OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND

Recommendations Recap

A summary of coronial recommendations and comments made between **1 April** and **30 June 2021**

Coroners’ recommendations and comments

Coroners perform essential functions within our society. They inquire into a range of unexpected deaths to establish the identity of the person who has died and the cause and circumstances of their death.

While inquiring into a death, a Coroner may make recommendations or comments for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred.

The Office of the Chief Coroner maintains a public register of these recommendations and comments and publishes summaries of those which are not prohibited from being published by order of court or law. Recommendations Recap includes all those recommendations and comments which have been summarised and published. This edition includes 48 recommendations and/or comments issued by Coroners between 1 April and 30 June 2021.

DISCLAIMER The summaries of Coroners’ findings included in this publication have been produced by Legal and Research Counsel. The best effort to accurately summarise those findings has been made; however, they are not exact replications of the original finding. If formal reference of a finding is intended, the original finding should be accessed.

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Recommendations and comments

1 April to 30 June 2021

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

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

Death in Custody

Lewis [2021] NZCorC 84 (31 May 2021)

CIRCUMSTANCES

Steven Casey Lewis, aged 63, died on 26 May 2015 at Manukau Police Station as a result of blunt force head trauma.

On the evening of 25 May 2015, Mr Lewis was chased from a house he had broken into. He tried to escape over a 1.8 metre fence, however the homeowner pulled him off and he fell to the ground. Mr Lewis lay on the ground for a couple of seconds before attempting to run away again, this time tripping on a clothesline. He was still on the ground when Police arrived and arrested him.

Mr Lewis was placed in a cell at the Police station and was checked regularly throughout the night. Police observed that he was slurring, his eyes were bloodshot and glazed and he was sleeping and snoring. Medical attention was not sought.

At inquest a forensic pathologist gave evidence that while these can all be symptoms of an evolving head injury, they are nonspecific and may also be attributed to a variety of other causes such as the effects of drugs, mental illness, fatigue or pre-existing medical conditions.

COMMENTS OF CORONER GREIG

I. Mr Lewis' death from an evolving but unknown head injury whilst detained in custody highlights an important (and difficult) issue for New Zealand Police. By virtue of the nature of their work, Police arrest and detain in custody a diverse cross section of the population. Police do not necessarily know what has gone on before an arrest - including whether a person is affected by drugs or alcohol, has sustained an injury that may not be apparent or has a medical condition that affects their presentation. Whatever the circumstances, Police responsibility for care, safety and security of a prisoner starts from the moment a person is arrested or detained and does not end until they are released or transferred into the care of another agency or person. Part of this responsibility includes assessing and monitoring the prisoner's wellbeing.

II. I am not critical of the actions of the Police and custody staff over the assessment and monitoring of Mr Lewis' wellbeing whilst detained and I have not identified instances where signs and symptoms of head injury should have been recognised. Nevertheless, Mr Lewis' death illustrates the potential for an unknown head injury to have tragic consequences whilst a person is in Police custody. Awareness of this potentially 'hidden danger', a knowledge of signs and symptoms that may indicate head injury and vigilance by all involved in the care of a person in Police custody are important in order to prevent deaths in circumstances similar to Mr Lewis' in future. As Inspector Paynter's review of Police, practice and procedures following Mr Lewis' death explicitly recognised, there is a risk that because "head injuries are often disguised by other behaviours of detained people such as alcohol, drugs or mental/physical impairment" staff incorrectly assume the behaviour is associated to conditions other than a head injury.

III. In view of these challenges, New Zealand Police have an ongoing responsibility to ensure that all constabulary staff and authorised staff involved in detaining prisoners in custody are sufficiently well trained both to recognise that some behaviours or symptoms displayed by prisoners, which may have alternative (and possibly more benign) explanations, may also be indicators of a head injury, and to understand that such behaviours or symptoms ought not be categorised without proper consideration.

RECOMMENDATIONS OF CORONER GREIG

I. I have acknowledged the work done by New Zealand Police to ensure that there is appropriate operational policy and training in place to make sure those involved in the management of people in Police custody are aware of the dangers of unknown head injury, what to watch for in relation to this, and the need for vigilance.

II. To highlight for staff the potential for tragic consequences when a person in custody has an unknown head injury and the Police instructions in this regard, I recommend that:

  a. A summary of this case be included in the NZ Police internal publication, "Ten One", to remind staff of the key messages with reference to the relevant section of the Police instructions.

III. New Zealand Police has advised that it considers the recommendation to be both appropriate and useful and that the Police media group will prepare an article for "Ten One."

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Lewis' body entered into evidence by the Police in the interests of personal privacy and decency.

Drowning

Bailey [2021] NZCorC 56 (7 April 2021)

CIRCUMSTANCES

Oliver Lucas Bailey, aged two, of Christchurch died on 2 September 2019 in Christchurch due to drowning.

On 2 September 2019, Oliver was playing outside at his home in Christchurch. After around 15 minutes of not hearing him, Oliver's mother, Amber Bailey, went outside to check on him. Ms Bailey found Oliver at the back of the property, unresponsive, floating in the water of the family's ornamental pool. Despite CPR efforts, Oliver could not be revived and was pronounced deceased at the scene.

COMMENTS OF CORONER JOHNSON

I. I do not consider that recommendations are required. The facts speak for themselves. Oliver's death is a tragic reminder of the dangers of young children around water.

II. The child and youth mortality review committee (CYMRC) reported that between 2013 and 2017 children aged between one and four died due to drowning at a rate of 21 per 100,000 population. I note that this category of death is second only to "transport" related deaths in this age group and was disproportionately larger than the remaining categories.

III. CYMRC state that New Zealand has a high rate of drowning compared to other OECD countries. A CYMRC special report into drowning from 2009 states that "deaths under five are preventable when the double protection of adequate supervision and appropriate environmental safe guards are in place". The report states that children under five years, especially infants, are intensely vulnerable to drowning even in very small bodies of water, so a lapse in supervision can be sufficient to allow an infant or child to drown.

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

Branje [2021] NZCorC 80 (11 May 2021)

CIRCUMSTANCES

Emily Dawn Branje, aged nine, of Rolleston died on 26 September 2019 at Hokitika River, West Coast due to drowning.

On 26 September 2019, Emily visited the mouth of the Hokitika River with her step-grandfather, Raymond Baxter, to watch him whitebait. Neither of them were wearing lifejackets. Mr Baxter watched the water conditions before waitbaiting, and told Emily to stand behind him away from the water. While standing behind him, she was pulled into the sea and carried into the current and open water. Despite efforts by Mr Baxter and locals who were in the vicinity, Emily could not be saved. She was located deceased two days later.

COMMENTS OF CORONER JOHNSON

I. Emily's death is an absolute tragedy. Emily was well loved and at the time of her death was in the care of her step-granddad whom she loved and who loved her. The circumstances serve to highlight the need for Emily to have been wearing a life jacket. She was pulled into the sea from where she was standing on the shore. She was then carried away by the sea, she was seen on her back, treading water as she had been taught. If she had been wearing a life jacket, she would have had a chance of survival.

II. Water Safety New Zealand provides advice on its website in relation to rock fishing:[1]

a. **Wear a lifejacket** – Mr Baxter thought it was safe for him and Emily not to wear lifejackets as he thought the conditions were not too rough.

b. **Pay particular attention to swell and tide information** – Mr Baxter was familiar with the tide conditions and from what he told Police he considered swell and tide information before he decided that the conditions were safe.

c. **Never fish in exposed areas during rough or large seas** – Mr Baxter felt that the sea "wasn't too rough" and that while there were some waves they were nothing to cause him concern. But it was less than 10 minutes before Emily was knocked off her feet by a wave and the all the other evidence shows that the water was rough.

d. **Spend at least ten minutes observing the sea conditions before approaching the rock ledge** – Mr Baxter told Police that he watched the water for about quarter of an hour to 20 minutes and thought it was safe.

e. **Never turn your back on the sea** – Mr Baxter was looking back over his right shoulder to check on Emily.

f. **Pay attention to warning signs** –Mr Baxter told Police that he could not recall seeing any warning signs on the day and there was no evidence gathered during the Police investigation to indicate there were any warning signs in place at the time. But Mr Baxter was very familiar with the area.

g. **Never fish from wet rocks where waves and spray have obviously been sweeping over them** –Mr Baxter told Police that he thought it was safe as the water wasn't coming over the spit.

III. I conclude that Mr Baxter, excited to be taking Emily out to watch him whitebait, underestimated the conditions that day.

IV. For Emily's family their pain and grief are ongoing. For Mr Baxter there is also guilt, remorse and regret. He said "*I estimate I have 20 years of this sentence to go before I die. I keep thinking I thought I had [*Emily*] safe, I wish I never took her*".

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs that show Emily, taken after death, in the interests of decency and personal privacy.

Espinosa [2021] NZCorC 62 (20 April 2021)

CIRCUMSTANCES

Kenny Cordova Espinosa, aged 28, died on 11 January 2019 at Otuihau/the Whangarei Falls of drowning.

Mr Espinosa and a friend went swimming in a waterhole at the bottom of Otuihau/the Whangarei Falls. Before getting in they asked a tourist, who was just getting out, if it was very deep and were advised that it was quite deep. Mr Espinosa

[1] https://watersafety.org.nz/how%20to%20stay%20safe%20while%20fishing.

and his friend began swimming in the shallows. However, Mr Espinosa, who was a competent swimmer, then swam into the deeper water.

When he began struggling and going under the water, Mr Espinosa's friend attempted to throw him a log in an unsuccessful attempt to help him float. Two tourists dived into the water and tried to find Mr Espinosa but were unable to do so. Mr Espinosa's body was found the following day, lying face up in in 6.2 metres of water, approximately 25 metres from the shore.

RECOMMENDATIONS OF CORONER MILLS

Otuihau/Whangārei falls

I. Otuihau/Whangārei Falls (the Falls) are on the outskirts of Whangārei. It is where the Hātea river drops twenty-six metres (around eighty-five feet) over a basalt lava flow and forms a large pool/waterhole at the bottom. The water quality and pool depth vary according to the rain fall, however, as evidenced by where Mr Espinosa was found, it is a deep waterhole.

II. The Falls are a popular place for both locals and tourists to visit. For many, it is an enticing place to cool off on a hot summer day. There are walking tracks along the edge of the Hātea River, and a loop track from car park at the top of the Falls around to the waterhole at the bottom and back up to the car park at the top.

III. At the bottom of the Falls a bridge crosses the outflowing stream and there is easy access to the waterhole at the bottom of the Falls on both sides of the bridge.

Signage

IV. Site visits to the Falls were conducted to assess what signage had been erected to advise visitors of the risks associated with swimming at the Falls.[2] Of note:

a. At the top of the Falls, by the low footbridge over the Hātea river that feeds the Falls, there is a "Health notice" advising that swimming "was not advised" due to possible contamination of the water.

b. In the same location there is a sign warning of the risks of diving due to "shallow rocks hidden beneath the water." The "no diving" sign appears to relate to a small pool in the river next to the footbridge above the Falls. All signs are in English but include an appropriate diagram.

c. I note, as the track to the bottom of the Falls is a loop track, it is possible to walk to the waterhole at the bottom of the Falls without passing these signs as they are located only at the footbridge over the Hātea river.

[2] A site visit was undertaken by Coroner Shortland 5 March 2019. A second site visit was undertaken by Coroner Mills on 22 March 2021.

d. There are various signs (images) warning of the dangers of climbing over safety barriers around the top of the Falls.

V. At the waterhole area at bottom of the Falls, where Mr Espinosa drowned, there are no signs or warnings about the risks or dangers of swimming under the waterfall or about water quality.

VI. Many waterfalls have a strong recirculating wave at their base and an area of aerated water.[3] People can get trapped at the base of a waterfall and drown.[4] Waterfalls and rivers are unpredictable and can change rapidly depending on weather and rain fall. While the surface can appear calm, there are often unseen obstacles, such as rocks and submerged logs and current below the surface. In addition, fresh water is less buoyant than salt water, making it harder to float. These factors combine to make swimming at waterfalls hazardous and are all features of Otuihau/ Whangārei Falls.

VII. In Aotearoa/New Zealand freshwater drownings (rivers, waterfalls and lakes) continue to account for a significant percentage of drowning fatalities.[5] In 2019 there were 21 preventable drownings in rivers and nine in lakes.[6] Sadly Mr Espinosa is not the first person to have drowned at Otuihau/the Whangārei Falls.[7]

VIII. Given the risks associated with swimming in waterfalls, and the previous drownings at the Falls, I am concerned about the lack of signage warning people of the hazards associated with swimming there. While there are limited signs at the top of the Falls, there are no signs at all at the waterhole (including water quality warnings) where people are more likely to swim.

IX. Mr Espinosa and his friends did query the depth of the waterhole, suggesting they had some concerns, however there was nothing official to warn them of the general risks of swimming at freshwater waterfalls. Good quality signs, in a consistent format with universally understood symbols and images play an important role in raising public awareness and alerting the public to the need to exercise caution.

X. A Coroner may make recommendations or comments for the purpose of reducing the chances of further deaths occurring in similar circumstances.[8] Any person or organisation to whom the comment or recommendation is directed must be given the opportunity to comment on the proposed recommendation or comment.[9] I therefore provided a copy of my draft Findings with the following recommendations to the Whangārei District Council:

XI. That the Whangārei District Council:

[3] https://watersafety.org.nz/River%20Features%20-%20Fact%20Sheet.
[4] Ibid.
[5] In the years 2013-17 over one fifth (22%) of all preventable drownings happened in rivers (WSNZ 2018). https://www.dpanz.org.nz/research/rivers/.
[6] 2019 Provisional Drowning Report, Water Safety NZ 9 January 2020 https://cdn-flightdec.userfirst.co.nz/uploads/sites/watersafety/files/PDFs/Drowning_Reports/2019-provisional-drowning-report.pdf.
[7] Four other people have reported to have drowned at Otuihau/Whangārei Falls since 2000.
[8] Coroners Act 2006 section 57A.
[9] Coroners Act 2006 section 57B(1).

a. review the signage at the Falls. I recommend that they consider installing signs that comply with the Australian New Zealand standard (AS/NZS 2416:2010) for water safety signs and beach flags to warn people of the risks of swimming at the Falls. These signs should be in the standardised format and colour with a white, contrasting background as per the standard.

b. consult with Police, Search and Rescue and Water Safety NZ as to the appropriate content of the signs, which could include matters such as warnings about depth, slippery rocks, possible submerged items, sudden drop offs as well as general advice on buoyancy in fresh water.

XII. I recommend that these signs be placed in the two access areas close to the waterhole at the bottom of the Falls, either side of the lower bridge, as well as in appropriate locations at the top of the Falls.

XIII. Whangārei District Council responded to my draft Findings and advised that the Council's Parks and Recreation Department will comply with the above recommendations. They advised that they intend to review the existing signage and, following consultation, will install appropriate signs that comply with the Australian New Zealand standards in the appropriate locations.

Lifesaving equipment

XIV. I note that Mr Espinosa's friends attempted to go to his assistance and threw a log into the waterhole to try and help him float. There is currently no lifesaving equipment at the waterhole.

XV. I therefore also recommended that Whangārei District Council consider installing a lifebuoy or angel ring at the waterhole. If a device such as this had been available, it may have increased the chance of Mr Espinosa's survival.

XVI. The Whangārei District Council has also responded to my recommendation and advise that they will install a life buoy at the bottom of the Falls.

XVII. I made these recommendations in the hope that, if implemented, they may reduce the risk of further deaths at Otuihau/Whangārei Falls.

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

Miron [2021] NZCorC 76 (5 May 2021)

CIRCUMSTANCES

Gil Miron, aged 24, of Israel died on 26 January 2020 at Mosquito Point, Whanganui due to drowning.

On 26 January 2020, Mr Miron was visiting Mosquito Point on the Whanganui River with a friend. They started to swim across the river together. When they had swum to the middle of the river (approximately 20 metres across), Mr Miron told

his friend that he was feeling tired and finding the swim difficult. The friend grabbed onto Mr Miron and called for help from others in the area. Despite efforts to keep Mr Miron afloat, he could not hold onto him, and Mr Miron sunk under the water. He was found deceased the following day.

RECOMMENDATION OF CORONER RYAN

I. I recommend that both the [Whanganui District Council] and [Horizons Regional Council] consider:

a. Updating current signage to reflect the risk of drowning at Mosquito Point if attempting to swim across the river, including information about how to avoid such danger and what to do in an emergency.

II. In addition, I endorse the advice from Water Safety New Zealand in regard to safely crossing rivers found on their website.[10]

Su [2021] NZCorC 57 (9 April 2021)

CIRCUMSTANCES

On 10 January 2017, Jingru Su (also known as Claire), aged 23, was found lying submerged at the bottom of a residential swimming pool in Hauraki, Auckland. Emergency services succeeded in resuscitating Ms Su, but she remained in a deep coma and died at North Shore Hospital on 15 January 2017.

Ms Su was a Chinese citizen who had resided in New Zealand for about six years. Her father said she was a fit and healthy young woman, but was not a strong swimmer and had never had any swimming lessons.

On the afternoon of 10 January 2017, Ms Su and her friend, Angi Wang, were alone together at another friend's home. Ms Su decided to go for a swim in the pool while Ms Wang took several videos of her. After she had been inside for around ten minutes, Ms Wang realised she could no longer hear splashing or any other sound coming from outside. She went to check on Ms Su and found her lying face down at the bottom of the pool's deep end.

After being resuscitated and rushed to hospital, it became clear that Ms Su had suffered significant neurological damage after cardiac arrest. She did not improve over the next few days and died on 15 January 2017. The Coroner was satisfied that Ms Su got into difficulty in the water and was unable to get to safety. There was no evidence to suggest she was under the influence of drugs or alcohol, was injured or had a medical event that may have rendered her incapable.

COMMENTS OF CORONER GREIG

I. Ms Su was essentially swimming alone and for an unknown reason got into difficulty. Her untimely death illustrates that home swimming pools pose potential hazards and safe use is important to prevent deaths.

II. Water Safety New Zealand has advised me that the key safety messages for adults using home swimming pools are:

[10] Found at: https://watersafety.org.nz/Community-Resources/How%20to%20Stay%20Safe%20around%20Rivers.

a. Never swim alone.

b. Learn water safety and survival skills.

c. Stay within your limits.

d. Learn CPR.

e. Avoid drugs and alcohol.

f. In an emergency dial 1-1-1.

g. Keep a throw rope or flotation device close by to assist anyone who gets into trouble in the water.

III. Whilst a number of these matters do not have relevance to the circumstances of Ms Su's death, for example there was no question of alcohol or drugs being implicated, I have included them for completeness of the safety message.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of Ms Su entered into evidence upon the grounds of personal privacy and decency.

Tupou [2021] NZCorC 88 (1 June 2021)

CIRCUMSTANCES

Violet Tupou, aged 17, of Auckland died on 3 June 2017 at Auckland due to drowning.

On 3 June 2017, Violet Tupou was playing with her tennis racket and tennis ball on a street near her home. Witnesses in the vicinity heard screaming and looked towards the sound. They saw Violet's legs sticking up in the air out of a stormwater drain (catchpit) kicking back and forth. Her feet were then observed to fall into the drain and disappear. Members of the public came to Violet's aid and pulled her out of the drain, but sadly she was unable to be revived and was declared deceased at the scene. It was ascertained by Police that Violet had lost her ball in the drain and sought to retrieve it, but became stuck inside the drain and drowned.

COMMENTS OF CORONER GREIG

I. In response to Violet's death, Auckland Council and Auckland Transport have made concerted and principled efforts to identify safety issues with catchpits, to assess the identified issues within a wider safety framework and to respond to recommendations made to improve safety of catchpits, within exigencies imposed by Covid 19 and ensuing budget restrictions. As set out earlier in these findings, a number of positive safety steps have been and are being taken by Auckland Council and Auckland Transport. I commend these organisations for the work they have done to date.

II. However, for the meantime, the risk of danger to the public from unauthorised removal of catchpit grates and the dangers associated with open catchpits (including people trying to retrieve lost items) remains.

RECOMMENDATIONS OF CORONER GREIG

I. To ensure that there is ongoing public awareness of catchpit hazards and Auckland Council's process for retrieval of items from catchpits, I **recommend**:

a. that Auckland Council and Auckland Transport prepare a further (or updated if deemed appropriate) public communications plan for improving/refreshing public awareness of catchpit safety.

II. I also **recommend**:

a. that the retrofitting of 'lockable safety catchpits' on catchpits that are considered higher priority remains on Auckland Council's asset improvement programme for implementation when the asset improvement programme is reinstated.

III. I request that Auckland Council sends a copy of these findings together with advice that the Opus International Catchpit Safety Review reports are available on its website to all Councils in New Zealand. In making this request I note that Auckland Council and WSP (formally Opus International Consultants) have already shared the findings from the Opus review with the industry through presentations at the 2019 Stormwater Conference and the 2019 Institute of Professional Engineers Australia (IPWEA) Conference and made the Opus reports publicly available on the Auckland Council website. However, in view of the evidence that there are likely to be more than 400,000 catchpit grates around New Zealand, the importance of disseminating widely information about safety issues related to catchpits that have been highlighted by inquiries following Violet Tupou's death, and ensuring these matters are specifically brought to the attention of all Councils, is important.

Auckland Council/Auckland Transport Response to Recommendations

IV. Auckland Council and Auckland Transport support the above recommendations and comments. They have responded specifically as follows:

a. Auckland Council and Auckland Transport support the recommendation that we prepare a public communication plan for improving/refreshing public awareness of catchpit safety. This will be led by Auckland Council with input from Auckland Transport.

b. Auckland Council and Auckland Transport support the recommendation of retrofitting 'lockable safety catchpits' on catchpits that are considered higher priority. Auckland Transport have allocated $250,000 in the renewal programme of the 2021/2022 budget for retrofitting 'lockable safety

catchpits'. The intention is that this is an ongoing renewal allocation, subject to the approval of Auckland Council's annual budget.

c. Auckland Council and Auckland Transport support the wide dissemination of these findings. We will send a copy of these findings, together with website access to the supporting WSP (formerly Opus International Consultants) reports, to all Councils in New Zealand. Auckland Council also intend to share this information with the following industry representative groups so that they may share the findings with their membership:

   i. Association of Consulting Engineers New Zealand (ACENZ);

   ii. Water New Zealand;

   iii. Taituarā – Local Government Professionals Aotearoa (formerly SOLGM);

   iv. Local Government New Zealand.

