had been in the care of Ngaphui Iwi Social Service (NISS) approved caregivers in Kaikohe.

A month before her death, the deceased told her parents that she had been sexually abused by one of her caregivers. Her parents told the deceased's CYF social worker, who passed the information on to NISS. Contrary to protocol, NISS informed the caregivers of the allegation while the children were still living with them. The deceased was confronted by her female carer about the allegations, which severely distressed her, as they had had a long-standing and close relationship.

For several reasons, including her despondency on the day of her removal from Kaikohe, the deceased was believed to be at risk of self-harm and provided with therapeutic support when she arrived in Auckland. She was screened for psychological distress and suicide risk, but because the test

was not applied correctly the deceased was not referred for further support. She then underwent an evidential interview on the subject of her sexual abuse, after which no counselling was organised. Nonetheless, the girls settled in well to their placement in Auckland. On the night of her death, however, the deceased had an argument with her sister that escalated into a physical confrontation. The girls were sent to their rooms and told if such behaviour continued they would not be allowed to stay. The next morning the deceased's sister found her dead.

The deceased had been through significant upheaval, including separation from her siblings and the loss of her relationship with her long-time female carer. The fact that her caregivers in Kaikohe were informed of the allegation while she still lived with them was not accepted child-centred practice and the ensuing confrontation had a significant impact on the deceased's mental health up until her death. She was also suffering from the psychological impact involved with pursuing her allegation of sexual abuse.

The review undertaken by the Office of the Chief Social Worker found that no counselling was organised after the deceased's evidential interview in order to 'preserve the integrity of the criminal process before a subsequent interview'. This was not part of any relevant policy in place at the time.

The misapplication of the screening test meant that the deceased lost a key opportunity for further intervention and support, including exploration of her risk of suicide. The social worker who applied the test has since undergone further training, and test scores are now calculated automatically, which eliminates the risk of human error.

Though her caregivers in Auckland were provided with her care plan, they were not informed of the timeframe of her alleged sexual abuse and they did not know that she had had an evidential interview on the subject or that she had undergone any screening for psychological distress. CYF conceded that the care plan did not meet the acceptable standard. It was not clear who was responsible for keeping the plan up to date.

## COMMENTS AND RECOMMENDATIONS

The coroner considered that the deceased's case is a tragic reminder to frontline social workers and people involved in the immediate care of children that the focus is on the child rather than the process. The coroner said an overall assessment of the deceased's situation and what she was experiencing was needed. However the coroner was satisfied that learning has been taken from the management of the deceased's case and steps have been taken to improve the frontline response.

The coroner commented that the quality of the care plans in this case fell below the standard required and was possibly not helped by individual social workers being able to circumvent the CYRAS system (the information casenote system). Evidence was given at the inquest that it was possible for social workers to save care plans to their own computer hard drives, which means updated plans would not be available to other staff working on the case unless they were uploaded to CYRAS. There was also evidence that the care plan document in the CYRAS system was not user friendly.

While the coroner accepted that it is policy not to withhold support or counselling services to a child who is involved in an evidential interview process she was concerned (on the basis of evidence at the inquest) that there is an impression for some social workers that such counselling or support should not be offered for fear it may compromise the criminal process.

The coroner recommended to CYF that it:

- review the format of the care plan so it is more user-friendly and therefore would be completed more quickly and comprehensively
- regularly audit existing care plans to ensure they are up to date and accessible on CYRAS
- take steps to ensure that all staff are regularly reminded of the importance of completing and updating care plans (particularly in relation to information-sharing with caregivers)
- Implement a checklist similar to that of Barnardos to ensure full information is provided at least verbally to caregivers.

She also recommended that, in consultation with the NZ Police, CYF clarifies the policy about providing support or counselling to children involved in the evidential interview process, and that it takes steps to ensure that frontline staff know about that policy.

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

See also *transport-related* below.

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## Case number

CSU-2012-CCH-000825  
2013 NZ CorC 53

## CIRCUMSTANCES

The deceased, an 8-month-old infant, died at her home of sudden unexpected death in infancy (SUDI). She had been sleeping in a portable cot in the lounge of her home on the morning of her death. She had awoken previously with a slight cold, and was placed in the cot on her stomach, with a loose blanket on top of her that was well clear of her head. She was found deceased later that morning, face down, with the blanket covering all but the very top of her head.

