IN THE HIGH COURT OF NIUE

Application No. IQ03/2019

IN THE MATTER OF	the Inquest Act 1964
AND	
IN THE MATTER OF	the death of LOVINI, DAVID NESS
BETWEEN	NAOMI LOVINI Applicant
AND	MINISTRY OF SOCIAL SERVICES, NIUE HEALTH DEPARTMENT AND NIUE FOOU HOSPITAL ON BEHALF OF THE GOVERNMENT OF NIUE Respondent

Judgment: 19 June 2020 (NZ Time)

CORONER'S DECISION OF CHIEF JUSTICE C T COXHEAD

Introduction

[1] Mr David Ness Lovini sadly passed away on 29 January 2019. His daughter, Naomi Lovini, has applied for an inquest into what she submits is a sudden and unexpected death of Mr David Lovini.

Procedural matters

[2] The Court apologies for the delay with the issuing of this decision. This application was filed in late February 2019. Upon receiving the application, I made directions on 8 March 2019 that persons wishing to file a response to assist the Court would need to file those responses within two months.

[3] The Health Department duly filed a response. However, for some reason that was not referred to me until 13 November 2019. I, then issued a further direction allowing the applicant time to file a reply. This was duly filed with the Court on 12 February 2020.

[4] The issuing of this decision was then further delayed when I requested from the Court staff a copy of the application. It has taken some time, longer than needed, for the Court to provide me with a copy of the application. In fact, the Court needed to ask the applicant for a copy of the application as it appears the Court no longer held a copy. I have also recently had to request from Court staff material of Coroner Hipa, the Police and the Hospital. None of this information was referred to me and that too has contributed to the delay in issuing this decision.

[5] I apologise on behalf of the staff of the Court who have failed to administer this application in a timely manner.

Ms Lovini's request for an inquiry

[6] Ms Naomi Lovini seeks a coronial inquest based on concerns regarding the treatment and poor health management of her father's condition over a two year period since 2017. She says that there was an error in the diagnosis and there was a lack of urgency given to the critical condition of her father after he was admitted to the hospital on 22 January 2019.

[7] In her very detailed and helpful submission, Ms Lovini sets out the sequence of events which she says ultimately led to the unexpected death of her father. These date back to 2017 when her father was admitted into the hospital as a result of being diagnosed with tuberculosis. Ms Lovini details the circumstances and events that led to her father being admitted to the hospital in 2017 and then lists her concerns. Her concerns can be summarised as:

Referral for commercial flights and medivac

(a) Referral for commercial flights were requested and issued too late. Are there other recent examples of commercial flights or medivac that left too late to save the lives of loved ones?;

(b) Are medivacs being left too late because of unrealistic expectations placed on doctors by external sources i.e. hospitals, governments and/or air ambulances?;

(c) What are the criteria or pre-requisites required for a patient to qualify for medivac and do these take into consideration the critical condition of patients?;

(d) Why was her father not put on a plane and sent to New Zealand where the hospitals have the equipment and tests necessary, which could have helped with her father's condition?; and

(e) Concerns with the process to submit a request for medivac.

Standard of health care offered on Niue

(a) General concern for the treatment offered on Niue;

(b) Given the lack of knowledge, experience and equipment available for certain conditions, should her father have been referred to New Zealand;

(c) What more can be done to ensure that the hospital meets the same or similar levels of standards as that offered in New Zealand or Australia?;

(d) Is the hospital appropriately staffed with enough qualified health professionals to oversee, run and administer the Niue healthcare system?;

(e) Does the healthcare budget fund for doctors and nurses to continuously retrain in new sciences, technologies, medical practices, medicines and other training, to refresh or upskill? All of which will help them be good practitioners when working in such a remote and isolated location; and

(f) Staff have advised that the hospital is not equipped to treat patients with lung conditions and knowing this, Mr Lovini should have been referred to specialists in New Zealand to receive proper medical care.

Facilities, equipment and maintenance

(a) The hospital not being adequately equipped to deal with her father's condition;

(b) Does the hospital have the right equipment available to care for patients?;

(c) What is the Health Department doing to ensure that equipment and facilities at the hospital are available, maintained or replaced? This includes having working beds, appropriate equipment to care for patients, nurse buttons in working order, dehumidifiers being made available, hygiene equipment maintained and life support equipment; and

(d) Are there lessons that can be learned from other sister Pacific Island nations?