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

Wood [2021] NZCorC 90 (3 June 2021)

CIRCUMSTANCES

Helen Margaret Wood, aged 62, died on 22 September 2017 at Kairaki Beach of drowning.

COMMENTS OF CORONER CUNNINGHAME

I. Pursuant to s57A of the Act, I make the following comment:

At 9:30pm on 22 September 2017 Helen Wood was setting up her whitebait trailer at the edge of the Waimakariri River, at Kairaki Beach. It was dark. She was alone. She had been drinking alcohol. Her judgement and perception were impaired due to intoxication. Ms Wood could not back the trailer to the water's edge so in order to position it, she drove her vehicle so close to the edge that its bonnet was over the water. At this point the river dropped off steeply. After uncoupling the trailer, Ms Wood returned to her vehicle and started it. It started to slide forward, and she was unable to stop the vehicle going into the water. The vehicle filled with water and she was unable to escape.

If whitebaiters need to use vehicles to get their gear close to the water, they must ensure that they can do so safely. Driving off-road near water, and in particular, on sand or on unstable lake edges or riverbanks, can be dangerous. The speed at which Ms Wood's vehicle sank into the river after the bank collapsed illustrates how quickly even a minor misjudgement in the positioning of a vehicle can result in tragic consequences.

Ms Wood was significantly over the legal blood alcohol limit. She should not have been using her vehicle. However, because using vehicles near water is risky at the best of times, recreational fishers

and whitebaiters should avoid drinking alcohol at all if they are intending to use their vehicles near sandy or otherwise unstable water edges.

II. I recommend that Water Safety New Zealand, the [West Coast Whitebaiters Organisation], and the New Zealand Fishing News disseminate the above comment. I leave it to those organisations to decide how best to do so. Other organisations and media may also wish to publicise the safety message.

III. Because the [Northern Pegasus Bay Advisory Group] and the [Waimakariri District Council] have been proactive after receiving my correspondence, I am not required to make any formal recommendations regarding the signage at Kairaki Beach.

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

Drugs

Curry [2021] NZCorC 70 (29 April 2021)

CIRCUMSTANCES

Ivan Sydney Curry, aged 50, died on 18 March 2018 at 72/139 Greys Avenue, Auckland Central of a combination of AMB-FUBINACA toxicity, multi-drug toxicity and atherosclerosis and dilated cardiomyopathy.

Shortly before 1:00am on 18 March 2018, Mr Curry was found by his partner slumped over on a chair in their apartment unresponsive. Emergency services attended and confirmed that he had died.

In the days leading up to his death, Mr Curry had consumed a significant amount of alcohol and synthetic drugs.

Toxicological analysis confirmed the presence of multiple drugs in Mr Curry’s blood, including AMB-FUBINACA and AMB-FUBINACA acid. AMB-FUBINACA is a synthetic cannabinoid and AMB-FUBINACA acid is a metabolite of AMB-FUBINACA.

The post-mortem examination found Mr Curry had an enlarged, dilated heart with coronary artery calcification and extensive pleural adhesions. The forensic pathologist advised that many of the drugs found in Mr Curry’s blood have a depressant action on the central nervous system and their combined use is likely to enhance this effect. She also noted that synthetic cannabinoids have been associated with sudden deaths and concluded that AMB-FUBINACA toxicity, multi-drug toxicity and atherosclerosis and dilated cardiomyopathy were all significant conditions that contributed to Mr Curry’s death.

COMMENTS OF CORONER WOOLLEY

I. Unfortunately, Mr Curry's death appears, in part, to be due to his consumption of synthetic cannabis.

II. The dangers of consuming synthetic drugs include:

a. It is promoted or sold as a form of synthetic cannabis, but that there is no cannabis in the product.

b. The synthetic drug can be made to look like cannabis by using dried plant or other material, but it is saturated in a synthetic drug not THC (tetrahydrocannabinol) the active ingredient in cannabis.

c. The pharmaceutical agents from which synthetic cannabis was developed were attempts to create new medications to treat spasms and epilepsy but were found to be unsuitable and were discarded. The nature of the synthetic drug is unknown to the purchaser and unknown or poorly understood by the manufactures/distributors in New Zealand.

d. The synthetic drugs, AMB-FUBINACA and 5F-ADB, have been the cause or contributing factor in a number of deaths in both the Waikato/BOP,[11] elsewhere in New Zealand, and overseas.[12]

e. The quantity and strength of AMB-FUBINACA and 5F-ADB is an unknown gamble which can have fatal consequences.

f. Individuals who fall unconscious after consumption of synthetic drugs can die if they do not receive timely and appropriate medical assistance; dying from cardiac event induced by consumption of the drug, or as a result of being comatose and asphyxiating on their own vomit, or they may suffer a hypoxic brain injury.

III. Due to the circumstances and cause of this death I repeat the recommendations made by Coroner Matenga in reliance on the expert evidence of Dr Quigley in the coronial inquiry into the death of McAllister, CSU-2017-HAM-000336:

a. In order to prevent future deaths from synthetic cannabinoids, Dr Quigley suggested that an all-encompassing harm reduction approach which reduces demand, supply and easy access to treatment for those seeking assistance should be developed. He cautioned that any recommendations on increasing enforcement, targets manufacture, trafficking and supply, while not overly penalising users as this can create a barrier to those seeking medical attention, even in cases of emergency.

b. Dr Quigley submitted that efforts should be made to inform users of synthetic cannabis, their families and associates, of the dangers of synthetic cannabinoids and the need to get help immediately if someone collapses. I agree.

c. Dr Quigley's advice for the families or associates of synthetic cannabis users was that if a person who has used synthetic cannabis collapses, that person should be immediately shaken to attempt to rouse that person. If the person rouses, that person should then be placed in the recovery position

[11] McAllister, CSU-2017-HAM-000336, Taoho, CSU-2017-ROT-000345.
[12] Adams AJ, Banister SD, Irizarry L, Trecki J, Schwartz M and Gerona R. " "Zombie" Outbreak Caused by the Synthetic Cannabinoid AMB-FUBINACA in New York" New England Medical Journal 376 (2017) 235-242.
Hasegawa K, Wurita A, Minakata K, Gonmori K, Yamagishi I, Nozawa H, Watanabe K and Suzuki O. "Identification and quantitation of 5-fluoro-ADB, one of the most dangerous synthetic cannabinoids, in stomach contents and solid tissues of a human cadaver and in some herbal products" Forensic Toxicology 33 (2015) 112-121.

and a call for help should be made. If the person does not rouse, then call for help and commence chest compressions. The call taker who answers the emergency call for help will provide assistance. Do not delay.

IV. Dr Quigley is a vocational specialist in Emergency Medicine, he has completed additional studies in clinical toxicology and conducted research in forensic toxicology. He is a recognised expert in emergency management and treatment of drug and alcohol presentations.

V. While I agree with, and endorse, Dr Quigley's advice, I am unable to make any recommendations in this regard, as I have not heard any evidence. I am aware however, that Coroner Mills is conducting a joint inquiry into deaths from synthetic cannabis which occurred in Auckland. I will refer this suggestion to Coroner Mills to consider in the course of her joint inquiry. No recommendations will be made by me.

VI. These findings will be distributed to the media for publication.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs that show the deceased in the interests of decency and personal privacy.

Hird [2021] NZCorC 66 (27 April 2021)

CIRCUMSTANCES

Anthony Reg Hird, aged 59, died at Kawerau on 30 November 2018 due to amitriptyline toxicity.

Against a background of a number of significant health conditions, Mr Hird had recently developed shortness of breath and was being investigated for heart failure. His regular medications included amitriptyline (100mg daily) to treat depression.

On the morning of 30 November 2018, Mr Hird presented to his GP with symptoms over the past week of increasing shortness of breath, nausea and swollen ankles. He also reported feeling unsteady on his feet and having several falls. His GP thought the deterioration was due to Mr Hird’s worsening heart failure and added a diuretic treatment to improve his symptoms. Reassured that he was due to have an ECG and follow-up hospital appointment later in the week, the GP sent Mr Hird home with his wife, Brenda Hird.

After they returned home, Mrs Hird went out to visit a relative for around an hour. She returned to find Mr Hird lying unresponsive on their lounge-room floor. Despite resuscitation efforts, Mr Hird was unable to be revived and was pronounced deceased at the scene by emergency services.

It was later revealed that in an attempt to ease his insomnia, Mr Hird had been taking a higher level of amitriptyline than that prescribed to him. Mr Hird had not consulted with his GP before doing so, and had not disclosed this information during the GP consultation on the day of his death.

RECOMMENDATIONS OF CORONER BATES

I. Although the exact dose of amitriptyline Mr Hird was taking is unknown, it is evident he elected to exceed the dosage prescribed by his doctor. This was not made known to his doctor prior to death. It was an

attempt by Mr Hird to manage his insomnia, and disastrous consequences followed. Had Mr Hird taken his medication as prescribed, or at least disclosed to his doctor what he was doing, he may still be alive. Prescription medication of any kind should only be taken as directed by a suitably qualified health professional. If for any reason individuals deviate from that direction, it is essential that they inform a health professional in a timely manner, so that appropriate medical advice, assessment and treatment can be delivered, and negative consequences are mitigated or avoided.

II. As a result of the circumstances outlined above, I do not make any further comments or recommendations pursuant to s 57(3) of the Coroners Act 2006.

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

McGeady [2021] NZCorC 86 (1 June 2021)

CIRCUMSTANCES

Dawn-Jeanette Kerehi McGeady ("Dawn"), aged 24, died on 13 November 2018 at 8 Edmonton Rd, Onehunga, Auckland, of multiple drug toxicity.

Dawn was known to abuse drugs. On the afternoon of Monday 12 November 2018, Dawn went to her father's house in Onehunga. At 3pm Dawn's older brother arrived at their father's house, and noticed that Dawn was asleep on the sofa and snoring loudly. When she was woken, at around 7.30pm, she did not look well and appeared to be hungover. Dawn and her father then went to visit a friend.

At around 12:30 – 1am on 13 November, they drove back home. Dawn was asleep in the back of the car and her father left her there but asked her brother to check on Dawn. Her brother found her asleep and snoring. At around 4:13am Dawn's father went to check on her. He found Dawn on the floor of the car's back seat, unresponsive and wet around the mouth. He removed her from the car, and began administering CPR. An ambulance arrived shortly after and confirmed that Dawn had died.

Police attended the scene and found a zip-lock bag of unknown plant material in Dawn's purse. The bag was sent to the Institute of Environmental Science and Research (ESR) for analysis. The material tested positive for pFPP (Para-Fluorophenylpiperazine, a piperazine-derived designer drug and a central nervous system stimulant) and the synthetic cannabinoid AMB-FUBINACA, then a Class C controlled drug.[13] The effects of piperazines are similar to methamphetamine or MDMA (ecstasy), but are reported to be of lower intensity.

COMMENTS OF CORONER BORROWDALE

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

[13] Following 2018 recommendations to the Minister of Health by the Expert Advisory Committee on Drugs, AMB-FUBINACA was reclassified from August 2019 as a Class A controlled drug under the Misuse of Drugs Act 1975.

II. Dawn McGeady died as the result of using a combination of restricted drugs, comprising methamphetamine, cannabis, synthetic cannabis and the psychedelic drug pFPP. There is no evidence before me to indicate that Dawn apprehended the potentially fatal consequences of their use.

III. Drugs of these kinds have featured extensively in coronial findings in New Zealand, and have been the subject of coroner's recommendations against their use.

IV. Synthetic cannabis, in particular, was in 2017 the subject of two joint statements of caution by the Chief Coroner and the Police. In the second of these, Chief Coroner Judge Deborah Marshall stated:

> Using any illicit drug carries risks, and in the case of synthetic drugs, they are known to cause potentially fatal seizures. I urge anyone considering using this drug not to do so, and for those who are, to reach out to services that may assist them.

V. In 2018 Coroner Matenga held an inquest into the death from synthetic cannabis of a Taupo man, and made recommendations based upon the expert evidence he received. These included recommendations for more drug-user information; an all-encompassing harm-reduction approach; and advice to families or associates on how to help a person who is in seizure or collapse.

VI. Currently, Coroner Mills is conducting a joint inquiry into a series of Auckland deaths from synthetic cannabis. I will not prejudge here the results of that broader inquiry into synthetic cannabis deaths. I make no recommendations, as Coroner Mills' inquiry is likely to produce recommendations that are based on a wider set of circumstances than this one case.

VII. Here, I simply repeat that the effects of synthetic cannabis, psychedelic drugs and methamphetamine - taken alone or in combination - can be rapidly and unpredictably fatal. I reinforce the Chief Coroner's advice to avoid all use of these dangerous drugs, and to seek professional help if you are a user.

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

Samuela [2021] NZCorC 100 (23 June 2021)

CIRCUMSTANCES

Tera Samuela, aged 63, died on 19 July 2017 at 32/3 Community Lane, Avondale of hypertensive arteriosclerotic cardiovascular disease and/or AMB-FUBINACA toxicity.

At around 5:35pm on 19 July 2017 Mr Samuela was found unresponsive in the kitchen of his home by a friend. Emergency services were contacted, but resuscitation was unsuccessful and he died at the scene. In the two days before his death, Mr Samuela was seen by witnesses to be drinking excessively and had purchased cannabis.

The post-mortem examination found that Mr Samuela had an enlarged heart with severe single-vessel coronary artery disease and thickening of its wall due to high blood pressure. The forensic pathologist advised that this degree of heart disease can result in sudden death from a fatal abnormal heart rhythm or a ‘heart attack’.

Toxicological analysis found cannabis, THC and AMB-FUBINACA acid metabolite were present in Mr Samuela's blood. Alcohol was also confirmed in Mr Samuela's at 163 milligrams per 100 millilitres in the blood and 213 milligrams per 100 millilitres in the urine.

The forensic pathologist was unable to conclude what the direct cause of Mr Samuela's death was, but advised that his hypertensive arteriosclerotic cardiovascular disease could have been lethal. In addition, AMB-FUBINACA toxicity could not be ruled out as a possible cause of Mr Samuela's death.

COMMENTS OF CORONER WOOLLEY

I. Although it is not possible to point to one direct cause of Mr Samuela's death, his death nonetheless occurred in the context of consumption of AMB-FUBINACA, a type of synthetic cannabis.

II. The dangers of consuming synthetic drugs include:

   a. It is promoted or sold as a form of synthetic cannabis, but that there is no cannabis in the product.

   b. The synthetic drug can be made to look like cannabis by using dried plant or other material, but it is saturated in a synthetic drug not THC (tetrahydrocannabinol) the active ingredient in cannabis.

   c. The pharmaceutical agents from which synthetic cannabis was developed were attempts to create new medications to treat spasms and epilepsy but were found to be unsuitable and were discarded. The nature of the synthetic drug is unknown to the purchaser and unknown or poorly understood by the manufactures/distributors in New Zealand.

   d. The synthetic drugs, AMB-FUBINACA and 5F-ADB, have been the cause or contributing factor in a number of deaths in both the Waikato/BOP,[14] elsewhere in New Zealand, and overseas.[15]

   e. The quantity and strength of AMB-FUBINACA and 5F-ADB is an unknown gamble which can have fatal consequences.

   f. Individuals who fall unconscious after consumption of synthetic drugs can die if they do not receive timely and appropriate medical assistance; dying from cardiac event induced by consumption of the drug, or as a result of being comatose and asphyxiating on their own vomit, or they may suffer a hypoxic brain injury.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs that show the deceased in the interests of decency and personal privacy.

[14] McAllister, CSU-2017-HAM-000336, Taoho, CSU-2017-ROT-000345.
[15] Adams AJ, Banister SD, Irizarry L, Trecki J, Schwartz M and Gerona R. " "Zombie" Outbreak Caused by the Synthetic Cannabinoid AMB-FUBINACA in New York" New England Medical Journal 376 (2017) 235-242.
Hasegawa K, Wurita A, Minakata K, Gonmori K, Yamagishi I, Nozawa H, Watanabe K and Suzuki O. "Identification and quantitation of 5-fluoro-ADB, one of the most dangerous synthetic cannabinoids, in stomach contents and solid tissues of a human cadaver and in some herbal products" Forensic Toxicology 33 (2015) 112-121.

Waara [2021] NZCorC 96 (15 June 2021)

CIRCUMSTANCES

Anaru Tui Waara (aka Anaru Tui Baker), aged 22, of Cannons Creek, Porirua died on 5 November 2019 at Cannons Creek, Porirua of acute combined methamphetamine, 4F-MDMB-BINACA, and 5-MDMB-PICA toxicity.

On 5 November 2019, Anaru was alone in a bedroom at his home with his infant stepson. Earlier in the day he had consumed synthetic cannabis. His partner’s mother, Ma Metuangaro, heard the child crying in the bedroom and went to investigate. She found Anaru lying face down on the floor and assumed he was sleeping. Approximately 15 minutes later, Anaru’s partner, Jaedyn Kelekolio, arrived home and found him in the same position and unresponsive. Despite resuscitation efforts, he was declared deceased at the scene.

COMMENTS OF CORONER RYAN

I. The evidence demonstrates that Anaru falling asleep after using synthetic cannabis was common. Both Jaedyn's and Ms Metuangaro's lack of surprise at finding him on the floor and assumption that he was asleep confirms this. Ms Metuangaro also told Police that she did not know much about Anaru's drug use, so it appears she did not appreciate that he was using synthetic cannabis.

II. I note it is unclear whether Anaru was asleep or unconscious when seen by Ms Metuangaro. Given this, I cannot discount the possibility that Anaru's death could have been avoided had assistance been provided prior to Jaedyn arriving back at home. But there is also no evidence before me to suggest that earlier medical intervention may have prevented his death.

III. The New Zealand Drug Foundation states that it is unsafe to use synthetic cannabinoids, but users should treat the drug with extreme caution to avoid injury or death.[16] If an individual falls unconscious after using synthetic cannabis, they could die. People are often very "out of it" or unresponsive after using synthetic cannabinoids. They may collapse or "drop", foam at the mouth or experience temporary paralysis. People providing assistance should place them in a stable side position if possible and continuously monitor their breathing.

IV. The New Zealand Drug Foundation provides the following advice in the event that a person becomes unresponsive following the use of synthetic cannabis:

   a. Ask loudly if they are ok. Shake them gently.

   b. If they are not responsive, dial 111 and request an ambulance.

   c. Check they are breathing and place them in a stable side position.

   d. If they are not breathing, start chest compressions.

[16] https://www.drugfoundation.org.nz/info/drug-index/synthetic-cannabinoids/.

V. I endorse the New Zealand Drug Foundation's advice.

Fall

Leeuwenburg [2021] NZCorC 58 (12 April 2021)

CIRCUMSTANCES

Benjamin Leeuwenburg died at Parahaki, Whangarei on 9 July 2020. The cause of death was cervical spine dislocation caused by falling from a ladder.

On 9 July 2020, Mr Leeuwenburg went outside to spray the shed roof. Mrs Leeuwenburg was inside the house at the time and went outside 20 minutes later to check on him. She found Mr Leeuwenburg on the ground next to a ladder, which had fallen over. Neighbours came over to assist but Mr Leeuwenburg could not be revived.

RECOMMENDATIONS OF CHIEF CORONER JUDGE MARSHALL

I. Under s57A of the Coroners Act 2006, a coroner may make comments as part of the findings if the comments are clearly linked to the factors that contributed to the death, are based on evidence considered during the inquiry and are accompanied by an explanation of how the comment may, if drawn to public attention, reduce the chances of further deaths occurring in similar circumstances.

II. The Accident Compensation Corporation (ACC) publishes tips for using ladders safely. It suggests asking someone to hold the ladder steady or, if that is not possible, to steady the ladder with sandbags.

III. This was a tragic accident that serves as a reminder of the dangers of using ladders - particularly when you are on your own.

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

Lemalama [2021] NZCorC 87 (1 June 2021)

CIRCUMSTANCES

Sam Lemalama, aged 41, died on 5 January 2018 at Auckland City Hospital of a severe brain injury.

On 1 January 2018, Mr Lemalama went to Kariotahi Beach with his family. They stopped at Waitangi Falls, Glenbrook to swim on their way home.

Waitangi Falls is in a rural location surrounded by dense vegetation. A local Police officer estimated that the waterfall is about 20 metres high and falls over a bed of rocks that is about 10 metres wide. There are numerous ledges at various heights that people climb up to jump off into the stream below, which is approximately 14 metres wide.

As the family was walking along the track to the waterfall, Mr Lemalama tried to reach for a branch, missed it and fell backwards onto the rocks below, suffering a severe head injury which led to his death. It is estimated that Mr Lemalama fell from a height of approximately three metres.

Auckland Council was consulted and advised that at the time of Mr Lemalama's death, there was a sign attached to a tree at the top of the waterfall, where people have been known to jump from into the pool of water at the base of the waterfall. The sign faces the road and states: "No jumping. Submerged rocks below, could result in serious injury." Auckland Council further advised that it erected two additional signs with the same wording at the base of the waterfall and on the other side of the tree at the top of the waterfall on 9 March 2018.

COMMENTS OF CORONER WOOLLEY

I. Above I have discussed the measures taken by the Auckland Council to erect additional signage at the Waitangi Falls to warn members of the public of the risks of jumping into the stream from the top of the waterfall. Although Mr Lemalama's fall appears to be the result of him not being able to grasp a tree branch to support him as he walked on the track up the waterfall, it appears his purpose in walking to that part of the track was to jump into the waterfall with the rest of his family. I consider it is important that clear signage is in place to warn the public about the dangers posed from the submerged rocks at the bottom of the waterfall. Given I have been notified by Auckland Council that additional signs have been erected at the waterfall, I do not consider it necessary to make any formal recommendations in this case, but I do urge members of the public to follow the safety advice on the signs.

