

Recommendations recap

A summary of coronial recommendations and comments
made between 1 July and 30 September 2013



OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Issue 7

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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 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 that have been made over a specific period of time. We have also summarised the responses received from agencies and organisations.

This edition of *Recommendations recap* features 41 recent coronial cases. These final findings were released by a coroner between 1 July 2013 and 30 September 2013.

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Adverse effects or reactions to medical or surgical care

Case number

CSU-2011-DUN-000181
2013 NZ CorC 106

CIRCUMSTANCES

The deceased, an 81-year-old man, died at Southland Hospital of an intracranial haemorrhage.

The deceased had a history of heart problems and had been fitted with a pacemaker five months before his death. He was admitted to hospital following three weeks of breathlessness and coughing, and diagnosed with chronic obstructive airways disease and a probable heart attack. Aspirin was prescribed to thin his blood as he was already on warfarin, and continual tests showed his warfarin levels were on track. Later a House Officer mistakenly prescribed an additional dose of warfarin, and from that time his warfarin levels were not monitored.

Four days after his admission to hospital he had stabilised and was discharged. After his discharge a family member noticed that his warfarin dose had increased. This was during the Easter holiday period when clinics were shut and so the deceased did not see his GP until a week after his discharge. He chose to have his blood test the day after he saw his GP, due to personal reasons. The test revealed an elevated level of warfarin. He was immediately given a dose of vitamin K to lower his warfarin level, but his condition deteriorated that evening and he was admitted to hospital with very high blood pressure and a significant brain bleed. He received ongoing treatment and his condition showed some improvement, but three days after his second admission to hospital he went into cardiac arrest and could not be revived.

The error in warfarin prescription was the result of unclear abbreviations in the hospital notes and happened despite the checks that were in place. Though the elevated warfarin level might have caused a bleed, it is most likely that it caused a greater volume of bleeding but not the haemorrhage itself. The hospital conducted a root cause analysis, found several areas of concern and made recommendations accordingly.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the circumstances of the death identified the lack of a continuous blood testing service in Southland. It appears as if no laboratory was available to conduct an INR test for blood samples taken over the Easter period. Because Southland takes its provincial holiday on the Tuesday following Easter Monday, laboratory testing does not happen for five days. The Southern District Health Board and its contractors should look into providing blood testing during this period, even a limited, after-hours service, to avoid delays like the one in this case.

He recommended that a copy of the finding be considered by the Southern District Health Board and that his comments (if they are accepted) be adopted along with the recommendations of the root cause analysis report.

Case number

CSU-2012-DUN-000310
2013 NZ CorC 98

CIRCUMSTANCES

The deceased, a 91-year-old man, died at Southland Hospital of pneumonia. He contracted pneumonia while being treated in hospital for injuries from a motor vehicle crash.

The deceased failed to comply with a 'give way' sign at an intersection and collided with another vehicle. Though he was taken to Southland Hospital for treatment, the initial x-ray was clear and the hospital was reluctant to admit him for care until he was about to leave the hospital and they noted his lower limb symptoms and then found a neck injury. Six days after his admission to hospital he reportedly suffered a fall, which was documented but not witnessed. It is unknown whether this made his injuries worse. The next day he underwent an operation to repair his injuries, which went well and was considered to be successful. However, some days after his operation symptoms of paralysis began to re-appear. The deceased then developed hypoxia and a chest infection. He died, his treatment reduced to palliative care, 10 days after his operation.

When the deceased was first admitted to the accident and emergency department, his family told the doctors of the deceased's adverse reaction to codeine and opiates. However, while being treated by Southland Hospital, at one point the deceased was prescribed codeine-type medication because the hospital had not recorded the advice given to them by his family.

Though the deceased's adverse reaction ultimately did not contribute to his death, he was placed at risk by the hospital's failure to document the family's advice and act on it.

The family suggested that the deceased's post-operation symptoms of paralysis were the result of another fall that was not witnessed or documented. The family at one point heard a 'falls monitoring alarm' go off without seeing medical staff respond, and so were concerned that the hospital's robust code on the reporting of falls was not being actively policed. The deceased, due to his age, scoliosis and general debility, would always have been at risk of falls, though it cannot be discounted that any re-injury was the result of something other than a fall.

COMMENTS AND RECOMMENDATIONS

Southland Hospital told the coroner at the inquest hearing that the deceased did not receive the high standard of care it aims for and normally gives to patients. Although the coroner was not satisfied by the evidence that the deceased suffered an unwitnessed and unrecorded fall at the hospital after the operation, which may have exacerbated his condition, the evidence is that the falls policy is not as rigidly policed as it should be.

The coroner commented that the failure by Southland Hospital staff to act on the family's advice about the deceased's allergy to certain medication may have helped create the opportunity for falling, stumbling or sneezing (which could have resulted in a re-injury). In response to a provisional finding the coroner received a submission from the Southern District Health Board and the lawyer for the doctor responsible for the deceased's care. The hospital documentation confirmed that the last dose of codeine was given at 6:45am two days after the deceased was admitted. This means the post-operative decline in the deceased's condition was noted 10 clear days after codeine was given.

The coroner recommended that a copy of the finding be considered by Southland Hospital and by the Southern District Health Board generally to help train staff. The coroner hoped that there will be no repeat of the circumstances that may have contributed to the death.

Case number

CSU-2010-CCH-000380
2013 NZ CorC 109

CIRCUMSTANCES

The deceased, a 68-year-old man, died at his home of overwhelming sepsis from a strangulated peritoneal hernia. The deceased had an operation six days before his death to repair two hernias. During the operation a small hole was made in the peritoneal lining (the membrane that lines the abdominal cavity) and repaired. A few hours after the operation he experienced abdominal pain and vomiting, but the pain went away with treatment and he was discharged. He made no further complaints of feeling unwell. On the day of his death he collapsed while sitting on the couch with his wife and could not be resuscitated.

Sometime after the operation a small loop of the deceased's small bowel herniated through the repaired area of the peritoneal lining, got trapped and was strangulated. This probably happened when the deceased experienced the abdominal pain after the operation. As his initial symptoms were addressed by treatment and he experienced no further symptoms, this condition wasn't noticed until his death.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the evidence shows that a peritoneal hernia following repair of a peritoneal defect is rare but not unrecognised. However because the hernia is inside the abdominal cavity there is no physical evidence of it in the groin and no tenderness there either. It can only be identified if a medical professional is very suspicious, particularly in the context of a known breach of the peritoneal sac in the original procedure.

The coroner thought the greater surgical community should be made more aware of this complication because of its significant nature and relative rarity. He therefore sent this finding to the New Zealand Association of General Surgeons for the information of its members, with the purpose of advancing their knowledge of strangulated peritoneal hernia following repair of a peritoneal defect.

Child deaths

See *transport-related* below.

Diving, scuba diving, snorkelling

See also *adverse effects of medical/surgical care, transport-related* and *falls*.

Case number

CSU-2011-AUK-000872
2013 NZ CorC 100

CSU-2011-AUK-000880
2013 NZ CorC 101

CIRCUMSTANCES

Two men drowned at Lake Pupuke in Takapuna while on a scuba diving course.

They were part of a group of five students who were diving with an instructor and two trainee instructors. Their dive on that day was the final dive of their 15-week entry-level course.

The proposed depth of the dive was 30–39 metres. Before the group descended one of the trainee instructors swam down to the 30 metre mark to attach a spare oxygen supply to the shot line (a safety rope). The instructor thought the shot line reached down 45 metres to the bottom of the lake, but the lake is 55 metres deep at this point. As the trainee instructor descended he noted that visibility faded to black-out conditions past the 25 metre mark. He passed this information on to the group and the instructor informed them that they would need to stay within arm's reach of each other.

As the group descended around the shot line they fell out of formation, with the two deceased descending faster than the others. With little to no visibility and unable to reach each other, the students started to panic.

The instructor swam down and grabbed one of the deceased, but could not see or feel the release for his buoyancy compensator device (BCD), to enable him to float to the surface. The deceased began to struggle with the instructor, and the instructor decided that his own life would be in danger if the two men continued to grapple. He released his own BCD and rose to help the other men.

The dive-buddy of the other person who died saw him descending and struggling, and placed his hand on the shot line. The others followed suit and the resulting slack in the line caused some of them to become tangled. The instructor, both trainees and three of the students eventually made it back to the surface. The student the instructor had tried to save became entangled in the shot line, and his body was recovered by police later that day. The body of the other man was recovered from the lake floor two days later by Navy divers.

It is likely that both men suffered from nitrogen narcosis, which can cause divers to become increasingly disoriented and confused as they descend. The lack of visibility may have made this worse. The man who became tangled in the shot line was found without his fins, suggesting that at some point his legs had been submerged in the mud on the lake floor. This indicated that both men eventually descended below the target depth.

The men were carrying too much weight for a dive in fresh water, and this likely made them descend too quickly. It is not clear whether they carried out a buoyancy check before diving, even though they had dived in Lake Pupuke before and therefore would have known that less weight is needed in fresh water to achieve neutral buoyancy. Both of their BCDs were functioning but were never inflated, and neither of the men dropped their weight belts at any point to correct their weight. Neither of them had experience of diving with low or zero visibility. During the pre-dive briefing there was no discussion of what to do if visibility became severely restricted, or how to communicate. None of the divers had a knife or a torch.

The organisation that ran the diving course now uses safety lines with enough flotation equipment attached that a number of divers can use it to help them rise to the surface if problems arise. They also include knives in divers' basic kits, and require torches to be carried on dives in Lake Pupuke.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to all diving instruction courses using Lake Pupuke that they should set the maximum depth on individual dive equipment so the target depth of a dive cannot be exceeded.

He also recommended to all diving instruction courses in New Zealand that they use an arrest line rather than a descent line when performing deep dives during training, and that they emphasise to their students the need to carry appropriate equipment on all dives, including:

- a dive knife or other form of cutting implement that is easily reachable in an emergency
- a source of light in restricted visibility
- a watch or timing device on all dives so divers can monitor time as well as depth.

He gave them copies of the findings and asked them to talk with trainee divers about the circumstances of these deaths. This will reduce the chance of similar deaths by highlighting the need to obey the instructor, carry appropriate gear, carry out pre-dive checks, consider the possibility of restricted or no visibility during the dive and encourage better planning of training dives.

RESPONSE FROM THE NEW ZEALAND UNDERWATER ASSOCIATION

The New Zealand Underwater Association (NZUA) forwarded the coroner's findings to dive operators operating in Lake Pupuke for their reference, along with a report containing the coroner's recommendations. The NZUA's report:

- notified dive operators that the coroner's findings are of interest to them, and that the comments and recommendations should form part of their preparations for dives in Lake Pupuke
- noted that the findings highlighted the fact that instructors are responsible for their students throughout the dive, and therefore for their safety practices
- strongly recommended that dive operators were aware of and adopted the coroner's recommendations.

Case number

CSU-2011-AUK-117
2013 NZ CorC 96

CIRCUMSTANCES

The deceased, a 42-year-old man, drowned at Allom Bay on Great Barrier Island while diving for scallops with his friend. The deceased went into the water alone while his friend skippered the boat. The deceased was underwater for around 25 minutes before he surfaced about 150 metres from the boat. He appeared to be struggling, so his friend moved the boat towards him in order to grab him. Before he could be reached, he sank under the water and could no longer be seen. When the deceased was found, his regulator wasn't in his mouth and his catch bag was tied to his buoyancy compensator device (BCD).