When a baby sleeps on their stomach, their risk of SUDI is significantly increased and it is therefore recommended that babies be placed on their backs. The risk is further exacerbated when combined with other factors, such as overheating that can occur when a baby is completely covered by a blanket. As the deceased's blanket was loose, it was possible for her to wriggle until it covered her almost completely. Furthermore as she wasn't in the same room as her parents, they had a reduced capacity to monitor her and these risks.

## COMMENTS AND RECOMMENDATIONS

The coroner commented that SUDI deaths are not just a health issue. They are a social issue as well and she agreed with the director of Change For Our Children, who said in the evidence that:

- It cannot be guaranteed that every baby even with the best care will not die of SIDS (sudden infant death syndrome), but parents and caregivers can and should eliminate risks that relate to development and so reduce SUDI deaths.

However, the coroner acknowledged that not all parents are aware of these risks or how to eliminate them.

The coroner recommended to the Ministry of Health that it provide strong advice publicly in the area of safe sleeping practices and environments for older babies who can move around and change position during sleep. She also recommended that this advice include launching an advertising campaign through media that promotes safe sleep principles to parents and caregivers of older babies and shows parents and caregivers how to set up a safe sleeping environment to ensure their baby's face is kept clear throughout the entire time they are sleeping.

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## Case number

CSU-2012-CCH-000934  
2013 NZ CorC 23

## CIRCUMSTANCES

The deceased, a 14-month-old infant, died at his home of accidental asphyxiation that happened when the cord of a roman blind accidentally wrapped around his neck during the night. His mother checked on him 3 hours after putting him to bed and found him standing in his cot with the cord around his neck.

## COMMENTS AND RECOMMENDATIONS

The coroner commented that the means for accidental strangulation of infants in cots are sometimes not considered or recognised and therefore special care must be taken to consider all potential dangers in an infant's sleeping environment.

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## Case number

CSU-2012-CCH-000151  
2013 NZ CorC 30

## CIRCUMSTANCES

The deceased, an infant boy who was less than 4 days old, died in his home of possible accidental asphyxiation caused by the obstruction of his nose, with early onset neonatal sepsis and pneumonia. His mother fell asleep while breast feeding him in her bed and woke up the next morning to find him lying beside her deceased.

When the deceased was born there was a spontaneous and prolonged rupture of his mother's membrane; an occurrence that increases the risk of infection for the baby. Though intravenous penicillin was provided to the mother during labour and the deceased showed

no further signs of infection before his death, wide evidence of pneumonia was found on post-mortem. However, the most likely cause of death was determined to be an obstruction of his nose caused while sleeping in an unsafe environment.

#### COMMENTS AND RECOMMENDATIONS

The coroner commented that the issue of babies sleeping on the same surface as a sleeping adult has been highlighted in a number of coroners' findings over the past few years. Recommendations have been made to the Ministry of Health to highlight to the public the risks of an adult sharing a sleeping surface with a baby. The coroner endorsed these recommendations and suggested that the Ministry of Health highlight the risks of a mother falling asleep while feeding a baby in bed when she is excessively tired or has been drinking.

## Transport-related

#### Case number

CSU-2011-HAM-000194  
2013 NZ CorC 55

#### CIRCUMSTANCES

The deceased died on State Highway 2 in Waitakaruru, of injuries sustained when the car he was a front seat passenger in collided with the back of a truck that had stopped. The truck had stopped in a queue that had formed as a result of a convoy and over-dimension load being transported ahead. The truck driver initially failed to notice the convoy due to low visibility. Though the truck driver braked heavily once he saw the traffic ahead, the collision could not be avoided.

The car's brakes contributed to the crash, as they were only operating at 69% of their full capacity. This would have affected the driver's ability to bring the car to a stop. The deceased was also not wearing a safety belt. Given the low impact speed, he would likely have survived the crash had he been wearing one.