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

Leisure Activities

Box [2021] NZCorC 94 (10 June 2021)

CIRCUMSTANCES

Jerome Benjamin Box, aged 52, died on 16 August 2014 at Mount Alta. The cause of death was high energy impact injuries to his chest, spine and head due to being ejected from a helicopter crash into mountain terrain.

On 15 August 2014 Jerome and four of his friends went to the Harris Mountain Heli-skiing (HMH) office to book and pay for their heli-skiing trip the next day. They had to sign a waiver and disclose how much they weighed. This information was provided to the HMH guides to calculate loads but their weights were not transferred to the pilot's daily load sheet.

On 16 August 2014 a pilot from The Helicopter Line Limited (THL), Dave Matthews, carried out a pre-flight inspection of the Eurocopter AS350-B2 (Squirrel) helicopter, registered in New Zealand as ZK-HYO (HYO). The HYO was new to the fleet and it was the first day of its operation. Mr Matthews calculated that HYO would be within its maximum weight, internal weight limit and centre of gravity (COG) limits once it was fully loaded. In doing that calculation, Mr Matthews added the weight of himself as pilot and six 80kg passengers.

When Jerome and his friends arrived to go heli-skiing/boarding in the Mount Aspiring National Park area they were guided by a HMH guide and were briefed by two HMH guides on safety around and inside the helicopter. This briefing did not include a directive that the seatbelt must be tight/snug across the hips.

When he saw the group, Mr Matthews realised they were all males and their weights would be in excess of 80kgs. He asked the group what they thought they weighed and one of them said they were all about 85kgs. Mr Matthews did "quick sums" in his head and calculated the HYO's weight with fuel to be 2,250kgs, which is HYO's internal maximum all up weight (MAUW). Mr Matthews did not add the mandatory 4kgs per passenger to account for their clothing and boots. If he had done so, this would have brought the internal load to 2,270kgs.

On their second run of the day the group sat in different seats in the helicopter from their previous run. Greg McLeod had been in one of the HYO's front seats, however the pilot thought his shoulders were too broad and asked him to swap with David Reid. One of the photographs of the group taken that day by Mr Reid shows that Jerome had the shoulder harness of his seatbelt diagonally over his shoulder and chest.

The group was to be taken to a designated landing site on a flat ridge near Mount Alta's summit, which was marked with a flag that acted as a wind marker for pilots. As Mr Matthews was flying, he assessed the wind as light and coming from the south. He wanted to confirm the direction and strength of the wind at the landing site, so approached it from the north-west. As he approached, he was unable to sufficiently confirm the direction of the wind. He overflew the landing site and turned to re-approach it from the south-east. It was then that he saw the flag for the first time, which indicated that the wind was a light southerly. Mr Matthews therefore flew back across the landing site and decided to make an approach from the north into the southerly breeze. The landing site was covered with snow and the ground sloped steeply away from the north into the southerly breeze. Instead of landing on the site, HYO crashed onto Mount Alta's north face below the landing area and rolled 300 metres down the mountain.

Mr Matthews and three passengers were ejected from the helicopter and sustained injuries. When HYO came to a stop the only people left inside were David Bensley and Mr Reid. Mr Bensley unclipped his seatbelt and then unclipped Mr Reid's and helped him out of the wreckage. Once outside, Mr Reid did a head count and realised they were one person short. As a result, Mr Bensley ran back to the helicopter and saw Jerome, outside the helicopter but pinned under the fuselage by his leg. He was unresponsive. Mr Bensley immediately started performing CPR but Jerome could not be revived.

The Civil Aviation Authority (CAA) and the Transport Accident Investigation Commission (TAIC) investigated the crash. Once those investigations were concluded the Coroner resumed the inquiry and proceeded to an inquest. During the inquest Mr Matthews testified that he believed that the accident was caused by the vortex ring state.

Seatbelts

TAIC investigation found that the force experienced in the impact exceeded the design capability of the helicopter, its seats and likely also the seatbelts (which were the usual type fitted to that make of helicopter and conformed with internationally agreed technical standards). Mr Bensley and Mr Reid, who remained in their seats, were not subjected to the same centrifugal forces as those seated outboard, including Jerome. In addition, those whose seatbelts were strapped properly and who were subjected to the same centrifugal forces as Jerome were still ejected as a result of the crash. Thus, even if had been advised to keep his seatbelt snug across his hips and had done so, Jerome still could have been ejected from his seat.

Vortex Ring State

Vortex Ring State (VRS) is a flight condition that occurs when a helicopter loses main rotor lift and experiences loss of control. TAIC noted that the onset of VRS can be sudden, resulting in the helicopter descending at a very high rate. However, TAIC found that it was "very unlikely" that HYO would have encountered VRS on the approach to the landing site. TAIC also found that it was "unlikely" that HYO encountered VRS when Mr Matthews carried out his escape manoeuvre. TAIC's overall conclusion was that it was unlikely (less than 33% occurrence/improbable) that VRS was a significant contributing factor to the crash. The Coroner agreed with TAIC's finding.

Weight

TAIC estimated the weight of HYO as it approached the landing site to have been 2,280kgs, which was 30kgs over the maximum permitted internal weight. In addition, the centre of gravity was about 3 centimetres ahead of the forward limit. TAIC also found that, without the aid of a weight and balance calculator it was never going to be possible for Mr Matthews to calculate HYO's longitudinal COG accurately.

TAIC noted that in order to accurately determine an aircraft's performance capability, it is necessary to know the total aircraft weight, the pressure altitude and the air temperature before the intended take-off and landing. Mr Matthews recognised that the helicopter would be heavy, but did not estimate the total weight accurately. Therefore, he would not have accurately known the combined effect of the total weight, the air temperature and pressure altitude. Equally, Mr Matthews was not provided with tools which would have enabled him to ensure he correctly calculated the weight and balance of HYO. The accident scales were not available to use to capture passengers' actual weights if necessary. He was also unable to use the weights and balance calculator as required by THL's Operations Manual. The Coroner accepted TAIC's finding that the helicopter was operating at (or close to) the limit of its performance capability to maintain a hover which in turn was a likely factor in Mr Matthews not achieving a safe landing. There was insufficient evidence for the Coroner to conclude that the lack of procedures and tools led to Mr Matthews failing to add the required 4kgs per passenger to the declared weights, resulting in HYO being over its internal MAUW.

RECOMMENDATIONS OF CORONER JOHNSON

I. I have received submissions from Mrs Box, Mr Gregory Box, THL and the CAA about the need for recommendations in this case and setting out possible recommendations I might make. I am grateful to them for their thoughtful suggestions. Additionally, the CAA provided me with an update of progress made regarding Helicopter Flight Data Management, which Mr Moore had raised in his evidence, and progress in relation to helicopter safety culture.

II. I have considered all these carefully in light of the evidence, my findings and the obligations and constraints imposed on me by the Act.

III. The Act provides that I may make specified recommendations and comments in relation to a death which may, if drawn to public attention, reduce the chance of future deaths in similar circumstances. Specified recommendations or comments is defined in the Act and means, in relation to a death, recommendations or comments on either or both of the following:

   a. the avoidance of circumstances similar to those in which the death occurred:

b. the way in which any people should act in circumstances of that kind.

IV. Understandably Mrs Box and Mr Gregory Box would like me to make specific recommendations to address factors which they believe led to Jerome's death.

Mrs Box's submissions

V. Mrs Box set out at the conclusion of her submissions the outcomes she desired from the inquest, being

a. a CAA regulated pilot training system with clear progression in defined categories;

b. flying hours defined by the specific category of work;

c. assessments/examinations by CAA representatives, independent of the operator;

d. CAA defined landing site categorisation with a minimum of two flags at each Heli ski landing site; and

e. operators held accountable for failure to act on properly documented procedures.

Mr Gregory Box's submissions

VI. Mr Gregory Box asked for recommendations in relation to

a. a daily inspection of all landing sites;

b. an upgrading of the minimum pilot training;

c. without notice inspections of operators by the CAA;

d. monitoring of the way the CAA performs its duties; and

e. a review of the way accidents are investigated, and the time taken to do so.

VII. I note that in determining what recommendations or comments I might make I am required to focus on the circumstances of this death as I have found them to be. The actions which have been taken by the CAA and THL in the years since Jerome's death are also relevant.

VIII. It is clear that a great deal of thought has gone into the submissions made by Mrs Box and her brother -in-law. Their focus is on improving the safety of helicopter tourism, particularly heli-skiing. I note that in determining what recommendations or comments I might make, I am required to focus on the circumstances of death as I have found them to be. I also need to take into account the actions taken by the CAA and THL in the years since Jerome's death.

IX. The recommendations which Mrs Box and Mr Gregory Box have invited me to make fall outside of my jurisdiction, given the findings I have made. Nevertheless, I hope they are able to take some consolation in the changes that have been made by both THL and the CAA since Jerome's death, including those outlined below.

Weight and Balance - Emergency Airworthiness Directive DCA/AS350/128

X. As soon as it became aware that HYO had been overweight and operating outside its permitted centre of gravity limitation when it crashed, the CAA issued an Emergency Airworthiness Directive (EAD) DCA/AS350/128, regarding loading of AS350 and AS 355 helicopters fitted with two-place front passenger seats, regardless of seat type, and concerning longitudinal and lateral weight and balance calculations. It includes limitations on the allowable weights in the dual front seats according to helicopter type and requires that actual weights of passengers are used for pre-flight weight and balance calculations. The original EAD was issued on 27 November 2015, and effective from that date. Mr Moore's evidence was that he believed there was "very little difference from the initial promulgation compared to the latest one" which he produced to the inquest.

XI. The CAA followed up the promulgation of the EAD by monitoring compliance over the following year then conducting a 'no-notice spot check' of operators.

XII. Mr Quickfall gave evidence that THL now weighs all passengers before flying and (except in very limited circumstances relating to remote locations) has calibrated scales at all offices and staging locations. Only these actual weights are used for making weight and balance calculations.

XIII. Given the conclusions I have reached in relation to the circumstances of Jerome's death, I consider this a significant action in preventing a future death in similar circumstances. Had this requirement been in place on 16 August 2014, the actual weights of the passengers would have been required, and there would have been restrictions on the permissible weight in the dual front seat, regardless of the fact that there was no limit imposed by the manufacturer of the DART Dual Seat installed in HYO.

XIV. Jerome and his friends would have had to be loaded differently to comply with the limitations now imposed in relation to the dual front seat. They could not all have been passengers in HYO at once. Consequently, the helicopter would have been within its permissible weight and COG. That would also likely have had flow on effects for the performance of HYO as it attempted to land at Mount Alta.

Seat belt use and VRS

XV. I have already concluded that, on the evidence I have available to me, the failure of THL to advise passenger to ensure their seatbelts were fitted tightly around their hips throughout the flight cannot be described as contributing to Jerome's death.

XVI. Nonetheless I note that, as a result of its investigation, TAIC recommended to the Director of Civil Aviation that it:

> remind aircraft operators and pilots of the importance of ensuring that aircraft occupants fasten and properly adjust their seatbelts at all times. (005/17)

XVII. Likewise, for reasons already set out in these findings, I have been unable to conclude that VRS contributed to Jerome's death. However, it was also the subject of a recommendation made to the Director of the Civil Aviation by TAIC, as a result of its investigation. It recommended the Director:

> remind aircraft operators and pilots of helicopter performance and environmental conditions that can lead to vortex ring state, and of the need to be alert to the potential for it to occur, even in apparently benign conditions. (006/17)

XVIII. Mr Moore confirmed in evidence to the inquest that the CAA had actioned these recommendations and produced a copy of articles published in the CAA's magazine Vector distributed to all aviation licence holders and published online.

XIX. THL proposes that I consider recommending that pilots are trained to use the Vuichard recovery as the primary recovery technique for VRS. The CAA, while recognising the benefits of the technique, does not agree with this proposal. In its view the both the standard recovery technique and the Vuichard technique have strengths and weaknesses and circumstances will dictate the use of one or the other. That view is reflected in the Vector article referred to above.

XX. I note that Airbus, the manufacturer of AS350 series of helicopters does not prefer one technique over the other and says in its Safety Information Notice No. 3463-S-00 that:

> The "classical technique" is effective in avoiding penetration beyond the incipient stage of VRS. However, the "Vuichard recovery technique" may be applied in case of early warning detection in specific operational conditions like rear wind in final approach or helicopter in front of an obstacle.

XXI. I do not consider I am able to make any recommendation in relation to VRS and recovery techniques because I have not been able to conclude that VRS was a factor that contributed to Jerome's death. If I am wrong in that, I consider that the balance of the evidence provided to me does not support the recommendation proposed by THL, that the Vuichard technique be taught as the primary recovery method.

Culture within the sector

XXII. Mr Moore told the inquest that in 2016 the CAA had designated the helicopter sector as one of eight safety focus areas. It did this in response to concerns at what it considered an unacceptably high accident rate among commercial helicopter operators, which did not seem to be improving despite the CAA employing the full spectrum of its regulatory interventions.

XXIII. The TAIC in its Final Report into the accident also expressed concern about:

> the possibility that a culture of operating outside the manufacturers' published and placarded 'never exceed' limitations had been normalised

and made a recommendation to the Director of Civil Aviation that the CAA:

> include the safety issue of helicopter operational culture in its current 'sector risk profile' review. (032/17)

XXIV. The CAA has included safety culture as a risk under the Part 135 Sector Risk Profile initiated in 2016. Additionally CAR Part 100 Safety Management, introduced in 2015, required all holders of an AOC to have a Safety Management System (SMS) acceptable to the Director in place by 1 February 2021. THL has been actively engaged with the CAA in implementing an effective SMS.

XXV. However, by way of letter dated 14 December 2020 from the CAA I am advised that the process of certification of operators' SMS has been affected by the COVID-19 pandemic and its various consequences on businesses. As a result, the CAA has been processing applications for exemptions to the requirement that the SMS should be in place by 1 February 2021. Exemptions have been granted under section 37 of the Civil Aviation Act 1990, but these do not exempt indefinitely. They only delay the implementation of SMS.

XXVI. The 14 December 2020 letter also states that the CAA continues to progress initiatives in training and standards as well as education and guidance in the helicopter industry. In 2019 it worked with the New Zealand Helicopter Association to ensure that occurrence data held on the CAA's database since about 2000 aligns with the US Helicopter Safety Team (USHST) taxonomy. The purpose of this so that New Zealand can take advantage of helicopter safety policies being developed by the USHST.

XXVII. THL has also taken steps to address concerns that incidents prior to this accident were the result of human error and the development of a culture of complacency among pilots by implementing Human Factors Training for staff.

XXVIII. Mr Moore's evidence was that:

> The combination of an operating and effective SMS and a positive safety culture is considered likely to improve safety performance.

Helicopter Flight Data Management

XXIX. A significant focus of both the TAIC's investigation and my inquiry has been to gather evidence about what happened on the final approach to the landing site, and how the crash happened. It would have greatly assisted my inquiry had there been a cockpit video recorder to continuously record instrument positions and flight control inputs.

XXX. In his evidence Mr Moore raised the question of Helicopter Flight Data Management (HFDM). HFDM had been the subject of a TAIC recommendation in 2016 to the Secretary for Transport as a result of an investigation into a fatal Robinson R44 crash.

XXXI. Coroners have continued to recommend HFDM, in particular where solo pilots have died in an aircraft crash.

XXXII. In its simplest form HFDM uses a cockpit video recorder to continuously record instrument positions and flight control inputs. Mr Moore's evidence was that information from HFDM can be useful not only in establishing the cause of accidents but can also allow operators to monitor pilot performance and adherence to procedures and enhance training and competency. He said there is growing international acceptance of HFDM as a system capable of benefiting aviation safety at reasonable cost.

XXXIII. Mr Moore set out in his evidence progress being undertaken to determine the benefits and costs of flight data and video recording in cockpits in certain classes of helicopters.

XXXIV. Following the inquest hearing the CAA provided me with an update regarding HFDM. A policy paper addressing HFDM was prepared for a meeting of the Issue Assessment Panel (the panel) on 12 November

2020. The paper discussed the benefits of HFDM noting that there are "compelling reasons for helicopter operators to adopt it to improve their oversight of flight operations."

XXXV. The panel agreed to the recommendations in the paper that in the first instance there would be non-legislative interventions to achieve voluntary uptake of HFDM including removing barriers to voluntary uptake. A review of the effectiveness of this approach will be undertaken and if regulatory intervention is required the issue will be referred to the Regulatory Interventions Team for further development of intervention options

XXXVI. There are no time frames in the paper.

XXXVII. As HFDM or its absence was not a factor in the crash which killed Jerome, I cannot make a recommendation about its use. However, given the evidence that it is capable of benefitting aviation safety at a reasonable cost, I endorse the efforts being made by the CAA to have operators fit HFDM in their helicopters.

XXXVIII. I also endorse the recommendations of the coroners who have recommended HFDM over the past years.

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

Gelberger [2021] NZCorC 83 (24 May 2021)

CIRCUMSTANCES

Leslie Gelberger, aged 45, died on 21 April 2017 in the water off Mairangi Bay, Auckland of multiple injuries (combined effects of blunt force injuries to the head, neck, torso and right upper arm, and chop injuries to the lower limbs).

Mr Gelberger was swimming alone in Waitemata Harbour, approximately 270 metres from shore, when a pilot boat (“Wakatere”) owned by Ports of Auckland Ltd collided into him at approximately 35 knots. Mr Gelberger and the Wakatere were both entitled to be in the location where the collision occurred, however the Wakatere was subject to a 12 knot speed restriction pursuant to the Auckland Council Navigation Safety Bylaw 2014.

Following the collision, both the master of the Wakatere and Ports of Auckland Ltd were charged and convicted of offences under the Health and Safety at Work Act 2015. The charge against Ports of Auckland Ltd alleged that the masters of the pilot boats regularly breached the speed restrictions and that the company did not have, or did not implement, adequate processes to ensure these restrictions were observed.

Mr Gelberger was described as a strong swimmer, who had swum this route many times before. While Mr Gelberger’s wife reported that Mr Gelberger often wore a brightly coloured swimming cap, when his body was found he did not have a cap on. It is impossible to know whether he was wearing one at the time of the collision.

RECOMMENDATIONS OF CORONER WINDLEY

I. In considering whether there are any comments or recommendations that I can make pursuant to s 57(3) of the Coroners Act 2006, which may reduce the chances of future deaths in similar circumstances to Mr Gelberger, I am mindful that s 57A requires that recommendations or comments are clearly linked to the factors that contributed to the death. Given the evidence before my inquiry, and the approach to

prosecution, does not disclose a breach of speed restrictions as a causative factor in Mr Gelberger's death, I cannot make any comment or recommendation with respect to any process changes or improvements that are indicated to avoid future collisions and deaths of swimmers on account of excessive vessel speed. Notwithstanding that, I understand from Maritime NZ that its subsequent auditing has demonstrated there have been improvements in Ports of Auckland Ltd's monitoring of pilot vessel speed.

II. As noted above, both the Wakatere and Mr Gelberger were entitled to be in the location where the collision occurred. I understand that immediately following the incident Ports of Auckland Ltd made changes to passage plans for the pilot vessels which effectively pushed their travel routes further away from the shoreline. This reduces the likelihood of ocean swimmers being encountered by pilot vessels in transition channels. This does not of course mitigate the ongoing risk of other vessels, in particular recreational craft, encountering swimmers in the vicinity of the shoreline.

III. My research has indicated that participation in ocean swimming and ocean swim events is increasingly popular in New Zealand but it appears there is no specific best practice safety advice directed at undertaking recreational ocean swimming. While Swimming NZ has produced a manual for ocean swimming, the focus of that resource is on organising and running ocean swim events rather than ocean swimming outside of organised events.

IV. Following consultation with Swimming NZ, Water Safety NZ, and Maritime NZ, I recommend that those organisations work collectively to develop and make public best practice advice for members of the public who undertake recreational ocean swimming. That advice should consider promoting the following suggested best practices to enhance ocean swimming safety:

   a. Always swim with a buddy

   b. Wear a brightly coloured swim cap to enhance visibility in the water

   c. Utilise a brightly coloured safety tow float, swim buoy or swim bubble to enhance visibility in the water

   d. Keep close to the shoreline, ideally no more than 50-100 metres from the shore

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs Police may have taken that show Mr Gelberger, in the interests of decency and personal privacy.

Huang [2021] NZCorC 85 (1 June 2021)

CIRCUMSTANCES

Yutai Huang, aged 51, died on 6 November 2019 in the water 500m south of Channel Island in the Hauraki Gulf of drowning.

Mr Huang was fishing and diving with a friend Jun Wang. The weather was fine and calm. Mr Huang entered the water wearing a wetsuit, a dive cylinder, a weight belt and a dive mask. He was also carrying a spear gun. However, Mr Huang forgot to put his flippers on and shortly after he entered the water he started having difficulty staying afloat.

Mr Wang moved the boat closer to Mr Huang but Mr Huang had disappeared under the water. Around three minutes later, Mr Huang resurfaced, face down in the water. Mr Wang signalled to another boat to come over, and with the help of a person on the other boat retrieved Mr Huang.

Once on the boat, Mr Huang was not responsive and there was blood coming from his mouth. Mr Wang and the other person tried to resuscitate Mr Huang before a rescue helicopter and a nearby navy vessel arrived to assist. Unfortunately, resuscitation was unsuccessful.

The Police National Dive Squad (PNDS) conducted an investigation and concluded that not wearing fins was a contributory factor to Mr Huang's death. Without them, his ability to control his position in the water was greatly reduced. The PNDS report, written by Constable Clayton-Greene, noted that the second stage regulator used by Mr Huang was malfunctioning and difficult to breathe from. In addition, Mr Huang had failed to inflate his Buoyancy Compensator Device (BCD) when he got into difficulty. This also contributed to his death.

The PNDS report further noted that Mr Huan did not wear a dive watch or dive computer or any other timing device. His depth gauge did not have a maximum depth indicator and he did not have a dive knife on him. He was also using obsolete and leaking regulators and potentially wearing too much buoyancy weight. The PNDS concluded that while these issues were not necessarily fatal on their own, they contributed to a combined domino effect with fatal consequences for Mr Huang.