When the deceased's equipment was recovered, his cylinder had 10 bar of oxygen remaining, which is 40 bar less than divers are recommended to have left at the end of a dive. The low oxygen level meant it would have taken more effort for him to draw air from the cylinder. There was also evidence his regulators had not been properly maintained, and some of the defects resulted in 'wet breathing' – the continuous leak of salt water into the diver's mouth, the inhalation of which can cause respiratory distress.

Further faults were found with his BCD, which meant it might not have inflated when needed. A BCD would need to be inflated to counteract any negative buoyancy caused by additional weight, like that of his scallop bag. If the BCD failed to inflate the deceased would need to exert himself to stay on the surface of the water. He may have become tired and, panicked by his lack of oxygen and wet breathing, was unable to stay on the surface.

COMMENTS AND RECOMMENDATIONS

The coroner recommended that recreational divers be reminded that safe diving practice includes the following:

- Dive with a buddy.
- All dive equipment should be well maintained and serviced every year.
- Equipment should be checked before all dives (for example, by checking for leaks).
- If a fault is found in a piece of dive equipment the dive should be cancelled until the fault is fixed or the faulty equipment replaced.
- Divers should practise emergency drills.
- If a diver begins to feel unwell or stressed during a dive, the dive should be aborted.

- Divers should plan to be on the surface with 50 bar or 500psi still in their cylinder, and they should monitor their air during the dive.
- If the diver has an extended break from the sport, they should do a refresher course.
- Divers should always carry a knife when diving.
- Divers should never attach a catch bag to their body.

The coroner forwarded this finding to the organisations below to help divers be aware of these recommendations through training, distribution or publication:

- New Zealand Underwater Association
- Water Safety New Zealand
- South Pacific Underwater Medicine Society
- National Diving Coordinator Occupational Safety and Health
- PADI Asia-Pacific
- Scuba Schools International (NZ) Ltd
- *Dive New Zealand* magazine.

Case number

CSU-2011-WHG-000082
2013 NZ CorC 108

CIRCUMSTANCES

The deceased, a 55-year-old male citizen of the United States of America, died of a cardiac event while diving at the Poor Knights Islands in Northland. While temporarily working in New Zealand he went on a dive trip with a colleague and 16 other divers with Dive Tutukaka Ltd (DTL). In a pre-dive questionnaire issued by DTL, the deceased did not disclose his history of heart disease as asked. Twenty minutes into the unguided dive the deceased indicated to his colleague, who was his dive buddy, that he would return to the surface, showing no signs of distress. After reaching the boat he remained face-down in the water and did not respond to the skipper's questions. The skipper rolled the deceased over and found that he wasn't breathing. Though CPR and resuscitation efforts were started on the boat, and a rescue helicopter was dispatched, the deceased could not be revived.

As previously mentioned, the deceased had an undisclosed history of heart disease, and had had one heart attack in the past. His increased risk of a cardiac event, coupled with the medication he was taking at the time, would have made him medically unfit for compressed gas diving. Had DTL known of the

deceased's true medical history they would not have allowed him on their excursion.

The evidence suggested that the deceased did not have as much diving experience as he claimed; rather than the 70 dives he told DTL he had completed, evidence of only 26 could be found, and on all of the dives entered into his dive computer he had exceeded the safe rate of ascent. There was also evidence that on this last dive his ascent was too rapid. Furthermore, though divers are recommended to end their dives with 50 bar still in their air tank, the deceased's tank was found to have only 5 bar left. The stresses placed on his body while diving, including his rapid ascent, and the panic associated with running out of oxygen likely triggered his cardiac event.

COMMENTS AND RECOMMENDATIONS

The coroner endorsed the recommendations made in the Police Dive Squad Report that all recreational divers be made aware of the following instructions:

- Ensure that persons are medically fit to dive.
- Ensure that those who are required to complete application forms for dives et cetera should always answer dive medical questionnaires honestly.
- Seek medical advice if diving with prescription drugs and seek medical advice if your health changes.
- Ensure equipment must be serviced within manufacturer's specifications annually.
- Correctly check and adjust buoyancy weight prior to each dive.
- End dives at 50 bar or 500 psi.
- Always dive with a buddy throughout the dive and stay together even during the ascent and surface if dive buddies separate.
- Ascend at the correct rate.
- Do not exceed depth and time limits of dive tables and plan your dive and follow that plan rigidly.
- Know the function of your dive computer and follow the alarms and warnings.
- The tightening of diver screening in the form of a diving medical and consultation with diver/students' general practitioner to identify medical conditions contrary to diving could reduce the number of diving deaths.

The coroner questioned the deceased's diving practices. There was sufficient evidence to infer he was not as experienced as he indicated to DTL. The evidence also confirms he had placed himself at risk on more than one occasion according to his dive computer and log books. This included being separated from his diving

buddy and deviating from the diving plan by diving deeper and longer than what was considered safe.

The coroner commented that on this fatal dive the deceased made at least two rash judgements that contributed to his death. One was running out of air and having to make a rapid and unsafe ascent to the surface. The second was that he misjudged the seriousness of his coronary heart history when engaging this chartered dive. Had he told DTL the extent of his coronary heart history he would have been denied the opportunity to dive and may well be alive today. He was always at risk of a major cardiac event before taking up diving. All those decisions are just a few of the factors that contributed to the deceased's death.

Drug/alcohol/ substance-related

Case number

CSU-2012-CCH-000330
2013 NZ CorC 83

CSU-2012-CCH-000626
2013 NZ CorC 84

CSU-2010-CCH-000761
2013 NZ CorC 89

CIRCUMSTANCES

The following comments and recommendations were the product of a joint inquest into the deaths of three young people in Christchurch resulting from irregular heart rhythms caused by the toxic effects of butane.

The first death was that of a 19-year-old male who died in his home after inhaling the contents of butane cans in his room. His family had seen the deceased buy the cans and noted them in the recycling bin, but they were unaware of the deceased's butane use or of its fatal effects.

The second deceased was a 12-year-old boy who died near a park after inhaling the contents of a butane can with friends. After inhaling he had an initial burst of energy but soon collapsed. His friends propped him up but noted he was struggling to breathe. Later, when they found he had stopped breathing they called an ambulance.

The third deceased was a 17-year-old girl who died near a park after inhaling the contents of several

butane cans with friends. She and her friends had shoplifted a large number of the cans and had spent the past day inhaling their contents in various places. The store where the girls had stolen the cans later moved them behind the counter and then removed them from stock entirely.

Butane can act on the heart muscles after a person has stopped using it, causing a spontaneous, abnormal heart rhythm that can be fatal. All three of the deceased were affected in this way.

Since these deaths, research carried out in Christchurch identified factors that put youth at risk of butane abuse, and an interagency meeting on the subject resulted in a Christchurch Retailers Awareness project, and several other community outreach and education initiatives. The Christchurch Retailers Awareness project aims to reduce access to volatile substances by giving retailers information and guidelines.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the Inter-Agency Committee on Drugs (IACD), the Department of the Prime Minister and Cabinet, the Minister of Social Development, and the Associate Minister of Health that the New Zealand Government establish a well-organised approach to the abuse of butane (and other volatile substances) as a priority.

She recommended that the Minister of Social Development direct the Ministry of Social Development's Chief Executive to include the issue of the abuse of volatile substances (particularly butane) in the Children's Action Plan, which the ministry is currently working on. The coroner also recommended that the Minister of Social Development ask the Children's Commissioner to oversee the issue once it is included in the Children's Action Plan.

The Minister of Social Development and the Associate Minister of Health were recommended to direct the Ministry of Social Development and the Ministry of Health to work together to hold a high-level summit or hui and ensure that all stakeholders are invited, including representatives from:

- all agencies working with children and young people
- the retail sector
- manufacturers of butane products
- all local councils
- people already working both nationally and locally who can give advice about what preventative interventions work and how to measure them.

She also recommended to the ministers that the goals of this summit be:

- building an interagency framework within which all actions and interventions taken nationally and locally to lower the risk of butane misuse will be based on evidence and consistent throughout the country
- determining whether there needs to be support for Māori communities to develop their own solutions to the problem of the abuse of butane and other volatile substances, in the same way they are being supported in relation to suicide. This is because statistics show that 30 out of the 63 butane-related deaths between 2000 and 2012 were people of Māori ethnicity.

The coroner recommended to all local councils that they follow the example of the Christchurch City Council's Community Safety Team, which worked with New Zealand Police and local retailers to increase awareness about volatile substances.

She recommended to the Safe Communities Foundation NZ that they encourage all local Safe Communities to work with their community and retailers within their areas to educate them about volatile substances and how they can sell these responsibly. She particularly encouraged them to work with small retailers who have resisted targeted interventions already made to them, such as those identified in Christchurch by the Injury Prevention Advisor at Christchurch City Council.

Lastly, the coroner recommended to the chairperson of the Media Freedom Committee that the committee advises its members that, until media guidelines are in place, the New Zealand media industry (including social media networks) use as a guide the considerations set out in the Chief Coroner's case study on butane, which are based on those expressed by the 1985 Senate Select Committee on Volatile Fumes in Canberra, Australia:

- The products subject to abuse should not be named and the methods used should not be described or depicted.
- Reports of inhalant abuse should be factual and not sensationalised or glamourised.
- The causes of volatile substance abuse are complex and varied. Reporting on deaths should not be superficial.

RESPONSE FROM THE IACD

The Chair of the Inter-Agency Committee on Drugs (IACD) provided the following response to the coroner's comments and recommendations.

As you are aware I currently hold the position of Chairman of the IACD. This cross agency committee is made up of the Chief Executive of the New Zealand Police, Department of Corrections, Ministry of Health, Ministry of Justice, New Zealand Customs Service, and the Department of Prime Minister and Cabinet.

The Committee's Terms of Reference encompass all drug related matters including: tobacco, alcohol, illegal and other drugs (including volatile substances).

At its recent meeting late last month, the IACD discussed the issue of volatile substance abuse via inhalation and your respective reports. The Committee agreed that this issue demands more attention than has been previously acknowledged, and that it was appropriate that the practice of volatile substance use (and Butane poisoning in particular) is included in the work now being done to prepare an update on the National Drug Policy.

As the IACD is providing the governance of this national policy revision it has committed to exploring this issue further and also intends on keeping coroners regularly informed as to the progress of this work and other developments that are relevant in the prevention, minimisation and management of this form of drug misuse.

RESPONSE FROM AUCKLAND COUNCIL

Auckland Council's Manager of Community Safety provided the following response to the coroner's comments and recommendations.

We are investigating what we can do with our work in Auckland Region. We run projects in Community Action of Youth and Drugs (CAYAD) and this would be an ideal project for adoption. I will recommend that the CAYAD team adopt a project along the lines of the coroner's recommendation.

Case number

CSU-2012-WGN-000324
2013 NZ CorC 97

CIRCUMSTANCES

The deceased, a 45-year-old man, was found dead on the vessel Bullfinch when he consumed an amount of citalopram that proved fatal in the context of his heart condition and long-standing substance abuse.

The deceased was a chronic alcoholic who had moved from his house to a boat. He had been treated by the Alcohol and Drug Inpatient Medical Detoxification Unit at Kenepuru (the Alcohol Unit) for alcohol detoxification a number of times in the eight years before his death, and had sought help from the Community Alcoholic and Drug Services (CADS) of the Capital and Coast District Health Board (CCDHB). Despite continually seeking help, his effective engagement with these services alternated with periods of disengagement and non-attendance. On his last discharge from the Alcohol Unit the month before his death, his prescribed medications included baclofen, a medication that can reduce the likelihood of alcoholic relapse, and citalopram.