#### COMMENTS AND RECOMMENDATIONS

The coroner recommended to organisations involved in the over-dimension load transporting industries and any related professional bodies or associations that they consider having a pilot travel beyond an intersection to give greater warning to oncoming

traffic that a convoy is in the process of turning, or about to turn, across their traffic lane. The caveat that the coroner added to this is that it would need to be done only in appropriate circumstances and he left it to the industry to consider what such circumstances might be. But it seemed to the coroner that the lesson that should be learned from this particular incident is that if visibility is reduced because of darkness or weather conditions, and it is possible that a queue may be waiting for the convoy to cross, then the pilots should give very clear and considerable forethought to whether they should put a pilot further up the road.

The coroner directed that the recommendation be incorporated into the code governing the load pilot industry so that the lessons learned from this incident will be incorporated into the training of pilots in the future.

#### Case number

CSU-2010-AUK-000954  
2013 NZ CorC 56

#### CIRCUMSTANCES

The deceased, an 87-year-old man, died at Auckland City Hospital as a result of injuries sustained from a motor vehicle crash. The deceased had driven the wrong way down an off-ramp and collided with 2 vehicles on the motorway. His wife was in the car with him and died at the scene.

The deceased had not held a driver licence since his previous licence expired 3 years before the crash. Some months before his death the Counties Manukau District Health Board Mental Health Services for Older People (where he was receiving treatment) wrote to the Papakura police and New Zealand Transport Agency (NZTA) expressing their concern that he was continuing to drive. They believed he posed a danger to himself and others. At the time he had been warned several times by staff and apparently by police. The NZTA sent a letter to the deceased reminding him that he was not permitted to drive.

The police had no record of receiving the Mental Health Services' letter and did not keep it on file, but they accept the letter should have been acknowledged and followed up on. Whether this would have reduced the risk posed by the deceased is uncertain, due to the difficulties in stopping a determined person from driving. Targeting high-risk drivers is a greater focus for police today than it was at the time of the deceased's death.

## COMMENTS AND RECOMMENDATIONS

The coroner commented that the deaths of the deceased and his wife raised serious issues about the practical difficulties of stopping a cognitively impaired unlicensed driver who had been identified as being at high risk of harming themselves or others if they continue driving.

A copy of the findings was sent to the Minister of Transport, the Chief Executive of the Ministry of Transport, the Chief Executive of the NZTA and the police commissioner to highlight the issues and to ask them to consider more formal processes. This included amending legislation to increase police powers for impounding vehicles of unlicensed drivers who have been identified as posing a high risk. A copy of the finding was also sent to the Chief Executive of the Counties Manukau District Health Board for the attention of staff of its mental health services for older people.

## RESPONSE FROM THE MINISTRY OF TRANSPORT

*The coroner received a written response to their comments and recommendations from the Manager Land Transport Safety at the Ministry of Transport dated 28 May 2013.*

I acknowledge the circumstances leading up to the crash in which [the deceased and his wife died], including the application of the medical review process which led to [the deceased] being unable to renew his driver licence. [The deceased's] own General practitioner, the NZTA and the Counties Manukau District Health Board's mental health services for older people advised [the deceased] that he was not legally entitled to drive, however he failed to comply with this advice. The result of this led to a tragic outcome for both [the deceased and his wife].

In your reports you raise the following matter for consideration, 'Whether more formal processes, including legislation increasing police powers to impound vehicles of unlicensed drivers in some circumstances, should be introduced to enable drivers who have been identified as posing a high risk to be more effectively stopped from driving'.

In your reports, the relieving area commander advises that in the United Kingdom there is legislation that allows police to immediately impound vehicles not insured or with certain licence breaches. He further states that the situation is different in New Zealand where impounding motor vehicles is available for boy-racer offences, but the power beyond this is very limited.

This is not an accurate description of the scope of the current legislative provisions relating to vehicle impoundment. The police have powers to impound motor vehicles in a wider range of circumstances not just offences relating to illegal street racing. These offences include driver licensing offences. I have enclosed a copy of section 96 of the Land Transport Act 1998 for your information.