RECOMMENDATIONS OF CORONER WOOLLEY

I. Mr Huang's death highlights the importance of scuba divers following diving best practice each and every time they dive, including checking their weighting and buoyancy, diving with a buddy for the whole dive, and ensuring they test their equipment pre-dive for leaks, correct fit or size and air quality.

II. In his detailed report, Constable Clayton-Greene made several recommendations for recreational divers which may assist to reduce the chances of similar deaths occurring in similar circumstances. Below, I accept and adopt those important recommendations, with some modifications.

III. I note that in 2011 Coroner McDowell made several recommendations in respect of the death of Mr Neville Poole, who died while diving for scallops in Allom Bay, Okupu, Great Barrier Island.[17] The recommendations made by Coroner McDowell were:

    a. Dive with a buddy.

    b. All dive equipment should be well maintained and serviced every year.

    c. Equipment should be checked before all dives (for example, by checking for leaks).

[17] Issue 7 Recommendations ReCap: Coronial Services 1 July to 30 September 2011 CSU-2001-AUK-000117 (2013 NZ CorC 96).

d. 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.

e. Divers should practise emergency drills.

f. If a diver begins to feel unwell or stressed during a dive, the dive should be aborted.

g. 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.

h. If the diver has an extended break from the sport, they should do a refresher course.

i. Divers should always carry a knife when diving.

j. Divers should never attach a catch bag to their body.

IV. Since Coroner McDowell's 2011 finding I am aware of 26 other findings of Coroners in New Zealand addressing deaths that occurred in the context of recreational diving mishaps. In a large number of those findings, the relevant Coroners have made recommendations about the need for recreational divers to adhere to safe diving practices. Common themes from these recommendations include:

a. Encouraging divers to adhere to buddy diving protocols;

b. Ensuring divers carry the correct amount of diving weight;

c. Ensuring that divers abandon their weight belts when in difficulty to maintain buoyancy;

d. Ensuring the duration and depth of a dive is sufficient for the amount of air in the dive cylinder;

e. Ensuring persons are medically fit to dive;

f. Ensuring that divers do not use suspect equipment and have their equipment regularly services; and

g. Ensuring divers are aware of, and practice, emergency drills.

V. Given there continue to be diving deaths from unsafe diving practices amongst recreational divers, I make the following recommendations pursuant to section 57A of the Coroners Act 2006:

Divers should:

a. Ensure their dive equipment is appropriate for their body size and weight, and their planned dive. This includes ensuring they are appropriately weighted for their planned dive.

b. Wear a dive watch / dive computer or other appropriate timing device.

c. Complete pre-dive checks before entering the water to ensure they are wearing all required dive equipment and to ensure their equipment is operating correctly.

d. Abandon their dive weights when in difficulty.

e. Dive with a buddy for the duration of the dive.

f. Have a support person or vessel remain in the dive area.

g. Ensure their dive equipment is regularly serviced, at least annually.

h. Regularly practice emergency diving drills and refresh themselves on safe diving practices.

VI. To assist divers being made aware of these recommendations through training, distribution or publication, this finding will be distributed to the following organisations:

a. The New Zealand Underwater Association

b. New Zealand Diving

c. Water Safety New Zealand

d. New Zealand Police

e. Surf Life Saving New Zealand

f. Maritime New Zealand

g. Dive New Zealand Magazine

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs that show the deceased in the interests of decency and personal privacy.

Medical Care

Bennett [2021] NZCorC 69 (29 April 2021)

CIRCUMSTANCES

Edna June Bennett, aged 96, died on 12 September 2014 at the Glenwood Masonic Hospital of bronchopneumonia as a consequence of relative immobilisation from dementia, the ageing process and subcapital fracture of the left femur in the context of generalised osteoporosis. Prior to her death she had lived in a serviced apartment at Glenwood Masonic Hospital since March 2011 and was under the care of Dr Ryan.

After certification of the cause of death (renal failure with recurrent urinary tract infections and dementia) the funeral director noticed that Mrs Bennett's right leg was in a strange position. A CT scan was completed and a subcapital fracture on the left femur was found.

It was not possible to ascertain when the fracture occurred and whether it happened on 11 July 2014, when Mrs Bennett was known to have had a fall. She also had a history of falls prior to that incident. Following the 11 July 2014 incident,

however, Mrs Bennett's ability to mobilise decreased and she required increasing doses of medication to manage her pain. Prior to her death Mrs Bennett was unable to talk but could visually show pain.

Following the Coroner's request for a specialist report, Mr Sudhindra Rao, a registered medical practitioner and practising orthopaedic surgeon, prepared an opinion, noting that the most likely reason why the fracture was not identified prior to Mrs Bennett's death was less than adequate clinical evaluation to ascertain the cause of her pain. Under usual circumstances this evaluation would have included a thorough musculoskeletal evaluation and appropriate imaging. On his review of the CT scan Mr Rao also noted an undiagnosed collapse of the right femoral head, which was likely responsible for the progressive loss of mobility in the previous year. Nevertheless Mr Rao noted that the level of care at the Glenwood Masonic Homes was generally of a very high standard. The matter was also investigated by the Deputy Health and Disability Commissioner who did not identify any lack of care in relation to Mrs Bennett's death.

COMMENTS OF CORONER FITZGIBBON

I. Mr Rao made the following recommendation in relation to his matter:

> Recommendations: Literature regarding management of domiciled elderly, particularly with a history of dementia and cognitive abnormalities, notes that evaluating pain in such individuals can be difficult. This is particularly the case where there are multiple co-morbidities and communication difficulties. This would appear to be the scenario in regard to Mrs Bennett.
>
> My recommendation in this case would be that the caregivers, including nursing and medical staff, have a high index of suspicion of fragility fractures such as fractured neck of femur. This would include constant observation, behavioural and physical changes in the individual. Furthermore, a thorough initial clinical evaluation and appropriate investigations as indicated, is more likely to allow for an accurate diagnosis and management.

II. Glenwood Masonic Home and Dr Ryan were provided with a copy of my draft findings and Mr Rao's recommendation. I do not consider formal recommendations are required in this instance, and that Glenwood Masonic Home have been provided with Mr Rao's suggested recommendations.

III. Glenwood Masonic reviewed their Falls and Pain Management Policies in 2015 and incorporated the best practice tools for assessment of resident's post fall and identifying pain. An adapted Abbey Pain Scale tool was also included for those unable to verbalise. These policies are on a two-yearly cycle. Education is mandatory at the commencement of employment and these topics appear on the annual education plan.

Motor Vehicle

Aitchison [2021] NZCorC 78 (10 May 2021)

CIRCUMSTANCES

Jackson James Aitchison, aged 17, died at Ballantyne Road, Wanaka on 10 October 2016. The cause of his death was cerebral contusion resulting from a motor vehicle crash.

On 10 October 2016, Mr Aitchison was driving his car east on Ballantyne Road on a section of road that transitioned from a sealed road to a gravel road, which had a temporary speed limit of 50 kilometres per hour. Mr Aitchison was travelling in excess of the temporary speed limit, when he lost control of his vehicle and crashed into a tree.

COMMENTS OF CORONER WINDLEY

I. I must consider whether it is necessary to make any comments or recommendations, pursuant to section 57A of the Coroners Act 2006, to reduce the chances of future deaths in similar circumstances to Jackson. Constable McGilbert identified the uneven road surface where the transition from gravel to seal had eroded was a potential contributor to the crash. Media reports at the time of Jackson's fatal crash indicate that there had been a history of a number of motor vehicle crashes on Ballantyne Road. The causes of these crashes may well be due to reasons other than the roading surface. In any event, the Queenstown Lakes District Council, who is the relevant roading authority, was reported to be aware of the concerns with this road, and works to seal the gravel part of the road was said to be under consideration at that time.

II. In response to my recent inquiry as to progress on this, Ben Greenwood, Roading Operations and Contracts Manager for Queenstown Lakes District Council, advised that Ballantyne Road currently remains as it was at the time of the crash, a mix of sealed and gravel surfaces. However, Mr Greenwood further advises that a project to upgrade Ballantyne Road to a fully sealed surface is scheduled for completion over the summer of 2020/2021.

III. Given there are planned works to address the uneven road surface, albeit some years after Jackson's fatal crash, I do not consider it necessary to make any additional comments or recommendations. I do however, strongly encourage the prioritisation of these works, to the extent there is scope for that, and request that the Office of the Chief Coroner be notified once these works have been completed.

IV. To that end, I direct a copy of these Findings be sent to the Queenstown Lakes District Council.

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

Ferris [2021] NZCorC 81 (11 May 2021)

CIRCUMSTANCES

Michael Nolan Ferris, aged 57 years, died on 2 November 2019 on Rosewill Valley Road, north of Timaru, after sustaining high impact injuries to his spine and abdominal organs in a single motorcycle accident.

At approximately 12:25am on 2 November 2019, Mr Ferris arrived at the Factory Bar after an evening of drinking. The bouncer at the Factory Bar saw Mr Ferris park his motorcycle across the road. Mr Ferris walked towards the bar and said he was going in for a drink. The bouncer knew that Mr Ferris had convictions for driving with excess breath alcohol.

At approximately 2:00am, Mr Ferris came outside, where he and the bouncer discussed other ways he could get home. The bouncer tried to persuade Mr Ferris not to ride his motorcycle, however Mr Ferris said he was just going around the

corner. The bouncer said that while Mr Ferris was not slurring his words and was steady on his feet, he could tell he was intoxicated.

At approximately 7:45am on 2 November 2019 two cyclists came across a motorcycle on the road. Mr Ferris was lying near it and it was clear that he was deceased. The Serious Crash Unit Report concluded that Mr Ferris fell from the motorcycle during an easy right turning bend and that alcohol was a major factor in the crash.

COMMENTS OF CORONER CUNNINGHAME

I. I do not consider that any formal recommendations or comments pursuant to s57A of the Act are required.

II. I do not endorse members of the public taking vigilante action against others, or forcibly restraining them, in circumstances such as the one which arose when Mr Ferris left the Factory Bar for the last time. However, if an intoxicated person is not willing to surrender their vehicle keys or commit to alternative transport, it may be prudent for the Police to be advised, so that they can take the necessary steps to prevent death or serious injury arising. I acknowledge that many New Zealanders might be reluctant to "dob in" someone, particularly if they are a friend, a colleague, or a family member, but that must be weighed against the risk of allowing someone to drive while intoxicated.

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

Karki [2021] NZCorC 73 (30 April 2021)

CIRCUMSTANCES

Ayush Karki, aged 31, died at Waikato Hospital on 30 November 2019. The cause of death was severe traumatic crush injury to the upper right chest sustained in a motor vehicle collision.

On 11 September 2019, Mr Karki was driving his car north on Tirohanga Road, Taupō. While exiting a sweeping right hand bend, he lost control of the car, crossed the centreline and crashed through a fence. At the time, Mr Karki was nearly three times the legal blood alcohol limit and was possibly fatigued.

COMMENTS OF CORONER ROBB

I. Considerable effort is made in New Zealand to promote the message that driving while intoxicated and fatigued is a dangerous cocktail that can so easily lead to a fatal outcome. The dangers associated with driving while intoxicated extend to endangering other road users. The messages about driving while intoxicated are coupled with regular campaigns to enforce the requirement to wear a seatbelt. Failure to wear a seatbelt increases the likelihood of serious injury or death. Our laws require the wearing of a seatbelt and forbid driving with excess blood alcohol for those safety reasons. This was another tragically avoidable death caused by driving while intoxicated and failing to wear a seatbelt.

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

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

Kay [2021] NZCorC 91 (8 June 2021)

CIRCUMSTANCES

Aaron Douglas Kay, aged 43, of Western Australia, died on 22 February 2020 from severe traumatic chest injuries sustained in a motor vehicle collision outside 1689 State Highway 25, Pipiroa, Ngatea.

Aaron arrived in New Zealand on 18 February 2020, intending to surprise his family. He hired a rental car and contacted an old friend. On 19 February, he went to the friend's house and stayed there until 20 February. At around 6:00pm that day, Aaron contacted Police advising that he was outside a closed Police station and was being chased by gang members. No units were available to assist. Aaron was then inadvertently let into the Police station where he told officers that he did not normally consume drugs but had taken methamphetamine for the past three days and had not slept. A relative, who lived locally, was contacted and agreed for Aaron to stay with them. Another relative at the house stated that Aaron did not sleep during the night of 20 February.

At around 11:00am on 21 February 2020 Aaron returned to his friend's house and stayed there overnight. His friend did not see Aaron consume drugs and did not know whether he had slept that night. Around 7:15pm on 22 February, Aaron was the sole occupant of his rented vehicle travelling east on State Highway 25. A member of the public was behind him and observed his vehicle leave the eastbound lane, correct and then speed off. Thirty seconds later they came across Aaron's vehicle crashed. Aaron died at the scene from his injuries. There was no evidence at the scene to suggest Aaron applied his brakes before the accident. Toxicology revealed that Aaron had consumed methamphetamine before his death. The cause of the collision was found to be fatigue attributable to his consumption of methamphetamine and lack of sleep.

COMMENTS OF CORONER ROBB

I. This inquiry dealt with the death of a loving husband and father who died in an avoidable motor vehicle collision. The events leading up to his death highlight the rapid and destructive nature of methamphetamine, leading to sleep deprivation for Aaron, and significantly disturbing his emotional balance. This death occurred as a consequence of fatigue in a background of methamphetamine consumption. The dangers of driving when significantly fatigued are again borne out by Aaron's death.

II. Numerous safety campaigns as well as other Coroners' findings and recommendations have highlighted the risks associated with drug impaired driving and driving while fatigue. I reiterate those warnings but make no additional recommendations pursuant to s 57(3) of the Coroners Act.

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

Khunwongsa [2021] NZCorC 75 (30 April 2021)

CIRCUMSTANCES

Somporn Khunwongsa, aged 49, died at Waikato Hospital on 30 November 2019. The cause of death was exsanguinating haemorrhage due to severe head injury, sustained in a motor vehicle collision.

On 30 November 2019, Somporn was driving east on Piako Road, west of Morrinsville. He lost control of his vehicle, struck a fence and rolled into a stock underpass. It is likely that Somporn had a lapse in attention caused by distraction or fatigue or inattention, or a combination of one or more of these factors.

COMMENTS OF CORONER ROBB

Safety barriers

I. Between 2015 and 2020, there have been several collisions in the section of Piako Road where this collision occurred, including a fatal head on collision in August 2018. Based on this information, the SCU made several recommendations, specifically that:

   a. there be continued education and enforcement concerning driving free from fatigue and distraction; and

   b. a central wire barrier be added to the section of Piako Road where the collision occurred to avoid head-on collisions; and

   c. side collision barriers be added to prevent roadside run off collisions.

II. Flexible road safety barriers are installed down the middle of a road to prevent head-on collisions or along the side of the road to help stop run-off-road collisions. When a vehicle hits a flexible barrier, the barriers absorb the impact and the steel cables flex, slowing down the vehicle and keeping it upright.

III. Had there been a central wire barrier and side collision barriers, it is possible that the outcome for Somporn may well have been different.

IV. I note the recommendations suggested by the SCU but remind myself that I am only able to make recommendations where I have concluded these to have been a factor in the collision and as a result a factor in the death of the driver.

V. The photographic evidence indicates that this roadway has the common characteristics of many rural roads in New Zealand. The circumstances of this collision indicate that the cause and contributing factors for the collision were most likely fatigue coupled with speed. The roadway itself was not a direct factor. While flexible road safety barriers would likely reduce the chances of a collision resulting in death, there is nothing on the evidence before me to suggest that this preventative measure is warranted on this roadway comparative to other rural roads. Consequently, I do not make any recommendations pursuant to section 57(3) of the Coroners Act 2006.

Risks of driving when fatigued

VI. Coroners together with Police and Waka Kotahi New Zealand Transport Agency have consistently highlighted the dangers of driving while fatigued and the exacerbation of those risks when driving at speed. There have been numerous publicity campaigns highlighting those risks and I endorse that ongoing work.

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

Kronast [2021] NZCorC 61 (19 April 2021)

CIRCUMSTANCES

John William Kronast, aged 61, of Ōpōtiki, died on 19 July 2019 from head injuries due to high energy impact sustained in a motor vehicle collision with a loaded trailer at Bridge 2886 State Highway 2, Kutarere, Waiotahe Valley.

Around 8:40am on 19 July 2019, John was the sole occupant of his vehicle travelling west on State Highway 2. At the same time, a member of the public was travelling eastbound along the same stretch of road towing a loaded trailer. As the vehicles approached each other on Bridge 2886, the trailer detached from the towing vehicle, crossed into John's path and collided with his vehicle. John died at the scene from the injuries he sustained.

An examination of the towing vehicle and trailer by Police showed that the towing vehicle was fitted with a detachable towbar assembly specifically designed to be used with that model of vehicle. The body of the towbar assembly (referred to as the "Receiver") was welded and bolted to the rear of the vehicle chassis. The Receiver had two flanges on either side. Each flange had a drilled hole in the centre where a safety chain could attach. The steel frame on which the towball was attached (referred to as the "ball-mount"), would slide into the Receiver. The ball-mount was secured to the Receiver by a locking pin that fitted into a cross drilled hole of the Receiver and ball-mount. The ball-mount had been modified to include a hole in which a D-clamp could attach from a safety chain instead of onto one of the flanges of the Receiver.

At the scene, Police observed that the ball-mount and tow-ball were still attached to the drawbar of the trailer by the safety chain, which was attached to the modified hole in the ball-mount. The ball-mount had slid out of the Receiver because the locking pin was missing. Police could not locate the locking pin to assess whether it had failed or if it had been removed and not replaced.

COMMENTS AND RECOMMENDATIONS OF CORONER ROBB

I. This collision is a tragic accident that has sadly taken John's life. I have found that the primary cause of the collision was the ball-mount sliding out of the Receiver because there was no locking pin. A significant contributory cause to John's death was the inability of the safety chain to prevent the trailer from breaking free of the towing vehicle.

II. Accordingly, the collision highlights a concerning gap in the regulations governing light vehicle towing in New Zealand. Specifically:

   a. There is no requirement for the safety chain of a trailer to be connected to the chassis of the towing vehicle; and

b. That a vehicle with a removable towing assembly will comply with the Land Transport Rule Vehicle Standards Compliance 2002 Rule 35001/2002 ("LTA Rule") even if the securing point for a safety chain is the removable ball-mount.

III. The existing requirement regarding safety chain attachment is specified in the Waka Kotahi New Zealand Transport Agency Vehicle Inspection Requirements Manual ("VIRM Manual"). The VIRM Manual is intended to assist vehicle inspectors and inspecting organisations (appointed under the LTA Rule) to achieve correct and consistent vehicle inspections and certifications. It states that a vehicle would fail an inspection if:

Mandatory equipment

1. A towbar fitted to a vehicle does not have provision for securely fitting the safety chain (Note 1) from a trailer coupling, except for:

   a) New Zealand Defence Force vehicles,

   b) Fire-fighting vehicles.

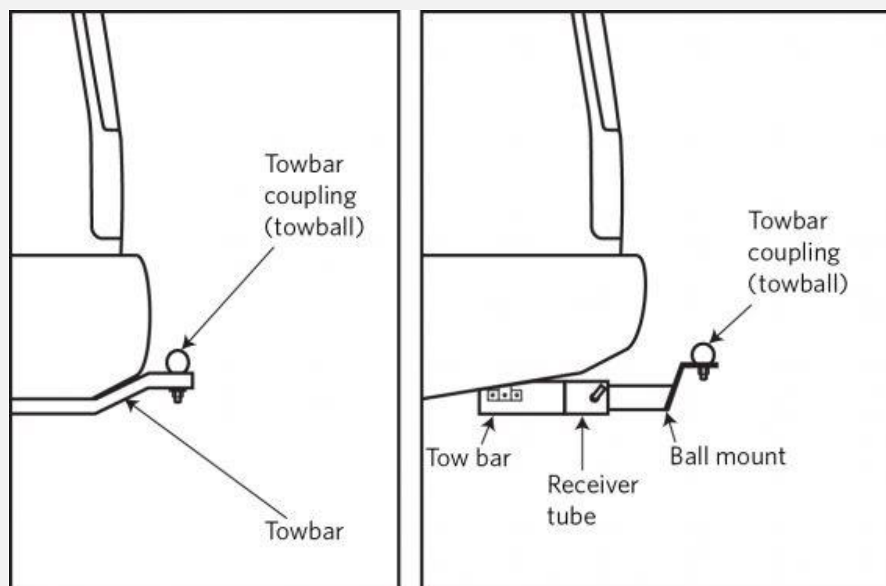
[…]

Note 1

For vehicles fitted with a towbar that has a removable ball mount, such as the one shown on the right-hand side Figure 12-1-1, if the safety chain attaches to the removable part, the security of the removable part should be verified (eg retention clip should be of sufficient strength and in good condition).

[…]

Figure 12-1-1. Towbar and towbar coupling



IV. Although the VIRM Manual directs inspectors to assess the suitability and condition of locking pins where the safety chain is to attach to the ball-mount not the chassis; the consequence is (should a vehicle pass inspection) that the security of the towed load relies entirely on the locking pin being infallible. Connecting the safety chain to a section of the ball-mount, which is not directly affixed to the chassis, in my view, vitiates the purpose of a safety chain to operate as a secondary anchor to the towing vehicle.

V. Accordingly, I make the following recommendations:

a. To Waka Kotahi: consider a requirement that removable towbar assemblies must have the safety chain securing point affixed to the chassis of the vehicle.

b. To the Ministry of Transport: consider a requirement that towing vehicles must have a safety chain connected from the trailer load to the chassis of the towing vehicle.

VI. Implementation of the above recommendations may reduce the possibility of further deaths in similar circumstances.

RESPONSES

VII. In accordance with section 57B of the Coroners Act, Waka Kotahi and the Ministry of Transport were provided with the opportunity to consider and respond to the proposed recommendations.