A Serious Adverse Events Review conducted by CADS noted several concerns around the quality of the documentation of the deceased's case. The deceased's file did not include numerous important details, such as the content of concerns raised on multiple occasions by the deceased's wife and whether or how they were addressed, the rationale behind the deceased's final discharge from the Alcohol Unit, and the planning in relation to his continuing use of baclofen. Several of the notes were also illegible.

COMMENTS AND RECOMMENDATIONS

The coroner endorsed the following recommendations made in the Serious Adverse Events Review:

If a client's family phones with a concern that is documented, a standard approach should be taken to addressing those concerns, including documentation listing the steps.

All notes, including multi-disciplinary team notes, should be typewritten, preferably through Electronic Health Record.

Any CADS client with a documented concern about adverse medical issues relating to withdrawals should have as much clinical information as possible and a plan in place to limit the possibility of withdrawal.

Clinical plans should indicate (either directly or by implication) the party responsible for carrying out the plan and the timeline expected for the given action.

Any discharge summary should include a thoughtful analysis of why discharge at that time would be clinically justifiable and any team discussions about this should be documented.

Off-label baclofen use for treating cravings in alcohol dependence should be limited to situations where a thoughtful analysis of the risks and benefits has been documented, including how overdose and withdrawal risk will be mitigated. It should also clearly specify who will be responsible for monitoring this treatment, as many practitioners will not have much experience using it for off-label purposes.

The coroner received a number of written communications from the deceased's wife asking questions about the adequacy of the management and care received by her husband from clinicians and others. The coroner carefully considered this correspondence. He also carefully considered the evidence before him relating to the treatment and care received by the deceased from clinicians and others. That evidence shows that the treatment and care the deceased received fell within acceptable parameters of reasonable care at all material times. The reviewer's recommendations, while important, do not reflect any failure of care by clinicians and others towards the deceased. They relate, fundamentally, to issues of communication, administration and proper medical services procedure.

The coroner considered that the evidence did not prove that the deceased took the overdose of citalopram with the intention of ending his life. The likely state of the deceased's mind at the time the citalopram was taken, together with the likely level of his alcohol intoxication, raises a doubt about whether he is likely to have sufficiently understood what he was doing and the likely consequences.

Fall

Case number

CSU-2013-PNO-000033
2013 NZ CorC 107

CIRCUMSTANCES

The deceased, a 53-year-old man, died at Nelson Hospital of pneumonia resulting from severe brain injury.

The deceased was found by his mother, having apparently slipped down the stairs of his Housing New Zealand flat and hit his head on the concrete at the bottom. He was taken by ambulance to Nelson Hospital and then transferred to Wellington Hospital where it was decided that palliative care only would be offered. He was transferred back to Nelson Hospital where he later died.

Empty alcohol containers were found in his flat, and other residents said he had smelt of alcohol before the incident. It is however impossible to judge if alcohol contributed to his fall. The steps, however, were worn from use and in need of repair, and were therefore a likely factor in the fall.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the manager of the particular Housing New Zealand flat that they look at the external steps to the rental property where the deceased died and decide if work is needed to improve users' safety.

Fire-related

Case number

CSU-2011-AUK-000309
2013 NZ CorC 120

CIRCUMSTANCES

The deceased, a 71-year-old man, died at his home of smoke and heat inhalation when the petrol fumes in his garden shed were set alight and the shed exploded.

The deceased had refuelled his lawn mower in the garden shed that morning and in the process spilled some petrol on the floor. Though he mopped the petrol up with a towel, the poorly ventilated shed was filled with volatile petrol fumes. For an unknown reason, the deceased later struck a match or used a lighter, causing the fumes to ignite in a violent explosion. Onlookers tried to put out the flames while they waited for Fire Services to arrive, but the flames were too intense for anyone to try to enter the shed.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the deceased's death is a tragic reminder of the care that has to be taken around flammable substances and volatile fuels, particularly in the absence of ventilation.

She noted that the Environmental Protection Authority publishes guidance on its website (epa.govt.nz/hazardous-substances/using-storing/at-home) about using and storing petrol. The guidance states that petrol is highly flammable and must be handled with great care. It also lists basic principles for managing petrol safely, including not having a naked light near petrol.

Other useful guidance can be found in the Queensland Government Department of Education and Training's health and safety fact sheet *Safe storage and handling of lawn mower fuel* (education.qld.gov.au/health/pdfs/healthsafety/safe-storage-handling-lawn-mower-fuel.pdf). The fact sheet also notes that mowers should always be refuelled outdoors where it is well ventilated and spilt fuel must have evaporated and the vapour dispersed before a naked light can be ignited in the area.

Petrol is stored and used in many New Zealand homes, mostly for petrol lawn mowers. The coroner was not able to find any similar coroner's cases in which recommendations have been made. It was not clear to her whether the flammability risks of petrol and/or the basic rules of safe storage and use of petrol are well

understood by people storing and using petrol at home. Given the lack of evidence available to her about the matters raised in this paragraph, she made no specific recommendations in this case.

However, she did direct that a copy of the findings be sent to the Chief Executives of the Environmental Protection Authority and the Accident Compensation Corporation and the Chief Executive/National Commander of the New Zealand Fire Service to highlight the circumstances of this death. She considered them better placed to decide if further information should be given to the public about safely storing and using petrol (and other flammable materials) at home.

RESPONSE FROM ACC

The Accident Compensation Corporation (ACC) provided the following response to the coroner's comments and recommendations.

Thank you for your letter to our Chief Executive.

He has noted the coroner's findings regarding the death of the deceased and has passed your letter and the findings on to our Injury Prevention team.

RESPONSE FROM THE EPA

The Environmental Protection Agency (EPA) provided the following response to the coroner's comments and recommendations.

Thank you for your letter regarding the coroner's findings into the death of the deceased. As the report noted, the EPA website does contain guidance on storing and handling petrol at home.

You might also be interested to know that next month we will be launching a national three year public awareness campaign on the dangers of exposure to hazardous substances and the importance of using them safely. The first year of the campaign will focus on workplace use of hazardous substances and the second year will focus on home and garden use. We intend to address the safe use of petrol in supporting education material. This work is planned to commence in about 12 months time.

I would also recommend you visit our new website hazardoussubstances.govt.nz. While this website primarily focuses on the safe use of chemicals in the workplace, there is a series of animated videos that have messages equally applicable for the home. In fact, one of the videos features a similar scenario to the circumstances surrounding the deceased's death.

In terms of the immediate future, the EPA will update the Hazardous *Substances in the Home* section of our website to include user friendly information on how to safely use and store hazardous substances at home. Part of this piece of work will include a section specifically dedicated to using and storing fuels at home and how to safely clean up spills. We intend to support this work with articles in community newspapers about safely using hazardous substances at home. We will also liaise with ACC and the Fire Service to identify additional awareness raising opportunities around this issue.

Homicide or interpersonal violence

Case number

CSU-2012-CCH-000394
2013 NZ CorC 135

CIRCUMSTANCES

The deceased, a 31-year-old woman from the Czech Republic, died at the Pentland Hills Forest near Waimate of wounds to the neck in the course of a homicide.

The deceased was on a working holiday in New Zealand. She had been dropped by friends at a lay-by area often used by hitchhikers, and intended hitchhiking the rest of the way from Cromwell to Cave, where her sister was. Later that afternoon the deceased sent a text to her sister to let her know that she had been picked up by someone and was on her way. Soon after that she called her sister to discuss the route they were taking, and again a little later to confirm where they would meet in Cave. Subsequent calls to the deceased went straight to her voicemail, and nothing more was heard from her.

Rather than taking her to her destination the stranger who had picked her up took her to the Pentland Hills Forest. He forced her to walk into the forest with him, then sexually assaulted and killed her. The deceased was reported missing by her sister the next day. Police conducted an investigation into her whereabouts, but it was a member of the public who discovered her body in the forest.

The deceased often used hitchhiking to get around, and had been warned by others of its potential dangers. She believed she took effective precautions.

The man who killed the deceased had a criminal history, including allegations of sexual abuse. He had once tried to abduct a girl, and in an evidential interview admitted he had wanted to take her into the woods, 'have some fun with her' and then kill himself. Earlier on the day he picked up the deceased, he had been told by the father of a girl he was accused of assaulting in the past that the family had officially made a complaint against him. When Police learned of the encounter they were concerned about the effect it might have had on him, but he was not at home when they went to his house to question him. It is unclear why he ended up driving to Cromwell. After assaulting and killing the deceased he took his own life nearby in the forest.

COMMENTS AND RECOMMENDATIONS

The coroner noted that New Zealand Police do not have an official policy on hitchhiking. However the Police Visitor Safety brochure gives the following advice: 'For your own safety hitchhiking or accepting rides from people you don't know is not recommended. If you do decide to hitchhike, police strongly advise you not to travel alone.'

Mental health issues

See self-inflicted.

Natural causes

See diving, scuba diving and snorkelling.

Police pursuits or deaths in police custody

Case number

CSU-2010-WGN-000022
2013 NZ CorC 167

CIRCUMSTANCES

The deceased, a 28-year-old man, died at Dennis Duggan Park, Johnsonville of blunt force injuries he sustained in a motorcycle crash. He was on a motorcycle trip from Timaru to the North Island and back. While on his way back to Wellington he was caught speeding by a police officer, and did not pull over when the police vehicle started to follow him. He turned off into Johnsonville and was pursued through the town, travelling over the speed limit for a suburban area. Not appearing to know where he was going, the deceased drove into a road with a dead end. The police officer knew this street was a dead end. As the deceased reached the end of the street, he crashed in Dennis Duggan Park. The deceased died as a result of his injuries.

The police officer did not initially consider himself to be 'in pursuit', but to be engaging in 'urgent duty driving'. It was not until he had followed the deceased into Johnsonville, and the deceased began pulling out around other vehicles, that the officer considered that a pursuit had begun. Police officers must tell Police Communications (Comms) as soon as possible that a pursuit has been started but a high volume of radio interruptions delayed the officer's communications with Comms. Generally it was found that the officer followed Police policy, although as he did not communicate his ongoing risk assessments to Comms, the option of abandonment was not able to be fully considered. Since this incident, New Zealand Police has updated their policy on fleeing drivers, and clarified when it might be appropriate to abandon a pursuit.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the Commissioner of Police that he consider amending the Police Fleeing Driver policy to consider police officer knowledge where a fleeing vehicle is likely to be travelling to a known street termination point, such as a cul-de-sac, and to abandon a pursuit in the interests of public safety.

RESPONSE FROM NEW ZEALAND POLICE

New Zealand Police provided the following response to the coroner's recommendation.

The current Fleeing Driver policy covers the ongoing risk assessment and decision making process through the use of Threat – Exposure – Necessity – Response (TENR) – the Police threat assessment methodology. The difficulty that Police face in promulgating a fleeing driver policy is to achieve an appropriately prescriptive policy which retains enough flexibility to be valuable in ever-changing circumstances.

The ever-increasing number of recommendations that are received from investigative bodies can add layers of complexity relating only to specific situations. Police are working with the Independent Police Conduct Authority (IPCA) to assess the policy and at this stage does not believe layering additional environment specific requirements adds value to the current risk assessment process. To the contrary, additional layering is seen as counterproductive, in that it can add confusion.