Section 96(1) imposes a mandatory requirement for police to immediately seize and impound a motor vehicle that is driven by a driver who is disqualified, or their licence is suspended or revoked. In the case of an unlicensed driver (including a person like [the deceased] who was driving on an expired licence) the police would, on a first offence, formally forbid the driver to drive until they obtain a current valid driver licence. If they are caught driving again while the forbidden-to-drive notice is still in force, the police must seize and impound their vehicle for 28 days.

This does, however, raise an issue about the way in which the vehicle impoundment provisions would apply in a case like this. There is likely to be a significant difference in road safety risk between a person like [the deceased] who cannot meet the medical requirements needed to renew an expired licence (and has been told that they are medically unfit to drive), compared to a person whose licence has expired simply because they may have forgotten to renew it. The current law, however, treats both forms of unlicensed driving in the same way – an infringement offence notice with a fee of \$400.00 for driving without an appropriate current driver licence and a forbidden-to-drive notice is issued.

Had the driver held a current driver licence that was revoked on medical grounds by the NZTA, they would be subject to vehicle impoundment on the first occasion they were detected driving on a revoked licence. There would not have been the intermediate forbidden-to-drive step, with vehicle impoundment only able to apply on a second or subsequent episode of unlicensed driving.

Officials from the Ministry of Transport will discuss this issue further with other relevant government agencies including the Ministry of Justice, NZ Police and the NZTA.

I am of the view that the solution to this difficult problem is unlikely to rest solely with legislative or enforcement interventions. One other possibility is whether support services for people with an impaired cognitive function could provide more support for families who have a family member who is unable



or unwilling to accept they can no longer drive for medical fitness reasons. While [the deceased's] medical advisers had extensively counselled both [the deceased and his wife] about the risks of him driving, it is not clear what actions, if any, his family had attempted to take to prevent him from doing so.

The Ministry of Transport is part of a government interagency working group that deals with issues relating to older persons. The Ministry of Transport's representative on this group will raise the issue for further discussion with the group. This issue, however, does not only apply to older people. It could easily apply to any person who has impaired cognitive function or judgement as a result of a mental illness or head injury.

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## Case number

### CIRCUMSTANCES

CSU-2010-CCH-110  
2013 NZ CorC 44

CSU-2010-CCH-111  
2013 NZ CorC 45

CSU-2010-CCH-112  
2013 NZ CorC 43

Three teenage boys died on Marsden Valley Road in Nelson of injuries they sustained in a motor vehicle crash. The blood-alcohol level of the driver was 4 times over the legal limit for a driver his age.

### COMMENTS AND RECOMMENDATIONS

The coroner commented that teenagers who are under the influence of alcohol lack judgement and might do things that seem out of character. Coupled with access to vehicles, this too often has fatal consequences. Unless or until society stops tolerating a heavy drinking culture and easy access to alcohol, it is difficult to anticipate significant lowering of the risk in alcohol-related motor vehicle crashes. The coroner noted that the blood-alcohol level for drivers under the age of 20 years has since been lowered to zero, and hopes this helps reduce these types of fatalities.

## Case number

CSU-2010-CCH-000358  
2013 NZ CorC 40

### CIRCUMSTANCES

The deceased died at Nelson Hospital of respiratory arrest following injuries he sustained in a motorcycle crash. The bend where he lost control starts moderately but tightens a lot towards the end. The deceased may at first have believed his speed was appropriate and later found it too fast to maintain the line of the corner.

### COMMENTS AND RECOMMENDATIONS

The coroner endorsed the recommendation made by the senior constable who investigated the crash that signs be put up to indicate the true nature and severity of the bend for the additional safety of all road users.

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## Case number

CSU-2011-AUK-000294  
2013 NZ CorC 104

### CIRCUMSTANCES

The deceased, an 86-year-old man, died on Awhitu Road in Franklin of injuries he sustained in a motor vehicle crash. He suffered from ischaemic heart disease. As no other causes could be identified the coroner considered it most likely that he was struck by some sort of medical event, or was inattentive. The coroner also noted that the deceased did not hold a valid driver licence.