VIII. The response from Waka Kotahi included the following:

a. Waka Kotahi accepts that a safety chain connected to the chassis or tow bar crossmember could have made a significant difference to the outcome of this incident. However, it is likely that there are other mechanical solutions that could result in a failsafe system.

b. Waka Kotahi accepts that there are gaps within current regulations and will be working with other relevant agencies such as The Ministry of Transport in the future to make improvements in this area.

c. The VIRM manual does not outline specific technical requirements for vehicles identified in the relevant legislation, but rather provides what Waka Kotahi believes is the most appropriate and lawful interpretation of the land transport rules applicable to the inspection of an individual vehicle.

d. Waka Kotahi agrees that the connection of a safety chain to a removable tongue does rely on the safety of the locking pin, assembly or mechanism. If this locking mechanism is not functional or unsafe then the towing system becomes unsafe. This is similar to any other mechanical component in the towing system, such as the drawbar, low tiedowns or the tow bar to chassis connections of the tow bar itself.

e. In respect of the specific recommendations made Waka Kotahi advised that these options have been considered in the past and deemed to be impractical on many vehicles or unable to be implemented in a reasonable manner that had notable increases in safe outcomes.

f. Waka Kotahi accepts that there are risks and opportunities for improved safety outcomes within the light towing sector. A project team has been established and is currently investigating these.

IX. I acknowledge the responses from Waka Kotahi, these provide an acceptance that improvements in safety measures in this area are warranted and are presently being investigated. In respect of light towing I acknowledge that a failure of one or more mechanical components in a towing system can lead to the towing system becoming unsafe. However, the safety chain serves the purpose of providing an extra layer of safety. If the safety chain is not connected to the vehicle, independent of the removable tow bar assembly, this secondary anchor ceases to be effective when the tow bar assembly fails. For that reason, the recommendations outlined above remain unchanged, however it is acknowledged that through its project team Waka Kotahi may well identify improved safety outcomes by way of a different solution.

X. No response was received from the Ministry of Transport.

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

Mahuika [2021] NZCorC 72 (29 April 2021)

CIRCUMSTANCES

Keiran Atirau Tokana Mahuika, aged 28, died on 26 March 2019 at Tiwai Road, Awarua Plains, Invercargill, from high energy impact injuries with severe head injuries sustained in a motor vehicle accident.

On the evening of 26 March 2019, Mr Mahuika and his friend Jonty Waddell visited two taverns where they consumed alcohol. At approximately 10:30pm they decided to return home. Mr Mahuika elected to drive, which did not concern Mr Waddell as Mr Mahuika was a “big bloke” who could handle his drink and appeared fine to drive. As they were travelling home on Tiwai Road, the vehicle veered off the road and collided with a tree, then traversed a wide drainage ditch and come to rest in a nearby paddock. Mr Mahuika died at the scene as a result of the injuries sustained in the crash.

Toxicology testing revealed that Mr Mahuika’s blood alcohol level was 133 milligrams per 100 millilitres. For comparison purposes, the legal blood alcohol limit for a New Zealand driver 20 years old or over is 50 milligrams per 100 millilitres.

The Police Serious Crash Unit (SCU) investigation concluded that Mr Mahuika was travelling at a very high speed and had moved to the right-hand side of the road to straighten up for a curve. Mr Mahuika’s entry into the curve was delayed. He exceeded the critical curve speed and subsequently lost control of the vehicle. The SCU considered that alcohol was the likely cause of Mr Mahuika’s poor decision making and his delayed entry into the curve.

COMMENTS OF JUDGE ROBINSON

I. I do not consider that I need to make any formal recommendations, but the circumstances serve to underscore the key road safety messages around speed and alcohol consumption.

II. I was struck by Mr Waddell's comment (above) that the deceased "was a 'big bloke' who could handle his drink and had appeared fine to drive".

III. I have previously commented on the inability of both the average person, and more experienced persons (such as bar staff, Police and even medical practitioners) to reliably assess whether a person is "fine to drive" notwithstanding alcohol consumption:[18]

a. It bears repeating that the general population has no ability to reliably assess whether they or others around them are affected by alcohol such that they should not be driving.

b. Those who would drive having consumed alcohol, and those around them need to be disabused of the notion that people have an ability to accurately assess whether someone who has consumed alcohol is "okay to drive" (or more to the point whether they are under the legal limit).

c. As I go on to discuss below, (and contrary to popular belief) people do not have an ability to judge a person's level of intoxication accurately enough to decide if they are fit to drive.

Effects of even low levels of alcohol consumption on driving risk

a. The alcohol limits for drivers are set at a low level recognising that that drivers put themselves and other road users at risk when driving in the 251 to 400mcg of alcohol per litre of breath range (51 to 80mg per 100ml of blood) because their cognitive and driving abilities are impaired.[19]

b. Data specific to New Zealand reflects overseas experience[20] that the relative risk of a fatal accident increases even at low blood alcohol concentrations. The table below sets out the relative risk (i.e. the number of times more likely an alcohol impaired driver is to be involved in a fatality than a sober driver) against a reference point of a sober driver aged 30+ driving with one passenger at night.[21]

	Age 15-19			Age 20-29			Age 30+		
Passengers:	0	1	2+	0	1	2+	0	1	2+
BAC 0	9.7	5.3	11.8	5.6	3.0	6.9	1.8	1.0*	2.3
BAC 30	27.7	15.0	33.9	16.1	8.7	19.6	5.3	2.9	6.4
BAC 50	55.9	30.3	68.3	32.4	17.5	39.6	10.6	5.8	13.4
BAC 80	159.9	86.6	195.2	92.7	50.2	113.1	30.4	16.5	37.2
BAC 100	322.1	174.5	393.3	186.7	101.1	228.0	61.3	33.2	74.9

*reference point.

c. While the table speaks for itself, it is worth noting that even a driver at exactly the blood alcohol limit (of 50mg/100ml and therefore driving legally), driving in the most favourable scenario (aged 30+ with one passenger) is almost 6 times more likely to have a fatal crash than someone with a blood alcohol of zero.

Can people judge if someone is "okay to drive"?

[18] *Inquiry into the death of Donald Robert Morighan* (Coroners Court, Dunedin, CSU 2015-DUN-397, 20 September 2017).
[19] Land Transport Amendment Bill 2014, Explanatory Note at 1.
[20] Brick and Ericksen *Intoxication Is Not Always Visible: An Unrecognised Prevention Challenge*, 33(9) Alcoholism: Clinical and Experimental Research, September 2009, pp 1489 – 1507.
[21] Keall, M.D, Frith, W.J and Patterson, T.L. (2004) *The Influence of Alcohol, Age and the Number of Passengers on the Night-Time Risk of Driver Injury in New Zealand. Accident Analysis and Prevention*, 36(1), 49-61 at 57.

a. Some publications identify signs and symptoms of intoxication by reference to blood alcohol concentrations. Even apparently minor effects such as altered mood involving increased feelings of wellbeing or friendliness can be symptomatic of a blood alcohol level in excess of the legal limit.[22]

b. In one study, the researcher found that the only observable signs of intoxication for a blood alcohol concentration in the range 61 - 80 mg/100ml (i.e. above the New Zealand drink driving limit) were the presence of alcohol on the subject's breath and the person swaying when undertaking Romberg's test (a somewhat specialised examination similar to a compulsory impairment test administered by Police to drivers who are suspected of being under the influence of drugs).[23]

c. That notwithstanding, the presence of breath alcohol is not a reliable indicator. One study found that only 33% of those who had a blood alcohol concentration in the range 61 - 80 mg/100ml had a detectable odour of alcohol on their breath.[24] In another more recent study, breath alcohol was detectable (by Police) in only 60% of instances where the blood alcohol concentration was 80 mg/100ml or less.[25]

d. Indeed determining whether one is safe to drive by reference to how the person feels or by their physical appearance or behaviour is fraught with difficulty. Firstly the effects of alcohol on an individual depends on many factors including gender, age, weight, overall health and habituation.[26]

e. Secondly, even experienced health professionals cannot accurately relate the signs and symptoms of alcohol consumption to particular blood alcohol concentrations.[27] It is therefore ridiculous for individuals to assume (as often occurs) that they are able to assess an ability to drive lawfully. Any judgment must surely be worse when the person making the assessment has themselves consumed alcohol.

f. New Zealand and overseas studies confirm that those who have consumed alcohol (even with relatively low blood alcohol concentrations) underestimate the amount of alcohol they have consumed, and cannot determine the level of their intoxication.[28]

g. In my view, if any effects of the consumption of alcohol are noticeable (even if minor) it is likely that the person is above the legal limit. That is only conclusion that can properly be drawn from the research that has been conducted in this area.

[22] http://www.alcohol.org.nz/alcohol-its-effects/about-alcohol/blood-alcohol-levels, (last accessed 20 July 2017). See also Table 126.1 Brust, J. C. M. (2015). Alcoholism in Louis (Ed.), *Merritt's Neurology* (13th ed.). Wolters Kluwer.
[23] Widmark, *Principles and Application of Medicolegal Alcohol Determination* (1981), Biomedical Publications, Davis CA at 115 cited in Brick and Ericksen *Intoxication Is Not Always Visible: An Unrecognised Prevention Challenge*, 33(9) Alcoholism: Clinical and Experimental Research, September 2009, pp 1489 – 1507.
[24] Widmark, *Principles and Application of Medicolegal Alcohol Determination* (1981), Biomedical Publications, Davis CA at 115 cited in Brick and Ericksen *Intoxication Is Not Always Visible: An Unrecognised Prevention Challenge*, 33(9) Alcoholism: Clinical and Experimental Research, September 2009, pp 1489 – 1507.
[25] Moskowitz H, Burns M, Ferguson S (1999) *Police Officers' Detection of Breath Odors From Alcohol Ingestion*. Accid Anal Prev 31:175–180.
[26] "At plasma concentrations in well excess of 100mg/100ml experienced alcohol drinkers may not appear intoxicated to very experienced observers. However this appearance of sobriety does not translate to safe operation of a motor vehicle… in which case very low plasma alcohol concentrations produce impaired performance": Sullivan JB, Hauptman M, Bronstein AC (1987) *Lack of Observable Intoxication in Humans With High Plasma Alcoholic Concentrations*. J Forensic Sci 32:1660–1665.
[27] Olsen et al Relationship Between Blood Alcohol Concentration and Observable Symptoms of Intoxication in Patients Presenting to an Emergency Department (2013) Alcohol and Alcoholism at 346, 48(4) at 386-389.
[28] Olsen et al *Relationship Between Blood Alcohol Concentration and Observable Symptoms of Intoxication in Patients Presenting to an Emergency Department* (2013) Alcohol and Alcoholism at 346, 48(4) at 386-389.

h. Researchers have noted:[29]

> Two conclusions having direct implications for prevention specialists are apparent as a result of this review: (i) the lack of visible signs of alcohol intoxication is no guarantee that the drinking driver is not impaired and (ii) if signs of visible intoxication (i.e., trouble walking, speech impairment, impaired cognition or affect, or other signs of intoxication) are present, the person is probably (more likely than not) intoxicated well in excess of the legal definition for driving while intoxicated and is at significantly increased risk for a fatal crash or injury. Better training of alcohol beverage servers and social hosts, and broader public awareness of the relationship between BAC, visible intoxication, obvious intoxication, and risk for a motor vehicle crash should be part of future prevention strategies.
>
> Most importantly, drivers who drink but do not show signs of visible intoxication may have BACs that exceed the current legal definition for intoxicated driving, and may be at high risk for injury to themselves and others.
>
> (emphasis added).

IV. The above is a long-winded way of saying:

a. It is a fallacy to think we can assess whether we are, or someone else is "fit to drive" after the consumption of alcohol; and

b. The key safety message must be that if any alcohol has been consumed, the person should not drive.

V. As to (b) above, Heineken (Dominion Breweries) are to be commended for their "When You Drive, Never Drink" campaign. That is the message, consistent with the New Zealand Transport Agency's "Drinking? Don't Drive" campaign that needs to be heeded by the community.

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

Parahi [2021] NZCorC 79 (10 May 2021)

CIRCUMSTANCES

Tony Sebastian Parahi, aged 57, died on 29 January 2019 on State Highway 36, of chest and abdominal injuries secondary to a motorcycle crash.

In the afternoon of 29 January 2019, Mr Parahi was riding his motorcycle on State Highway 36 towards Ngongotaha. Casey Cave was also travelling along State Highway 36 in the same direction, driving a tractor and trailer unit. Mr Cave pulled over to the left of the road to allow two vehicles to pass, before making a right-hand turn across both lanes into a driveway on the opposite side of the road. As he did so, Mr Parahi came from behind him. Mr Parahi took evasive action,

[29] Brick and Ericksen *Intoxication Is Not Always Visible: An Unrecognised Prevention Challenge, 33(9) Alcoholism: Clinical and Experimental Research*, September 2009, pp 1489 – 1507 at 1504.

but lost control of the motorcycle and was thrown onto the road. The motorcycle landed on top of him and he sustained fatal injuries.

The Police Serious Crash Unit (SCU) investigated the crash, noting that the speed limit in the area of the crash was 100km/h and calculating Mr Parahi's pre-brake speed at between 62.5 km/h and 78.4 km/h. At inquest a specialist advisor criticised the SCU investigation on the basis that the Police (i) failed to investigate low friction values without the antilocking braking system (which Mr Parahi did not have) as this would have led them to find that the road friction values were very low, akin to a wet surface; and (ii) miscalculated Mr Parahi's speed due to missing a tyre mark on the road and using low rates of deceleration. The Coroner accepted these criticisms.

COMMENTS OF CORONER HESKETH

I. I make the following comments:

a. The Police Serious Crash Unit that analysed this scene included four different Police officers. The Police accepted that this was not best practice in terms of continuity and may have resulted in gaps in their analysis.

b. The Police officers involved in this investigation did not have any specific friction testing training and were not experts in this area. Police training in friction testing would be useful to improve recognition of unusual or unusually low results.

c. Waka Kotahi NZ Transport Agency is identifying roads, where safer speed limits can make a big difference in saving lives, and where communities are calling for change. State Highway 36 has been identified as one of them. Within the next 12 months Waka Kotahi will be undertaking a technical assessment of the current speed limits for this road.

d. There are a number of important safety projects around the country and Waka Kotahi needs to prioritise the timing of these to ensure the biggest difference in reducing deaths and serious injuries is made. More information on the speed review process can be found at: www.nzta.govt.nz/safety/our-vision-of-a-safe-road-system/safe-network-programme/speed-management/deciding-speed-limits.

RECOMMENDATIONS OF CORONER HESKETH

I. I make the following recommendation:

a. The Police should provide unusual or unusually low friction testing results to the relevant roading authority.

Self-Inflicted

Faasipa [2021] NZCorC 95 (15 June 2021)

CIRCUMSTANCES

Tuatala Vaimalama Faasipa ("Vai") was 15 years of age when she died at Cannons Creek, Porirua, on 24 September 2018, in circumstances amounting to suicide.

Vai had a history of alcohol abuse and antisocial behaviour. On 23 September 2018, she and two other teenagers were believed to be involved in a robbery of a liquor store. Police arrested Vai and others approximately an hour after the robbery. Because Vai was heavily intoxicated, Police did not interview her that evening. However, they told Vai and her parents who came to collect her, that Police would be in contact to schedule an interview. Her parents thought it best for Vai to stay with her sister who lived nearby and with whom she had a good relationship.

However, Vai never went to her sister's house after her parents dropped her off. Instead, she went to her boyfriend's house across the road. An altercation broke out between them and Vai's sister came to assist. Vai was returned to her parents where she talked to her mother until the early hours of 24 September 2018. Vai was reassured by her mother that she would be there for her in the morning. Tragically, later that morning Vai's body was discovered in the garden, deceased. She died in circumstances amounting to suicide.

COMMENTS OF CORONER BORROWDALE

I. The following comments are made pursuant to section 57(3) of the Coroners Act 2006, for the purpose of public education aimed at avoiding further suicide by young people in circumstances similar to those in which Tuatala Vaimalama ("Vai") Faasipa died.

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

III. Information about the ways you can support someone who is thinking of harming themselves is available at https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide.

IV. The website contains information about what to do if you think someone needs urgent help, which I repeat here:

> If someone has attempted suicide or you're worried about their immediate safety, do the following:
>
> - Take them seriously. Thank them for telling you, and invite them to keep talking. Ask questions without judging.
> - **Call your local mental health crisis service or go with the person to the emergency department at the nearest hospital.**
> - **If they are an immediate danger to themselves or others call 111.**
> - Remain with them and help them to stay safe until support arrives.
> - Try to stay calm and let them know that you care.

V. Some options and the contact details of some agencies that can help are listed below:

For counselling and support - these are free and generally available anytime:

- Lifeline - 0800 543 354
- Samaritans - 0800 726 666

For children and young people

- Youthline - 0800 376 633, free text 234 or email talk@youthline.co.nz (for young people, and their parents, whānau and friends)
- What's Up - 0800 942 8787 (for 5-18 year olds; 1 pm to 11 pm)
- The Lowdown - visit the website, email team@thelowdown.co.nz or free text 5626 (emails and text messages will be responded to between 12 noon and 12 midnight)
- SPARX - an online self-help tool that teaches young people the key skills needed to help combat depression and anxiety.

VI. More than half of youth suicides involve alcohol or illicit drug exposure.[30] Alcohol intoxication is often associated with youth suicide. I encourage policymakers and agencies that are active in suicide prevention to continue to focus on primary prevention measures, including limiting alcohol access and use among young people, as well as on the mental health treatment aspects of suicide.

VII. I do not consider it necessary to make any recommendations pursuant to s 57(3) of the Coroners Act 2006.

Note: Orders under sections 71 and 74 of the Coroners Act 2006 (Coroners Act) apply. Accordingly, no person may, unless granted an exemption under section 71A of the Coroners Act, make public the method or suspected method of this death, or any details that suggest the method or suspected method of the death, and may not publish photographs taken of Vai during the investigation into her death, on the grounds that it is in the interests of decency and personal privacy.

Fothergill [2021] NZCorC 92 (9 June 2021)

CIRCUMSTANCES

Graeme Duncan Fothergill died on 27 January 2020 at 4/104 Alexandra Crescent, Hastings in circumstances amounting to suicide.

Mr Fothergill was divorced from his wife Karina. He had a long-standing history of alcohol and mental health issues and, since 2014, had considerable albeit intermittent engagement with Mental Health and Addiction Services. His involvement with Mental Health Services was more intensive from September 2019. However, as he refused to attend an appointment with an Addiction Clinician, he was discharged from Mental Health Services in November 2019.

[30] *He Ara Oranga: report of the Government Inquiry into Mental Health and Addiction 2018* at 10.2: https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/chapter-10-suicide-prevention/10-2-what-needs-to-happen/
See also “Youth suicide in New Zealand: a Discussion Paper” P Gluckman 2017 at: https://www.pmcsa.org.nz/wp-content/uploads/17-07-26-Youth-suicide-in-New-Zealand-a-Discussion-Paper.pdf. This paper, by the Government’s Chief Science Advisor, Professor Sir Peter Gluckman, was prepared in response to a request from the Prime Minister to consider mental health issues, with a specific focus on education.

In December 2019 Karina became concerned for Mr Fothergill and contacted the Emergency Mental Health Service. When a nurse spoke to Mr Fothergill, he became angry. Karina considered his anger stemmed from the nurse's insistence he agree to addiction treatment.

Mr Fothergill's alcohol problem in a background of a number of significant stressors led to a deterioration in his mental health state in January 2020. Mr Fothergill received significant input from Mental Health Services, including admission as an inpatient, the provision of a key worker, and attendance at the Intensive Day Program.

Mr Fothergill had resigned from his job and sought a medical certificate from his GP for the purposes of obtaining a benefit from Work and Income New Zealand (WINZ). There was a delay in the process which Karina considered was tremendously traumatic for Mr Fothergill. She believed WINZ should have a priority system for people who are at-risk, to provide prompt and timely assistance.

Karina also believed the Mental Health Services team could have done more to protect Mr Fothergill's life during his stay in the unit by involving his family in his assessment and treatment plan. She also suggested the team should have followed up with family when Mr Fothergill did not attend appointments with his key worker and the Intensive Day Program. Karina noted that Mr Fothergill was exceptionally good at putting up a front and was only able to be truly vulnerable to very few people even within his family. It would have been easy for him to present to mental health workers as bright and future focused but close family members would have been able to get through his tendency to cover up his true feelings.

RECOMMENDATION OF CORONER RYAN

I. In her submissions, Karina has suggested that several recommendations should be made in the hope that practices would be changed to reduce the chance of further deaths occurring in similar circumstances.

II. I have considered her submissions and consider there are some recommendations that could usefully be made pursuant to section 57A of the Act, for the purposes set out in section 4. That is because they relate to factors that may be relevant to the circumstances of Mr Fothergill's death.

III. Accordingly, I make the following recommendations:

   a. The Hawkes Bay District Health Board should consider whether its current policy and practice adequately and properly provides for consultation with close family members for mental health in-patients regarding the care and treatment plans for those patients, and whether appropriate weight is placed on the involvement and views of close family members with overall patient management.

   b. The Hawkes Bay District Health Board should consider finding ways to treat severely at-risk mental health patients despite the patient's refusal to address their addictions.

IV. These recommendations are addressed to the Chief Medical Officer, Hawkes Bay District Health Board.

   c. Work and Income New Zealand should consider establishing a priority system for clients who are significantly at-risk of self-harm and for whom delays in providing support are likely to exacerbate their distress and increase that risk.

d. If Work and Income New Zealand currently has a priority system in place for people in a precarious mental health state, then they should review the effectiveness of that system to ensure that it is being properly and effectively applied.

V. This recommendation is addressed to the Chief Executive, Ministry of Social Development.

SUBMISSIONS BY HBDHB

VI. After being provided with a copy of proposed recommendations contained in my provisional Finding, the DHB made submissions.

VII. With regards to recommendation (a) above, the DHB points out that the Raranga te tira - Partnership (involving working together in partnership across the community) is all about working in partnership with patients and families. In addition, the DHB has two mental health-specific policies/procedures that expand on this value.