Both the IPCA and Police recognise that there are dangers in making incremental changes to the policy, rather than looking at the objectives and effectiveness of the policy.

This is a matter Police takes seriously and the coroner's recommendation will form part of the discussion with the IPCA on how to achieve the safest outcomes.

(CMDHB). He had, without any problems, gone through a period of training in how to self-administer dialysis at home, before he began using home haemodialysis (Home HD) a month before his death. On the day of his death the deceased was dialysing with his wife present, but not his daughter, who was his trained dialysis assistant. When dialysis is finished the remaining blood in the machine is 'flushed' back into the patient's body, by drawing in saline solution from an attached bag. On this occasion the deceased's blood was accidentally pumped into the saline bag instead. His family called emergency services and the CMDHB Renal Unit when they saw him turn pale and begin to lose consciousness, but neither could revive the deceased.

Patients are advised that for the first year they should dialyse only with their trained assistant present. Despite the deceased's satisfactory level of training with the procedure, he deviated from this advice, as his wife had not been trained in how to use the dialysis machine. Patients are also advised to watch the saline bag during the wash-back phase to ensure that it is not filling with blood. However, on this day the bag had been placed slightly behind the deceased and he would not have been able to see the blood accumulate.

It has been suggested to Gambro, the manufacturer of the dialysis machine, that the blood line connectors be changed to make this kind of mistake impossible. They declined to do so, as no similar incidents had been reported to them.

CMDHB now offers training with extra emphasis on the wash-back stage of dialysis.

Product-related

See also *fire-related*.

Case number

CSU-2011-AUK-000282
2013 NZ CorC 94

CIRCUMSTANCES

The deceased, a 66-year-old man, died at his home of haemolytic shock, which happened when he connected the blood lines to his home dialysis machine incorrectly, causing it to drain his blood. The deceased suffered from kidney disease and was being treated by the Renal Unit of Counties Manukau District Health Board

COMMENTS AND RECOMMENDATIONS

The coroner commented that the training given to the deceased to prepare him for Home HD was extensive. The follow-up and support he received after starting Home HD seemed to be at an appropriate level. However, the Home HD procedure is complicated and is done by a person who is unwell. Given the time it takes to carry out Home HD and the number of times it must be done each week, it seems vital that steps are taken to make the procedure as fail-safe as possible.

The coroner recommended to Gambro that it review its position on changing its haemodialysis machines to make it impossible for the blood lines to be connected incorrectly.

Case number

CSU-2011-CCH-000016
2013 NZ CorC 103

CIRCUMSTANCES

The deceased, a 29-year-old man, drowned at Cashin Quay in Lyttelton when he fell into the water while cleaning and greasing the wire hoisting ropes used to lower the lifeboats on the vessel Volandam.

The deceased was employed to carry out maintenance on the vessel's safety equipment. On the day of his death he and his co-worker were working high above the water, and were attached to the Volandam with safety harnesses. While lowering one of the boats down, the wire at the bow end of the lifeboat broke, taking the safety line with it. The two men fell into the cold water, and were quickly moved by the wind towards the bow of the ship. The deceased could not swim and had chosen not to wear a life jacket on this day, although he was supposed to. He went under the water, and couldn't be seen by the rescue boat. His body was later found by commercial divers.

A part of the fall wire rope at the bow end of the lifeboat had not been properly maintained and lubricated, and was therefore heavily corroded. Because of the way the davit (the mechanism used to launch the lifeboats) had been used, the wire could not be greased and cleaned at the corroded point. A tensile fracture of the remaining cross section of the wire at the corroded section caused the wire to fail and the boat to drop.

The company that operates the Volandam has since required an inspection of the lifeboat davit systems on all its fleet.

COMMENTS AND RECOMMENDATIONS

The coroner endorsed the recommendations that the Transport Accident Investigation Commission made in their investigation:

That as a matter of urgency the Navalimpianti Tecnimpianti Group (NTG), the manufacturer of the davits, alert all owners of vessels fitted with the type of davits on the Volandam of what immediate inspections and maintenance should be carried out to prevent a fall wire rope failure for the same or similar reason this one failed on the Volandam.

That the NTG make a technical assessment of other lifeboat davit models and, if similar safety issues exist with them, alert the owners of them and issue them with instructions on what inspection and maintenance should be carried out to prevent a similar failure of a fall rope wire.

That the NTG review the design of the davit system with a view to remedying the tendency for the fixed davit arm to flex inwards under load and contact moving parts of the structure, which could lead to premature failing of components within the system.

Recreational or leisure activities

Case number

CSU-2011-HAM-000364
2013 NZ CorC 95

CIRCUMSTANCES

The deceased, a 38-year-old man, died at Waikato Hospital of traumatic injuries from a skiing accident. He was a relatively inexperienced skier who lost control and hit a pylon at Whakapapa ski field on Mt Ruapehu. He was taken to Iwikau Medical Centre on the mountain, which called the St John's Emergency Ambulance Communications Centre (Comms) and asked for an emergency helicopter to be put on standby. The doctor at the medical centre assessed that his injuries were time-critical and he should be urgently taken to a hospital. The medical centre called Comms to confirm the need for a helicopter and one arrived two hours and 45 minutes after the call was made. The deceased was transferred to Waikato Hospital, where he suffered a cardiac arrest and could not be revived.

The helicopter crew received an activation page 21 minutes after the medical centre confirmed to Comms that a helicopter was needed. This delay was due to the Comms officer's difficulty in verifying that the call met the criteria for sending a helicopter. However, the St John's policy in this situation is that verification was not needed. It is not clear if this delay affected the outcome, although in a time-critical situation all delay should be minimised.

There was a further time lapse of 53 minutes between the helicopter landing on the mountain, and lifting off with the deceased. However, there are no clear points at which this delay could have been reduced, given how far away the helipad was from the medical centre, and the pre-flight medical attention the deceased needed.

Whakapapa ski field has since added extra protection around this particular pylon. And St John's has since implemented more robust helicopter dispatch protocols, with all dispatchers receiving training in these new protocols.

COMMENTS AND RECOMMENDATIONS

The coroner commented that he would like to think that the parties involved during the 53-minute period that the helicopter spent on the ground at Mt Ruapehu would review their actions and consider if, in future, the time could be reduced.

He directed this comment to the Iwika Medical Centre and St John's Ambulance Service.

Case number

CSU-2012-DUN-000206
2013 NZCorC 134

CIRCUMSTANCES

The deceased, a 53-year-old man, died at the Dingleburn track in Ahuriri Valley of exposure, which was complicated by the multiple injuries he sustained in a fall and hypoglycaemia. While walking back to his car down the Dingleburn track, the deceased slipped on a patch of moss and fell down a steep slope. He was likely immobilised by the injuries he received in the fall, or even rendered unconscious, and never moved from this position. He had been expected to return to where he was staying that night. When he failed to appear by the next morning the Police were contacted. His body was found 13 days later.

The deceased was a type one diabetic, but meticulously self-managed his medication, especially on his tramping trips. Nevertheless his condition probably reduced his capacity to survive.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this death may have been avoided if the deceased had used a personal locator beacon (PLB). If the deceased had still been conscious after his fall, he could have switched on a PLB and alerted rescue authorities.

The coroner drew public attention to the availability of PLBs and the advantages of using them, while also recognising there are 'dead spots' in some areas that may not allow the signal from a PLB to be intercepted by a satellite.

Self-inflicted

Case number

CSU-2011-AUK-000660
2013 NZ CorC 82

CIRCUMSTANCES

The deceased, a 16-year-old boy, died of self-inflicted injuries.

The deceased first became involved with Child, Youth and Family (CYF) just over two years before his death, when he was referred to their Youth Justice section after being arrested. He was living with his mother at the time. Throughout the rest of the year his behaviour deteriorated, resulting in his expulsion from school. At the end of the year his maternal grandmother asked the Waitemata District Health Board (WDHB) Crisis Team for help. He was diagnosed as having gradually increasing psychotic symptoms and admitted to the Child and Family Unit at Auckland City Hospital (CaFU). He was later made subject to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) for ongoing compulsory treatment. The deceased was admitted two more times to the CaFU, and was treated by services from both the WDHB and the Auckland District Health Board (ADHB). Neither of his parents were best placed to support him, so he moved continually from house to house. He stayed for a time with his paternal aunt and with his half-sister.

Eight months before his death his psychiatrist changed his medication to a fortnightly injection, because he was not taking his medication. Although CYF were involved initially, they closed their file with him six months before his death, considering that he had no care and protection needs and had reached a period of stability. Mental health services from the WDHB and ADHB unsuccessfully tried to re-engage CYF during and after his third admission to the CaFU the following month. During this hospital stay he admitted to suicidal ideation. There was concern about the care provided by both his father and his paternal aunt, and his mother was unable to look after him because he was aggressive towards her. Alternative accommodation was looked into at the Richmond Fellowship Residential Facility and the Buchanan Rehabilitation Centre, but the deceased vehemently did not want to stay at Richmond and Buchanan only very rarely took people under 18.

He was discharged into his mother's care two months before his death, and therefore the WDHB's Early Psychosis Intervention (EPI) West Team were the primary providers of his mental health care. Without CYF involvement he no longer had access to support that had been helpful in the past, like the mentor provided to him by Intensive Clinical Support Services (ICSS). Early in the next month the deceased was diagnosed with clinical depression and prescribed anti-depressants, which he never took. He then once again became physically aggressive towards his mother and had to live with his father. He later admitted to his psychiatrist that he had had suicidal thoughts since leaving the hospital, but denied any plans. He was told to contact Crisis Services if he became suicidal or depressed. His father was told about the deceased's suicidal ideation and that the deceased would need to be closely monitored.

From that point mental health services had difficulty contacting the deceased. He was not at home at times when home visits were arranged, and he could not be reliably contacted by phone. He was last seen by staff over a month before his death. The deceased missed his injection two weeks later, and his family expressed their opinion that his medication should stop. Subsequent attempts to contact the deceased or his family, or arrange for him to have his medication administered, were unsuccessful. On the night before his death, the deceased's father saw him lay down to watch tv in the living room, and the next morning he was not in his room when he checked. His family reported him missing to Police, and his body was later found.

The deceased's actions appeared deliberate and he had talked before of ending his life in this way. From the evidence the coroner concluded that his death was the result of suicide.

It was difficult for the deceased to be provided with consistent follow-ups to his health care because he frequently changed his place of residence. This also meant he lacked a stable, supportive environment, which would have helped his recovery.

Although he was subject to a community treatment order, it is considered better to not actively force someone to undergo treatment. Enforcement of treatment would usually mean an admission to hospital, and in the month leading up to his death, in which he missed two injections, the deceased was not considered unwell enough to be admitted to hospital. The WDHB considers there to be a very high threshold to be met before they will involve the police in such matters. It is

indeterminable whether the outcome would have been different if the deceased had been given his medication.

Although the deceased clearly had significant mental health issues that needed medical intervention he also had significant care and protection issues that made it difficult for any single agency to work with him. It was hoped that with CYF involvement following his third stay in hospital there would be a greater opportunity to engage the deceased in meaningful activities, particularly with the support ICSS could provide.

Their support had in the past been particularly helpful to the deceased. CYF however did not appreciate that this young person's needs occupied both spheres. The Office of the Chief Social Worker reviewed CYF's involvement in the case and found that the prevailing mindset at the time was that the deceased's needs were primarily mental health needs. The view that care and protection concerns and mental health needs are binary presentations prevented CYF from following up on the deceased's care and protection issues.