### COMMENTS AND RECOMMENDATIONS

The coroner commented that as the deceased did not hold a valid driver licence, it was not possible to be sure that he would have met the New Zealand Transport Agency's (NZTA) medical requirements even though the coroner noted his general practitioner's comments that he appeared fit for his age and that results of his eye tests 2 years before his death met the NZTA's minimum requirements. There is no evidence that his failure to have a driver licence contributed to the crash. Nevertheless the coroner felt she needed to point out that the driver licensing regime is designed to protect members of the public from unsafe drivers and that the particular requirements for licence renewal for older drivers are designed to protect them and other road users.



Although the road safety engineer and road safety analyst conducting the inspection did not consider that the road contributed to the deceased's crash they recommended some enhancements to improve the safety of the area – specifically:

- install curve advisory signs and chevron boards for each approach (to improve delineation for approaching traffic)
- replace damaged edge marker posts
- install hazard markers on the power poles to make them stand out more
- look into moving the power pole that was struck by the vehicle.

The Manager of Road Corridor Operations at Auckland Transport confirmed to the coroner that all these recommendations have now been implemented.

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## Case number

CSU-2012-HAM-000577  
2013 NZ CorC 34

## CIRCUMSTANCES

The deceased died on Te Pahu Road in Hamilton of injuries sustained in a motor vehicle crash. An expert (crash analyst) estimated that he was travelling between 120 and 132 kilometres per hour before the crash and this may have been a contributing factor. He also may have been distracted or experiencing physical discomfort.

## COMMENTS AND RECOMMENDATIONS

The coroner recommended to the district council that the roading authority consider installing appropriate curve warning signs for the southbound approach to the corner where the crash occurred or any other appropriate safety measures that would enhance the overall safety of the area.

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## Case number

CSU-2011-DUN-000509      CSU-2011-DUN-000510  
2013 NZ CorC 49              2013 NZ CorC 50

## CIRCUMSTANCES

Two tourists from Shanghai in China died on the Milford Road, State Highway 94, of injuries they sustained in a motor vehicle crash. The driver of the vehicle (who was also a tourist) lost control of the vehicle on a hairpin bend. Immediately before the

crash, the vehicle had stopped at a lookout point. An expert (in mechanical engineering) considered it likely that the car's engine was not turned on when they left the car park of the lookout and that this was why the car became very difficult to steer. With the engine off, power steering and power braking would have been disabled. Neither of the deceased had safety belts on and both were thrown from the vehicle in the crash. The driver of the vehicle and another passenger survived the crash.

The driver of the vehicle had failed the practical test for a New Zealand driver licence. Although her application for a New Zealand driver licence had invalidated her Chinese driver licence for use in New Zealand she had presented it as her valid full driver licence to the car rental agency.

Since the crash, The New Zealand Transport Agency (NZTA) agreed that a guard rail be installed on the corner.

## COMMENTS AND RECOMMENDATIONS

The coroner recommended to the NZTA and the commissioner of police that they look into stricter enforcement of driver licence requirements for visitors to New Zealand.

He also recommended to the NZTA alone that greater publicity could be given to the obligations of passengers in a motor vehicle to wear safety belts at all times when the vehicle is moving.

## RESPONSE FROM THE NEW ZEALAND TRANSPORT AGENCY (NZTA)

*The coroner received a response to his recommendations from the NZTA dated 5 July 2013.*

The NZTA agrees with the inquest findings that the driver was in breach of New Zealand driver licensing requirements, and that seat belts may have made a significant difference to the outcome of the crash for the rear seat passengers.

Driver licence requirements for visitors:

The primary provisions for drivers visiting New Zealand are found in clause 88 of the Land Transport (Driver Licensing) Rule 1999 (the Rule).

As a signatory to the United Nations Convention on Road Traffic 1948, New Zealand deems valid and current foreign driver licences to have the same status as the New Zealand equivalent. However, there are limits to the exercise of that permission, as follows:

- A visitor who remains in New Zealand for more than 12 months is required to convert their overseas licence to a New Zealand driver licence.
- The holder of a New Zealand driver licence (learner, restricted or full) is not permitted to drive using an overseas licence.