VIII. Notwithstanding this, I am still of the view that the recommendation should stand.

IX. In relation to recommendation (b) above, the DHB points to restrictions imposed upon it by legislation regarding compulsory treatment of patients with addictions. The DHB also considers that in general, there is no consistent scientific evidence that compulsory treatment of addictions has significant beneficial effect.

X. In my view, the DHB has misinterpreted the purpose of the recommendation. It is not aimed at treating the addiction, but rather treating the underlying mental illness of the patient with the addiction. It is not uncommon in coronial cases to find that severely mentally unwell patients were turned away from mental health services because they had addictions which they were not willing to address. It is unclear to me whether a person with a mental illness and an addiction can be helped with their mental illness without first being helped with their addiction issues. That is a matter for the clinicians to contend with.

XI. It is still my view that the recommendation should stand.

XII. In its submissions, the DHB points out that the Mental Health and Addictions Service has worked in collaboration with the Ministry of Social Development (MSD) in the development of a new "Crisis Hub". It has been agreed that MSD staff will present at scheduled times to assist those individuals presenting in mental and/or social distress that require specific services. It is also planned that alongside clinical staff will be a peer support workforce to assist and support individuals through their journey.

XIII. I am encouraged by this initiative. It is likely to help reduce the stress on already distressed people who are navigating the process of obtaining the requisite financial assistance.

SUBMISSIONS BY MSD

XIV. MSD also made submissions after receiving a copy of the proposed recommendations in my provisional Finding.

XV. The MSD submissions point out that the delay in completing Mr Fothergill's application for financial benefits was due to him failing to provide all of the required information, namely his IRD number and verification of his bank account details. As a result, his application lapsed on 14 February 2020.

XVI. The MSD response explains why the process to obtain appropriate financial support was protracted. This demonstrates the need for the initiative now in place as set out in [XII] above.

XVII. In its submission, MSD also sets out its approach to dealing with persons at risk of self-harm. The approach involves a model encompassing three elements: recognize, ask, get help. Those at risk of self-harm should be recognised when they approach staff, they should be asked the right questions (primarily to determine whether there is any intent to act on thoughts), and staff should obtain help for individuals that obviously require it.

XVIII. MSD records that it endeavours to support all New Zealanders with mental health concerns, and believes that the current process for identifying risks and providing support appropriately achieves this.

XIX. From the submissions provided, I am not convinced that the concerns intended to be addressed in recommendations (c) and (d) in [IV] above are currently adequately covered. For that reason, those recommendations stand.

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death.

Kawhena [2021] NZCorC 74 (30 April 2021)

CIRCUMSTANCES

Ariana Chere Kawhena, aged 15, died on 27 November 2019 at Waikato Hospital in circumstances amounting to suicide.

Ariana did not have any diagnosed mental health issues or episodes of self-harm. However, it was clear from her social media posts and text message history that she had thoughts of suicide leading up to her death.

COMMENTS OF CORONER ROBB

I. I do not make, nor intend to imply, any criticism of anyone who Ariana had direct contact with and to whom Ariana had made comments about suicide. As noted above, the comments made by Ariana were made more than once and over a long period, but not acted upon on numerous occasions. In that context, determining that Ariana had made a final decision to end her life on the day she did would likely not have been possible.

II. No doubt the individual(s) she was communicating with were of, or close to, her youthful age and may well be dealing with their own significant emotional upset as a result of Ariana's death. Teenage concerns can be acutely private and with a significant reluctance to communicate or pass on information to adults.

III. However, Ariana's text messaging reveals a significant depth of feeling, distress, and hurt, and those messages are on occasion coupled with statements that she would end her life. Helping her to manage her

response to stressful events in her life, her feelings for another, her feelings of distress, may have been possible with the assistance of adult whānau coupled with professional help.

IV. Ariana's tragic death does lead me to reiterate and provide a reminder about the Ministry of Health advice for anyone who becomes aware of suicide threats being made.

V. The Ministry of Health website provides the following information:[31]

If you're worried someone may be suicidal

If you are worried that someone is suicidal, ask them. It could save their life.

If they need urgent help

If someone has attempted suicide or you're worried about their immediate safety, do the following.

- Call your local **mental health crisis assessment team** or go with them to the emergency department (ED) at your nearest hospital.
- If they are an immediate physical danger to themselves or others, call 111.
- Remain with them and help them to stay safe until support arrives.
- Try to stay calm and let them know you care.
- Keep them talking: listen and ask questions without judging.

If you think someone is at risk

Ask them – it could save their life

Asking about suicide will not put the thought in their head.

Ask them directly about their thoughts of suicide and what they are planning. If they have a specific plan, they need help right away.

Ask them if they would like to talk about what's going on for them with you or someone else. They might not want to open up straight away, but letting them know you are there for them is a big help.

Listen and don't judge. Take them seriously and let them know you care.

Help them find support

Help them to find and access the support they need from people they trust: friends, family, spiritual, community or cultural leaders, or professionals.

Don't leave them alone – make sure someone stays with them until they get help.

Support them to access professional help, like a doctor or counsellor, as soon as possible. Offer to help them make an appointment, and go with them if you can.

If they don't get the help they need the first time, keep trying. Ask them if they would like your help explaining what they need to a professional.

How to be supportive

Be gentle and compassionate with them. Don't judge them – even if you can't understand why they are feeling this way, accept that they are.

[31] https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal#urgenthelp.

Try to stay calm, positive and hopeful that things can get better.

You don't need to have all the answers, or to offer advice. The best thing you can do is be there to really listen to them.

Let them talk about their thoughts of suicide – avoiding the topic does not help. Ask them if they've felt this way before, and what they did to cope or get through it. They might already know what could help them.

Do not agree to keep secrets about their suicidal thoughts or plans. It's okay to tell someone else so that you can keep them safe.

Don't pressure them to talk to you. They might not want to talk, or they might feel more comfortable talking to someone who is not as close to them.

Don't try to handle the situation by yourself. Seek support from professionals, and from other people they trust including family, whānau or friends.

Services that offer more information and support

Listed on the Ministry of Health website. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated.

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Ariana taken during the investigation into her death in the interests of decency and personal privacy.

Lincoln [2021] NZCorC 71 (29 April 2021)

CIRCUMSTANCES

Graeme Henry Lincoln, aged 63, died at Rotorua Hospital on 26 January 2020 from a self-inflicted injury, in circumstances amounting to suicide.

Mr Lincoln had a long history of depression and anxiety. He had become increasingly anxious in the weeks before his death due to his heart condition and the wait for an ablation procedure.

From 15 January 2020, Mr Lincoln presented on an almost daily basis to Rotorua Hospital's emergency department (ED) with symptoms of atrial flutter and anxiety. On 23 January 2020, Mr Lincoln arrived by ambulance after expressing suicidal ideation, but was discharged home without being assessed by Acute Response Team (ART) staff. On the morning of 24 January 2020, Mr Lincoln's case was discussed at an ART team meeting, and it was agreed he should be seen by a psychiatrist if he presented again. However, due to confusion over whether Mr Lincoln's case had been closed or not, he was not noted on a 'Be Aware Of' board or handed over with the plan from morning to evening ART staff that day. Mr Lincoln presented again that evening with suicidal thoughts. He was seen by an ART nurse, who did not consult with or refer Mr Lincoln to any of the psychiatric medical team before sending him home.

On the morning of 25 January 2020, Mr Lincoln phoned a friend and told him that he was about to end his life. The friend called emergency services and went straight to Mr Lincoln's home, where he was found alive but unresponsive and rushed to hospital. He passed away the following day.

Following Mr Lincoln's death, Lakes District Health Board (LDHB) undertook a review which identified a number of contributory findings by its mental health services. In particular, the LDHB's Root Cause Analysis report (RCA)

acknowledged that the missed opportunity for psychiatric assessment and potential admission for further observation and treatment on 24 January 2020 may have contributed to Mr Lincoln's death.

The RCA report included seven recommendations designed to improve patient care, with implementation timeframes ranging from January 2021 to December 2021.

COMMENTS OF CORONER BATES

I. Mr Lincoln presented to Rotorua Hospital on multiple occasions between 15 January 2020 and when he took steps on 25 January 2020 to end his life. It is most regrettable that on more than one occasion when he presented, insufficient depth of assessment, inadequate recording of patient notes, and communication failures, both externally and within the ART, resulted in Mr Lincoln not receiving the level of care and attention he required. It is particularly unfortunate that Mr Lincoln did not undergo a thorough psychiatric assessment on the evening of 24 January 2020, despite a plan made at the ART Multidisciplinary Team meeting earlier that day that this is what should occur if he re-presented. Had a psychiatric assessment been completed there is every reason to suspect it would have led to Mr Lincoln being admitted to hospital for further observation and mental health care. Had he not been discharged that evening his death may have been avoided.

II. I welcome the recommendations arising from the RCA process and expect them to be implemented.

III. Because the RCA report completed by LDHB clearly identifies the failings I have referred to, areas for improvement, details changes that have been made since Mr Lincoln's death and that are planned over the coming year, I do not make any further formal comment or recommendation pursuant to s 57(3) of the Coroners Act 2006.

Note: Pursuant to section 71 of the Coroners Act 2006, no person may make public the method of death, or any detail that suggests the method of death. The death may be described as a suicide. An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Mr Lincoln entered into evidence in the interests of personal privacy and decency.

McLaughlin [2021] NZCorC 93 (9 June 2021)

CIRCUMSTANCES

Takanui Peneaha McLaughlin was 12 years of age when he died at his address in Tūrangi, on 8 August 2017, in circumstances where his death was self-inflicted but did not amount to suicide.

Takanui had a history of making threats of self-harm when he became angry. On 8 August 2017, after he returned home from school, he had an argument with his older siblings. The argument became physical before a parent intervened. During the argument, Takanui made another threat of self-harm. As was normal for Takanui, rather than continue an argument he would leave to vent his anger which he did.

Soon after Takanui left, his body was discovered in a garage at his home by a friend who had come to visit him. Despite efforts to resuscitate Takanui, tragically he had passed away.

COMMENTS OF CORONER ROBB

I. I do not make, nor intend to imply, any criticism of anyone who Takanui had direct contact with and to whom Takanui made threats about suicide. As noted above, these were comments that were made often and over a long period, but not acted upon. Anything said by his siblings I have determined was not said with an intention that Takanui take his own life. I have accepted the statements made by a number of Takanui's whānau that spoke to the love and strong bond between Takanui and his siblings. I accept that evidence without any reservation. However, his tragic death does provide an opportunity to reiterate and provide a reminder about the Ministry of Health advice for anyone who becomes aware of suicide threats being made.

II. The Ministry of Health website provides the following information:[32]

> **If you're worried someone may be suicidal**
>
> If you are worried that someone is suicidal, ask them. It could save their life.
>
> **If they need urgent help**
>
> If someone has attempted suicide or you're worried about their immediate safety, do the following.
>
> - Call your local **mental health crisis assessment team** or go with them to the emergency department (ED) at your nearest hospital.
> - If they are an immediate physical danger to themselves or others, call 111.
> - Remain with them and help them to stay safe until support arrives.
> - Try to stay calm and let them know you care.
> - Keep them talking: listen and ask questions without judging.
>
> **If you think someone is at risk**
>
> **Ask them – it could save their life**
>
> Asking about suicide will not put the thought in their head.
>
> Ask them directly about their thoughts of suicide and what they are planning. If they have a specific plan, they need help right away.
>
> Ask them if they would like to talk about what's going on for them with you or someone else. They might not want to open up straight away, but letting them know you are there for them is a big help.
>
> Listen and don't judge. Take them seriously and let them know you care.
>
> **Help them find support**
>
> Help them to find and access the support they need from people they trust: friends, family, spiritual, community or cultural leaders, or professionals.
>
> Don't leave them alone – make sure someone stays with them until they get help.
>
> Support them to access professional help, like a doctor or counsellor, as soon as possible. Offer to help them make an appointment, and go with them if you can.
>
> If they don't get the help they need the first time, keep trying. Ask them if they would like your help explaining what they need to a professional.

[32] https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal#urgenthelp.

How to be supportive

Be gentle and compassionate with them. Don't judge them – even if you can't understand why they are feeling this way, accept that they are.

Try to stay calm, positive and hopeful that things can get better.

You don't need to have all the answers, or to offer advice. The best thing you can do is be there to really listen to them.

Let them talk about their thoughts of suicide – avoiding the topic does not help. Ask them if they've felt this way before, and what they did to cope or get through it. They might already know what could help them.

Do not agree to keep secrets about their suicidal thoughts or plans. It's okay to tell someone else so that you can keep them safe.

Don't pressure them to talk to you. They might not want to talk, or they might feel more comfortable talking to someone who is not as close to them.

Don't try to handle the situation by yourself. Seek support from professionals, and from other people they trust including family, whānau or friends.

Services that offer more information and support

Listed on the Ministry of Health website. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated.

III. I do not make any further comments or recommendations pursuant to section 57(3) of the Coroners Act 2006.

Note: Orders under sections 71 and 74 of the Coroners Act 2006 (Coroners Act) apply. Accordingly, no person may, unless granted an exemption under section 71A of the Coroners Act, make public the method or suspected method of this death, or any details that suggest the method or suspected method of the death, and may not publish photographs taken of Takanui taken during the investigation into his death, on the grounds that it is in the interests of decency and personal privacy.

Morey [2021] NZCorC 64 (21 April 2021)

CIRCUMSTANCES

Donald Charles Morey, aged 71, died on 10 October 2017 at Kingsley Mortimer Unit, North Shore Hospital, Auckland in circumstances amounting to suicide.

Mr Morey was admitted to the Kingsley Mortimer Unit on 19 September 2017 following a period of declined mood. He was initially treated as a voluntary patient but was not allowed leave from the unit. He was to have 1:1 observations due to his risk to himself.

On 2 October 2017 there was a multidisciplinary team meeting and a meeting with Mr Morey's family. It was identified that his depression had worsened and he had made implied comments about suicide. He was placed under a compulsory treatment order pursuant to the Mental Health (Compulsory Assessment and Treatment) Act 1992. Mr Morey was clearly distressed by this and 1:1 observations recommenced.

Over the following days, Mr Morey disclosed suicidal thoughts to family and staff at the unit. Between 6 October 2017 and 9 October 2017, he appeared much better and denied thoughts of self-harm. It was believed that he had “turned a corner” in his treatment and was on his way to recovery.

On 10 October 2017, Mr Morey expressed to his key nurse that he would feel better without 1:1 observations as he found it intrusive to have someone with him at all times. Following a multidisciplinary team meeting that day, Mr Morey’s observations were reduced from 1:1 to every ten minutes.

Not all of Mr Morey’s observations were completed as scheduled that afternoon, with only two being completed between 2:50pm and 4:00pm. Shortly before 4:00pm, another patient alerted a nurse to Mr Morey, who was found unresponsive with self-inflicted injuries. Despite the best efforts of medical staff, he could not be resuscitated.

COMMENTS OF CORONER BELL

I. The failure by healthcare staff to maintain the appropriate checks on Mr Morey, provided him with a significant window of opportunity in which to take his life. It is not possible to say with any degree of certainty that if Mr Morey's observations had either remained at 1:1, or the 10-minute observation performed, this tragic outcome may have been avoided, nevertheless an opportunity was lost.

II. Having regard to what was known about Mr Morey at the time, it is regrettable that there was no other placement for him that was more suited to his needs. I am still concerned that it has been more than three years since Mr Morey's death and there is no alternate facility for patients in a similar position to be housed by Waitematā District Health Board.

III. I urge Waitematā District Health Board to provide an acute psychogeriatric facility for Mental Health Services of Older Adults' patients and be given priority to manage both the anticipated demand to create an inpatient unit that will be better suited to caring for service users who fall between community care and elderly rest home care.

RECOMMENDATIONS OF CORONER BELL

I. I have considered whether recommendations or comments pursuant to section 57(3) of the Coroners Act 2006 are required in this case. While I acknowledge his daughters' concerns that the mental health ward was not the best place for Mr Morey's recovery, I also acknowledge (as they did) that there was not another option present for Mr Morey's treatment.

II. Having identified issues with the mental health care provided to Mr Morey that could have been better, I am satisfied nevertheless, that the Serious Incident Report depicts that Waitematā District Health Board have appropriately reflected on the clinical care provided to Mr Morey and have identified the key factors/findings where improvement of services was warranted. The recommendations and action plan are appropriately directed to minimise recurrence of identified issues.

III. As such, I do not propose making any formal recommendations. However, a copy of this finding will be sent to the Ministry of Health to consider as part of the ongoing review of Mental Health Services.

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Mr Morey entered into evidence in the interests of personal privacy and decency.

Munokoa [2021] NZCorC 63 (20 April 2021)

CIRCUMSTANCES

Juan Ricky Munokoa, aged 20, died at Jordan Park Reserve in Auckland on 10 July 2020 in circumstances amounting to suicide.

Juan sent a number of text messages to his former partner prior to his death, including on the day of his death, referencing suicide.

RECOMMENDATIONS OF CHIEF CORONER JUDGE MARSHALL

I. Under section 57A of the Coroners Act 2006, a coroner may make recommendations or comments in the course of an inquiry into a death. The recommendations or comments are made for the purpose of reducing the chances of further deaths occurring in circumstances similar to those in which the death occurred.

II. Pursuant to section 57A I endorse the recommendations made by the Ministry of Health[33] that if you are concerned someone is suicidal you should help them to find and access the support they need from people they trust. Do not leave the person alone and support them to access professional help.

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of the deceased taken by Police, in the interests of decency and personal privacy.

Parkes [2021] NZCorC 102 (29 June 2021)

CIRCUMSTANCES

Jamie Christopher Parkes died on 29 September 2017 at 817 Old Tai Tapu Road, Canterbury in circumstances amounting to suicide.

COMMENTS OF CORONER HESKETH

I. In 2016 there were 554 suicide deaths in New Zealand; a rate of 11.3 per 100,000. From 1996 to 2016, the rate of suicide decreased significantly from 14.2 to 11.3 per 100,00 population, a decrease of 20%. The peak rate during this period was in 1998 (15.0 per 100,000) and the lowest rate was in 2014 (10.8 per 100,000).

[33] www.health.govt.nz

II. The Chief Coroner issued a press release in August 2020, part of which she said "In the 2017/18 year the rate was 13.67 deaths per 100,000 people; that has increased to 13.93 in 2018/19…The reasons people make this decision are numerous and depend on many factors: their early life experiences at home and at school, their employment status, their mental health, their economic and health status, their sense of belonging, their sense of purpose, their worldview and more. It's up to all of us to look out for our family, friends and neighbours – to ask how they're going and coping with pressures in life, and to offer our support, to offer hope…"

III. Upon reviewing the evidence in this sad case it is clear that Mr Parkes was very loved and cared about by his family and close friends. His employer was supportive of him taking the time he needed to sort things out in his private life and there were many texts from family and friends of support, concern for his well-being and offers of help.

IV. It is a useful reminder that as difficult as it is to detect someone's intentions; expressions of suicidal thinking by someone should be taken seriously, as they were by his family and friends in this very sad case.

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of the deceased entered into evidence in the interests of personal privacy and decency.

Peck [2021] NZCorC 59 (14 April 2021)

CIRCUMSTANCES

Anthony David Peck, aged 51, of Whakatāne, died on or about 18 June 2019 in circumstances that amounted to suicide.

Anthony had a fractious relationship with his partner and would threaten to self-harm after they had an argument. The threats continued after they separated. His partner arranged counselling services through Tūhoe Hauora. However, Anthony would not engage with those services.

COMMENTS OF CORONER ROBB

I. I have endeavoured to highlight the difficult position that Anthony placed his family in, and that they were tragically not provided with a realistic opportunity to prevent his death. However, for members of the public who may be willing to accept help I reiterate the Ministry of Health advice concerning suicide threats.

II. The Ministry of Health website provides the following information:[34]

> **If you're worried someone may be suicidal**
>
> If you are worried that someone is suicidal, ask them. It could save their life.
>
> **If they need urgent help**
>
> If someone has attempted suicide or you're worried about their immediate safety, do the following.

[34] https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal#urgenthelp.

- Call your local **mental health crisis assessment team** or go with them to the emergency department (ED) at your nearest hospital.
- If they are an immediate physical danger to themselves or others, call 111.
- Remain with them and help them to stay safe until support arrives.
- Try to stay calm and let them know you care.
- Keep them talking: listen and ask questions without judging.

If you think someone is at risk

Ask them – it could save their life

Asking about suicide will not put the thought in their head.

Ask them directly about their thoughts of suicide and what they are planning. If they have a specific plan, they need help right away.

Ask them if they would like to talk about what's going on for them with you or someone else. They might not want to open up straight away, but letting them know you are there for them is a big help.

Listen and don't judge. Take them seriously and let them know you care.

Help them find support

Help them to find and access the support they need from people they trust: friends, family, spiritual, community or cultural leaders, or professionals.

Don't leave them alone – make sure someone stays with them until they get help.

Support them to access professional help, like a doctor or counsellor, as soon as possible. Offer to help them make an appointment, and go with them if you can.

If they don't get the help they need the first time, keep trying. Ask them if they would like your help explaining what they need to a professional.

How to be supportive

Be gentle and compassionate with them. Don't judge them – even if you can't understand why they are feeling this way, accept that they are.

Try to stay calm, positive and hopeful that things can get better.

You don't need to have all the answers, or to offer advice. The best thing you can do is be there to really listen to them.

Let them talk about their thoughts of suicide – avoiding the topic does not help. Ask them if they've felt this way before, and what they did to cope or get through it. They might already know what could help them.

Do not agree to keep secrets about their suicidal thoughts or plans. It's okay to tell someone else so that you can keep them safe.

Don't pressure them to talk to you. They might not want to talk, or they might feel more comfortable talking to someone who is not as close to them.

Don't try to handle the situation by yourself. Seek support from professionals, and from other people they trust including family, whānau or friends.

Services that offer more information and support

Listed on the Ministry of Health website. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated.

Note: Orders under sections 71 and 74 of the Coroners Act 2006 (Coroners Act) apply. Accordingly, no person may, unless granted an exemption under section 71A of the Coroners Act, make public the method or suspected method of this death, or any details that suggest the method or suspected method of the death, and may not publish photographs taken of Anthony taken during the investigation into his death, on the grounds that it is in the interests of decency and personal privacy.