[8] Ms Lovini is clear that her request for an inquiry touches on the processes, standards, facilities, equipment and maintenance that maybe hindering the exceptional doctors and nurses who try to keep the Niue community healthy and in no way does her requests reflect the personal attention, affection or interaction offered by the doctors and nurses at the hospital.

[9] The men and women who cared for her father showed nothing but kindness, support and generosity towards him. She has nothing but respect and gratitude for their hard work in

keeping him healthy. However, if these same doctors and nurses had the resources and authority to provide adequate treatment, she says her father may still be alive today.

[10] Ms Lovini hopes that through an inquest, answers to the many concerns raised can be provided and importantly improvements to the health care dealing with critical conditions, emergency and facilities will occur. It is her hope that a coronial inquest will result in much needed improvements to the health care systems, facilities on Niue and prevent harm and save lives.

Response of the Department of Health

[11] The response on behalf of the Health Department notes that Mr Lovini died due to pneumonia superimposed on COPD- emphysema.

[12] The submission details Mr Lovini and his condition and then records the hospital interactions with Mr Lovini since 3 of March 2015 up until January 2019.

[13] There is a letter from Dr Waimanu Pulu, Senior Medical Officer at the Niue Foou Hospital, to medical advisors in New Zealand. The response email notes that Niue certainly gave this patient every possible medical intervention and the treatment that he would have been given in New Zealand is exactly the same as was administered in Niue.

[14] Unfortunately, the Health Department's response does not address many of the concerns raised by Ms Lovini.

Discussion

[15] Ms Lovini raises genuine concerns with regards to the Niue Health Department. While the issues are hospital and health department related, given some of the aspects that touch on financial issues such as the health care budget fund for doctors and nurses and funding for equipment, maintenance and replacement, there is a wider government aspect to some of these concerns. In other words, while the hospital may seek to address some of the concerns that Ms Lovini raises at another level, the concerns will need to be addressed through Government funding.

[16] An inquest is limited in its purpose and does not extend to addressing Government funding and resourcing issues.

[17] The Niue Inquest Act 1964 requires that an inquest shall be held for the purpose of establishing the fact that a person has died, the identity of the deceased person and when, where, and how the death occurred. Section 15 of the Act states:

> **15 Purpose of inquest in respect of death**
>
> An inquest shall be held for the purpose of establishing –
>
> (a) The fact that a person has died;
>
> (b) The identity of the deceased person;
>
> (c) When, where, and how the death occurred.

[18] There is also a requirement that an inquest shall be held when a person appears to have died while in custody or it appears on reasonable cause that the person has died either a violent or unnatural death or has died a sudden death of which the cause is unknown.

[19] Mr Lovini's death report, states that Coroner Hipa was satisfied that the death occurred through natural means. Coroner Hipa considered information provided by the Police, the Medical Report and the Life Extinct form. Coroner Hipa was able to answer all of the matters covered in s 15 of the Act and, therefore correctly declined to hold an inquest.

[20] Having considered all the information now on file, I too am satisfied that Mr Lovini's death was through pneumonia superimposed due to chronic obstruction of airway disease. The identity of the deceased, when, where and how death occurred, are all known factors and an inquest is not required. If I was to grant an inquest, it could only be in terms of the matters noted in s 15 of the Act. In this case, the granting of an inquest would only be to establish how the death occurred, given that the fact of death and the identity of the deceased are not in dispute.

[21] In this situation Ms Lovini has raised some genuine concerns that have affected her and her family and may also affect other people of Niue. I would encourage the Health Department to give serious consideration to the matters raised by Ms Lovini and to reflect on their processes and procedures and determine whether there are steps that can be taken to improve systems. I am sure the Health Department will recognise that there is a need for

constant improvements so that Niue can remain confident in the services of the Niue Foou Hospital and the wider Health Department.

Decision

[22] The request for an inquest into Mr Lovini's death is declined.

Dated at Rotorua, Aotearoa/New Zealand this 19th day of June 2020

C T Coxhead
CHIEF JUSTICE