The review concluded that the fact that no one agency was best placed to address the deceased's situation calls into question whether the current interagency systems are well prepared enough to address complex sets of circumstances. It cannot be said whether greater cooperation from CYF would have changed the outcome for the deceased.

COMMENTS AND RECOMMENDATIONS

The coroner highlighted the limited availability in Auckland of suitable accommodation options for young people under the age of 18 years who have both mental health needs and care and protection issues, and whose parents/whānau are not able to give them a stable base or the care needed. The lack of options made finding accommodation that might work for the deceased much more difficult.

The coroner made no recommendation on this matter but drew the issue to the attention of the Ministers of Health and Social Development, the Children's Commissioner, and the Chief Executives of the Ministry of Health and the Ministry of Social Development.

The coroner commented that another issue in this case was the poor interagency cooperation CaFU at ADHB and the EPI West Team at WDHB received from CYF. Both these mental health services are highly specialised providers of mental health services to children and young people. They cannot provide mental health care in isolation from other issues in a young person's life and where relevant they should be able to rely on good

interagency cooperation with New Zealand's statutory child protection agency to ensure the strongest response possible for their clients. The CYF review of the deceased's care identified this issue.

At the inquest some positive examples of CYF and CaFU and the EPI West Team working together were acknowledged, but the evidence was that the mental health services still cannot always depend on consistent interagency cooperation with CYF.

The coroner recommended to the Chief Executive of the Ministry of Social Development that the Ministry assess whether CYF has sufficiently improved its practice to ensure the shortcomings identified in this inquiry and in the Office of the Chief Social Worker's review have been addressed.

The coroner recommended to the Chief Executive of the Ministry of Social Development and the Chief Executives of ADHB and WDHB that the Ministry (in consultation with the ADHB and WDHB) review whether the arrangements between CYF and ADHB and WDHB are sufficiently robust to enable a properly collaborative response between CYF and the DHBs' mental health services to meet the complex needs of young people (up to the age of 17 years) who have both mental health needs and care and protection issues.

The coroner recommended that the Chief Executives of ADHB and WDHB review whether further collaborative processes are needed to better manage the community mental health care of children and young people whose living arrangements include both DHB areas.

Lastly, the coroner recommended to the Chief Executive of WDHB alone that its Mental Health Service considers whether it should adopt a lower threshold for considering when to ask the Police to enforce a community treatment order in relation to overdue medication.

RESPONSE FROM THE CHILDREN'S COMMISSIONER

The coroner received a report from the Children's Commissioner (the Commissioner) in response to the comments and recommendations.

The Commissioner noted that the coroner had specifically drawn his attention to the limited availability of accommodation for young people who have both mental health and care and protection needs, and acknowledged that this is a problem that affects regions other than Auckland as well. This is impacted upon by multiple issues, including the need to find locations that allow the young person's connectedness to their whanau and community to be supported.

The Commissioner's Office is focusing on the Child, Youth and Family's (CYF) current work to address these concerns, within the Commissioner's function to monitor the policies and practices of CYF.

The Commissioner identified two important tenets of this work:

- The first being that a review completed in November 2012 resulted in a new services design which would allow more effective services to be delivered to children and young people with high and complex needs. Full implementation of the new service design was due to be completed in a few weeks following the issue of the Commissioner's response to the coroner.
- CYF was also working on a proposal to refocus the function of their 12 special group homes around the country to better meet the needs of children and young people with high and complex needs.

The Commissioner also stated that the effectiveness of the interagency services between CYF and the Auckland and Waitemata District Health Boards is a concern that has been identified by his staff, and his Office is following up the coroner's recommendation to the Ministry of Social Development.

He has met with the Senior Advisory District Inspector for Mental Health and the Wellington-based District Inspector for Mental Health to discuss the interface between Mental Health and CYF. The meeting produced strategies for how to improve the effectiveness of the agencies within their responsibility in this regard.

The Commissioner will advise the coroner of the outcome of the investigation into the matters set out above, once it had been completed.

RESPONSE FROM WAITEMATA DHB

The Waitemata District Health Board (Waitemata DHB) provided the following response to the coroner's comments and recommendations:

Waitemata DHB and Auckland DHB took on board the recommendation and are working collaboratively with Child, Youth and Family and the Ministry of Social Development to address the issues that the deceased's case highlighted.

I attach for your reference a copy of the recent minutes and associated documents to demonstrate the work that is being undertaken between Waitemata DHB, Auckland DHB and Child Youth and Family.

With respect to the specific recommendation addressed to Waitemata DHB to consider a lower threshold for considering police involvement in relation to overdue medication when an individual is under the Mental Health (Compulsory Assessment and Treatment) Act, this has been discussed and the Clinical Director understands the issues behind this recommendation. This is a complex area and there is no simple response that can be provided, each case will be determined on its merits, taking the concerns raised by you into account.

SUDI and other infant deaths

Case number

CSU-2010-CCCH-000865
2013 NZ CorC 99

CIRCUMSTANCES

The deceased, a two-month-old infant, died at his home of probable accidental asphyxia in an unsafe sleeping environment. The deceased's mother fed him while lying on her bed, and fell asleep. She was awoken later that afternoon by a friend of the family, who had just arrived at the house. He picked the deceased up when he noticed that he was pale and had blue lips, and then started CPR. The deceased could not be revived.

Although the deceased normally slept in a bassinet by his mother's bed, she would keep him with her during the day if she had a nap.

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 and recommendations have been made to the Ministry of Health to highlight the risks to the public. The coroner endorsed these past recommendations.

She noted that there has been a great deal of education and evidence given at coroners' inquiries from many experts in recent years. Where an adult sleeps on the same sleeping surface as a baby under one year old the baby is at high risk of dying suddenly and unexpectedly from suffocation or asphyxia. As babies are nose breathers, their noses can become obstructed if their mother falls asleep while feeding them.

Case number

CSU-2013-ROT-000090
2013 NZ CorC 116

CIRCUMSTANCES

The deceased, an infant of three months, died at his home of accidental positional asphyxia. He was put on his stomach with his twin sister in a cot in the room where his parents slept. When his mother checked on him later that evening, she found him facedown, wedged between the mattress and head of the cot. He was blue, not breathing, and he could not be revived.

While sleeping, the deceased had moved around and wedged himself in a position that caused him to asphyxiate.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the evidence indicates that the deceased was very healthy and well cared for, and lived in a very supportive environment with his parents and siblings. The parents were commended by the coroner for providing the deceased with a cot to sleep in, rather than having him share their bed. His only concern was that the deceased was placed down to sleep in his cot on his tummy, rather than on his back. The coroner noted that Plunket advice about safe sleeping practices refers to the fact that the risk of suffocation is reduced when babies sleep on their backs.

The Plunket website also provides advice about avoiding gaps between mattresses and the sides of cots, because babies can become wedged and be deprived of oxygen. The coroner commended all organisations involved in promoting safe sleeping practices for babies, and encouraged them to continue to educate parents to closely examine the sleeping environments for their babies and eliminate any dangers.

Case number

CSU-2012-CCH-000235
2013 NZ CorC 143

CIRCUMSTANCES

The deceased, a one-year-old infant, died at Christchurch Hospital of global ischaemic brain injury, which occurred as a result of positional asphyxia in a cot accident. She was found in the morning by her aunt, having rolled over in her cot and pushed up against the wooden bars. The bottom of the wooden bars weren't properly affixed to the cot and had swung outwards, allowing her to fall off the edge of the mattress and become trapped by the top part of the wooden bars, with her head pressed against the mattress. The family tried to resuscitate her and called emergency services who transported her to Ashburton Hospital. She was then flown to Christchurch Hospital but died two days later.

The cot the deceased slept in was loosely constructed and constituted an unsafe sleeping environment, directly resulting in her death. Her death fell outside the Sudden Unexpected Death in Infancy Classification by one day, and was accordingly not considered by the SUDI liaison person.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the Ministry of Health promotes 'keeping your baby safe during sleep'. This includes the following advice:

- Make sure your baby's bed has no gaps between the frame and the mattress – that could trap or wedge your baby.

He considered that this advice was directly relevant to this case. He made no formal recommendations.

Case number

CSU-2011-HAM-000355
2013 NZ CorC 216

CIRCUMSTANCES

The deceased, a three-month-old infant, died at his home of an undetermined cause, but was consistent with sudden unexpected death in infancy (SUDI) in the context of co-sleeping.

After spending an evening at the home of relatives, the deceased was put to bed at about 10pm. It was a cold night and his mother decided that the family (the deceased, his two older siblings and herself) should sleep together on a mattress on the floor

of the lounge. At around 4am the next morning, the deceased's father came home to find him lying face-down on the mattress. On inspection he was showing no signs of life. The deceased could not be revived.

At post-mortem there were no obvious markers of what caused this death. However it happened in the context of such risk factors as co-sleeping, low-birth weight, bottle feeding and prone sleeping, which brings it under the classification of SUDI. These risk factors, which constituted an unsafe sleeping environment, could have been avoided.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this death highlights the need for infants to be sleeping in a safe environment. Although there is no evidence that any of the known SUDI risk factors directly caused this death, child health experts accept that the presence of any of these risk factors increases an infant's chance of death.

Transport-related

See also adverse effects of medical/surgical care and police pursuits.

Case number

CSU-2012-PNO-000302
2013 NZ CorC 85

CSU-2012-PNO-000303
2013 NZ CorC 86

CSU-2012-PNO-000304
2013 NZ CorC 87

CSU-2012-PNO-000305
2013 NZ CorC 88

CIRCUMSTANCES

Four men from Argentina died on State Highway 4 between Ohakune and National Park from injuries they sustained in a head-on collision with a truck. The driver tried to overtake other vehicles between two blind corners. The truck could see the light of the car coming from the other side of the corner, but did not expect the oncoming vehicle to be in his lane. The driver of the truck and one passenger of the car survived the crash, but four other occupants, including the driver, died at the scene.

On the stretch of road where the crash happened, the lines separating the north- and south-bound lanes were mainly dotted yellow lines. The Crash Investigation Report completed by Police suggested that these markings be changed to solid double yellow lines to show that no passing manoeuvres at all should be undertaken.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the New Zealand Transport Agency, or the relevant authority, that they paint double yellow no-passing lines at the crash site as soon as possible.

Case number

CSU-2011-AUK-001593
2013 NZ CorC 91

CIRCUMSTANCES

The deceased, a 59-year-old man, died at Dairy Flat of the injuries he sustained when his motorcycle went off the road while he was navigating an 'S' bend and crashed into the sloped drain at the side of the road.

He had been drinking with friends at a private residence earlier in the evening, but left with a pillion passenger on the back of his motorcycle. He was found to have a blood-alcohol level that was three times the legal limit for a driver, and traces were found that indicated possible cannabis use. Both of these elements likely contributed to the crash. The crash happened in a rural area, with moderate to poor visibility; the road had minimal road markings, and no warning signs or street lights.

COMMENTS AND RECOMMENDATIONS

The coroner endorsed the following changes that the Serious Crash Unit recommended to the road at the site of the crash:

- a white centre line and white edge lines should be painted on the road
- street lighting should be put in
- warning signs or chevron boards should be put in through the 'S' bend.
- The coroner commented that Auckland Transport advised her that the following work has been approved and passed to their Maintenance team for implementation:
- install 'S' bend warning signs
- review the use of older chevron boards at the 'S' bend

- install white centre lines throughout the length of the 'S' bend
- repaint the faded edge lines.