Ross [2021] NZCorC 82 (12 May 2021)

CIRCUMSTANCES

Jake James Newman Ross, aged 21, died between 3 and 5 October 2017 at a hotel in Auckland in circumstances amounting to suicide.

Jake engaged with numerous clinicians for treatment of depression and anxiety, including general practitioners (GPs), a psychologist, psychiatrist Dr Shieff and a holistic medical doctor.

COMMENTS OF CORONER BELL

I. Jake's mother in an email to me wanted it noted that emotional support for those suffering mental health conditions is very poor. She comments that GPs are not trained specifically in mental health and the increasing burden on them is inappropriate considering the increasing suicide rate in New Zealand. The model for treatment is prescribing medication to the patient then they look at psychology. Ms Ross also reported that Jake was tired of explaining the same feelings to each practitioner and queried why health information could not be shared.

II. Ms Ross quoted the following statistics;

    a. There are approximately 3000 registered psychologists in NZ which is approximately 1 for every 312 suffering with mental health condition.
    b. If working 1 to 1 on a patient realistically a psychologist can only see 60-80 people a year. There are approximately 700 registered psychiatrists in NZ, so a similar problem with getting an appointment when needed.

Responses to Ms Ross

III. I forwarded a copy of Ms Ross' email to Ministry of Health and Dr Shieff and invited them to comment.

IV. Dr Shieff in response to the issues raised by Jake's mother indicated he concurred with the commonplace situation of frustration expressed by patients in the face of the need to repeatedly provide historical information in regard to their problems. He further stated it would certainly relieve a significant component of that burden, if previously collected information was shared between practitioners. Whilst this occurs, not uncommonly, in the form of material provided at the time of referral. There is an understandable reticence amongst mental health professionals to disperse patient's specific information, out of concern to protect their privacy and the confidentiality of historical material.

V. Dr John Crawshaw, Director of Mental Health responded on behalf of the Ministry of Health as follows;

a. There are approximately 3000 registered psychologists

Registered psychologists work in a range of fields, which includes District Health Boards, Corrections, Education, Health etc. In 2016-17, there were 2757 psychologists registered with the New Zealand Psychologist Board across all scopes of practice. Of this total, 139 account for people registered either as psychology interns or trainee psychologists. The majority of New Zealand trained psychologists are registered under the clinical scope.

b. Approximately 936, 000 people have a mental health condition

Although Mrs Ross does not explicitly state the number of people who have a mental health condition, she suggests that there is one psychologist for every 312 people who have a mental health condition, equating to 936,000 people in New Zealand who may have a mental health condition.

According to the Ministry of Health 2017/18 Health Survey, approximately 336,000 adults (15-year olds and over) suffered from psychological distress in the last four weeks prior to participating in the survey. This number includes both incidence and prevalence data. If measuring lifetime prevalence rates, however, the National Mental Health Prevalence Study, Te Rau Hinengaro (Oakley Browne et al. 2006) indicates that a 12-month prevalence of any disorder is estimated to be 20.7% of the New Zealand population.

In terms of the caseload of which a psychologist undertakes, it will vary considerably. It may depend on, for example, the age of the client, the complexity of their difficulties, the duration of difficulty, and if the psychologist is seeing a family or an individual. For psychologists seeing clients with mild/moderate psychological distress, or in settings where limited sessions are allocated, 60-80 clients per year is not unreasonable. In settings where the psychologist is seeing people with greater needs and greater distress, or engaged in group work, individual annual caseloads are likely to be smaller.

c. There are approximately 700 registered psychiatrists

According to the results of The New Zealand Medical Workforce in 2016 survey, in 2016 there were 829 practicing psychiatrists in New Zealand.

VI. I direct that a copy of this finding be sent to Ministry of Health, Mental Health Services.

Note: An order under s 71 of the Coroners Act applies. No person may make public the method of death, or any detail that suggests the method of death. An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs of Jake taken during the investigation into his death in the interests of decency and personal privacy.

Wheeler [2021] NZCorC 97 (16 June 2021)

CIRCUMSTANCES

Guy Wheeler, aged 38, died on 16 October 2019 near the Pahiatua farm in circumstances amounting to suicide.

Mr Wheeler had lived in the family home with his parents all his life and worked on their dairy farm. His mother told Police that Mr Wheeler had found his father's death the previous year very distressing, and that being without a partner or children of his own was also a source of distress to him.

At the time of his death, Mr Wheeler was on bail for breaching a Temporary Protection Order granted to his ex-girlfriend, who had ended their relationship several months earlier. As a consequence, he had been directed to attend four assessment sessions prior to a non-violence course. His counsellor, Mr McCorkindale, reported that Mr Wheeler gave no indication of any suicidal ideation during these sessions.

However, in the weeks before his death Mr Wheeler expressed thoughts of ending his life to a friend, Jocelyn Taranchokov. In addition, he told his mother and a Police officer that he was feeling suicidal and had a prepared a Will. Police referred Mr Wheeler to the Community Mental Health Service, but when contacted Mr Wheeler refused to engage.

On the day of his death, his mother recalled that Mr Wheeler appeared upset and talked about ending his life after returning from his last assessment session with Mr McCorkindale. Later that afternoon his brother, Todd Wheeler, said that Mr Wheeler appeared to be heavily intoxicated. When she heard Mr Wheeler leave their home on his ATV, Mrs Wheeler was concerned about his state of mind and went to look for him on foot. Around half an hour later, she found Mr Wheeler in a hay shed, deceased.

COMMENTS OF CORONER WINDLEY

I. People who take their own lives usually do so as a result of a complex range of factors.[35] The Ministry of Health has reported that "it is usually the end result of interactions between many different factors and experiences across a person's life".[36]

II. The evidence before my inquiry indicates that Mr Wheeler had not expressed suicidal ideation to a medical professional but had expressed such thoughts to Ms Taranchokov, his mother, and the Police officer who engaged with him on 23 September 2019. I have no doubt that Mr Wheeler's family did their best to ensure his safety. Unfortunately, it appears that despite a referral to Community Mental Health services by Police a few weeks earlier, Mr Wheeler declined to engage.

III. The evidence also suggests the possibility that Mr Wheeler's mood was labile and subject to fluctuation. Mr McCorkindale reported that there was no reason for any concern in relation to Mr Wheeler's risk of self-harm during their session on the day of Mr Wheeler's death. However, it was at least Mrs Wheeler's recollection (though at odds with that of Todd Wheeler) that Mr Wheeler returned home in a very upset state and subsequently made comments about ending his life. Unfortunately, it appears that Mr Wheeler had also begun to use alcohol to address acute periods of anxiety and distress. When seen by his brother later that

[35] Ministry of Health, *New Zealand Suicide Prevention Action Plan 2013-2016* (May 2013).
[36] Ministry of Health, *A strategy to Prevent Suicide in New Zealand 2017: A draft for public consultation* (April 2017).

afternoon he was observed to be so inebriated he was incoherent and floundering but he declined medical assistance. When he subsequently left the house on his ATV, his mother endeavoured to follow him out of concern for his mental state. Mrs Wheeler told Police that while she was shocked by his death, it was not a total surprise to her as he had previously talked about ending his life.

IV. Knowing whether a family member has a current plan and intention to act on suicidal thoughts, and knowing how to respond, is challenging even in the closest of families. The Ministry of Health and Mental Health Foundation has published resources for anyone who may be worried that someone may be suicidal.[37] The advice includes a caution against trying to handle the situation by yourself and a suggestion to seek support from counselling and support services, and other people they trust, including other family and friends. It cannot be known why on 16 October 2019 Mr Wheeler did not voice his thoughts of self-harm to people close to him as he had on 23 September 2019.

V. Sadly, while the specific combination of stressors that I identify in Mr Wheeler's death are unique to him, suicide of men of his age who live and work in rural settings is not. Rural communities are more likely to experience risk factors for poor mental health and suicide. The Government's Every Life Matters Suicide Prevention Strategy includes a list of initiatives such as Farmstrong, Rural Support Trusts, and GoodYarn Farmer Wellness Workshops that provide mental health support for rural communities. Mr Wheeler's attendance at the sessions with Mr McCorkindale appears to have provided an opportunity for Mr Wheeler to explore his stressors and his behavioural responses, and for his risk of self-harm via "mood monitoring" to be proactively considered. Mr McCorkindale regarded Mr Wheeler as being participative and thoughtful during these sessions. In light of that it is difficult to know what other support or engagement could have made a difference and may have potentially avoided Mr Wheeler's death.

VI. Having regard to the particular circumstances of Mr Wheeler's death and the initiatives I identify above, I do not consider there to be any additional comments or recommendations I can make, that may reduce the chances of future deaths in similar circumstances.

Note: Pursuant to section 71 of the Coroners Act 2006, no person may make public the method of death, or any detail that suggests the method of death. The death may be described as a suicide. An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs of Mr Wheeler entered into evidence in the interests of personal privacy and decency.

Wilson [2021] NZCorC 60 (14 April 2021)

CIRCUMSTANCES

Martin Wilson, aged 37, of Thames, died on 13 June 2019 in circumstances that amounted to suicide.

[37] See: www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal; and https://mentalhealth.org.nz/resources/resource/are-you-worried-someone-is-thinking-of-suicide.

Martin's relationship with his partner had deteriorated. On the night of 13 June 2019, an argument broke out between Martin and his partner in which he made a threat of self-harm. He left the house and his body was later discovered in a locked garage at the property.

COMMENTS OF CORONER ROBB

I. I do not make, nor intend to imply, any criticism of anyone who Martin had direct contact with and to whom Martin had made comments about suicide. As noted above, these were comments that were made in the context of heated arguments. However, Martin's death is a reminder of the need to take threats of suicide or self-harm seriously.

II. The Ministry of Health website provides the following information:[38]

> **If you're worried someone may be suicidal**
>
> If you are worried that someone is suicidal, ask them. It could save their life.
>
> **If they need urgent help**
>
> If someone has attempted suicide or you're worried about their immediate safety, do the following.
>
> - Call your local **mental health crisis assessment team** or go with them to the emergency department (ED) at your nearest hospital.
> - If they are an immediate physical danger to themselves or others, call 111.
> - Remain with them and help them to stay safe until support arrives.
> - Try to stay calm and let them know you care.
> - Keep them talking: listen and ask questions without judging.
>
> **If you think someone is at risk**
>
> **Ask them – it could save their life**
>
> Asking about suicide will not put the thought in their head.
>
> Ask them directly about their thoughts of suicide and what they are planning. If they have a specific plan, they need help right away.
>
> Ask them if they would like to talk about what's going on for them with you or someone else. They might not want to open up straight away, but letting them know you are there for them is a big help.
>
> Listen and don't judge. Take them seriously and let them know you care.
>
> **Help them find support**
>
> Help them to find and access the support they need from people they trust: friends, family, spiritual, community or cultural leaders, or professionals.
>
> Don't leave them alone – make sure someone stays with them until they get help.
>
> Support them to access professional help, like a doctor or counsellor, as soon as possible. Offer to help them make an appointment, and go with them if you can.

[38] https://www.health.govt.nz/your-health/conditions-and-treatments/mental-health/preventing-suicide/if-youre-worried-someone-may-be-suicidal#urgenthelp.

If they don't get the help they need the first time, keep trying. Ask them if they would like your help explaining what they need to a professional.

How to be supportive

Be gentle and compassionate with them. Don't judge them – even if you can't understand why they are feeling this way, accept that they are.

Try to stay calm, positive and hopeful that things can get better.

You don't need to have all the answers, or to offer advice. The best thing you can do is be there to really listen to them.

Let them talk about their thoughts of suicide – avoiding the topic does not help. Ask them if they've felt this way before, and what they did to cope or get through it. They might already know what could help them.

Do not agree to keep secrets about their suicidal thoughts or plans. It's okay to tell someone else so that you can keep them safe.

Don't pressure them to talk to you. They might not want to talk, or they might feel more comfortable talking to someone who is not as close to them.

Don't try to handle the situation by yourself. Seek support from professionals, and from other people they trust including family, whānau or friends.

Services that offer more information and support

Listed on the Ministry of Health website. All services are free, and are available 24 hours a day, 7 days a week unless otherwise stated.

Note: Orders under sections 71 and 74 of the Coroners Act 2006 (Coroners Act) apply. Accordingly, no person may, unless granted an exemption under section 71A of the Coroners Act, make public the method or suspected method of this death, or any details that suggest the method or suspected method of the death, and may not publish photographs taken of Martin taken during the investigation into his death, on the grounds that it is in the interests of decency and personal privacy.

Sudden Unexpected Death in Infancy (SUDI)

Sudden Unexpected death in Infancy (SUDI) is an ongoing issue in New Zealand and Coroners continue to endorse the advice of the Ministry of Health. SUDI findings are also referred to the agencies responsible for SUDI prevention strategies.

Aramoana [2021] NZCorC 89 (3 June 2021)

CIRCUMSTANCES

On 10 September 2019, Kayden Hemi Aramoana, aged one, died at Gisborne Hospital as a result of Sudden Infant Death Syndrome (SIDS).

In the week before his death, Kayden became unwell with diarrhoea and vomiting. His mother, Kimberly Aramoana, took Kayden to the emergency department (ED) on 8 September 2018, where he was examined, treated and discharged. However, they returned the following day and Kayden was hospitalised overnight on the Paediatric Ward. His mother and aunt stayed in the room with him, where Kimberly slept on the same adult-sized hospital bed with Kayden. The ward

nurse had spoken with Kimberly about safe sleep practices, although it was not standard practice and the nurse understood she could not enforce this for babies older than six months. The CUBRO cot in Kayden's room had been removed at Kimberly's request, after she advised it was her normal practice to bed share with Kayden.

Kayden had a mildly increased respiratory rate, but no respiratory distress was noted. His vital signs remained stable throughout the evening and early the following morning. At 5:50am, Kayden was found unresponsive and could not be revived. He appeared to have twisted from a propped-up position on pillows down under a blanket which covered his face and mouth.

While the cause of Kayden's death was unable to be determined, the Coroner was concerned that Kayden had been placed in an unsafe sleeping environment. Propping an infant on an adult-sized bed with a blanket wrapped around them is a risk factor which has often led to sudden unexplained death in infancy (SUDI).

The principles of safe infant sleep essentials are well known and well publicised through the Child Wellness programme, the Ministry of Health website, in Doctor's Surgeries and hospitals. For every sleep, an infant should be:

- **Face up** – the supine sleep position affords the infant to clear airway, optimises their drive to breath, and enhances the gag reflex. Putting babies to sleep on their backs reduces the risk of SUDI. Babies are less likely to roll onto the front (the most dangerous sleep position) if they are put to sleep on their backs rather than their sides.
- **Face clear** – ensure the faces clear of loose wraps and bedding, free from other people who might overlay the infant, free from gaps that could trap or wedge the infant, and free of objects (eg soft toys, pillows or pets) that might cover the face, cause strangulation or restrict breathing. If wrapped, the bedding must not restrict breathing, and for older more mobile babies (over three months), allow the arms to be free.
- **Free of the risk of wedging** – avoid using ill-fitting mattresses in cots. Babies can also become trapped or wedged if there are gaps between the frame and the mattress around cots sides or with saggy porta-cots.
- **Smoke free** – babies who are exposed to tobacco before or after birth have less drive to breathe with decreased arousal and are at greater risk of apnoea. Tobacco exposure before birth also increases risk of low birth weight and pre-– term birth which increases the risk of SUDI. All pregnant woman and mothers are advised and assisted to stop smoking and offered referral to smoking cessation services as outlined in the Ministry of Health's recommendations.
- **In their own safe space to sleep:**
    - placing baby in a baby bed with a firm and flat mattress and face clear of bedding;
    - they should not be able to fall, become wedged, or trapped in gaps between the frame and the mattress;
    - babies must not be placed on a pillow or couch, either alone or with anyone else;

- o make sure there is nothing in a baby bed that might cover baby’s face or lift their head – no pillows, toys, loose bedding or bumper pads;
- o make sure baby is kept at a comfortable temperature to avoid overheating;
- o no bed sharing – www.health.govt.nz/your-health/healthy-living/babies-and-toddlers/breastfeeding-O/getting-ready-breastfeed/your-breastfeeding-plan/skin-skin-contact-and-oxytocin

- **In the same room as a responsible carer** – babies who sleep in the same room as a responsible carer have reduced risk for SUDI.
- **Breastfed** – breastfed babies have reduced risk of infection, increased arousal, and reduced risk of SUDI.
- **Immunised** – immunisation protects babies from many childhood diseases and is also associated with a reduced risk of SUDI.

COMMENTS OF CORONER HESKETH

I. In spite of the safe sleeping arrangements available to infants aged 6 months to 2 years at the Paediatric Ward, this did not occur during Kayden's admission. I urge Kayden's parents to review all the safe sleep practices set out above and research the Ministry of Health's website for more information.

II. Furthermore, the evidence I have before me indicates there was confusion by some nursing staff about safe sleep practices within the Ward. On the one hand the portion of the Paediatric Nursing Assessment form records provision for a 'Safe Sleep Assessment' and relates to babies six months or under. On the other hand Hauora Tairāwhiti's guideline entitled 'Guideline: Safe Infant Sleeping -Birth to 1 Year' relates to the age range of infants up to twelve months. The admission form should be amended to include babies and infants up to 12 months of age.

III. Hauora Tairāwhiti has thorough and extensive guidelines in place for safe infant sleeping. The recognised risk factors for sudden unexplained death in infancy (SUDI) are well defined within the document. The guidelines are important and hospital staff should take the lead to ensure the safe sleep message is understood by parents whose children are admitted.

IV. Kayden was just outside the age range captured by these guidelines, however in view of his physical state of health he was vulnerable to the identified risk factors. Hauora Tairāwhiti had upgraded to CUBRO cots in 2018. Despite him being just over 12 months old it would have been more appropriate for Kayden to have had his own sleeping environment if that could have been achieved.

V. I have no doubt Kimberly meant well when keeping Kayden with her, it was what he was used to. In this sad case, no one was fully aware of how vulnerable Kayden was at the time. He had been showing all signs of improvement until his sudden and unexpected decline in the early hours of the morning of 10 September 2019. This is a tragic case of sudden unexpected death in infancy.

RECOMMENDATIONS OF CORONER HESKETH

I. I recommend the portion of the Paediatric Nursing Assessment form headed 'Safe Sleep Assessment -SUDI Prevention (Babies < 6mths) be amended to include (Babies and Infants < 12 months) to coincide with the Ministry of Health advice.

II. I recommend all staff working in the Paediatric Ward at Hauora Tairāwhiti review the 'Guideline: Safe Infant Sleeping-Birth to 1 Year' and adopt its principles when admitting babies and infants to the Ward. The messages set out in the guideline should be clearly expressed to the parents of any baby or infant who is admitted and who wish to stay over with their children.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any photographs taken of the deceased entered into evidence upon the grounds of personal privacy and decency.

Baby A [2021] NZCorC 98 (17 June 2021)

CIRCUMSTANCES

Baby A, nine months old, died on 17 July 2019 due to accidental asphyxia.

On 17 July 2019, Baby A was put to sleep on a bed inside a ‘sleep tent’ which had been erected by his parents. Later on, Baby A’s mother checked on him and found that he was hanging off the side of the bed, with his neck caught in the band that held the sleep tent to the mattress. Despite resuscitation efforts, Baby A could not be revived.

COMMENTS OF CORONER CUNNINGHAME

I. Tragically, [Baby A] died as a result of a sleep accessory being used with the best intentions by loving parents, who were unaware of the risks inherent in the use of such items for infants and young children.

II. I now turn to whether any specific recommendations pursuant to s 57A of the Act might be made in these findings. Recommendations may be made for the purpose of reducing the chances of further deaths occurring in similar circumstances. While many Coroners have commented on the importance of ensuring that babies have a safe sleeping environment, these findings are the first to concern a death arising from use of a sleep tent.

III. I have considered whether it would be feasible for me to recommend that sleep tents be sold with a warning that they are not to be used for infants, or whether design requirements for sleep tents could be mandated in order to reduce risk. I have concluded that consumer education is likely to have greater impact, for reasons which I set out below.

IV. I am not convinced that a voluntary product safety standard developed for sleep tents will sufficiently limit risk to children. There is no legal obligation on suppliers and manufacturers to implement any voluntary product safety standard requirements. Further, since they appear to be relatively uncommon in New Zealand stores, it seems likely that most consumers will acquire them from overseas. This may limit the impact of any implemented voluntary product safety standard because the onus is on suppliers to implement the standards at their discretion.

V. The case could be made for a mandatory product safety standard to be developed for sleeping tents. However, I am not convinced that regulations for sleeping tents would be made for sleeping tents given their comparative rareness in the New Zealand market compared to infant products to which mandatory standards do attach (e.g., toys and cots). In addition, I note protections exist under the Consumer Guarantees Act, although I recognise that individual consumers may face barriers in enforcing them.

VI. I have concluded that ensuring that parents are aware of up to date safe sleep advice is the most effective way to mitigate the risks inherent in using sleep tents. Organisations that work in the child and maternal health sector are best placed to disseminate this information.

VII. In preparing these recommendations, I consulted with NSPCS, in accordance with my obligations under s 57B of the Act. Fay Selby-Law, NSPCS general manager, advised that her organisation was also unfamiliar with the use of sleep tents.

VIII. Ms Selby-Law stated "[NSPCS agrees] that safe sleep messaging information is vital in preventing SUDI in both antenatal and postnatal contexts" and that [Baby A's] death is "a timely reminder for [NSPCS] to ensure safe sleep information is shared to whānau and families at every opportunity and every engagement by health professionals."

IX. Ms Selby-Law advised that NSPCS works with the Maternal and Child health sector, which includes the Ministry of Health, District Health Boards (DHBs) Wellchild Tamariki providers, professional organisations, tertiary providers, and teen parenting units.

X. NSPCS produces a suite of digital resources that support safe sleep and provide information about other risk and protective factors for SUDI. A funded regional coordination function supports localised delivery of key messaging, as well as region-specific approaches to support the demographic of the relevant locality. NSPCS regional coordinators hold the key connection between DHBs and the local safe sleep coordinators within the DHB system.