The driver in this incident was in breach of the restriction placed on a person who had commenced the conversion process. Since she held a New Zealand learner driver licence, which required that she drove accompanied by a supervisor at all times she was also in breach of the conditions for that New Zealand licence.

In practical terms, however, such offending is very difficult for the police to detect at the roadside if the only driver licence they are shown is an overseas licence. The rental car company would also not have known that the driver was, in this case, in breach of her New Zealand licence condition.

Some Australian driver licence agencies attempted to introduce additional controls into their overseas driver licence conversion processes, by marking or hole-punching the overseas licence that is being converted. However, they encountered objections from the countries that had issued the cards, on the ground that those nations do not permit alteration of their documents.

The police have identified issues with the existing provision in clause 88 of the Rule. The Government therefore sees possible improvements to the way we regulate overseas driver licence use as one of the issues to be considered in a general review of driver licensing provisions, to commence this year or early next year.

Seat belt use:

You have also recommended that more emphasis be given to encouraging the wearing of seatbelts by passengers in moving vehicles.

As a background, NZTA currently promotes seat belt use through:

- a brochure called *What's different about driving in New Zealand* for visitors and immigrants to New Zealand, which is often made available to visitors through rental car companies. The brochures are available in a range of languages including simplified Chinese and traditional Chinese, and can be found online at [nzta.govt.nz/resources/whats-diff-driving-nz/](http://nzta.govt.nz/resources/whats-diff-driving-nz/)
- *The New Zealand road code*, through the NZTA website at [nzta.govt.nz/vehicle/choosing/features-protect/safetybelts/](http://nzta.govt.nz/vehicle/choosing/features-protect/safetybelts/)

At an international level, New Zealand has high rates of compliance with restraint requirements (although these do not differentiate between local vehicle occupants and visitors). *Ministry of Transport: Seatbelt Survey 2011* details can be viewed through [transport.govt.nz/research/roadsafetysurveys/Pages/safetybeltstatistics-rearseat2011.aspx](http://transport.govt.nz/research/roadsafetysurveys/Pages/safetybeltstatistics-rearseat2011.aspx)

At more of a community level, local authorities that have a low seat belt wearing rate may identify this as a local road safety issue to focus on and provide local campaigns and programmes to improve their use. The NZTA supports this activity through financial assistance from the Land Transport Programme. Restraint use is an area of continued and emerging focus in Safer Journeys ([saferjourneys.govt.nz](http://saferjourneys.govt.nz)) but it isn't an area that the national advertising campaign currently focuses on.

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## Case number

CSU-2011-AUK-000206

2013 NZ CorC 207

## CIRCUMSTANCES

The deceased, a 13-month-old girl, died at Waitakere Hospital of injuries sustained when she was struck by a motor vehicle on the driveway of her home. Her aunt was leaving the property and before she left, the deceased's mother tried to get the deceased into the house. The child who had been asked to take the deceased into the house couldn't find her, and the deceased did not respond when her name was called. The aunt checked her mirrors before reversing, but the deceased was standing in the blind spot of the vehicle.

There was no fence separating the driveway from the lawn, nor was the driveway gated, both of which might have prevented the deceased from being able to walk behind the car when it was in use.

## COMMENTS AND RECOMMENDATIONS

The coroner commented that the major factors contributing to these child injuries or deaths are:

- property design, such as where there is no fence between the driveway and the area where children play
- vehicle design, including poor rear vision
- human factors, such as inadequate child supervision or the driver not being alert to the possibility that a child may be in the vicinity.

As noted by the Child and Youth Mortality Review Committee, direct supervision is one protective strategy but even the most vigilant supervisors will fail, so physical protective strategies are very important.

The coroner noted that tragedies such as this serve as a reminder that supervising adults and drivers need to be mindful of the inherent risks associated with children on or near areas used by vehicles. Children are extremely unpredictable and can move quickly. Driveway safety is an area of ongoing research and development. The coroner sent copies of the findings to Safe Kids New Zealand and the Child and Youth Mortality Review Committee as part of their ongoing consideration of these issues.