She had been advised by the Serious Crash Unit that, at the date of these findings, only the centre and white edge lines have been painted.

Case number

CSU-2013-HAS-000011
2013 NZ CorC 90

CIRCUMSTANCES

The deceased, a 19-year-old man, died on Te Mata Peak Road of injuries he sustained when his car left the road on the upper section of the peak, hit a rock and tumbled down the steep slope. He wasn't wearing a safety belt and was thrown from the vehicle.

The deceased's car left the road in a straight line as it approached a sharp right-hand bend. There was no evidence of braking or excessive speed, nor was there sufficient evidence that the deceased intended to die when he drove off the road. It is possible that the deceased was trying to avoid an obstacle, such as livestock or another vehicle.

In a report prepared for the Hastings District Council (HDC) by one of its traffic engineers, the engineer stated that 91% of the crashes on Te Mata Peak Road happened on bends, and even though the upper section only has 7% use in the hours of darkness, that is when the crashes generally happened.

A crash reduction study was undertaken by the HDC for Te Mata Peak six months before this accident, with the aim of reducing the number and severity of crashes. The HDC report advises that the study established three main areas of action: speed management, vehicle containment and risk taking by young drivers.

Effectively the crash reduction study resulted in a recommendation that on the upper section of road there is a speed limit of 20 kilometres per hour, that roadside containment barriers be placed on curves and that, given the low volume of traffic and number of crashes involving young drivers, the park be closed during the hours of darkness.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the upper section of the road to Te Mata Peak is narrow and winding, with at least five blind corners. It is described in the Transport Safety Plan as a high-risk environment that in its current form needs a significant amount of driver care and attention, with failure to meet that obligation likely resulting in a crash with serious to fatal consequences.

The HDC has recognised that the road and roadside in the upper section of road do very little, if anything, to protect a driver in the event of a mistake. There are no barriers on blind corners in the upper section of the road. In the coroner's findings from a similar death two years before, the coroner recommended that the landowners and the HDC as roading authority place appropriate barriers on the relevant corner to both indicate the bend and prevent vehicles leaving the road at the bend.

No such barriers were placed on any of the bends on the upper section of Te Mata Peak. Had such a barrier been in place on the bend where the deceased's vehicle left the road the coroner considered it unlikely that it would have plunged down the very steep bank resulting in the deceased's death.

There are no road markings on Te Mata Peak Road from the water tower to the summit. There are no fog lines or rumble strips to alert motorists to the edge of the road. There are no reflectors to help motorists at night. There is no street lighting. There are blind corners with unrecoverable steep drop-offs on a 50 kilometres per hour narrow winding road in places that the coroner considered were only wide enough for one-lane traffic.

The coroner recommended to the HDC that they, as the roading authority, build a roadside containment barrier on the outside of the corner on Te Mata Peak where this fatality happened and on the other blind corners on the upper section of the road to prevent vehicles accidentally leaving the road and going over the very steep banks with fatal consequences.

He also recommended that appropriate markings be placed on the road edge to help drivers see the outer edge of the road. The coroner considered that reflector markings will especially help drivers at night if the HDC decides not to close the upper section of the road to vehicles during the hours of darkness.

RESPONSE FROM HASTINGS DISTRICT COUNCIL

The HDC gave the following response to the coroner's comments and recommendations.

Following the inquiry into the death of the deceased, the HDC have initiated a number of improvements on Te Mata Peak Road, taking into account your recommendations and those identified within the HDC's crash reduction study.

Completed measures:

- White edge lines are installed on the upper sections of Te Mata Peak Road from the main park entrance to the summit car park.
- Timber guard rail has been installed on the corners.

Programmed measures:

- Reduced speed limit – currently under public consultation and due to be formally considered by the HDC at a Council meeting on 30 January 2014.
- Motor vehicle restriction on the upper section of T- Peak Road during the hours of darkness – to be formally considered by the HDC early 2014.

Case number

CSU-2010-HAM-000386

2013 NZ CorC 105

CIRCUMSTANCES

The deceased, aged 17 years, died at Waikato Hospital of injuries he received when the van in which he was the front-seat passenger crashed into an earth bank three weeks previously. He was travelling from Taupo to Rotorua with 10 other people in a van with only five proper seats, and none of the young people were wearing safety belts. Consequently, the 11 young people were thrown out of the van in the collision. A number of them were taken to Rotorua Hospital.

The young people were driving back from a party in Taupo in the early hours of the morning. It was raining at the time and there was low visibility. The driver of the van was sober, but had wanted to sleep somewhere and drive back later in the day because he was tired. He had also commented on his tiredness during the drive, and had stopped to buy caffeine tablets and an energy drink. The driver's fatigue is considered to have played a role in the crash, as was his relative inexperience. It is also very likely that the driver was texting when the crash happened.

The left front tyre of the vehicle was badly worn, fitted the wrong way around the rim, and only secured by three of the five wheel nuts. This made the wheel unsteady and decreased its road adhesion in wet conditions and directional stability. Although the driver was driving within the speed limit, the speed of the car was not appropriate for the poor conditions and the number of people in the vehicle.

COMMENTS AND RECOMMENDATIONS

The coroner considered that all of the factors contributing to this accident are of concern to the court, but the most important was that a group of young people had crowded into a van with an inexperienced driver. People need to be educated about the severe risk of not being properly restrained by safety belts or having properly approved seating, as well as having a driver who is very tired and doesn't want to drive and wants to stay overnight, and then later buys V drinks for energy and No-Doz tablets; the danger signals are there. Yet they carried on in atrocious weather conditions with the almost inevitability of an accident. If it wasn't caused by texting, it would probably have been by fatigue and the possibility that the driver fell asleep.

The coroner directed a copy of the findings to the Ministry of Transport, the Ministry of Education and the Ministry of Youth Development and asked them to keep supporting a youth education campaign and a public education campaign about the dangers of driving while distracted, which includes the use of cellphones, texting, fatigue, overloading of vehicles, driving to the appropriate weather conditions and the compulsory wearing of safety belts.

Case number

CSU-2012-HAM-000619
2013 NZ CorC 115

CIRCUMSTANCES

The deceased, a 77-year-old woman, died at Waikato Hospital of cardiac failure after she was struck by a motor vehicle. She stepped in front of a motor vehicle, possibly because the umbrella she was carrying obstructed her view of the road. CPR was carried out at the scene and emergency services were called, but the deceased died shortly after.

The driver of the vehicle was travelling at 56 kilometres per hour in a 50 kilometres per hour zone, and was unable to see the deceased and react to her presence in time to avoid hitting her. The designated crossing point where the deceased crossed was placed on a paved, raised median strip and surrounded by plants. Although the plants would not have completely hidden the deceased from sight they added to the 'visual noise' of the surroundings and possibly impaired the driver's ability to see the deceased before she crossed.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this death highlights the need for pedestrians to be cautious when crossing the road and drivers to be alert to pedestrians crossing the road at all times. If the deceased had been more cautious she would not have tried to cross the road until she was confident there were no approaching vehicles likely to hit her. Similarly, if the driver of the car had reduced his speed because of the poor weather and restricted visibility, he may have seen the deceased earlier and had more time to avoid her.

Case number

CSU-WHG-2011-000164
2013 NZ CorC 114

The deceased, a 59-year-old man, died as a result of injuries sustained when his car was struck by a vehicle trying to overtake while he was turning right into his driveway. It is not clear whether the deceased was indicating as he turned. The driver of the other vehicle called the police but they did not attend the scene as the deceased and his wife appeared to have only minor injuries. The deceased had no problems walking even though he complained of pain to his right side and his chest, and experienced shortness of breath. The next morning his wife found him deceased in bed.

The deceased had fractured his ribs and cut his hand in the crash. His wife and family asked him to get medical attention as a precaution but he didn't and ultimately died as a result of his injuries.

There had been 10–12 similar crashes along this stretch of road in the seven years before this death. Residents had been concerned by vehicles travelling down the straight road commonly seeming to go over the speed limit of 80 kilometres per hour and the potential dangers associated with manoeuvres to overtake residents pulling into or out of their properties.

COMMENTS AND RECOMMENDATIONS

The coroner endorsed the following recommendation, which was submitted to the court in the course of an investigation by the deceased's family:

That the Northland roading authorities consider a reconfiguration and/or a remarking of the road with solid yellow 'no-passing' lines preventing any overtaking in certain stretches of the road.

Case number

CSU-2013-WHG-000034
2013 NZ CorC 129

CIRCUMSTANCES

The deceased, an 18-month-old boy, died at his home of injuries he sustained when he was hit by a reversing motor vehicle.

On the day of his death, the deceased was being looked after by his grandmother, who lived in a rural property that had a driveway next to his parents' driveway. Late in the afternoon he slipped his grandmother's notice and went home, before going out onto the driveway to greet his father as he came home from work. His father knew that the deceased often ran onto the driveway, and so went slowly and watchfully. However, the deceased came from an unexpected direction and ran into the path of the vehicle as it reversed back towards the house. He was knocked down by the rear passenger side of the vehicle, and the left rear wheel went over him. He died immediately of his injuries.

As the deceased ran towards the vehicle he would have been visible only very briefly in the mirrors, as his height in relation to the vehicle's canopy would have also made him very difficult to see.

There were no fences between the shared driveway and the deceased's grandmother's house or the deceased's parents' house. The family were aware of the risks posed to the deceased, and knew that he liked to ride his bike up and down the driveway. Their strategy of mitigating these risks was to drive slowly and carefully.

COMMENTS AND RECOMMENDATIONS

The coroner commented that, 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 (such as fences and child-proof gates on exits leading to driveways) are very important. (Safekids New Zealand and the Child and Youth Mortality Review Committee are the two key organisations focused on

preventing and reducing child death and injury from driveway incidents. During 2011 and 2012 Safekids ran a national driveway run-over prevention campaign.)

The coroner noted that tragedies like this remind people 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 forwarded copies of these findings to Safekids and the Child and Youth Mortality Review Committee as part of their ongoing consideration of these issues.

Case number

CSU-2010-AUK-001596
2013 NZ CorC 122

CIRCUMSTANCES

The deceased, a 13-year-old boy, died in Auckland of the injuries he received in a motor vehicle crash that happened when he tried to take a moderate right-hand bend at a speed well above the limit. He went off the road, crashed through several properties, went across a side road and collided with a fence. He was not wearing a safety belt and died at the scene.

The deceased was placed in the custody of Child, Youth and Family (CYF) a year and a half before his death because he had been involved in a violent incident and CYF had received notifications of concern about his home situation. CYF had difficulty finding family members that they could approve and who were able to take him. When first placed with non-family caregivers he ran away and his whereabouts was unknown for three months. After he was found he was placed with new CYF-approved non-family caregivers in Kaitia, where he did well.

Three months before his death he received three phone calls from his mother and appeared unsettled. In the morning he had left the property with another boy who was staying at the house. Police were told of their disappearance immediately, and the caregivers told the deceased's social worker in South Auckland the next day. The police officer in charge filed a missing person report for each of the boys, and placed an alert on both of their names into the police intelligence system. She later called the mother of the other boy and confirmed that he was staying with her. There was no word of the deceased and the call to his social worker was unreturned. The police officer took no further action.