XI. I asked whether NSPCS could advise of any organisations that might most usefully be the subject of recommendations regarding safe sleep in relation to sleep tents. Having considered the long list of organisations with which NSPCS works, I consider it is more practical for me to limit any recommendations to the primary organisation, so that information might be disseminated through communication and training, rather than the Coroners' office to attempt to identify and contact all relevant maternal and child health organisations.

XII. Having considered the facts of this case, Ms Selby-Law advised that the NSPCS, with advice from the Expert Advisory Group considers:

> *Anything that is within or covers an infant bed other than bedding is dangerous and poses risk. That is our message.*

XIII. I accept the expert advice that sleep tents are not safe for use with infants. I also accept that there are benefits in ensuring that the safe sleep message is delivered in a clear and unambiguous way.

XIV. The safe sleep information provided by Plunket, which I referred to above, gives examples of specific items which might pose a risk to safe sleep. The difficulty with a list is that it can almost never be exhaustive, and readers may assume that an item not included on a list is safe. There is no evidence that users of sleep tents have been given a false sense of security because they are not included as dangerous items in safe sleep information.

XV. The sentence put forward by Ms Selby-Law at paragraph [XII] does not attempt to list particular items which may expose babies to the risk of harm. This means that the message is not complicated by the possibility of caregivers assuming that items not on the list might be safe to be used on their babies' bed.

XVI. Ms Selby-Law further advised that NSPCS will develop a specific training module for safe sleep which will be rolled out over the next two years as the organisation updates its current training for the sector and interested parties. This training module will focus on keeping all babies safe, every time they sleep. NSPCS will look at how culturally relevant education for parents and caregivers of Asian and other ethnicities can be implemented.

RECOMMENDATIONS OF CORONER CUNNINGHAME

Recommendation One

I. I recommend that the NSPCS training model continues to promote the clear, unambiguous message that anything that is within or covers an infant bed is dangerous and poses risk.

II. I recommend that organisations and individuals within the sector are encouraged to avoid listing items that may be dangerous for sleep, to avoid the risk of a caregiver assuming that an item not included in a list is safe to use.

Recommendation Two

III. NSPCS, in its role delivering education and information to the maternal and child health sector, is in a position to disseminate these findings to the organisations with which it works so that relevant staff (which might include health workers and social workers) can be aware that sleep tents may be used by some parents and caregivers.

IV. I therefore direct that NSPCS disseminates a copy of these findings to the organisations with which it works so that awareness of the use of sleep tents in New Zealand, and the risks they pose to infants, is shared among the sector.

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of any details that will allow the identification of Baby A and his family, including the town where Baby A lived, as well as any photographs taken of Baby A, his bed and his bedroom in the interests of personal privacy and decency.

Edmonds [2021] NZCorC 65 (23 April 2021)

CIRCUMSTANCES

Tareha Kaitoa Edmonds, aged three weeks and five days, died at Waiuku between 10 and 11 December 2017. The cause of death was sudden unexpected death in infancy.

On 10 December 2017, Tareha was co-sleeping with his parents. This was unusual as he had his own cot and bassinet. Tareha's parents were not sure why he was co-sleeping with them, and his mother had consumed three bottles of wine that evening.

RECOMMENDATIONS OF CORONER TETITAHA

I. There is substantial information available regarding the dangers of parents sleeping with infants. There were options for safe sleeping within this household including a cot next to the bed.

II. The consumption of 3 bottles of wine over 5 ½ hours equates to over 24 standard drinks - well in excess of legal limit to safely drive. The effects of alcohol upon a person's ability to make safe choices is well known. I can infer from the amount of alcohol consumed that this may have impaired a parent's judgement about where Tareha should have been placed to safely sleep.

III. Where there is impaired judgment due to alcohol, a sober parent or carer should be placed in charge of an infant. The possibility of accidental injury including suffocation is too high. This infant had a safe sleeping bed which he should have been placed into. His death may have been prevented if this child had been placed to sleep in his cot.

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

Rika [2021] NZCorC 77 (6 May 2021)

CIRCUMSTANCES

Steven Te Kau Rika, 3 days of age, died on 14 January 2019 at Tauranga of sudden unexplained death in infancy (SUDI).

COMMENTS OF CORONER BATES

I. There has been discussion in this Finding regarding Steven's sleeping arrangements, whether they were safe on 13-14 April 2019, and what may constitute a safe sleeping environment. I therefore take this opportunity to reinforce to the general public the message of safe sleeping for infants. In my view this message cannot be repeated too often. In the past coroners have made multiple recommendations to agencies to ensure the safe-sleeping message from health professionals is consistent, and appropriately given to new parents. It is an important message because it is effective in preventing infant deaths.

II. Ms Thompson-Rika's descriptions of Steven sleeping alone in his bassinette overnight on 13-14 January 2019 constitute a safe sleeping environment. Had Steven been sleeping in or on the bed shared by his parents, as initially stated to Police, that would have constituted an unsafe environment.

III. Considerable effort is being made in New Zealand to promote the message that every sleep for a baby should be a safe sleep. That is, for every sleep, babies up to one year of age should be put to sleep on their backs, in their own sleeping space (a firm, flat and level surface with no pillow), with their face clear. The challenge is to ensure the safe sleep message, and what research shows safe sleep means for a baby, is clear to all parents and caregivers. It must also be delivered in a way that is understood, and the importance of the message appreciated. I am satisfied that the safe sleep message was given to Steven's whānau and that this advice was usually followed by them.

IV. The Ministry of Health launched a SUDI prevention programme in August 2017, directed at significantly reducing the number of deaths of babies. A key focus of the programme is to target the two key modifiable risks of SUDI: exposure to tobacco smoke during pregnancy and unsafe bed-sharing. I have already addressed unsafe sleeping/bed sharing.

V. I record that some members of Steven's whānau, including Steven's mother, continued to smoke tobacco during and after the pregnancy. I have no doubt that Steven was exposed to tobacco smoke. It will remain unknown to what, if any, extent that exposure contributed to Steven's death. Exposure to tobacco smoke continues to be a known SUDI risk and should be avoided if at all possible. I make no additional comment on this point.

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

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

Salt [2021] NZCorC 101 (28 June 2021)

CIRCUMSTANCES

Vahnah-Faith Abigail Salt, aged 5 months, died on 16 June 2018 at Morningside, Auckland of sudden unexpected death of an infant (SUDI).

COMMENTS OF CORONER TETITAHA

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

II. These comments are directed to the Housing New Zealand/Kāinga Ora, Ministry of Health and Te Hapai Hauora National SUDI Prevention Coordination Service.

III. The circumstances of this case raise concerns about the environment the baby lived within and the advice and resources available to mothers and children in similar situations. There were up to 6 adults and a baby sharing this 4 bedroom home. Two of the adults shared the baby's bedroom. During the night it appears the

baby was required to co-sleep with her mother and/or grandmother. The baby and her whānau were also suffering from respiratory illnesses.

IV. Co-sleeping appeared the only option available to this mother and child in these circumstances. There were indications the mother could not afford her own home and required the assistance and support of whānau and friends to enable her to return to work to provide financially for her child.

V. Safe sleeping devices would have also been a challenge for this whānau. This infant may not have been able to comfortably fit within a bassinet, wahakura or pēpī pod. The dimensions of a pēpī pod are 40 cm W x 72 cm L x 15.5 cm H and a wahakura dimensions are 35 cm W x 70 cm L x 20-25 cm H. At her last visit to the GP her height was 67 cm and weight was 7.5 kgs. It is unlikely this child would have been able to comfortably sleep in either safe sleeping device. It is also unlikely to have fit in her overcrowded bedroom.

VI. This property was also described as a "damp" house. There was also what appeared to be an old fireplace in the bedroom which may have contributed to the rising damp within the bedroom. Coroners have previously commented upon the contribution of damp houses to the deaths of children. It is likely this baby's respiratory illnesses as well as the poor health of her whānau may have been due to the dampness of the house.

VII. In a previous decision, I sought advice from the Ministry of Health and Te Hāpai regarding safe sleeping advice to parents in similar circumstances. I am told there is no or little advice the Ministry are able to offer parents whom are co-sleeping in these circumstances. The Ministry was also aware that Māori and Pasifika babies can outgrow a pēpi pod/wahakura after 3 months.

VIII. The only actions that could have prevented the death of this child would have been improving her mothers' financial circumstances and better housing.

RECOMMENDATIONS OF CORONER TETITAHA

I. Housing New Zealand/Kaingā Ora have responded to a draft copy of my recommendations. They have now conducted an inspection of the property and provided a report. The report acknowledged there are some maintenance issues that could have or should have been addressed. It also provided a response to the above recommendation which is replicated below:

> On 12 April 2021, Kāinga Ora completed its annual tenancy inspection at the Property. The Kāinga Ora staff recorded that the Property was in average condition, with signs of wear and tear throughout the home, and signs of mould on the wallpaper and ceilings in the bedrooms.
>
> In order to address the mould concerns identified at the Property, Kāinga Ora has committed to stripping all wallpaper, having its specialist contractor treat and clean any mould, and repainting all walls and ceilings on an urgent basis. Kāinga Ora has also raised jobs for other redecoration and maintenance work, including replacement of all carpet and vinyl, and supplying the family with a skip bin to assist them with throwing away unwanted belongings inside the house and in the yard.
>
> In addition, Kāinga Ora has escalated the Property for an early Healthy Homes intervention. On 21 April 2021, the Healthy Homes Programme Team conducted an inspection with a view to identifying the scope of works required to

bring the Property up to Kāinga Ora's new Healthy Homes specifications. The work, which is scheduled to be completed by the end of May 2021, will include:

(a) replacing curtains and topping up underfloor and ceiling insulation;

(b) removal of trees blocking sunlight to the front and rear of the Property;

(c) upgrading the kitchen and bathroom extractor fans, and the range hood;

(d) upgrading the heat pump in the living room, and installing wall heaters in all bedrooms; and

(e) conducting a drainage report, and a roof report in order to detect leaks (if any), remove the chimney and clean all spouting.

Ms Salt and her family have advised us that they wish to stay in the Property, as it is their family home. We are therefore working with the family to arrange suitable alternative accommodation for them while the remedial works are being carried out.

We are confident that the actions and scope of works that Kāinga Ora is due to undertake at the Property, including treating the mould, bringing the Property within the Healthy Homes specifications, and completing all repairs and maintenance, will fully meet the Coroner's recommendation in the Provisional Findings.

II. Housing New Zealand/Kāinga Ora are thanked for their report and the preventative action now being taken.

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

IV. Housing New Zealand/Kāinga Ora should continue to investigate and remedy any defects causing dampness at the property located at 12 Malvern Road, Morningside Auckland and in any other Housing New Zealand properties as required by law. This recommendation shall improve the health of these occupants including preventing respiratory illnesses that may have contributed to this death.

V. The Ministry of Health/Te Hapai Hauora National SUDI Prevention Coordination Service consider reviewing the advice and resources available to vulnerable infants as part of their wider review of SUDI. I am aware a Ministry of Health Advisory Committee has been convened for the purposes of considering this issue. It is more appropriate that recommendations come from that process.

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

Van der Stap-Tungia [2021] NZCorC 67 (27 April 2021)

CIRCUMSTANCES

Hunter Eric Van der Stap-Tungia, aged two months, died on 20 April 2020 at Hamilton of sudden unexpected death in infancy (SUDI) associated with an unsafe sleeping environment.

On the night of 19 April 2020, Hunter was swaddled with both arms inside his blanket and placed into his parents' king size bed. His older brother, his mother and his father were also in the bed that night. These sleeping arrangements were common for the family. When Hunter's father got up for work, his mother realised Hunter was unresponsive.

COMMENTS OF CORONER LLEWELL

I. I have considered whether there are comments or recommendations I could usefully make that may reduce the chance of death in similar circumstances.

II. In these circumstances, I do not consider formal recommendations are necessary. However, I take this opportunity to highlight Ministry of Health / Manatū Hauora guidelines on safe sleeping which are attached to my findings. It is an ongoing challenge, and in the public interest to ensure this critical message is reinforced.

Make every sleep a safe sleep

Sudden unexpected death is a risk to babies until they are about 12 months old, but most deaths can be prevented. There are things that we can do to protect our babies.

Although for some babies the cause of death is never found, most deaths happen when the babies are sleeping in an unsafe way.

Always follow these safe-sleep routines for your baby and your baby's bed.

Make sure that your baby is safe

To keep your baby safe while sleeping, make sure:

- they always sleep on their back to keep their airways clear
- they are in their own bassinet, cot or other baby bed (e.g., pēpi-pod® or wahakura) - free from adults or children who might accidentally suffocate them
- they are put back in their own bed after feeding - don't fall asleep with them (to protect your back, feed your baby in a chair rather than in your bed)
- they have someone looking after them who is alert to their needs and free from alcohol or drugs
- they have clothing and bedding that keeps them at a comfortable temperature - one more layer of clothing than you would wear is enough; too many layers can make your baby hot and upset them
- they are in a room where the temperature is kept at 20°C.

You can check that your baby is warm but not too hot by feeling the back of their neck or their tummy (under the clothes). Baby should feel warm, but not hot or cold. Your baby will be comfortable when their hands and feet are a bit colder than their body.

Make sure that your baby's bed is safe

Baby's bed is safe when:

- it has a firm and flat mattress to keep your baby's airways open

- there are no gaps between the bed frame and the mattress that could trap or wedge your baby
- the gaps between the bars of baby's cot are between 50 mm and 95 mm - try to get one with the gaps closer to 50 mm if you can
- there is nothing in the bed that might cover your baby's face, lift their head or choke them - no pillows, toys, loose bedding, bumper pads or necklaces (including amber beads and 'teething' necklaces)
- baby has their feet close to the end of the bed, so they can't burrow under the blankets
- baby is in the same room as you or the person looking after them at night for their first 6 months of life.

It is never safe to put your baby to sleep in an adult bed, on a couch or on a chair.

If you choose to sleep in bed with your baby, put them in their own baby bed beside you - for example, a pēpi-pod® or wahakura. This may help to reduce the risk of your baby suffocating while they are asleep.

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

Vuna [2021] NZCorC 55 (1 April 2021)

CIRCUMSTANCES

Elizabeth Dianna Isabella Hepoto-Vailahi Vuna, 11 months old, died at Glenn Innes, Auckland on 3 November 2018. The cause of death was sudden and unexpected death in infancy.

As Elizabeth had outgrown her pēpī pod, she would co-sleep with her parents. Due to her whānau's financial position, there was not another bed available for her. Elizabeth's parents were aware of the safe sleeping messages but believed that they only applied for the first six months of life.

COMMENTS OF CORONER TETITAHA

I. There are areas that require comment regarding reducing or preventing SUDI deaths such as Baby Elizabeth's.

II. Infant death rates in 2017 were highest for the Pacific peoples and Māori ethnic groups (8.7 and 5.9 per 1000 live births, respectively). These rates were significantly higher than rates for the European or Other and Asian ethnic groups (3.4 and 3.7 per 1000 live births, respectively). Similar differences were seen in the previous 5 years.

III. From the evidence these parents did everything they could within their financial circumstances to ensure their child would thrive. This included stopping maternal smoking, obtaining and using the pēpi pod until the child outgrew it and breastfeeding.

IV. It was when Baby Elizabeth outgrew the pēpi pod her parents resorted to co-sleeping. There was no evidence of any other available bedding. Another whānau member was staying in the second bedroom

which I infer was to assist the parents financially. It is not difficult to infer that the parents and Baby Elizabeth were sleeping together in one bedroom on a mattress on the floor due to financial hardship.

V. The house was damp. Previous Coroners have commented upon the contribution of damp housing to toddler deaths. Baby Elizabeth suffered viral respiratory infections throughout her short life. There was evidence the baby may have aspirated noted by the attending paramedic. Other Coroners have concluded that the condition of the house could have contributed to death.

VI. I sought advice from the Ministry of Health and Te Hāpai regarding safe sleeping advice to parents in these circumstances. I am told there is no or little advice the Ministry are able to offer parents whom are co-sleeping in these circumstances. Children who are older than 6 months generally have a reduced risk of death due to co-sleeping. The Ministry was also aware that Māori and Pasifika babies can outgrow a pēpi pod/wahakura after 3 months.

VII. Based upon the advice received it is difficult to see how this death could have been avoided other than by improvement of Baby Elizabeth's parents' financial circumstances. There is little or no advice about safe co-sleeping that could be given to her parents. This whānau was living in a damp overcrowded home because this is what they could afford in Auckland/Tāmaki Makaurau. Co-sleeping was more probably than not the only option available to Baby Elizabeth. Her sleep position would appear to make little difference when sharing bedding with adults and another child.

VIII. It is redundant to advise parents who are experiencing financial hardship to go out and buy a cot or baby bed. There was little or no available advice or resources on safe sleeping that could have been given to these parents in their circumstances at that time that could have prevented the death of Baby Elizabeth.

IX. The only action that could have prevented the death of this child would have been improving her parents' financial circumstances by employment and better housing.

X. Further research into safe sleeping strategies and making sleep safe devices for larger babies under one year of age may also assist.

XI. These comments are directed to the Ministry of Health and Hāpai Te Hauora National SUDI Prevention Coordination Service.

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

Workplace

Tomlinson and Tomlinson [2021] NZCorC 99 (18 June 2021)

CIRCUMSTANCES

Nadine Ann Tomlinson, aged 33, and Angus Scott Tomlinson, aged 3, died on 30 September 2018 at the dam on Waihemo Downs, 1744 Dunback-Morrisons Road, near Palmerston of drowning.

The Tomlinsons lived on a farm, consisting of flat paddocks, hilly areas and a deep pond behind a dam. On 30 September 2018 Mrs Tomlinson and Angus went to collect a dead animal in a tractor. The tractor was not fitted with a secondary seat with a seatbelt for Angus so he would stand either behind or to the left-hand side of the driver.

In order to pick up the animal Mrs Tomlinson had to collect a trailer, which was parked near the dam on top of a hill. Having done so, Mrs Tomlinson drove the tractor and trailer down a steep slope towards a track next to the dam. The tractor sped up and despite her extensive driving experience, it appears that Mrs Tomlinson only applied the left-hand side brake pedal with the intention of turning right in the direction of the dead animal. However, this caused the tractor to sledge and continue tracking straight into the dam. The weight of the trailer may have influenced the braking capability of the tractor. The tractor and trailer entered the dam and became submerged. Mrs Tomlinson successfully removed the tractor door and escaped with Angus, however neither was able to reach the surface and drowned.

Later testing of the tractor revealed that when applying the single brake, the tractor would not stop easily and would lock up and sledge. However, the brakes worked very well when both wheels were braked.

RECOMMENDATIONS OF CORONER JOHNSON

I. I do not consider that I need to make any comments or recommendations pursuant to section 57A of the Coroners Act 2006. WorkSafe NZ concluded its report with a number of health and safety lessons for farmers, which I outline in full below and endorse:

> Farmers need to consider more carefully the risks they expose themselves and their children to. Sadly, many children are seriously injured or killed on New Zealand farms. Since the year 2000, WorkSafe have recorded 42 children and young people (0 - 18 years old) workplace fatalities in the agriculture sector.
>
> The agriculture sector has an opportunity to learn from this incident, passengers must not be carried in any vehicle that does not have sufficient seating, restraints or is not fit for the purpose for carrying passengers. By having unseated, unrestrained or people in positions in or on vehicles not designed to carry passengers, the hazards and risks associated with the use of any vehicle are significantly increased. These learnings are also applicable across other sectors where vehicles and young people are involved.
>
> In relation to the tractor braking systems, the farming industry should also take learnings from this investigation that braking distance and efficiency are greatly increased when both right and left brakes are applied correctly on a tractor.

Farm tracks need to be made as safe as possible and maintained.

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

Viju [2021] NZCorC 68 (28 April 2021)

CIRCUMSTANCES

Aldrich Viju, aged four, died on 18 November 2016 at a childcare centre in Auckland of the effects of hanging due to a ligature from a cord attached to a toy stilt.

Aldrich was found unconscious on a daycare slide with the cord from a plastic toy stilt around his neck and chest area.

Aldrich's death was the subject of an investigation by Worksafe. The resulting Worksafe report examined the childcare centre's level of compliance with legal obligations and concluded that there had been no failures or breaches. The report also noted that the most likely consequence of wearing stilts while going down a slide would be no, or only minor, injury. Similarly, wearing stilts in other circumstances, such as in the sandpit, would not present an obvious risk of strangulation.

After Aldrich's death, a separate incident occurred at an unrelated childcare centre, which resulted in injury. This incident was the subject of a separate Worksafe investigation, which concluded that there had been a breach of safety guidelines involving play equipment. This led to the publication of a Worksafe safety notice titled "Managing strangulation hazards on playground equipment".

RECOMMENDATIONS OF CORONER HERDSON

I. Having weighed the totality of the available evidence, I am satisfied that there is a need to make recommendations as contemplated by the Coroners Act 2006. The recommendations amount to an endorsement and reiteration of the safety alert published by Worksafe in 2017, titled "Managing strangulation hazards on playground equipment".

II. I recommend that:

  a. The safety alert contained on the Worksafe website titled "Managing strangulation hazards on playground equipment" dating from the time of its publication in 2017, is revisited by Worksafe for consideration of it being revised and/or republished by Worksafe.

  b. Worksafe notify the Ministry of Education of any revised and/or republished safety alert.

  c. A communication from the Coronial Services Unit is sent to Safekids Aotearoa to establish there is awareness about the safety alert as currently published (regardless of whether or not it is revised and/or republished at a later date).

Note: An order under section 74 of the Coroners Act 2006 prohibits the publication of photographs entered into evidence showing Aldrich in the interests of decency and personal privacy. It also prohibits the publication of any information that shows the names, and any names or particulars likely to lead to the identification of three individuals connected to the

childcare centre Aldrich was attending on the day of his death, on the grounds of interests of justice, decency and personal privacy.

OFFICE OF THE
CHIEF CORONER
OF NEW ZEALAND