## Water-related (general)

*See [child deaths](#) above.*

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### Case number

CSU-2012-HAM-000477  
2013 NZ CorC 71

### CIRCUMSTANCES

The deceased, a tourist from the United States of America, died at the intersection of State Highway 3 and Waitomo Caves Road of injuries he sustained in a motor vehicle crash. He failed to stop at a Stop sign and collided with another vehicle. The large size of the raised islands that separate opposing traffic flows at this intersection make the position of the Stop line difficult to see. The deceased would also have been unfamiliar with driving on New Zealand roads.

### COMMENTS AND RECOMMENDATIONS

The coroner acknowledged that the New Zealand Transport Agency (NZTA) is looking into ways to make this intersection safer and he encouraged the NZTA to progress this matter as quickly as possible. He noted that the Waitomo Caves are a very popular tourist attraction and many of those tourists are unfamiliar with New Zealand roads and intersection layouts. It is therefore imperative that intersections such as this are made as safe as possible for the sake of those tourists as well as local motorists.

# Acronym glossary

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

ACC	Accident Compensation Cooperation
AD	(Emergency) Airworthiness Directive
CAA	Civil Aviation Authority
CATT	Crisis Assessment and Treatment Team
CB	citizens band (short-distance radio)
CO <sub>2</sub>	carbon dioxide
CPR	cardiopulmonary resuscitation
CT scan	(x-ray) computed tomography scan
CYF	Child Youth and Family
CYRAS	information case note system
DHB	district health board
CCDHB	Capital and Coast District Health Board
WDHB	Waitemata District Health Board
DMP	district mobilisation plans
ECG	electrocardiogram
EPIRB	emergency position indicating radio beacon
GP	general practitioner
GPS	global positioning system
HAP	hospital acquired pneumonia
IC	incident controller
ICP	incident control point
IMT	incident management team

MHz	megahertz
MNZ	Maritime New Zealand
MP	member of parliament
MRI	magnetic resonance imaging
MTA	Maritime Transport Act 1994
NEWS	North Shore Hospital's warning system for the deterioration of acutely ill adults
NISS	Ngaphui Iwi Social Service
NPBSF	National Pleasure Boat Safety Forum
NZ	New Zealand
NZPHDA	Public Health and Disability Act 2000
NZS	New Zealand Standard
NZTA	New Zealand Transport Authority
PFD	personal flotation device
PLB	personal locator beacon
RCCNZ	Rescue Coordination Centre New Zealand
SAR	search & rescue
SIDS	sudden infant death syndrome
SUDI	sudden unexpected death in infancy
TAIC	Transport Accident Investigation Commission
VHF	Very high frequency (radio channel)
WSNZ	Water Safety New Zealand

# 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.

Topic/theme	See <i>Recommendations recap</i> – issue #
Adverse effects or reactions to medical/surgical care	1, 2, 3, 4, 5, 6
Aged and infirm care	1, 2, 4, 5, 6
Aviation incident	3, 6
Care facilities (other)	1, 3, 5
Child deaths	1, 2, 4, 5, 6
Deaths in custody	2, 3, 4, 5, 6
Diving, scuba diving, snorkelling	1, 3
Drugs, alcohol, or substance abuse	1, 2, 3, 4, 5, 6
Electrocution	5
Fall	2, 3, 4, 5
Fire-related	2, 5, 6
Homicide or interpersonal violence	2, 3, 4, 5
Labour or pregnancy related	1, 3, 4
Mental health issues	1, 2, 3, 4, 5, 6
Natural causes	1, 2, 3, 4, 5, 6
Overseas deaths	3, 5
Police pursuits or deaths in police custody	5
Product-related	2, 3, 5, 6
Recreational or leisure activities	1, 2, 3, 4, 5, 6
Self-inflicted	1, 2, 3, 4, 5, 6
SUDI and other infant deaths	1, 2, 3, 4, 5, 6
Transport-related	1, 2, 3, 4, 5, 6
Water-related (general)	1, 2, 3, 4, 5, 6
Water-related (recreational fishing or boating)	3, 4, 5
Work-related (agriculture)	1, 2, 3, 4, 5
Work-related (other)	1, 2, 4, 5

Coronial Services of New Zealand  
Purongo O te Ao Kakarauri

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