The deceased's social worker contacted the deceased's family, with whom he was believed to be staying, but could not find him. Five and a half weeks before the deceased's death another social worker took over the case, and he was notified 10 days later that the deceased had been seen arriving at a supervised access meeting between his mother and siblings. The deceased evaded CYF custody once again.

The next day he was picked up by a police officer in relation to an unrelated incident. The officer saw the missing person alert, but did not know that he was supposed to be in CYF custody. He returned the deceased to his stepmother's address and left a message with the officer in charge of the missing person's file. The social worker had no contact with the police about the search for the deceased, and was not clear on who was in charge of the police file. The deceased remained at large until the day of his death when he crashed the stolen vehicle he was driving.

Contrary to Police Missing Persons Policy, the officer in charge of the deceased's file did not consider the case to be a high priority, and did not tell the Counties Manukau Police Station, despite rightly believing that he would be staying in that area. Had police in that area been told, they would have tried to find him. In addition, the officer in charge did not give regular updates on the progress of the case, in accordance with police policy. As a result of this approach no proper effort was made by police to find the deceased, and a significant chance to return him safely to CYF custody was lost.

Had the police intelligence system included a note about his placement in CYF custody, as well as his missing person status, he could have been returned to CYF care when he was picked up by the police officer the day after he evaded his social worker at the access meeting. This reflects a systems failure in the police alert system.

CYF has no specific policy on how to handle situations where children have run away from their placement. It is considered best practice for regular contact to be maintained between the social worker and police, although on this occasion there was little or no contact. The lack of structured, formal communication between CYF and police meant another opportunity to locate and return the deceased was lost.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the Commissioner of Police and the Chief Executive of the Ministry of Social Development that they finalise, as a matter of priority, the national joint Police–CYF policy on the management of children and young people in CYF care who are reported as missing (the new joint policy). In addition, joint training for police and CYF staff on the new joint policy should be undertaken in all regions of New Zealand.

She recommended to the Commissioner of Police that New Zealand Police assess what steps are needed to ensure that all police staff are familiar with the requirements of the national Missing Persons policy and whether training on the new joint policy should be mandatory for all police.

Lastly she recommended that the Chief Executive of the Ministry of Social Development considers whether the new joint policy on its own provides sufficient guidance and structure to help its staff manage children and young people in CYF care who have been reported as missing, or whether further internal practice guidance is needed.

RESPONSE FROM NEW ZEALAND POLICE

New Zealand Police's Acting National Manager of Criminal Investigations provided the following response to the coroner's comments and recommendations.

I write on behalf of the National Crime Manager to acknowledge receipt of your findings and recommendations into the death of the deceased.

Police accept the findings and acknowledge that staff did not adhere to our Missing Persons policy. We therefore lost the opportunity to locate and safely return the deceased to Child, Youth and Family (CYF) care.

I note the Acting Assistant Commissioner wrote to you on 2 September to address each of your recommendations.

I can further advise that Police and CYF continue to work together to implement a new system for the reporting of missing children and young people in the care of CYF to Police.

This new process will not only improve communication and information sharing between CYF and NZ Police, but improve internal processes within each agency. These changes will be incorporated into the existing Memorandum of Understanding between Police and CYF.

I trust that the above response provides you with an assurance that the Police are committed to ensuring our own processes are robust around the management of children and young persons in CYF care who are reported missing. Should you require clarification or further information regarding this matter, please do not hesitate to contact me directly, or the Officer in Charge of the Missing Persons Unit.

Case number

CSU-2013-WGN-000131
2013 NZ CorC 136

CIRCUMSTANCES

The deceased, an 81-year-old woman, died at Wellington Hospital of injuries received in a motor vehicle crash when she drove onto the motorway (State Highway 2) from an off-ramp on Cornish Street in Petone. Although many cars were initially able to avoid her, she eventually collided with an oncoming car that had been unable to change lanes because a truck was in the next lane.

Locals had seen people try to get onto the motorway from the off-ramp before, and were able to stop the cars from turning while they were stopped at the traffic signals. There was no such time in this case for anyone to stop the deceased.

Even though the deceased had passed a medical test to renew her driver licence two months previously, a friend had observed that her driving skills were deteriorating; she was driving slowly and would stick to familiar areas. She had not driven on the motorway in some time. It is not clear why she was in the area when she drove onto the motorway as she was unlikely to have been familiar with it. It is likely that she was lost and confused and did not realise she had turned onto the motorway and was in the wrong lane.

COMMENTS AND RECOMMENDATIONS

The coroner noted that the Police Crash Investigation Report recommended improvements to Cornish Street and State Highway 2 in an attempt to prevent a similar tragedy from happening. The coroner directed a copy of that report to be sent to the New Zealand Transport Agency.

Case number

CSU-2013-HAS-000023
2013 NZ CorC 132

CIRCUMSTANCES

The deceased, a 76-year-old man, died at Hawke's Bay Hospital of injuries he received when he drove into the path of an approaching vehicle. He was taken to Waikato Hospital and then transferred to Hawke's Bay Hospital, where he died.

His wife was in the car with him and survived the crash. Just before the deceased turned, she had looked left to see if it was safe. It seems they did not see the car coming from the right, or they thought there was enough room to turn safely.

The intersection is an 'offset' intersection and does not line up with the road that continues ahead of it, which is on the opposite side of the through road. It is therefore more dangerous to navigate. Realignment could make the intersection safer.

COMMENTS AND RECOMMENDATIONS

The coroner noted that there are warning signs on the road the deceased was on (and possibly elsewhere) alerting drivers to the major intersection ahead and the high crash area. He recommended that this finding and the Police Crash Investigation report be referred to the New Zealand Transport Agency so they could consider realigning the complex offset cross intersection.

Case number

CSU-2010-PNO-000499
2013 NZ CORC 214

CIRCUMSTANCES

The associated recommendation was the product of a coronial review of cycling deaths in New Zealand that the coroner produced after conducting several inquests into the deaths of cyclists who died around the same time. It applied to this fatality in addition to the coroner's specific comment.

The deceased, a 34-year-old woman, died on State Highway 3 near Mt Stewart, of injuries she received when she was struck by a motor vehicle.

She was training for the annual Lake Taupo Cycle Challenge with a friend, riding between Palmerston North and Sanson. Both cyclists were wearing high-visibility jackets on the fine, clear day. A car going in the same direction came up behind the

deceased, who was travelling at the back of the pair, drifted over the fog line and clipped the back wheel of her bicycle. She was thrown onto the bonnet of the car and landed on the grass verge beside the road. She died of her injuries at the scene.

The driver pleaded guilty to charges of careless driving and causing the death of the deceased, and was sentenced to community work and disqualified from holding or obtaining a driver licence for 10 months.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this inquest was included in the joint inquest into cycling deaths to look at the overall problem of cycling safety and avoiding future cycling deaths. On this point, the deceased's father raised a point that rumble strips along the fog line would have avoided his daughter's death as the driver would have been aware that his vehicle was drifting to the left. At another inquest the coroner had raised the suggestion of using rumble strips with the experienced road cyclists who came to give evidence. This inquest involved a group of eight cyclists who rode together regularly. The general consensus was that rumble strips along the fog line might save the life of a person in a car approaching from behind the cyclists but they can be very dangerous to cyclists, especially in wet weather. The most experienced cyclist, who still raced competitively, felt that rumble strips would be a hazard to cyclists. Everyone giving evidence felt that providing more room to the left of the fog line would be a safer option.

The coroner recommended to the New Zealand Transport Agency (NZTA) that they convene an expert panel drawn from stakeholders with an interest and expertise in cycling and road safety, to consider the evidence gathered by this review and any other evidence it considers necessary, with a view to compiling a list of recommendations to central and local government which will improve cycling safety in New Zealand and prevent further cycling crashes and fatalities.

Case number

CSU-2010-HAM-000584
2013 NZ CorC 215

CIRCUMSTANCES

The associated recommendation was the product of a coronial review of cycling deaths in New Zealand, which the coroner produced after conducting several inquests into the deaths of cyclists who died around the same time.

The deceased, a 45-year-old woman, died at Waikato Hospital of injuries she received when she was hit by a motor vehicle. She was riding with a group of seven other cyclists, with whom she rode regularly for exercise and to train for upcoming cycle events. The group were cycling between Morrinsville and Walton on rural roads in weather conditions of light drizzle. As they rounded an easy downhill left-hand corner, a car came from the opposite direction. As the driver went around the corner she likely tried to change her steering, but over-corrected and swerved sideways, colliding with three of the cyclists. One died at the scene, and the deceased and another were taken to hospital, where they later died.

The driver pleaded guilty to three counts of careless driving causing death and was disqualified from driving for a year and sentenced to community work, and had to pay reparation on each charge.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the New Zealand Transport Agency (NZTA) that the NZTA convene an expert panel drawn from stakeholders with an interest and expertise in cycling and road safety, to consider the evidence gathered by this review and any other evidence it considers necessary, with a view to compiling a list of recommendations to central and local government which will improve cycling safety in New Zealand and prevent further cycling crashes and fatalities.

Water-related (general)

See also *diving, scuba diving and snorkelling*

Case number

CSU-2010-WHG-000003
2013 NZ CorC 17

CIRCUMSTANCES

The deceased, aged 18 years, drowned at the Wairua Waterfalls, Mangakahia while swimming with his cousins. All the young people were jumping off the falls into the water, from a height of around 12–15 metres. On his last jump the deceased was unbalanced and consequently fell face-forward. He hit the water awkwardly, with his head taking the brunt of the force. An onlooker saw his head snap back as he hit the water.

It is likely that, due to the angle and force at which he hit the water, he became unconscious or concussed, and was unable to swim to the surface. His body was found by divers the next day.

The falls are a popular recreation spot for local people, who are by and large aware of the potential dangers.

COMMENTS AND RECOMMENDATIONS

The coroner noted that approximately one year before the deceased's death a woman received serious injuries after jumping from the falls. He accepted that there must be a balance between enjoying the feature safely and ensuring a pragmatic warning to potential users is available. He recommended that the council responsible for this land and water feature are invited to consider erecting warning signs about the dangers of jumping from the falls.

Case number

CSU-2012-DUN-000208
2013 NZ CorC 110

CSU-2012-DUN-000209
2013 NZ CorC 111

CSU-2012-DUN-000488
2013 NZ CorC 112

CSU-2012-DUN-000489
2013 NZ CorC 113

CIRCUMSTANCES

The associated comments and recommendations are the result of a joint inquest into the deaths of four men, who drowned in two separate fishing boat accidents off the coast of Fiordland. None of the men have been found and remain missing.

The first two deceased were the skipper and crewman of the *K-Cee*, which was moored in Doubtful Sound. On the day of their deaths the two men set out in rough conditions that at least two other vessels had considered too dangerous to work in. The two deceased were tending to their crayfish pots when the boat was overcome by the conditions and broke up on the rocks of Rocky Point. Neither of the two men usually wore life jackets while working.

The second two deceased were the skipper and crewman of the *Governor*, and were trawling a net just past Yates Point on the day of their accident. The conditions on that day were rough and other vessels had turned back to port at that point. The net on the boat caught, and they weren't able to 'buoy it off', which they had told a nearby skipper they would try to do. Trapped by the net, their vessel quickly became overwhelmed in the conditions. The crew would have had less time to respond to the crisis as water could enter the boat at more points than was desirable, because the stern of the vessel hadn't been protected adequately and the rear hatches had not been fastened closed.

Both boats had an emergency position indicating radio beacon (EPIRB), but when both crews were in difficulty their EPIRBs would have been inaccessible. If the EPIRBs had been of the 'float-free' variety, they may have been able to be accessed and activated. It is generally considered that EPIRBs should be used in conjunction with other methods of communication.

It is not clear if any of the men were wearing life jackets on the day their ships went down. Life jackets help wearers stay on top of the water, protect the wearer from the effects of the cold and help them conserve energy, all of which can help a person survive. In New Zealand, the wearing of life jackets by fishermen is voluntary.

The Fiordland Fisherman's Radio Service is reactive rather than proactive; rather than call a vessel to check their status and conditions they wait for each vessel to give them this information. There are also some deficiencies in radio coverage in Fiordland, due to a lack of resources. As a result the crew of either boat may have tried to send a radio message before their ship sank that never got through.

COMMENTS AND RECOMMENDATIONS

The coroner noted that both the *K-Cee* and the *Governor* had EPIRBs. Both appear to have been trapped and rendered inoperable when each of the boats sank. Although the coroner accepted that, in some situations, even a 'float-off' or 'float-free' beacon may become jammed it had become apparent to him that a float-free beacon, fitted appropriately, is essential.

The coroner was also aware, in the context of both the present inquest hearing and previous hearings, of the debate about the wearing of life jackets. Some fishermen wear inflating vests as a matter of routine; others choose not to because of a perceived lack of comfort or interference with their ability to work. He was satisfied, from what he heard, that there

are personal flotation devices (PFDs) or life jackets available that would be appropriate for crew on fishing boats to wear while working. The argument that a life jacket merely supports a wearer for a little longer before they succumb to the cold and drown can be responded to by the observation that, if a radio or telephone distress call can be made and/or an EPIRB signal sent, then a PFD ought to keep its wearer alive until rescue.

The coroner recommended that a copy of his findings be forwarded to Maritime New Zealand and the Minister of Transport to draw their attention to the issue of the wearing of life jackets.

He felt it was obvious during the inquest hearing that some fishermen operating in Fiordland are unaware of the technological benefits provided by the EPIRBs that are now available and considered that Maritime New Zealand could therefore expand its education programme.

The coroner also noted that Maritime New Zealand is responsible for ensuring radio coverage for emergency channels. The evidence is that radio signals in Fiordland are below the optimal level. Every effort should be made to address this problem.

He also felt that Maritime New Zealand should consider whether the fitting of float-free beacons ought to be made compulsory as part of the survey required of fishing boats.

Case number

CSU-2012-CCH-000062
2013 NZ CorC 141

CIRCUMSTANCES

The deceased, a 44-year-old man, drowned at the Mokihinui River. While swimming he got into difficulty and a friend saw him go under the water. He was unable to be rescued before he drowned.

Subsequent testing found that he had an amount of alcohol in his blood that was, comparatively, almost three times the legal blood-alcohol level for an adult driver in New Zealand. Although the coroner was unable to ascertain how the deceased came to ingest this alcohol, it is likely that it impaired his ability to swim.

COMMENTS AND RECOMMENDATIONS

The coroner noted that Water Safety New Zealand promotes the message 'alcohol and water don't mix'. This includes the following advice:

Alcohol dramatically reduces your chances of survival by:

- making it harder to stay afloat due to lower concentrations of blood going to the brain and muscles contributing to heat and fluid loss
- sharply reducing the ability to hold your breath
- suppressing airway protection reflexes
- making it easier to inhale water.

The coroner considered that this advice had direct relevance to this case.

Water-related (recreational fishing and boating)

Case number

CSU-2012-WGN-000676
2013 NZ CorC 123

CIRCUMSTANCES

The deceased, a 53-year-old man, drowned at the Waiohine River when the inflatable pontoon raft he was operating with his wife and a friend overturned. The other two occupants were able to reach the side of the river, but the deceased was swept out of sight by the current. Emergency services were called, and a search and rescue operation was started. Early on in the search, a police officer with experience in rescue operations and knowledge of this area suggested that aviation assets be made available. This suggestion was not acted on for about 20 minutes. Rescuers found the deceased's body later that afternoon.

COMMENTS AND RECOMMENDATIONS

The coroner recommended to the Department of the Prime Minister and Cabinet that they consider officially recognising the bravery of the Greytown resident who saved the wife of the deceased.

He also recommended to the District Commander at the Wellington Central Police Station that the emergency management and response mechanisms of Police Communications be reviewed to ensure that the reasonable recommendations of experienced front-line police officers are acted on immediately.

Case number

CSU-2013-HAM-000049
2013 NZ CorC 117

CIRCUMSTANCES

The deceased, a 52-year-old man, drowned at Tauranga Harbour after his boat was swamped by a large wave and capsized. The other occupants were wearing wetsuits and managed to get life jackets after the boat capsized. The deceased was not wearing a wetsuit or life jacket, and got into difficulty. He was an experienced skipper and was familiar with the area, but became overwhelmed by the conditions.

COMMENTS AND RECOMMENDATIONS

The coroner commented that this death could have been prevented if the deceased had been wearing a life jacket at the time the boat capsized. It is extremely fortunate that the other three occupants of the boat survived this ordeal.

He noted that the Bay of Plenty Regional Council (BoPRC) refers to the legal requirement for pleasure boats using the harbour in their publication Safe use of the Tauranga Harbour that every pleasure boat should have a personal flotation device (PFD) for each person on board. In addition, the guide states that everyone should wear a PFD in all situations where there is a heightened risk. 'Heightened risk' is defined as crossing bars, strong tides or water that is rough for the size of the boat. Although the coroner had no direct evidence on this point, he suspected that at the time the deceased's boat was swamped and capsized, it was in a position of heightened risk either because of the roughness of the water in relation to the size of the boat or because it was approaching or had crossed the bar.

The coroner had no evidence about whether the deceased was aware of this particular guide issued by BoPRC or the legal requirements for wearing a PFD where there was heightened risk. If the deceased was not aware of this requirement, then he should have been, because he was the skipper of a boat using the harbour. This responsibility was even greater, given that he was carrying passengers. If the deceased was aware of this requirement, then for reasons known only to himself, he chose to ignore the rules.

Case number

CSU-2011-ROT-000318
2013 NZ CorC 127

CIRCUMSTANCES

The deceased, a 55-year-old man, drowned at Tauranga Harbour, while out fishing with his son. The two men picked up some weights, weighing a total of 110 kilograms, from a nearby bay. The weights were attached to the nets they had aboard and they began feeding the nets out into the water. While they were doing this a small wave came over the stern. The boat took on water, and they had nothing they could use to bail out the water. The boat ultimately sank and both men found themselves in the water. The deceased struggled significantly and his son tried to help him. The deceased told his son to get to the shore. Police were alerted and they found the deceased in the water a short time later.

COMMENTS AND RECOMMENDATIONS

The coroner noted that the evidence established the following:

- There were no life jackets on the boat.
- There was no bailing equipment.
- There was no radio.
- There was no cellphone.
- The weight of the boat was significantly over the safety limits.

The coroner commented that to go out in a boat in these circumstances was ill advised and people using boats need to take basic safety precautions.

Case number

CSU-2012-ROT-000372
2013 NZ CorC 128

CIRCUMSTANCES

The deceased, a 23-year-old man, drowned at Tauranga Harbour. He and his friends stole an empty aluminium dinghy and attached a stolen boat motor to it. About half an hour into the trip the boat started to take on water. The boat eventually became swamped and sank. None of the individuals were wearing life jackets as there were none on board. The other three men managed to make it to shore but the deceased did not.

COMMENTS AND RECOMMENDATIONS

The coroner commented that the errors in judgement made by the men resulted in a fatality. Basic safety precautions had not been taken: no bailing equipment, life jackets or communication devices were available on the boat, and no family or friends knew where the men were. The coroner hoped that bringing this to the attention of the public would support the ongoing message of boating safety in New Zealand.

Case number

CSU-2011-ROT-000295
2013 NZ CorC 124

CSU-2011-ROT-000301
2013 NZ CorC 125

CIRCUMSTANCES

Two men, aged 20 and 45, drowned at Lake Arapuni while on a fishing trip. Police were informed of their disappearance when they failed to return and both were found deceased by the Police Dive Squad. Although the boat was in a bad state of repair and the hull was possibly compromised, this could not be determined as the boat was not recovered.

Lake Arapuni was created when the damming of the Waikato River caused an area of native forest to be flooded. The tops of the trees sit just underneath or at times over the level of the water, meaning that the serene appearance of the lake belies its hazardous nature. It is most likely the boat struck one of the submerged trees and sank immediately.

COMMENTS AND RECOMMENDATIONS

The coroner commented that drawing attention to some of the errors the men made on their fishing trip may save lives in the future.

The men had not told anyone of their trip and had no communication devices, which would have enabled them to call for help. The coroner considered that the men should have told their family and friends of their plans and timelines. Furthermore, both men were wearing heavy clothing and they also had high levels of alcohol in their systems, which may have impacted on their ability to stay buoyant in the water. When the men were found, they were not wearing life jackets. It is difficult to determine whether a life jacket would have saved them, but it would have increased their chances of survival.

Acronym glossary

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

ACC	Accident Compensation Corporation
ADHB	Auckland District Health Board
BCD	buoyancy compensator device
BoPRC	Bay of Plenty Regional Council
CADS	Community Alcoholic and Drug Services
CaFU	Child and Family Unit (Auckland City Hospital)
CAYAD	Community Action of Youth and Drugs
CCDHB	Capital and Coast District Health Board
CMDHB	Counties Manukau District Health Board
CPR	cardiopulmonary resuscitation
CYF	Child, Youth and Family
DHB	District Health Board
DTL	Dive Tutukaka Ltd
EPA	Environmental Protection Authority
EPI	early psychosis intervention
EPIRB	emergency position indicating radio beacon
GP	general practitioner
HDC	Hastings District Council

Home HD	home haemodialysis
IACD	Inter-Agency Committee on Drugs
ICSS	Intensive Clinical Support Services
INR	International normalised ratio (test)
IPCA	Independent Police Conduct Authority
Ltd	limited (company)
NTG	Navalimpianti Tecnimpianti Group
NZ	New Zealand
NZTA	New Zealand Transport Agency
NZUA	New Zealand Underwater Association
PADI	Professional Association of Diving Instructors
PFD	personal flotation device
PLB	personal locator beacon
SUDI	sudden unexpected death in infancy
TENR	Threat – Exposure – Necessity – Response
tv	television
WDHB	Waitemata District Health Board

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 or surgical care	1, 2, 3, 4, 5, 6, 7
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, 7
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, 7
Electrocution	5
Fall	2, 3, 4, 5, 7
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Homicide or interpersonal violence	2, 3, 4, 5, 7
Labour or pregnancy related	1, 3, 4
Mental health issues	1, 2, 3, 4, 5, 6, 7
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Overseas deaths	3, 5
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Product-related	2, 3, 5, 6, 7
Recreational or leisure activities	1, 2, 3, 4, 5, 6, 7
Self-inflicted	1, 2, 3, 4, 5, 6, 7
SUDI and other infant deaths	1, 2, 3, 4, 5, 6, 7
Transport-related	1, 2, 3, 4, 5, 6, 7
Water-related (general)	1, 2, 3, 4, 5, 6, 7
Water-related (recreational fishing or boating)	3, 4, 5, 7
Work-related (agriculture)	1, 2, 3, 4, 5
Work-related (other)	1, 2, 4, 5

Coronial Services of New Zealand
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